

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

ANGELA S. PROPST, )  
 ) CASE NO. 5:12CV00089  
 )  
 Plaintiff, )  
 )  
 v. ) REPORT AND RECOMMENDATION  
 )  
 )  
 CAROLYN W. COLVIN,<sup>1</sup> )  
 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 May 12, 2009 protectively-filed applications for a period of disability and disability insurance benefits and supplemental security income 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 questions presented are whether the Commissioner's final decision is supported by substantial evidence, or whether there is good cause to remand for further proceedings. 42 U.S.C. § 405(g). For the reasons that follow, the undersigned will RECOMMEND that an Order enter GRANTING, in part, the plaintiff's motion for summary judgment, DENYING the Commissioner's motion for summary judgment, and, for good cause shown, REMANDING this case to the Commissioner for further consideration.

In a decision dated February 15, 2011, an Administrative Law Judge ("Law Judge") found that plaintiff had worked since her alleged disability onset date, December 17, 2003.<sup>2</sup> (R.

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<sup>1</sup> As the defendant's brief points out, Carolyn W. Colvin became the Acting Commissioner of Social Security on February 14, 2013. Pursuant to Rule 25(d) of the Federal Rules of Civil Procedure, Carolyn W. Colvin should be substituted for Michael J. Astrue as the defendant in this suit.

22.) While finding that plaintiff had worked from 2005-2008, and had \$20,091.09 in earnings in 2008, the Law Judge appears to have given plaintiff the maximum benefit of the doubt and found that she had not engaged in substantial gainful activity<sup>3</sup> since her onset date and continued through the sequential evaluation.<sup>4</sup> (R. 22-23.)

The Law Judge determined plaintiff's degenerative disc disease and affective disorder were severe impairments either singly or in combination.<sup>5</sup> (R. 23.) However, he concluded that plaintiff's migraines were non-severe, finding that they were fairly well controlled with Botox injections and had not resulted in significant functional limitations. *Id.* 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. 23-24.) Further, the Law Judge found that plaintiff possessed the residual functional capacity ("RFC") to perform a range of light work with limitations: specifically, that plaintiff could not climb ladders, ropes, or scaffolds; could only perform handle short and simple instructions; and could tolerate interaction

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<sup>2</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) (2004). In order to qualify for a period of disability and disability insurance benefits, plaintiff must establish that she became disabled prior to the expiration of her insured status, which is March 31, 2012. *See* 20 C.F.R. § 404.131(a); (R. 22, 173.)

<sup>3</sup> Substantial gainful activity is "work activity that involves doing significant physical or mental activities," and it is typically determined by the amount of a claimant's earnings. *See* 20 C.F.R. § 404.1574.

<sup>4</sup> The sequential evaluation is a five step process used by the Commissioner to evaluate whether a claimant is disabled. *See* 20 C.F.R. § 404.1520(a)(4). If a claimant is found not disabled at any level prior to the final level, the inquiry is to stop. *Id.*

<sup>5</sup> A severe impairment is any impairment or combination of impairments which significantly limits a claimant's physical or mental ability to do basic work activities. *See* 20 C.F.R. § 404.1520(c). Disabling impairments must either result in death or last or be expect to last for a continuous period of at least twelve months duration. 20 C.F.R. § 404.1509; SSR 82-52 (August 20, 1980).

with coworkers and supervisors as needed for task completion and minimal contact with the public. (R. 24-32.)

The Law Judge relied on portions of the testimony of Gerald K. Wells, Ph.D., CRC, a vocational expert (“VE”), which were in response to questions premised on the Law Judge’s RFC finding. (R. 32-33, 49-55.) Based on this testimony, the Law Judge determined that plaintiff was unable to perform her past relevant work but that there were other jobs that existed in significant numbers in the local and national economy which plaintiff could perform: specifically, an appointment clerk, file clerk, and office helper. (R. 32-33.) Accordingly, the Law Judge found that plaintiff was not disabled. (R. 33-34.)

