

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
Danville Division

SUSAN H. JEFFERSON,)
Plaintiff,)
) Civil Action No. 4:15-cv-1
v.)
) REPORT AND RECOMMENDATION
CAROLYN W. COLVIN,)
Acting Commissioner of Social Security,) By: Joel C. Hoppe
Defendant.) United States Magistrate Judge

Plaintiff Susan H. Jefferson asks this Court to review the Commissioner of Social Security’s (“Commissioner”) final decision denying her applications for disability insurance benefits (“DIB”) and supplemental security income (“SSI”) under Titles II and XVI of the Social Security Act, 42 U.S.C. §§ 401–434, 1381–1383f. Having considered the administrative record, the parties’ briefs and oral arguments, and the applicable law, I find substantial evidence supports the Commissioner’s decision that Jefferson is not disabled. Therefore, I recommend that the Court **DENY** Jefferson’s Motion for Summary Judgment, ECF No. 19, **GRANT** the Commissioner’s Motion for Summary Judgment, ECF No. 21, and **AFFIRM** the Commissioner’s final decision.

I. Standard of Review

The Social Security Act authorizes this Court to review the Commissioner’s final decision that a person is not entitled to disability benefits. *See* 42 U.S.C. § 405(g); *Hines v. Barnhart*, 453 F.3d 559, 561 (4th Cir. 2006). The Court’s role, however, is limited—it may not “reweigh conflicting evidence, make credibility determinations, or substitute [its] judgment” for that of agency officials. *Hancock v. Astrue*, 667 F.3d 470, 472 (4th Cir. 2012). Instead, the Court asks only whether the Administrative Law Judge (“ALJ”) applied the correct legal standards and

whether substantial evidence supports the ALJ's factual findings. *Meyer v. Astrue*, 662 F.3d 700, 704 (4th Cir. 2011).

“Substantial evidence” means “such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.” *Richardson v. Perales*, 402 U.S. 389, 401 (1971). It is “more than a mere scintilla” of evidence, *id.*, but not necessarily “a large or considerable amount of evidence,” *Pierce v. Underwood*, 487 U.S. 552, 565 (1988). Substantial evidence review takes into account the entire record, and not just the evidence cited by the ALJ. *See Universal Camera Corp. v. NLRB*, 340 U.S. 474, 487–89 (1951); *Gordon v. Schweiker*, 725 F.2d 231, 236 (4th Cir. 1984). Ultimately, this Court must affirm the ALJ's factual findings if “conflicting evidence allows reasonable minds to differ as to whether a claimant is disabled.” *Johnson v. Barnhart*, 434 F.3d 650, 653 (4th Cir. 2005) (per curiam) (quoting *Craig v. Chater*, 76 F.3d 585, 589 (4th Cir. 1996)). However, “[a] factual finding by the ALJ is not binding if it was reached by means of an improper standard or misapplication of the law.” *Coffman v. Bowen*, 829 F.2d 514, 517 (4th Cir. 1987).

A person is “disabled” if he or she is unable to engage in “any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.” 42 U.S.C. §§ 423(d)(1)(A), 1382c(a)(3)(A); 20 C.F.R. §§ 404.1505(a), 416.905(a). Social Security ALJs follow a five-step process to determine whether an applicant is disabled. The ALJ asks, in sequence, whether the applicant (1) is working; (2) has a severe impairment; (3) has an impairment that meets or equals an impairment listed in the Act's regulations; (4) can return to his or her past relevant work based on his or her residual functional capacity; and, if not (5) whether he or she can perform other work *See* 20 C.F.R. §§

404.1520(a)(4), 416.920(a)(4); *Heckler v. Campbell*, 461 U.S. 458, 460–62 (1983). The applicant bears the burden of proof at steps one through four. *Hancock*, 667 F.3d at 472. At step five, the burden shifts to the agency to prove that the applicant is not disabled. *See id.*

