

IN THE UNITED STATES DISTRICT COURT  
FOR THE WESTERN DISTRICT OF VIRGINIA  
HARRISONBURG DIVISION

KATHY S. HOOVER,	)	CASE NO. 5:11CV00106
	)	
Plaintiff,	)	
v.	)	<u>REPORT AND RECOMMENDATION</u>
	)	
MICHAEL J. ASTRUE,	)	
Commissioner of Social Security,	)	
	)	By: B. Waugh Crigler
Defendant.	)	U. S. Magistrate Judge

This challenge to a final decision of the Commissioner which denied plaintiff's April 21, 2009 protectively-filed applications for a period of disability and disability insurance benefits under the Social Security Act ("Act"), as amended, 42 U.S.C. §§ 416, 423, and 1381, et seq., is before this court under authority of 28 U.S.C. § 636(b)(1)(B) to render to the presiding District Judge a report setting forth appropriate findings, conclusions, and recommendations for the disposition of the case. The question presented is whether the Commissioner's final decision is supported by substantial evidence. 42 U.S.C. § 405(g). For the reasons that follow, the undersigned will RECOMMEND that an Order enter DENYING the Commissioner's motion for summary judgment, GRANTING the plaintiff's motion for summary judgment, and RECOMMENDING this case to the Commissioner to calculate and pay benefits.

In a decision dated May 27, 2011, an Administrative Law Judge ("Law Judge") found that plaintiff had not engaged in substantial gainful activity since September 1, 2008, her alleged date of disability onset.<sup>1</sup> (R. 12.) The Law Judge determined plaintiff's degenerative changes of the cervical spine with radiculopathy, tricompartment arthrosis and a tear of the medial meniscus

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<sup>1</sup> Disability is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment or combination of impairments that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. 42 U.S.C. § 1382c(a)(3)(A).

of the left knee, acromioclavicular joint hypertrophy and some morphology suggesting extrinsic impingement with associated minimal distal infraspinatus tendinosis of the right shoulder, and fibromyalgia were severe impairments, but that her hypertension, bipolar disorder, and marijuana dependence were not severe impairments. (R. 12-13.) He also concluded that, through the date of the hearing, plaintiff did not suffer an impairment or combination of impairments which met or equaled a listed impairment. (R. 13-14.) Further, the Law Judge found that plaintiff possessed the residual functional capacity (“RFC”) to perform light work except that she could stand and/or walk for two hours in an eight-hour workday, sit for six hours in an eight-hour workday, is limited with respect to pushing and pulling with the lower extremities, could climb ramps and stairs, kneel, stop, and crawl occasionally, and could never climb ladders, ropes, and scaffolds or balance.<sup>2</sup> (R. 14.)

The Law Judge relied on portions of the testimony of J. Herbert Pearis, a vocational expert (“VE”), which was in response to questions premised on the Law Judge’s RFC finding. (R. 16-17, 37-40.) Based on this testimony, the Law Judge determined that plaintiff was able to perform her past relevant work as a call center operator, as it is generally performed in the national economy, and could also perform other jobs existing in the national economy. (R. 16-17, 38-40). The Law Judge found plaintiff not disabled under the Act.

Plaintiff appealed the Law Judge’s May 27, 2011 decision to the Appeals Council. (R. 1-9.) In its September 7, 2011 decision, the Appeals Council found no basis to review the Law Judge’s decision. (R. 1-2.) The Appeals Council denied review and adopted the Law Judge’s decision as the final decision of the Commissioner. *Id.* This action ensued and briefs were filed.

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<sup>2</sup> Light work is defined in 20 C.F.R. § 404.1567(b) as involving lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. A job in this category requires a good deal of walking or standing, or when it involves sitting most of the time, some pushing and pulling of arm or leg controls.

The Commissioner is charged with evaluating the medical evidence and assessing symptoms, signs, and medical findings to determine the functional capacity of the claimant. *Hays v. Sullivan*, 907 F.2d 1453, 1456 (4th Cir. 1990); *Shively v. Heckler*, 739 F.2d 987 (4th Cir. 1984). The regulations grant some latitude to the Commissioner in resolving conflicts or inconsistencies in the evidence, which the court is to review for clear error or lack of substantial evidentiary support. *Craig v. Chater*, 76 F.3d 585, 589-590 (4th Cir. 1996). In all, if the Commissioner's resolution of the conflicts in the evidence is supported by substantial evidence, the court is to affirm the Commissioner's final decision. *Laws v. Celebrezze*, 368 F.2d 640, 642 (4th Cir. 1966). Substantial evidence is defined as evidence, "which reasoning mind would accept as sufficient to support a particular conclusion. It consists of more than a mere scintilla of evidence but may be somewhat less than preponderance." *Id.* at 642.