Plaintiff appealed the Law Judge’s February 15, 2011 decision to the Appeals Council. (R. 1-16.) Plaintiff filed extensive additional evidence with the Appeals Council (R. 1254-1543.), but in its August 15, 2012 notice, the Council found no basis to review the Law Judge’s decision, denied review, and adopted the Law Judge’s decision as the final decision of the Commissioner. (R. 1-2.) This action ensued, briefs were filed, and oral argument was held by telephone before the undersigned on March 8, 2013.

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 a 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. When the Appeals Council considers additional evidence offered for the first time on administrative appeal and denies review, courts must consider the record as a whole, including the new evidence, in determining whether the Commissioner’s final decision is supported by substantial evidence. *Meyers v. Astrue*, 662 F.3d 700, 707 (4th Cir. 2011); *Wilkins v. Secretary*, 953 F.2d 93, 96 (4th Cir. 1991).

In her brief in support of her motion for summary judgment and in oral argument for the undersigned, plaintiff argues that the Law Judge erred by: (1) not considering plaintiff’s arm injury a severe impairment; and (2) “ignoring” the plaintiff’s supporting medical opinion evidence of record; (3) finding that plaintiff was capable of performing light work. (Dkt. No. 15, at 11-19.) The undersigned will address these challenges below.

Plaintiff alleges that she became disabled after falling on ice in December 2003, injuring her elbow, shoulder, back and neck.<sup>6</sup> Plaintiff underwent an open reduction internal fixation procedure on her right elbow shortly after the accident, and a physical examination and x-rays in January 2004 showed that she was healing well, with mild sensory deficits but greatly reduced flexion. (R. 502.) Plaintiff continued to improve with the help of physical therapy and was cleared to return to work by February 2004 and again in March 2004 with a twenty pound lifting restriction. (R. 503-504.) However, plaintiff complained of significant pain and her elbow range of motion began to plateau and even decline as her elbow stiffened following surgery. (R. 504-505.) Moreover, her insurance company declined to pay for a soft tissue stretching splint which her doctor considered an important part of her treatment. *Id.* Reports from March through May

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<sup>6</sup> Plaintiff claims that she has had intermittent problems with her neck and right arm since being in a motor vehicle accident in 1988. (R. 554.) She contends that her symptoms became worse after her fall. *Id.*

2004 document that plaintiff improved in range of motion by only ten degrees over six weeks, had difficulty performing activities of daily living, and was not allowed by her employer to work with restrictions. (R. 504-507.) However, in August and September 2004, following hardware removal in June, plaintiff's flexion improved dramatically, though with limitations at the extremes of the range, continued pain, and imaging evidence of osteopenia. (R. 500, 509-512.)

Plaintiff also complained of chronic right shoulder pain, and an MRI of her shoulder in February 2005 revealed tendinosis with a possible partial tendon tear. (R. 466.) A physical examination showed "exquisite" sensitivity along her ulnar nerve and some limitations in her elbow range of motion, which the treating physician found to be evidence of ulnar nerve dysfunction. (R. 500-501.) From April through June, plaintiff improved with therapy and continued to show good strength and range of motion in her shoulder. (R. 494-498.) However, she experienced tingling and numbness in her arm, spasms in her neck and back, displayed some positive signs of nerve impingement, and an EMG nerve conduction study showed that plaintiff had significant compressive neuropathy of the ulnar nerve in her elbow. *Id.* An injection in June provided only 20% pain relief in her shoulder, and while her treatment provider was hopeful that therapy would alleviate most of her pain and limitations, he believed that she would benefit from elbow surgery. *Id.* Plaintiff underwent a right ulnar nerve anterior submuscular transposition in July 2005, which alleviated the numbness and tingling in her arm, and physical therapy helped her return to near normal range of motion. (R. 490-493.) However, she continued to have pain, especially in her neck and head, and she asked for a referral to a neurologist or neurosurgeon. (R. 490-493.)

