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CLERK, U.S. DISTRICT COURT
2004 MAR 15 P 3: 32
DISTRICT OF UTAH
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IN THE UNITED STATES COURT FOR THE DISTRICT OF UTAH

CENTRAL DIVISION

LAURIE JONES, Plaintiff, vs. JO ANNE BARNHART, Commissioner of Social Security, Defendant.	**OPINION AND ORDER** Case No. 2:02-CV-00899 PGC

Plaintiff Laurie Jones filed this action seeking judicial review of a final decision of the Commissioner of Social Security denying her application for Disability Insurance Benefits ("DIB") and Supplemental Security Income ("SSI") under Titles II and XVI of the Social Security Act.[1] The court has reviewed the materials carefully and determines that oral argument would not be helpful. For the reasons explained below, the court finds no valid basis for reversing the decision of the Commissioner and, accordingly, denies Ms. Jones' appeal.

[1] *See* 41 U.S.C. § § 401-433, 1381-1383f.

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Background

Medical Evidence

Ms. Jones was born on January 16, 1977, and alleges she became disabled on September 13, 1996, when she was 19 years old because of DeQuervain's tenosynovitis (an inflammation of tendons of the wrist), heart problems, and depression.

Medical records from Mountain View Hospital indicate Ms. Jones injured her right wrist at work on August 15, 1996; her right wrist x-rays were normal; she was diagnosed with DeQuervain's tenosynovitis and possible ganglion cyst of the right wrist.

On January 24, 1997, Ms. Jones underwent a surgical release without complication.

From March 10, 1997, to March 21, 1997, Ms. Jones underwent physical therapy. She showed improvement to normal limits, and her functional capacity was limited secondary to her complaints of wrist pain.

On March 24, 1997, Scott Jackson, M.D., who treated Ms. Jones following her surgery, noted that Ms. Jones had reached maximum medical improvement and that her "range of motion and strength are within normal limits." He felt "she may return to work activities as needed" and saw no need for an impairment rating.

On April 8, 1997, Curtis C. Johnson, M.D., diagnosed Ms. Jones with right dorsal carpal ganglion cyst. On April 24, 1997, the cyst was surgically removed without complication. Dr. Johnson's follow up notes indicated Ms. Jones was "doing well."

On June 20, 1997, Dr. Johnson reported a "completely resolved dorsal carpal ganglion with full motion and strength, but persistent symptoms with regard to the intersection on the right."

On June 24, 1997, Chun Hwang, M.D., examined Ms. Jones and determined that her heart was essentially within normal limits after the results of a 24-hour study. Dr. Hwang indicated Ms. Jones had an average heart rate of 100 b.p.m., with some episodes of 197 b.p.m., suggestive of an automatic focus origin. Dr. Hwang recommended an echocardiographic study and electrophysiological studies, which were normal. He treated Ms. Jones with medication.

On August 19, 1997, Dr. Johnson performed a right intersection release without complication. Dr. Johnson's follow up notes indicated Ms. Jones was "doing well." He released her to return to work with restrictions that she should lift no more than five to 10 pounds with her right hand.

On September 17, 1997, Dr. Johnson reported Ms. Jones "was doing very well" and had "excellent range of motion" of both her wrist and thumb. Dr. Johnson released Ms. Jones from his care and indicated she could "return to normal activity without restriction."

On November 11, 1997, Dr. Jackson noted some weakness in Ms. Jones' right thumb and referred her back to Dr. Johnson. On November 21, 1997, Dr. Johnson noted that, although Ms. Jones reported some pain and the inability to independently flex and extend her thumb, he did not believe she had an impairment in her thumb.

In December 1997, Alan L. Colledge, M.D., examined Ms. Jones and found that her 16 percent thumb impairment converted to a six percent hand impairment, which is equal to a five

percent upper extremity impairment and a three percent total body impairment. Dr. Colledge stated that Ms. Jones "really has regained most of her motion," she "can floor to waist lift 20 pounds with both hands, with the right she is limited to about 12 pounds[, and she] can lift and carry 15 pounds[,] with the right about 10 pounds."