Plaintiff asserts that the Law Judge erred in finding that bipolar disorder was not a serve impairment, improperly assessed her credibility, including her complaints of pain, and that the finding that plaintiff was capable of light work is not supported by substantial evidence. (Dkt. No. 17, at 3-5.)

Plaintiff claims that she became disabled on September 1, 2008, but the earliest medical record after the alleged date of onset is with her primary care physician, Alan J. Morgan, M.D., on November 7, 2008. (R. 296-299.) Dr. Morgan noted that the plaintiff had fatigue, malaise, heartburn, joint pain, back pain, neck pain, and depression, but denied headaches and memory difficulties. (R. 297.) On examination, she reported marked to moderate tenderness of the cervical and thoracic spines, lower lumbar spine, SI joint areas, trapezius, medial knees, ankles, left clavicle, and anterior pelvis. (R. 298.) However, she reported no tenderness in her elbows and only minimal paraspinal muscle tenderness. (*Id.*) Plaintiff was taking amoxicillin, atenolol,

cipro, imitrex, lexapro, lisinopril-hydrochlorothiazide, lithium, prilosec, and vicodin for her depression, fibromyalgia, gastroesophageal reflux, hypertension, migraines, and osteoarthritis of the spine. (R. 296.) Plaintiff returned to Dr. Morgan in April 2009, reporting that her pain medications were not helping and that she was unable to afford her effexor. (R. 300.) Dr. Morgan discontinued all of her medications with the exception of amitriptyline and meloxicam and referred the plaintiff to the free clinic. (R. 301.) In July 2009, the Harrisonburg-Rockingham Free Clinic sent plaintiff for an MRI of her left knee, which showed both tricompartment arthrosis, which was most severe at the patellofemoral joint and was associated with lateral subluxation and tilt, and a large cleavage tear of the medial meniscus with a parameniscal cyst posteriorly. (R. 321.)

On July 22, 2009 the plaintiff saw an orthopedic, Gregory Hardigree, M.D., who noted that she had gross lateral subluxation of the patella, osteophytes in the medial aspect of the intercondylar groove, central osteophytes off both femoral condyles as well as the medial and lateral aspects of the condyles, an interosseous ganglion in the proximal tibia, and a meniscal tear. (R. 328.) Dr. Hardigree opined both that plaintiff would need a knee replacement and also that limited surgery likely would not benefit her. (R. 329.) He recommended viscosupplementation<sup>3</sup> as a potential temporary fix, and stated that he did “not think there is any way she can do a job that is not completely sit down.” (R. 329.)

Plaintiff underwent an MRI of her cervical spine on August 26, 2009, which showed “multilevel degenerative spondylosis in a patient with developmentally fairly short cervical pedicles leading to narrowing.” (R. 407.) The free clinic referred plaintiff to an orthopedist, Olumide Danisa, M.D. On September 2, 2009, Dr. Danisa examined the plaintiff and found her

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<sup>3</sup> Viscosupplementation is a procedure that treats symptomatic osteoarthritis by injecting hyaluronic acid, a substance naturally occurring in joints, into the patient’s knees to act as a lubricant and shock absorber .

“right shoulder showing obvious weakness in the shoulder, difficulty to abduct and externally rotate.” (R. 379.) Dr. Danisa noted that the MRI “shows multiple-level degenerative disease; however, there does not seem to be significant stenosis or compression which would account for her pathology.” (R. 379.) Because of this inconsistency, Dr. Danisa referred the plaintiff for an MRI of her shoulder and a nerve conduction study of her upper extremity. (R. 380.) The MRI showed AC joint hypertrophy and some acromial morphology suggesting an extrinsic impingement and associated minimal distal infraspinatus tendinosis. (R. 360.) The nerve conduction study, which was not performed until October 20, 2009, was abnormal, showing “an acute right cervical polyradiculopathy primarily affecting the C5, C6, and to a lesser degree C7 nerve roots and a mild, chronic right median mononeuropathy (i.e. carpal tunnel syndrome) at the wrist with no features of active denervation.” (R. 370.)