In November 2005, Raymond V. Harron, D.O. found that plaintiff suffered spasms and decreased range of motion in her cervical spine. (R. 382-382.) An MRI revealed nerve root and

spinal cord compression resulting from a large disc herniation at the C5-C6 level. *Id.* Her condition was further aggravated when she fell down a flight of stairs in December 2005. (R. 672.) Plaintiff was observed to experience a lot of pain in her upper extremity, and tenderness with limitations on motion in her right elbow from a contusion and a possible non-displaced radial head fracture, and was limited in lifting beyond five to ten pounds. (R. 488, 672.)

Plaintiff's treatment providers were hopeful that she would see a substantial improvement in her right upper extremity pain following surgery on her cervical spine.

In February 2006, plaintiff underwent an anterior cervical discectomy performed by Dr. Harron on her right C5-C6 disk herniation to decompress her spinal cord and a lateral nerve root. (R. 551-555.) The fusion was a success, with only mild loss of disc height and disc bulging remaining, along with mild stenosis and hypertrophy, and no sign of nerve root or spinal cord compression. (R. 384-385, 464, 539, 541.) However, plaintiff continued to have pain in her shoulder, elbow, and radiating down her arm (R. 545-546.), with imaging evidence of a tendon tear, tendinopathy, and mild degenerative changes in her elbow with an olecranon and coronoid osteophyte and continued concern of a possible hairline radial head fracture. (R. 483, 535.) Plaintiff's strength, gain, and reflexes continued to remain generally normal, and a normal EMG in August 2006 led her treatment providers to include she had a right shoulder impingement with joint arthritis and rotator cuff tendinitis. (R. 545, 641-642, 645, 659, 660.) Right shoulder arthroscopy, subacromial decompression, and distal clavicle excision were performed sometime around September 2006, and plaintiff was said to be doing well with less pain after surgery, which was well controlled by pain medication, and "excellent" radiographs. (R. 543-544.)

Examinations and imaging from October through December 2006 revealed that plaintiff had fairly normal range of motion in her cervical spine, shoulder, and elbow; normal strength,

normal sensation, normal reflexes, and no soft tissue abnormalities. (R. 386-387, 482, 533.)

However, she continued to complain of pain, tingling, and numbness going down her arm, and there was evidence of some degenerative changes in plaintiff's cervical spine with possible osteolysis or retraction of a screw and osteonecrosis. (R. 482, 533, 536.)

In December 2006, plaintiff's cervical spine hardware had to be removed due to infection, and plaintiff was placed on long term antibiotics. (R. 373-377.) In February 2007, plaintiff complained of pain radiating from the left side of her neck down her shoulder and arm, but, other than some spasm in her cervical spinal musculature, plaintiff's physical examination findings were normal. (R. 390.) An EMG and a nerve conduction study were normal, while a CT scan of her cervical spine showed some spondylotic changes, but no nerve root or spinal cord compression. (R. 393, 450-453.) In May 2007, plaintiff complained of elbow pain and numbness and tingling in all of her fingers, and x-ray imaging again revealed a small olecranon and coronoid spur, though no significant joint space narrowing or symptoms of impingement. (R. 481.) However, plaintiff also indicated that her neck and shoulder pain had improved, and her physical examination findings were essentially normal. *Id.* A July 2007 CT scan revealed a possible abscess in the soft tissue of plaintiff's neck, but it was otherwise negative (R. 367.), while November and December 2007 barium swallows showed signs of an esophageal diverticulum, possibly the cause of her chronic dysphagia,<sup>7</sup> but plaintiff showed no impairments on physical examination other than a moderate degree of muscle spasm. (R. 345-347, 365, 396, 595, 889.)

MRIs performed in January and May 2008 showed that plaintiff was experiencing some broad based disc bulging and mild arthritic changes, but they revealed no abscesses in her

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<sup>7</sup> From here, the treatment record becomes a bit less regular, because plaintiff primarily sought treatment for her chronic dysphagia, which she has not alleged impaired her ability to work, and from pain management, which the undersigned will discuss later in this report.

cervical spine or evidence of nerve root or spinal cord compression. (R. 397-398.) Physical examination in January indicated that plaintiff had muscle spasms, limited range of motion, and multiple trigger point areas throughout her cervical spine, but no other symptoms were noted and plaintiff declined to return to physical therapy. (R. 397.) By May, however, her treatment provider noted no abnormalities. (R. 398.)