On February 25, 1998, Richard Kirkham, Ph.D., performed a consultative psychological evaluation in conjunction with Ms. Jones' application for vocational services. Dr. Kirkham noted Ms. Jones graduated from high school with a 3.94 grade point average and that she was currently attending college. Ms. Jones stated she wanted vocational rehabilitation services to help her find a job that would accommodate her restrictions and help pay for school. She stated she owned her own car and had a valid driver's license. Ms. Jones' IQ test scores (full scale score of 107) placed her in the average range of intelligence, and her academic skills were at a comparable level. Dr. Kirkham diagnosed major depressive disorder, recommended psychotherapy to relieve her current sources of stress, and referred her to her primary care physician for antidepressant medicine.

On March 5, 1998, a physician from the Utah State Office of Rehabilitation, in conjunction with Ms. Jones' workers' compensation claim, completed a form indicating that Ms. Jones' major depression and wrist injury were disabling and permanent conditions.

On May 12, 1998, Dr. Johnson's follow up note indicated he had not seen Ms. Jones for "quite some time." He diagnosed "possible early recurrence of dorsal carpal ganglion cyst" and stated that Ms. Jones was using her right wrist in normal activity and "she may certainly continue

to do so." Dr. Johnson's notes through November 1998, indicate he treated Ms. Jones for a dog bite on her right hand and that she could continue to use her hands normally.

On September 21, 1998, Richard T. Knoebel, M.D., an orthopedic surgeon who performed a consultive medical examination, reported that Ms. Jones' right wrist/thumb tendinitis resulted in a three percent whole person impairment and that she was able to return to work at her prior job or "any job she wishes." Dr. Knoebel noted that Ms. Jones was prescribed non-steroidal anti-inflammatory medication for pain, but she stated she did not have the money to fill the prescription. Ms. Jones reported to Dr. Knoebel that she worked a temporary job one day in July 1997, that she had applied for other jobs, but had not been accepted; and that her off-work activities included quilting, housework, grocery shopping, walking and biking. Ms. Jones complained of right wrist and thumb pain when driving, gripping, writing, and lifting. On physical examination, Dr. Knoebel found that Ms. Jones had normal wrist range of motion and normal grip strength. Dr. Knoebel noted that:

> There is a definite lack of effort on Plaintiff's part and even resistance to passive range of motion [,] making the range of motion impairments strongly suspect with strong suggestion of poor effort. [Plaintiff] has no atrophy of her hand musculature or the forearm musculature. [Plaintiff] has good grip and pinch strength.

Dr. Knoebel recommended that Ms. Jones, who reportedly smoked one pack of cigarettes daily for the previous two years, stop smoking and use over-the counter analgesics and a right hand splint on an as-needed basis.

On November 4, 1998, Dr. Colledge reported that Ms. Jones should "listen to her body and try to find [jobs] that she feels she can do without having increased pain or difficultly."

In January 1999, Ms. Jones was treated at Utah Health Clinic for a dog bite and for a urinary tract infection.

On February 9, 1999, Dr. Hwang noted that an electrocardiogram revealed a grossly abnormal sinus tachycardia (rapid beating of the heart, conventionally applied to rates over 90 b.p.m. rate of 110-120 b.p.m.). Dr. Hwang prescribed Inderal and Lasix, and recommended she return in three months for recheck.

On February 26, 1999, Dr. Johnson noted Ms. Jones was doing "pretty well" and had full motion of her wrist.

On April 14, 1999, Dr. Colledge noted on follow-up that Ms. Jones reported right wrist pain after working for four hours. Dr. Colledge suggested anti-inflammatory medication and prescribed Naprosyn for discomfort. He recommended that she stay active and opined that "her work restriction should continue to be in force."

On June 3, 1999, Jonathan Ririe, Ph.D., performed a consultative psychological evaluation. Dr. Ririe noted that Ms. Jones had taken a year off of college; was involved in a Workers' Compensation lawsuit with her last employer; and was prescribed Prozac, which she stopped taking because she did not like being dependent on medication. Ms. Jones stated she had applied for "over 100 jobs," but was not hired because of restrictions resulting from her injury. Dr. Ririe stated that Ms. Jones did not appear to be suffering from clinical depression; he diagnosed depressed mood due to medical condition and he recommended the following:

> Continued participation in school and a return to her normal routine would likely be in her best interest. Participation in counseling, learning to deal with the limitations of her physical functioning, both due to her heart condition as well as to the tendinitis, may prove beneficial as well. It is likely that if she continued to

> return to her pervious level of functioning, including pursuing her educational goals, the depressed mood will lift.