II. Procedural History

Jefferson applied for DIB and SSI on August 11, 2011. Administrative Record (“R.”) 11, 104, 213, 218, ECF No. 14. She alleged disability as of March 4, 2011, caused by a back injury, nerve damage causing a loss of feeling in her right hand and leg, a slipped disc, fibromyalgia, diabetes, hypertension, high cholesterol, and problems sleeping. R. 251. At the time of her alleged onset, she was 40 years old, R. 213, and she had worked as a cashier and in child care, R. 252.¹

The state agency denied Jefferson’s DIB and SSI claims at both the initial and reconsideration levels. R. 102, 112, 125, 138. On July 10, 2013, Jefferson, with counsel, appeared via video conference before ALJ Mary C. Peltzer for a hearing in which Jefferson and a vocational expert (“VE”) testified. R. 37–81.

ALJ Peltzer denied Jefferson’s application for DIB and SSI in an opinion issued on August 8, 2013. *See* R. 8–31. The ALJ found Jefferson had severe impairments of diabetes mellitus with neuropathy, degenerative disc disease of the lumbar spine, hypertension, history of asthma, obstructive sleep apnea, and obesity. R. 14–24. ALJ Peltzer found Jefferson’s depression to be non-severe. R. 21–24. She then determined that none of Jefferson’s severe impairments, alone or in combination, met or medically equaled a listed impairment. R. 24–26.

¹ Jefferson had previously sought benefits for disability caused by injury to her ankles. This claim was denied by ALJ Brian Kilbane in a written opinion issued on November 18, 2005. R. 85–93. That prior claim was considered by the ALJ in this case, but given very little weight because of the substantial time period between claims and differences in the impairments alleged. R. 11.

As to Jefferson’s residual functional capacity (“RFC”),² the ALJ found that she was capable of performing light work,³ with additional limitations in standing and walking, certain postural activities, and exposure to environmental irritants. R. 26–29. The ALJ found this RFC precluded Jefferson from performing any past relevant work, R. 29, but also found that she could still perform other jobs in the national economy and was therefore not disabled, R. 30–31. The Appeals Council declined Jefferson’s request for review, R. 1–3, and this action followed.

III. Relevant Evidence

A. Physical Impairments

The relevant medical record dates back to October, 2010, at which time Jefferson saw Robert Goodnight, M.D., her primary care physician, for regular evaluation and medication management regarding diabetes mellitus type II with neuropathy, hypertension, and asthma. She complained of pain in her back and lower extremities, headaches, high blood pressure, and sleep issues. Her lungs were clear to auscultation, and she exhibited no wheezes, rhonchi, or rales. She had normal range of motion of the spine with no tenderness or evidence of scoliosis, full strength and sensation in all extremities, and normal gait. R. 391–95.

² Residual functional capacity, or “RFC,” is an applicant’s *maximum* ability to work “on a regular and continuing basis” despite his or her limitations. SSR 96-8p, 1996 WL 374184, at *1 (July 2, 1996). The RFC takes into account “all of the relevant medical and other evidence” in the applicant’s record, 20 C.F.R. §§ 404.1545(a), 416.945(a), and reflects the “total limiting effects” of the person’s impairments and related symptoms, *id.* §§ 404.1545(e), 416.945(e); *see also* SSR 85-15, 1985 WL 56857, at *6 (Jan. 1, 1985) (“Any impairment-related limitations created by an individual’s response to demands of work . . . must be reflected in the RFC assessment.”).

³ “Light work” involves lifting no more than twenty pounds at a time, but frequently lifting objects weighing ten pounds. 20 C.F.R. §§ 404.1567(b), 416.967(b). A person who can meet these lifting requirements can perform light work only if he or she also can “do a good deal of walking or standing, or do some pushing and pulling of arm or leg controls while sitting.” *Hays v. Sullivan*, 907 F.2d 1453, 1455 n.1 (4th Cir. 1999).