Around September 2008, plaintiff again underwent surgery on her right elbow to remove the olecranon spur. (R. 471.) She complained of pain and numbness in her arm, though she acknowledged that both had improved following surgery, and her treatment provider concluded, “I think I have done all that I can do,” and recommended that she rely on pain management to control her pain. *Id.* An MRI and a CT scan of her neck indicated that plaintiff’s fusion was stable, and that she had mild disc desiccation, a Zenker’s diverticulum, and an anterior spur. (R. 351-353, 400, 418.) Plaintiff noted improved but persisting pain and muscle spasm in her neck, which was confirmed on physical examination. (R. 399.)

Imaging evidence and physical examinations generally revealed no significant changes in plaintiff’s condition throughout 2009. (R. 350, 401-402, 679, 799, 802.) In May 2009, plaintiff demonstrated normal gait, mood and affect, but she also had tenderness, dysesthesia, and limitations in her range of motion of her neck and shoulder and on a joint exam. (R. 674.) Plaintiff went to the emergency room complaining of migraine headaches in November 2009 and February 2010. (R. 1128-1132.) Physical examination was perfectly normal, including normal range of motion in her neck and upper extremities and no neurological deficits, and plaintiff was discharged in good and improved condition. *Id.* In July, plaintiff underwent another MRI and another EMG, having complained of increasing upper right extremity pain and paresthesias. (R. 1150, 1166.) The EMG revealed a “decreased number of motor units firing with an increase in

polyphasic units,” and some increased insertional activity, though it was otherwise unremarkable, leading the treatment provider to suspect right cervical radiculopathy. (R. 1166.) Meanwhile, the MRI revealed evidence of post-surgical changes at C5-6, including loss of cervical lordosis, and evidence of degenerative disc disease at C6-7 with osteophytic disc complex. (R. 1150). However, the findings were stable when compared with the previous MRI on June 17, 2009, and no other abnormalities were observed. *Id.*

Throughout her alleged period of disability, plaintiff has complained of serious pain in her neck, shoulders, and upper extremities.<sup>8</sup> In addition to the surgical interventions described above, plaintiff has received near constant treatment through pain management and physical therapy to control her pain and improve her functioning. The record is somewhat inconsistent on how successful these treatments have been in controlling her pain. Dr. John noted that Percocet controlled her shoulder pain and soreness well in September 2006 (R. 544), and there are several reports that her current medications adequately managed her chronic pain symptoms and maintained her level of functioning. (R. 642, 675, 685, 687.) However, a report from November 2010 noted of plaintiff’s pain medications that “it does not sound like they have been significantly beneficial and they have not improved her function over the years.” (R. 1522.) Plaintiff underwent a cervical steroid injection in November 2007 because her symptoms had failed to respond to more conservative treatment, and her treatment providers hoped that the procedure would reduce her need to take medication or receive further treatment. (R. 890.) Plaintiff stated in May 2010 that she did not feel that her pain medication was effective. (R. 1157.) Reports also indicate that pain medication did not always alleviate the effects of plaintiff’s acute migraines. (R. 567, 1128-1132.)

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<sup>8</sup> Plaintiff’s treatment providers speculate that her pain may be the cause of her recurrent sleep problems. (R. 853-854.)

The November 2010 report does note that plaintiff had a good response to steroid injections and symptomatic relief from physical therapy. (R. 1522.) The rest of the record supports those findings. In July 2006, plaintiff stated that a shoulder injection relieved 70% of her pain. (R. 546.) An October 2008 cervical intralaminar epidural was 75% effective at controlling plaintiff's pain for three weeks. (R. 689.) Trigger point injections and nerve blocks provided her 65 to 90% pain relief for at least several days. (R. 642, 679, 1386.) Meanwhile, Botox injections every three months diminished her headaches by 75% and relieved her head, shoulder, and neck pain by 80% to near 100%. (R. 567, 577, 596, 628, 641, 1088, 1383.) In May 2007, plaintiff also stated that elbow injections had helped her in the past. (R. 481.)