Dr. Ririe opined that Ms. Jones could manage her income.

From April 15, 1999, to June 6, 1999, Ms. Jones was treated for pneumonia and asthmatic bronchitis. A physical examination performed on June 24, 1999, was unremarkable.

State agency physicians who reviewed the medical evidence on May 29, 1999, with supplemental rationale dated June 30, 1999, assessed Ms. Jones with the ability to lift up to 20 pounds occasionally by lifting more weight with her left hand; lift 10 pounds frequently; push and/or pull the same weights with her lower extremities; sit, stand, and/or walk, with normal breaks, about six hours in an eight-hour workday; frequently balance, stoop, knee, and crouch; occasionally climb; never crawl; and limited to no frequent use of her right wrist for hand controls.

State agency psychological consultants reviewed the medical evidence and completed a Psychological Review Technique Review Form (PRTF) with mental Residual Functional Capacity ("RFC") assessment, dated June 25, 1999, and August 9, 1999, with technical rationale dated June 30, 1999, and supplemental rationale dated August 25, 1999. The PRTF indicated that Ms. Jones had an affective disorder resulting in slight restriction of activities of daily living; moderate difficulties in maintaining social functioning; and seldom caused deficiencies of concentration, persistence or pace. The mental RFC assessment indicated that Ms. Jones was capable of 1-2 step instructions; was moderately limited in the ability to understand, remember and carry out detailed instructions; could maintain attention and concentration for extended periods; could complete a normal workday and workweek without interruptions from

psychologically based symptoms and perform at a consistent pace without an unreasonable number and length of rest periods; could accept instructions and respond appropriately to criticism from supervisors; and could set realistic goals or make plans independently of others.

On June 5, 1999, Ms. Jones was treated at the emergency room for asthmatic bronchitis and left lower lobe pneumonia.

In August 1999, Ms. Jones received follow up treatment for bronchitis.

On September 8, 1999, Ms. Jones presented to Utah Valley Regional Medical Center with complaints of a rapid heartbeat. An ECG was normal. She was diagnosed with arrhythmia (loss or abnormality of rhythm; an irregularity of the heartbeat) and a history of inappropriate sinus tachycardia. She reported she stopped taking Lopressor because it gave her a bellyache and nausea. Her medications were adjusted.

On December 1, 1999, Ms. Jones was hospitalized at Utah Valley Regional Medical Center for cardiac dysrhythmia (defective heart rhythm). Electrophysiology testing showed arrhythmia without structural heart disease, and an ECG showed sinus bardycardia (slowness of the heartbeat, usually under 50 beats per minute), otherwise normal. She was discharged the following day and advised to take one aspirin daily.

In January and February 2000, Ms. Jones received follow up treatment for irregular heartbeat.

On February 15, 2000, Brian G. Crandall, M.D., performed a cardiac evaluation at the request of David V. Collins, M.D.. A physical examination was essentially within normal limits; Dr. Crandall diagnosed inappropriate sinus tachycardia and recommended a beta blocker.

On March 22, 2000, Joseph K. Miner, M.D., completed a cardiac functional capacity questionnaire which indicated that Ms. Jones' symptoms resulted in marked limitations of physical anxiety during tachycardia attacks. Dr. Miner concluded that her physical symptoms caused depression and anxiety; that she was capable of low stress jobs; that her reported cardiac symptoms were frequently severe enough to interfere with attention and concentration; and that her prognosis was poor without total ablation of natural pacemaker and insertion of an artificial pacemaker. Dr. Miner opined that Ms. Jones, during an eight-hour workday, could stand and/or walk less than two hours; sit about two hours. He concluded her ability to walk without severe pain was variable, depending upon the frequency of her attacks, and that she would need to take several (three to four) unscheduled breaks, up to several hours at a time. Dr. Miner estimated that Ms. Jones would likely be absent from work as a result of impairments or treatment more than four times a month.