Prior to the nerve conduction study, on October 8, 2009, plaintiff reported to the emergency room of Rockingham Memorial Hospital (RMH) with depression. (R. 340.) Mark Bowser, LCSW, noted that she had not been prescribed psychiatric medications for some time and opined that her current global assessment of functioning (GAF) was a 41, although it may have been as high as 58 in the previous year.<sup>4</sup> (R. 354, 357.) On October 9, 2009, James Styron, M.D., admitted the plaintiff to the hospital, noting that her mood was depressed, her affect was slightly labile with tearfulness, her insight is fair, her judgment is poor, her thought content is

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<sup>4</sup> The GAF is a numeric scale ranging from zero to one hundred used to rate social, occupational and psychological functioning “on a hypothetical continuum of mental health-illness.” American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 32 (4th ed. 1994) (DSM-IV). A GAF of 51 to 60 indicates the individual has “[m]oderate symptoms...or moderate difficulty in social, occupational, or school functioning...”, while a GAF of 41 to 50 indicates the individual has “serious symptoms...or any serious impairment in social, occupational, or school functioning.” DSM-IV at 32. A GAF as low as 31-40 indicates “some impairment in reality testing or communication...or major impairment in several areas such as work or school, family relations, judgment, thinking, or mood.” *Id.*

positive for recent obsessional or intrusive thoughts of suicide, and her GAF was 40. (R. 350-351.) She was hospitalized until October 13, 2009, and then continued treatment with the partial program until November 3, 2009, when she had to stop due to financial inability. (R. 468.)

On November 4, 2009, plaintiff sought treatment from the Harrisonburg-Rockingham Community Services Board (CSB), reporting that she was compliant with her prescribed medications but was unable to afford them. (R. 468.) During that visit, Denise Janaka, LPC, determined that plaintiff had a GAF of 49, while Michelle Wood, RN, reported a GAF of 50. (R. 463, 470.) Plaintiff followed up at CSB on November 12, 2009, November 25, 2009, December 10, 2009, January 4, 2010, and February 1, 2010. (R. 455, 456, 457, 459, 460). Plaintiff's medication was increased on November 25, 2009 and December 10, 2009. (R. 457, 459.) On January 4, 2010, plaintiff reported that she had not taken her medication for two weeks, but she agreed to restart medications and reported medication compliance at her February 1, 2010 appointment. (R. 455-456.)

On January 20, 2010, plaintiff followed up with Dr. Danisa regarding her upper extremity numbness, tingling, dysesthesias, and right shoulder pain. (R. 380.) Dr. Danisa noted that the "MRI comes back positive for an extrinsic compression of the shoulder with AC joint arthritis. The nerve conduction study shows evidence of C5, C6 and C7 radiculopathy which seemed to be acute and also some mild carpal tunnel problems to correlate with her MRI of the neck which . . . showed C5-6, C6-7, C7-T1 and C4-5 spondylosis, loss of lordosis." (R. 380.) The plaintiff did not desire surgical intervention, which Dr. Danisa recommended, and was unable to afford physical therapy sessions, so Dr. Danisa gave her shoulder exercises to perform on her own. (R. 380.)

Due to financial difficulties, the plaintiff was forced to move to Staunton to live with her mother. As a result, she was discharged from CSB on February 25, 2010. Her GAF at discharge was a 49. (R. 453.) Plaintiff was unable to transfer her case after moving and, a week after her medications ran out, she reported to RMH, where Mark Boswer, LCSW, determined she had a GAF of 38 and recommended she be admitted. (R. 497, 500.) On April 8, 2010, Dr. Styron determined that plaintiff had a current GAF of 35, and he restarted the medications with which plaintiff had been noncompliant. (R. 513.) A physical exam on the same date noted that plaintiff was “in mild physical distress, particularly related to her multiple musculoskeletal issues.” (R. 514.) Tests of strength in her extremities were reportedly within normal limits, but she had a limited range of motion caused by an impingement in her right shoulder, mild distal tendinosis of the right rotator cuff, tricompartmental arthrosis in her left knee, and a long cleavage tear of the medial meniscus of the left knee. (R. 514-515.) Plaintiff tested positive for THC (marijuana) and benzodiazepines during this visit.<sup>5</sup> (R. 510.) On April 12, 2010, plaintiff was discharged with an estimated GAF of 55-60, caused by her type 2 bipolar disorder, history of substance abuse, and anxiety disorder. (R. 516.) Plaintiff returned to CSB treatment on April 19, 2010, where she was determined to have a GAF of 52. (R. 452.) On May 4, 2010, the free clinic terminated plaintiff from receiving services there due to the positive test for marijuana. (R. 397.)