On March 9, 2011, Jefferson sought evaluation for a work excuse because of back pain.⁴ She stated that she had reported to the emergency room for treatment of her pain a few days earlier and was prescribed pain medication and muscle relaxants. Jefferson claimed that she could not get up and down or dress herself without assistance. She complained of tingling in her hips and thighs bilaterally and stated that she walked with difficulty. On physical examination, she exhibited extreme pain on palpation over L5-S1 and marked tenderness over the paravertebral muscles. She indicated pain in her hips, right greater than left, that was exacerbated on palpation of the paravertebral muscles. R. 385–87. X-rays from the emergency room showed a loss of disc height at L5-S1 with an impression of degenerative disc disease, but were otherwise unremarkable. R. 386, 411. She was referred to the spine clinic at the University of Virginia Health System (“UVAHS”) and continued on muscle relaxants and opioid pain medications, although she was advised that her opioid medication would not be very effective at treating the source of her pain. R. 386.

One week later, an MRI taken at UVAHS revealed bulging discs, which caused mild left foraminal stenosis at L4-L5 and severe canal stenosis with mild bilateral foraminal stenosis at L5-S1. R. 407–08.

After consulting with Gregory Helm, M.D., at UVAHS on April 5, Jefferson elected to undergo surgery because the pain from her bulging discs was too great. R. 349. On April 28, 2011, she underwent a bilateral partial hemilaminectomy, discectomy, and interlaminar decompression at L5-S1. R. 342–43.

On June 14, 2011, Jefferson reported to Judy Broughton, a family nurse practitioner at Jefferson’s primary care practice, with complaints of pain around the incision site on her back

⁴ Although it is not in the doctor’s notes at this time, Jefferson told her counselor in a later therapy session she was injured by a basketball hoop falling on her while she was working at K-Mart. R. 677; *see also* R. 606 (explaining that basketball goal fell on her in December 2010).

and bilateral “jerking” of her arms while carrying items such as plates. Findings on physical examination were unremarkable. R. 375–77. She followed up with UVAHS on June 22, at which time she still complained of back pain and lancinating pain in her left leg and both arms. On examination, she demonstrated difficulty getting from the couch to the examining table and exhibited extreme tenderness around the surgical site. Sensory examination was within normal limits, and motor examination was also within normal limits except in both iliopsoas, which gave way under minimal pressure. A CT myelogram was ordered to determine if there were any further issues. R. 333.

The myelogram was performed on July 13, 2011, revealing spondylosis of the lumbar spine, most notable at L5-S1, with moderate left and mild to moderate right neural foraminal stenosis. R. 355–56. Dr. Helm, after reviewing the imaging, cautioned against further surgery in a letter to Broughton, stating he was “not totally convinced” the back problems were “severe enough to warrant surgery.” R. 459. Notably, Dr. Helm recommended “conservative measures” for further treatment, and explicitly recommended a weight-loss program to deal with Jefferson’s obesity as “the best long-term option” *Id.*

Jefferson visited Dr. Goodnight again on August 2 complaining of back pain and stating that she intended to start seeing a pain specialist. She also complained of migraines, sleeping difficulties, memory loss, and numbness in her toes. Her asthma symptoms were in remission. Findings on physical exam were unremarkable, with normal range of motion of the spine and no tenderness to palpation. Dr. Goodnight prescribed continued use of Tegretol and an increased dose of Cymbalta. R. 372–74.

At another surgical follow-up with Susan Johnson, M.D., at UVAHS on August 23, Jefferson stated that she still experienced problems in her lower back and lancinating pain in her

left leg and both arms. She described her back pain as radiating into the bilateral gluteal region and sometimes as far as the top of her feet. She complained that her lower back pain was constant, rendered her immobile for most of the day, not relieved by heat or ice, made worse by activity, and mildly remitted with rest. Jefferson also claimed that she had been diagnosed with fibromyalgia.⁵ On physical examination, she had normal strength and sensation in her extremities, negative straight leg raise and facet loading tests, positive Patrick's maneuver (left greater than right), and tenderness over the paraspinal muscles and SI joint. Dr. Johnson recommended conservative treatment measures, including anti-inflammatory drugs, increased doses of gabapentin, physical therapy, weight loss, glucose control, and biofeedback and relaxation techniques. She also left open the possibility of SI injections if other measures did not work and if noticeable weight loss occurred. R. 581–84.