In a letter dated May 3, 2000, Lunn Hunter Anderson, M.D., reviewed Ms. Jones' medical records and identified three impairments: paroxysmal tachycardia (recurrent attacks of tachycardia, usually with abrupt onset and termination), tendinitis of the right forearm and wrist, and depression. Dr. Anderson opined that Ms. Jones' impairments did not meet or equal the severity of any listed impairment, and that Ms. Jones' impairments should not prevent any activity short of extremely heavy lifting and carrying.

Ms. Jones' Testimony

Ms. Jones testified that she completed the twelfth grade; attended one year of college; and worked in the past as a packager, garment sewer/inspector, assembly worker, and drywall

cleaner. She also testified that she was single and lived in a single-family home with her parents, two brothers, and one sister. She attended college in 1997 and 1998 and she finished five courses with average grades. She attempted to return to school in January 2000, but quit because she was getting too tired and dizzy.

Ms. Jones further testified she last worked in the spring of 1998 – for four hours – and that she had two temporary jobs in 1997. She received Workers' Compensation benefits in 1997 for temporary total disability after three surgeries on her wrist, and she received a lump sum Workers' Compensation settlement in January 1999. She received unemployment insurance benefits from December 1997 through April 1998 and applied for jobs during that time. Finally, she testified she was ready, willing, and able to work.

Vocational Expert Testimony

At the hearing, a vocational expert, Alan Heal, classified Ms. Jones' past work as follows: a packager – unskilled and requiring medium exertion; a garment inspector and sewing machine operator – semi-skilled and requiring light exertion.

In the first of several hypothetical questions, Mr. Heal was asked to assume an individual of Ms. Jones' age, education, and past work experience; with the following RFC:

> [C]apable of performing work at the light exertional classification, but has exceptional limitations which prevent [] standing or walking with normal breaks in an eight-hour workday for [] more than two hours. Can perform pushing and pulling with the right upper extremity no more than occasionally and can lift no more than 10 pounds with the right extremity. Can perform no more than frequent reaching or handling with the right extremity. Should avoid moving mechanical parts[] and other hazards. Can perform no overhead reaching with the right hand, arm. There's mental limitations which prevent no more frequent understanding, remembering and carrying out of detailed instructions, maintain a production rate schedule or working under close supervision of supervisors.

Mr. Heal responded that such an individual could not perform Ms. Jones' past relevant work, but could perform various unskilled, light jobs. He provided the Dictionary of Occupational Title (DOT) numbers and the numbers of such jobs available in the national economy: Cashier II, 1,000,000 jobs; Information Clerk, 50,000 jobs; Storage Rental Clerk, 40,000 jobs.

When asked to assume that the same individual could perform only sedentary jobs, Mr. Heal identified the following unskilled, sedentary jobs, and he provided the DOT numbers and the numbers of such jobs available in the national economy: Surveillance System Monitor, 85,000 jobs; Telephone Quotation Clerk, 32,000 jobs; and Dowel Inspector, 20,000 jobs.

Mr. Heal testified there were no jobs available, at either the sedentary or light levels, for a person who needed to lay down three hours out of an eight-hour workday, could not complete a normal workday or could not complete tasks 25 percent of the time.

Administrative Decision

The ALJ issued a decision on August 8, 2000, concluding Ms. Jones was not disabled within the meaning of the Act. The ALJ found that while Ms. Jones' paroxysmal tachycardia, tendinitis in her right wrist and forearm, and depression were severe impairments, they did not equal an impairment or a combination of impairments in the Listings.[2] He determined that she retained the RFC to perform a range of light work activities. Based upon the testimony of a vocational expert, the ALJ determined that while Ms. Jones could not perform her past relevant work and had no transferrable skills, she could nonetheless perform other work existing in

[2] *See* 20 C.F.R. part 404, subpt. P, app.1

significant numbers in the national economy. The ALJ concluded that Ms. Jones was not disabled, as defined in the Act.