Plaintiff reported back to the emergency room at RMH on May 7, 2010 after she sliced her wrists in three places. (R. 493.) Her GAF was 55, and she was diagnosed by Mark Nesbit, M.D., as suffering depression with suicidal gesture and polysubstance abuse and was released. (R. 488, 495.) Plaintiff tested positive for marijuana, benzodiazepines, and Ecstasy/MDMA. (R. 495.) On May 12, 2010, plaintiff followed up at CSB where her medications were increased, and

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<sup>5</sup> Plaintiff’s prescribed medications at this time included Clonazepam (i.e. Klonopin) which is a benzodiazepine. (R. 503.)

she was determined to have a GAF of 50. (R. 439, 443.) On May 14, 2010, plaintiff saw Dr. Danisa for her continuing shoulder and neck pain. (R. 472.) Dr. Danisa noted that she “does have objective and organic problems, but these are far outweighed by her neuropsychiatric issues.” (R. 472.) Pointing out that she had decompensated during her last visit, Dr. Danisa opined that “if she does go to Northern Virginia it may be best she has the surgery there.” (R. 472.)

Plaintiff reported compliance with her medications at her follow-up at CSB on June 3, 2010, but on June 4, 2010, she reported to the emergency room at RMH (R. 438, 482.) Plaintiff stated that she was suffering headaches because she ran out of blood pressure medication, and because the free clinic would no longer refill the prescription for her. (R. 482.) Michael C. Ilagan, M.D., diagnosed the patient with high blood pressure, noncompliant with medications and use of marijuana, and he refilled her medications so she could resume compliance. (R. 483.) On July 1, 2010, plaintiff met with her case manager at CSB who reported that she had been diagnosed with bipolar disorder type 2, cannabis dependency, alcohol abuse, and nonspecific anxiety disorder and that she had a GAF of 52. (R. 435.) Although she was provided with a physical examination form, no further physical evaluation appears in the record; however, she continued mental health treatment with the CSB, reporting that she was compliant at each med check appointment until March 1, 2011. (R. 422, 425, 427, 429, 431, 436.) Plaintiff’s medication was altered on each of her next five appointments, though no GAF was reported for any of them. (R. 422, 425, 427, 429, 431.) At her visit on March 1, 2011, plaintiff stated that she “sleeps most of the day and forgets to take her medications,” and her prescription for Seroquel was discontinued during this appointment. (R. 422-423.) The evidence in the record indicates

that plaintiff was scheduled to follow-up at CSB on March 29, 2011. (R. 422.) Given plaintiff's medical history, it is clear that the Law Judge erred in several respects.

The Law Judge found that the plaintiff had the residual functional capacity (RFC) to perform light work with some limitations. This finding directly conflicts with all of the medical testimony and, therefore, is not supported by substantial evidence. Light work requires "a good deal of walking or standing." 20 C.F.R. § 404.1567(b). The Law Judge based his findings on the opinion of Dr. Hardigree and the State agency medical consultant. (R. 16.) While it is true that the State agency medical consultant stated that plaintiff could stand or walk for a total of two hours, he also stated that the plaintiff's "fibromyalgia and severe left knee arthritis . . . would limit her ability to stand, walk and operate hand controls." (R. 161.) Furthermore, the medical consultant's findings of fact stated that "the claimant's knee problems would limit her to sed work." (R. 159.) The State agency medical consultant and the Law Judge both based their decisions on the opinion of Dr. Hardigree, who opined that plaintiff would not be able to do a job that required standing or walking. (R. 329.) Furthermore, Dr. Hardigree opined that plaintiff was incapable of doing a job requiring any standing or walking, and this is inconsistent with the definition of even sedentary work, which requires occasional standing and walking. 20 C.F.R. § 404.1567(a). While the Law Judge is permitted to resolve inconsistencies in the evidence, here he did not explain why, on the one hand, he found the opinion of the only treating physician for plaintiff's knee impairment to be "highly credible," but, on the other, concluded that plaintiff possessed a residual functional capacity (RFC) which was inconsistent with his credibility determination. (R. 16.) While this error is mitigated somewhat by the fact that the Law Judge determined plaintiff could perform past relevant sedentary work, it calls into question the verity of the Law Judge's other findings.