Plaintiff has also been treated for depression for many years. Plaintiff's psychiatrist, E.P. Burdick, M.D., diagnosed plaintiff with bipolar disorder and consistently found her to be depressed and anxious, though no other physical or mental symptoms were noted before April 2009. (R. 743, 746, 749, 752, 755, 763-764.) After April 2009, Dr. Burdick noted that plaintiff's recent memory and concentration were impaired, though originally only mildly so. (R. 735, 737, 740.) Plaintiff's therapist, Susan Young, LCSW, diagnosed plaintiff with moderate major depressive disorder and found her to be depressed and anxious, as well as suffering sleep disturbance, low energy, and anhedonia; but otherwise found her normal and able to care for herself. (R. 932-940, 1101.) The Harrisonburg/Rockingham Community Services Board indicated in March 2010 that plaintiff suffered chronic depression and episodes of severe depression, had suicidal thoughts off and on over the last few years, had problems sleeping, had problems with memory and concentration, and suffered a variety of other symptoms including lack of energy, anhedonia, apathy, etc. (R. 1151-1156.) Michelle Wood, PMHNP-BC, of the Community Services Board diagnosed plaintiff with recurrent severe major depressive disorder,

with rule out PTSD, severe psychosocial and environmental problems, and assigned her a Global Assessment of Functioning Score of 51.<sup>9</sup> (R. 1155-1156.) Ms. Wood's contact notes indicate that plaintiff's depression continued with only slight improvements from medication. (R. 1157-1160, 1319-1323.) Physical examinations by other treatment providers have been less consistent in finding symptoms of depression, with several reports noting normal mood and affect. (R. 674, 1128-1132.)

Plaintiff has also worked during her alleged period of disability. Plaintiff has earnings from 2004 through 2008. (R. 135-137, 150.) In 2008, plaintiff earned more than \$20,000 while working for H&R Block, well above the level for substantial gainful activity,<sup>10</sup> and often worked full time and with extensive overtime in late 2007 and in much of 2008. *Id.* In 2009 and 2010, plaintiff filed for unemployment and received substantial quarterly unemployment payments.<sup>11</sup> (R. 152.)

To repeat, plaintiff first contends that the Law Judge erred at Step 2 of the sequential evaluation by finding that her arm and shoulder impairments were not severe. Even if a Law Judge errs by failing to find an impairment to be severe, this error is harmless if the Law Judge adequately considers the effects of the impairment in the subsequent steps, including determining

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<sup>9</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 score of 51-60 indicates moderate symptoms or moderate difficulties in social, occupational, or school functioning. *Id.*

<sup>10</sup> The earnings level for presumptive substantial gainful activity is currently \$1040 a month. U.S. Social Security Administration. Substantial Gainful Activity. <http://www.ssa.gov/oact/cola/sga.html>. Last updated October 16, 2012.

<sup>11</sup> The receipt of unemployment benefits which require a party to indicate that they are ready, willing, and able to work is inconsistent with the claim that one is disabled and unable to perform substantial gainful activity as a result of their impairments. *See Lackey v. Celebrezze*, 349 F.2d 76, 79 (4th Cir. 1965); *Sease v. Astrue*, No. 5:07cv00086, 2008 WL 4522476, at \* 4 (W.D.Va. Oct. 6, 2008).

residual functional capacity at step 4. *See Brooks v. Astrue*, No. 5:10cv00104, 2012 WL 1022309, at \*11-12 (W.D.Va. March 26, 2012).