Evidence Submitted to the Appeals Council

After the ALJ hearing, Ms. Jones submitted additional medical evidence to the Appeals Council. In a treatment note dated March 15, 2000, Steven C. Horton, M.D., diagnosed inappropriate sinus tachycardia and noted:

> The patient is having a multitude of symptoms on the Sectral. There does appear to be a strong element of an emotional overlay here and her symptoms are much more severe than what would normally [be] predicted by medicines. However, she is adamant she wants to discontinue it and she does not wish to try a reduced dose. Therefore I have given her instructions to reduce her dose in half for several days and then to discontinue the medicine altogether. Given the multitude of medicines that she has been tried on and the relatively benign nature of her "arrhythmia" I have not suggested any further new medicines.

A heart rate diary indicated that Ms. Jones engaged in various activities with either no resulting symptoms or varying symptoms, such as fatigue, palpitations, pain, or light-headedness, without syncope.

An undated handwritten note indicated Ms. Jones received a Workers' Compensation settlement of $7,947.38 in January 1999.

On May 22, 2000, James R. Ravenaugh, M.D., Utah Heart Clinic, noted Ms. Jones was doing reasonably well. While she experienced occasional episodes of tachyarrhythmias (any disturbance of the heart's rhythm, regular or irregular, resulting by convention in a rate over 100 beats per minute during physical examination) with associated chest pain and lightheadedness, she had not experienced syncopal episodes. She was reluctant to proceed with high dose beta

blockade and permanent pacemaker placement. Dr. Ravenaugh placed her on a trial of very low dose of Lopressor.

On July 6, 2000, Dr. Crandall noted Ms. Jones reported she was not doing well on Lopressor. She continued to report significant symptoms, but she did not want to take any medications for a six-month period. Dr. Crandall recommended she refrain from doing so and return in six-months for follow-up.

Administrative Proceedings

Ms. Jones' applications were denied initially and upon reconsideration. After a hearing, an Administrative Law Judge ("ALJ") issued a decision on August 9, 2000, finding that Ms. Jones was not disabled within the meaning of the Act. The Appeals Council determined that there was no basis for changing the ALJ's final administrative decision. Thus, the decision of the ALJ became the final decision of the Commissioner.[3] Ms. Jones has exhausted her administrative remedies and this case is now ripe for judicial review under section 205(g) of the Act.[4]

Standard of Review

The court reviews the Commissioner's decision to determine whether substantial evidence in the record as a whole supports the factual findings and whether the correct legal standards were applied.[5] Substantial evidence is "such relevant evidence as a reasonable mind

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[3] *See* C.F.R. §§ 404.981, 416.1581 (2002).

[4] 42 U.S.C. § 405(g).

[5] *Castellano v. Secretary of Health & Human Services,* 26 F.3d 1027, 1028 (10th Cir. 1994); *Hamilton v. Secretary of Health & Human Services,* 961 F.2d 1495, 1497-98 (10th Cir.

might accept as adequate to support a conclusion."[6] The Court may neither "reweigh the evidence nor substitute [its] discretion for that of the [ALJ]."[7] Where the evidence as a whole can support either the agency's decision or an award of benefits, the agency's decision must be affirmed.[8] However, the Commissioner's decision is subject to reversal if the incorrect legal standards were applied.[9]

Discussion

Ms. Jones argues that the ALJ erred by concluding that her mental and physical impairments did not rise to the level of a Listing impairment and by concluding that work existed in the national economy that she could perform. Neither argument has merit.

I. Listing Impairment

Ms. Jones argues that the ALJ erred by finding that her impairments did not meet or equal a listing impairment. Specifically, she argues that her impairments equaled Listing 4.05, relating to cardiac problems, and Listing 12.04, relating to affective disorders. The burden of establishing a disability under the Listings is on the claimant.[10] To demonstrate an impairment meets or equals a listing impairment, the claimant must show that her impairments met or equaled in

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1992).

[6] *Hamilton*, 961 F.2d at 1498.

[7] *White v. Massanari*, 271 F.3d 1256, 1257 (10th Cir. 2001).

[8] *See Ellison v. Sullivan*, 929 F.2d 534, 536 (10th Cir. 1990).

[9] *See Bernal v. Bowen*, 851 F.2d 297, 299 (10th Cir. 1988).