The Law Judge also completely dismissed the plaintiff's complaints of her right arm difficulties. At the hearing, plaintiff's counsel inquired the VE about whether jobs would still be available to the plaintiff if she had difficulties using her dominant right-arm. (R. 40-41.) The VE's response was that plaintiff would not be capable of performing her past relevant work or any jobs available in the national economy. (R. 41.) The Law Judge found that the plaintiff's complaints were not credible because she worked part-time as a caregiver, declined surgical intervention, had not provided evidence of ongoing, regular treatment by an orthopedist, and had not been taking strong narcotic analgesic medications for her pain. (R. 15.)

At the hearing, plaintiff testified that she missed a lot of work from her part-time job, had difficulty performing the tasks, and eventually stopped altogether because of her right arm. (R. 29.) The limitations and their effect are supported by all the objective medical evidence and certainly have their vocational effects. Furthermore, while the Law Judge noted that plaintiff had refused surgery, he made no finding that the plaintiff refused surgery without a good reason.<sup>6</sup> Pursuant to 20 CFR § 404.1530, the Commissioner may deny benefits to a claimant who fails to follow prescribed treatment. However, the claimant "must be given a full opportunity to express the specific reasons for his decision not to follow the prescribed treatment." *Nunley v. Barnhart*, 296 F. Supp. 2d 702, 704 (W.D. Va. 2003). The Law Judge does not appear to have considered either the plaintiff's mental condition or financial condition in assessing whether her alleged noncompliance with the recommendation of surgery was reasonable. For example, the record shows that she decompensated in Dr. Danisa's office when surgery was recommended to her, suggesting that her mental condition may account for her noncompliance. (R. 380.) Inability to pay may also excuse noncompliance "if the individual is unable to afford prescribed treatment . . .

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<sup>6</sup> Given the page reference, the undersigned assumes the Law Judge was referring to the plaintiff's refusal to have surgery on her shoulder, although plaintiff has also refused recommended surgery for her knee. (R. at 329.)

. for which free community resources are unavailable.” Social Security Ruling (SSR) 82-59. This justification is especially relevant here since plaintiff was terminated from the services at the free clinic shortly before her final appointment with Dr. Danisa. (R. 397, 472.) This inability to pay also explains why plaintiff did not have “ongoing, regular treatment by an orthopedist.” (R. 15.) In fact, Dr. Danisa recommended plaintiff at least attend physical therapy, which she did not because she could not afford it. (R. 380.) Dr. Danisa also opined that plaintiff’s “emotional and neuropsychiatric problems seem to predominate her problems.” (R. 472.) Justification has been established by the substantial evidence in this case. The Law Judge’s reliance on plaintiff’s use of Naproxen to determine the severity of her pain is undercut by her treating physician’s recommendation of surgery, the plaintiff’s laundry list of daily medications, and the potential effect of plaintiff’s cannabis dependence. (R. 35, 380, 503). For all these reasons, the Law Judge’s credibility determination with regard to the plaintiff’s use of her right arm is therefore erroneous.

Finally, the Law Judge’s finding that plaintiff does not have a severe mental condition is not supported by substantial evidence. The Law Judge relied on the plaintiff’s GAF of 52 on April 19, 2010 and an estimated GAF of 55-60 on April 12, 2010 to find that the plaintiff “exhibits mild restriction of activities of daily living, mild difficulties in maintaining social functioning, mild difficulties in maintaining concentration, persistence, or pace, and no episodes of decompensation, which have been of extended duration.”<sup>7</sup> (R. 13.) In so doing, the Law Judge stated he was “adopt[ing] the opinion of the states physicians . . . that the claimants mental impairments are not severe.” (R. 15.) This finding ignores the record in several ways. First, the