As shown above, while a part of plaintiff's radiating pain in her shoulder and upper extremities is likely a result of her degenerative disc disease, plaintiff also has independent arm and shoulder impairments for which she has received surgery on several occasions. From the time of her fall in December 2003 through 2005, a large portion of plaintiff's complaints concerned pain and limitations in her use of her elbow and shoulder, requiring such surgery as an open reduction internal fixation in December 2003 and right ulnar nerve anterior submuscular transposition in July 2005. From 2006, there is imaging evidence of a tendon tear, tendinopathy, and mild degenerative changes in her elbow with an olecranon and coronoid osteophyte and a possible hairline radial head fracture, for which plaintiff's treatment providers performed right shoulder arthroscopy, subacromial decompression, and distal clavicle excision sometime around September 2006 and surgery on her elbow in September 2008. While plaintiff's condition often improved following therapy and surgery, the undersigned is hard pressed to imagine that her impairments did not cause her more than minimal functional limitations. 20 C.F.R. § 416.924; SSR 96-3p (July 2, 1996). Moreover, there is good evidence that these fall related injuries and impairments lasted for a continuous period of twelve months duration or greater. 20 C.F.R. § 404.1509. It is the undersigned's view that the Law Judge's severity determination at Step 2 of the sequential analysis is not supported by substantial evidence.

Moreover, the Law Judge did not adequately consider the limitations imposed by these impairments during the alleged period of disability later in the sequential analysis. The Law Judge does refer to plaintiff's arm and shoulder pain and paresthesia, discusses normal EMG tests, and vaguely refers to plaintiff's musculoskeletal complaints and normal physical

examinations. (R. 26-30.) However, it appears clear that the Law Judge did not carefully consider plaintiff's arm and shoulder impairments apart from her degenerative disc disease. Though he vaguely referred to a single elbow surgery, he does not discuss it, her other arm and shoulder surgeries, or any of the related imaging evidence. While he points to unremarkable EMGs in 2006 and 2007, he does not refer to clear EMG evidence of right ulnar neuropathy in 2005 which led to her surgery in July 2005. The Law Judge never discussed any limitations that did, or were likely to, result from plaintiff's arm and shoulder impairments, despite plaintiff's doctors twice imposing lifting limitations, the first of which led to her losing her job in 2004. Tellingly, at the end of his RFC determination, the Law Judge only discusses plaintiff's physical limitations "in terms of the claimant's alleged degenerative disc disease." (R. 30.)

The undersigned acknowledges that there is conflicting evidence on some fronts. On the one hand, plaintiff's therapist, Ms. Young, opined that plaintiff was not disabled by her mental impairments (R. 922-926.), and there is evidence of record that plaintiff's condition has improved greatly with surgery, physical therapy, and frequent pain management injections. Moreover, plaintiff has worked during the alleged period of disability, even to levels that could constitute substantial gainful activity, and she has received unemployment income. By the same token, there is clear objective imaging evidence, reports of physical examinations, and mental status reviews, each establishing that plaintiff suffers impairments which reasonably would be expected to cause her pain and limit her functional abilities. Moreover, plaintiff's treatment providers John Sherry, M.D. and J. Michael Syptak, M.D., consultative examiner Barry S. Hensley, Ed.D, and the Virginia Department of Rehabilitative Services, clearly a neutral treating source, all opined that plaintiff was disabled. (R. 712-721, 1161-1162, 1247-1253.)

The critical factor in all this for the undersigned lies in the Law Judge's resolution of the severity of plaintiff's arm and shoulder impairments. The evidence is legion and establishes beyond peradventure that these impairments are severe as the term is defined by the regulations and decisional authorities. The Law Judge's decision finding them not to be severe cannot be and is not supported by the substantial evidence. Moreover, the Law Judge did not consider these impairments and their effects as he proceeded through the sequential evaluation, especially in view of the fact that the inquiry reached the final sequential level. Accordingly, the Law Judge's findings regarding the vocational effects of these impairments must be reexamined in light of their clear severity. *See Gordon v. Schweiker*, 725 F.2d 231, 236 (4th Cir. 1984). Good cause has been shown to remand this case for further consideration.<sup>12</sup>

For all these reasons, it is RECOMMENDED that an Order enter GRANTING, in part, plaintiff's motion for summary judgment, DENYING the Commissioner's motion for summary judgment, and, for good cause shown, REMANDING this case to the Commissioner for further consideration.

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

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<sup>12</sup> While the undersigned recommends this case be remanded for further consideration, this finding should not be taken to suggest that the undersigned would find plaintiff to be disabled. Assessing the vocational effects of what the undersigned has found as a matter of law to be severe impairments is first for the Commissioner, not the court.

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

May 10, 2013  
Date