[10] *Bernal,* 851 F.2d at 300.

severity all of the specified medical criteria.[11] Here, Ms. Jones' treating and examining physicians and her own activities all support the ALJ's conclusions that her impairments did not rise to the level of a Listing impairment.

A. Treating physicians

An ALJ may properly rely on the opinions of reviewing physicians when determining whether the claimant's ailments meet or equal a Listing impairment.[12] In particular, the findings of treating physicians are entitled to significant weight.[13] However, none of Ms. Jones' treating physicians found that her physical impairments resulted in functional limitations precluding all work activity for any consecutive twelve month period after September 13, 1996, her alleged onset of disability date.

In March 1997, after Ms. Jones' first surgical release, Dr. Jackson found that Ms. Jones' right wrist range of motion and strength were within normal limits. Dr. Jackson allowed her to return to work activities as needed. In June 1997, after her ganglion cyst was removed, Dr. Johnson found Ms. Jones had full motion and strength in her right hand. In September 1997, after a right intersection release, Dr. Johnson released Ms. Jones to "return to normal activity without restriction." In December 1997, Dr. Colledge found that Ms. Jones could lift 20 pounds floor to waist with both hands.

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[11] *See Sullivan v. Zebley,* 493 U.S. 521, 530-531 (199).

[12] *Ostronski v. Chater*, 94 F.3d 413 (8th Cir. 1996).

[13] *See Bean v. Chater,* 77 F.3d 1210, 1214 (10th Cir. 1995); *see also* 20 C.F.R. § 404.1527, 416.927.

A treating physician's opinion about the nature and severity of a claimant's impairments carries weight, but only if it is supported by diagnostic techniques and is consistent with other evidence in the record.[14] The ALJ discounted the limitations contained in Ms. Jones' cardiac assessment because it conflicted with every other treatment notes in the record. In addition, the cardiac assessment conflicted with the opinion of the medical expert who reviewed the medical evidence as recently as in May 2000. None of the medical evidence from Dr. Hwang and the other physicians who treated Ms. Jones' sinus tachycardia indicated this impairment prevented her from any work for a period of 12 consecutive months. Because every treating physician who worked with Ms. Jones recommended she return to work, the ALJ's conclusions were more than substantially supported by the evidence in the record.

B. Examining and Consulting Physicians

An ALJ also may rely on the opinions of examining or consulting physicians to determine the severity of a claimant's impairments.[15] Dr. Knoebel, an orthopedic surgeon who performed a consultative physical examination, found that Ms. Jones had a normal wrist range of motion and normal grip strength and that she could return to her prior job or any work she wished. Also, the findings of fact made by State agency medical and psychological consultants regarding the nature and severity of an individual's impairment are treated as expert opinions and entitled to weight. [16] Here, the state agency physician assessments also concluded that Ms. Jones retained the RFC for

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[14] *See Bean*, 77 F.3d at 1214.

[15] *See Hamilton,* 961 F.2d at 1498.

[16] *See* 20 C.F.R.§ 404.1527 (f)(2), 416.928(f)(2); SSR-96-6p.

light work activities. In short, all of the consultative and examining physicians supported the ALJ's conclusions regarding Ms. Jones' impairments.

C. Other Medical Evidence

Other medical evidence supported the ALJ's conclusion that while Ms. Jones' mental impairment was severe, it was not disabling. In February 1998, Dr. Kirkham determined that Ms. Jones had a depressive disorder, but did not find any disabling functional limitations. Specifically, he referred her to a primary care physician for antidepressant medication and recommended psychotherapy. In June 1999, Dr. Ririe found in June 1999 that Ms. Jones did not appear to be clinically depressed; he diagnosed a depressed mood due to her medical condition and recommended she return to school and a normal routine. In May 2000, Dr. Hunter opined that Ms. Jones did not have a significant (or even a much less disabling) mental impairment.