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<sup>7</sup> The Law Judge also referenced a statement on plaintiff’s April 19, 2010 CSB case opening form estimating that plaintiff’s highest GAF in the past year had been a 60. (R. 13, 452.) The undersigned notes that there is no evidence corroborating the validity of this estimation, especially as it conflicts with an October 8, 2009 medical record estimating plaintiff’s highest GAF in the past year at only 58. (R. 357.)

findings of the state agency physicians do not rise to the level of substantial evidence. The opinion of the first state agency physician was rendered in August 2009, prior to patient's hospitalization in October 2009, at which point she was determined to have a GAF of 41. (R. 160, 357.) The opinion of the second state agency physician in March 2010 appears to have been formulated without most of the evidence regarding plaintiff's psychiatric treatment, records of which were requested but not received. (R. 183-192.) For example, none of the information from the CSB was in the record at the time the state agency physicians opined that plaintiff did not suffer a severe mental condition. (R. 421.) These opinions are not entitled to any weight here because the bases for them do not reflect the state of the medical record.

The Law Judge's opinion that the plaintiff had a GAF of between 52 and 60 when she was compliant with her medications also is irreconcilable with the objective medical evidence. The Law Judge did note that plaintiff had GAF scores as low as 35, 37, and 49, but gave these scores little weight because they "do not reflect the results of treatment and appear to reflect the claimant's failure to follow her medication regimen." (R. 16.) As outlined above, plaintiff was largely compliant with her medication, though she suffered some periods of noncompliance caused by financial inability. For example, plaintiff reported being compliant with her medication from the time of her hospitalization in October 2009 through the time of her discharge from CSB on February 25, 2010, with the exception of a two week period at the end of December 2009. During this time period, plaintiff's GAF was 50 with two GAF scores of 49. (R. 453, 463, 468.) Plaintiff then was briefly noncompliant from the time she ran out of her medication until she checked herself into RMH, at which time her GAF was 35-38. (R. 500, 516.) Plaintiff then continued to be compliant with her medications until March of 2011. Although upon her discharge from RMH on April 12, 2010, plaintiff was estimated to have a

GAF of 55-60, plaintiff's actual GAF was only a 52 on April 19, 2010. (R. 452, 516.) On May 8, 2010 her score was a 55, on May 12, 2010 it was 50, and on July 6, 2010 it was 52. (R. 435, 445, 488.) Furthermore, throughout this entire period plaintiff's medications were being constantly altered, certainly demonstrating that the medication was not effective even with perfect compliance. While there are no GAF scores in the record following July 6, 2010, the fact that plaintiff's medications continued to change suggests that compliance had not resolved her mental impairments.

Finally, even if the Law Judge was correct in his finding that plaintiff's GAF was a 52-60 when she was compliant with her medication, this finding is inconsistent with his conclusion that plaintiff suffers only mild symptoms. A GAF between 51 and 60 indicates that the individual has moderate difficulty functioning. DSM-IV at 32. The evidence clearly established, however, that plaintiff's GAF with compliance was much more commonly at 49 or 50 during the relevant period, although it was as low as 35 when plaintiff's financial inability caused a brief period of noncompliance. A GAF of 49-50 would indicate serious symptoms and would have mandated a finding that plaintiff was disabled. Even more moderate limitations would have made unavailable those few jobs identified by the VE even under the Law Judge's flawed RFC. The Law Judge's finding that plaintiff's mental condition was not a severe impairment is not supported by substantial evidence.

For all these reasons, it is RECOMMENDED that an Order enter GRANTING the plaintiff's motion for summary judgment, DENYING the Commissioner's motion, and RECOMMENDING the case for the calculation and payment of benefits.

The Clerk is directed to immediately transmit the record in this case to the presiding United States District Judge. Both sides are reminded that pursuant to Rule 72(b), they are

entitled to note objections, if any they may have, to this Report and Recommendation within fourteen (14) days hereof. Any adjudication of fact or conclusion of law rendered herein by the undersigned not specifically objected to within the period prescribed by law may become conclusive upon the parties. Failure to file specific objections pursuant to 28 U.S.C. § 636(b)(1)(C) as to factual recitations or findings as well as to the conclusions reached by the undersigned may be construed by any reviewing court as a waiver of such objection. The Clerk is directed to transmit a certified copy of this Report and Recommendation to all counsel of record.

ENTERED: s/ B. Waugh Crigler  
U.S. Magistrate Judge

December 5, 2012  
Date