A lack of significant and ongoing medical treatment can discredit claims of disabling depressive symptoms.[17] The ALJ reviewed the objective medical evidence of Ms. Jones' mental impairments and found that the medical record contained no specific evidence of treatment for her allegations of disabling depression. The only evidence of treatment for a mental impairment was Ms. Jones' statement she was prescribed Prozac which she chose not to take because she did not want to be dependent on medication. This decision not to continue on Prozac, despite physicians's recommendations, undercuts her claims that she was "disabled." Again, the ALJ's conclusions are well-supported by Ms. Jones' own choices.

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[17] *See Musgrave v. Sullivan,* 966 F.2d 1371, 1376 (10th Cir. 1992); *see also Luna v. Bowen,* 834 F.2d 161, 163 (10th Cir. 1987).

D. Non-medical evidence

The nonmedical evidence also supports the ALJ's conclusions. Ms. Jones argues that the worker's compensation decision labeling her "disabled" should bind the Social Security agency. Ms. Jones received temporary benefits and a lump sum settlement as a result of her Worker's Compensation claim. In conjunction with the Worker's Compensation claim examination, however, an orthopedist examined her and determined that Ms. Jones exhibited a lack of effort during range of motion testing. This court's review is limited by the record created below, and the record evidence overwhelmingly indicates that Ms. Jones did not suffer any physical or mental impairments significant enough to rise to the level of a Listing impairment.

E. Credibility

The ALJ acknowledged that Ms. Jones' impairments would produce pain and other symptoms. In determining Ms. Jones' credibility, however, the ALJ reviewed all the evidence in the record, both medical and nonmedical, and determined she was not entirely credible. Ms. Jones testified she applied for work and received unemployment insurance benefits after the alleged onset of disability. This decision to receive unemployment benefits – which implies she was willing to work – during the time Ms. Jones was allegedly "disabled" further supports the ALJ's conclusions.[18]

Ms. Jones' life activities also conflicted with her allegations of disabling impairments. She testified she attended college for two semesters, applied for over 100 jobs, worked temporary

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[18] *See Johnson v. Chater*, 108 F.3d 178, 180 (8th Cir. 1997); *see also Decker v. Secretary of Health & Human Servs.*, 86 F.3d 953, 955 (10th Cir. 1996).

jobs, traveled five or six times during the summer, and had no problems taking care of her personal needs. Notably the ultimate determination of whether a claimant is "disabled" is a decision reserved for the Commissioner.[19] The court's limited role is to review reasonableness of that conclusion. In this case, based on all of the evidence in the record, the ALJ reasonably concluded that Ms. Jones' impairments did not rise to the level of a Listing impairment.

II. Work in the National Economy

Ms. Jones argues that ALJ's decision not to accept certain of the vocational expert's responses was error. However, an ALJ does not have to accept the limitations established in a hypothetical question when the question was based on limitations that the ALJ did not find credible.[20] As discussed above, the ALJ (like the physicians) did not find Ms. Jones' claims credible. Ms. Jones argued she needed unscheduled breaks. This claim, however, was based primarily on her own subjective complaints, and no medical evidence supported this limitation.

The ALJ presented the VE with a hypothetical that accurately reflected Ms. Jones age, work history, education, work history, and RFC. Based on that hypothetical, the VE identified various jobs existing in significant numbers in the national economy that could be performed.

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[19] *See* 20 C.F.R. sec. 404.1527Ie), 416.927Ie).

[20] *See Bean,* 77 F.3d at 1214.

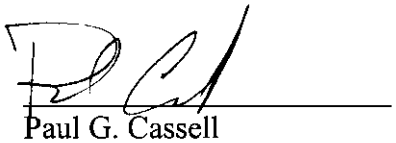
Based on that testimony, the ALJ properly concluded that Ms. Jones was not disabled within the meaning of the Act. The ALJ's findings are well-supported by substantial evidence in the record.

Conclusion

The court DENIES Ms. Jones' Petition for Review, affirms the Commissioner's decision, and dismisses this case. The Clerk of the Court is directed to CLOSE THIS CASE.

DATED this 15th day of March, 2004.

BY THE COURT:



Paul G. Cassell
United States District Judge

tsh

United States District Court
for the
District of Utah
March 16, 2004

* * CERTIFICATE OF SERVICE OF CLERK * *

Re: 2:02-cv-00899

True and correct copies of the attached were either mailed, faxed or e-mailed by the clerk to the following:

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