On October 24, 2011, Jefferson reported to Elizabeth Hagan, a family nurse practitioner at Jefferson's primary care practice, that over the past two weeks she had blacked out three times while driving. Pertinent reported symptoms included chest pain, nausea, dizziness, orthopnea, paroxysmal nocturnal dyspnea, palpitations, and shortness of breath. She also complained of depression and profuse sweating. EKG and physical examination were unremarkable. Because of her blackouts, Jefferson was taken to the emergency room and informed that under state law she could not drive for six months. R. 549–51.

At the hospital, Owais Jeelani, M.D., examined Jefferson, who was complaining of retrosternal chest tightness and associated sweating and back pain. She also mentioned that Nurse Hagan stated her blood pressure did not look good. The physical examination was unremarkable. Given her risk factors, Dr. Jeelani elected to admit Jefferson to the hospital for

⁵ Jefferson stated in a May 2012 visit with a pain specialist that she was diagnosed with fibromyalgia syndrome in 2007. R. 606. The only other place this diagnosis is even mentioned in the record, however, is her initial exam with the sleep specialist, Dr. Brown. R. 577, 580.

observation and further testing. R. 490–91. Reviewing an X-ray of Jefferson’s chest Douglas May, M.D., found no bony abnormalities, the heart and mediastinal contours within normal limits, and clear lungs. R. 521–22.

On consultation, neurologist Rafael Hurtado, M.D., concluded that Jefferson’s blackout episodes were more likely the result of falling asleep and that sleep apnea was a likely diagnosis, but syncope, presyncope, and seizure should be evaluated through an EEG and overnight pulse oximetry. A physical examination was again unremarkable. R. 479–81. Dr. Hurtado found no sign of seizure or other neurological disorder from the EEG. R. 531. Cardiologist Brian Zagol, M.D., found no remarkable cardiac issues. R. 484–85.

Upon discharge, Dr. Jeelani noted Jefferson was ruled out as having any form of acute coronary syndrome. She was referred to UVAHS for a sleep study and warned against driving again until a determination was made regarding whether she had obstructive sleep apnea (“OSA”), narcolepsy, or nothing at all. R. 474–77.

On November 10, Nurse Broughton conducted a physical exam that was mostly unremarkable, except that Jefferson fell asleep when not being spoken to, and the sensation in her feet was not present in all areas. Broughton advised Jefferson that the treatment of her suspected OSA would only be effective with use of a CPAP machine and weight loss. R. 545–48.

The following day, Jefferson saw Cynthia Brown, M.D., a sleep specialist at UVAHS, and she reported myriad sleep problems, including nocturia and episodes of sleep paralysis. The general physical examination was unremarkable except, again, for Jefferson’s tendency to fall asleep when not spoken to, and Dr. Brown identified OSA as a likely diagnosis. R. 576–80. That night, Jefferson underwent a sleep study, resulting in an impression of mild overall severity of

OSA, but severe OSA with severe oxyhemoglobin desaturation during REM sleep. R. 573–74. Jefferson underwent a nasal CPAP titration study five days later, which successfully eliminated most apneas and hypopneas and kept oxyhemoglobin saturation within normal limits. Treatment with a nasal CPAP machine was prescribed. R. 572–73.

In a follow-up visit on February 2, 2012, with Jill Holmes, N.P., at the UVAHS sleep clinic, Jefferson reported that the nightly use of the CPAP machine helped with her OSA symptoms, but was not doing much to reduce her daytime sleepiness. Holmes noted the large quantity of drowsiness-causing medications prescribed, many of which were at their maximum dosage, and recommended that Jefferson consult with her primary care provider and a psychiatrist to see about reducing and/or eliminating her prescriptions. The general physical exam was unremarkable. R. 601–04. Another sleep study conducted by Dr. Brown three weeks later found no evidence of pathologic sleepiness or sleep onset REM periods, and Jefferson maintained her CPAP regimen as originally prescribed. R. 593–94, 596–99.

On February 23, Jefferson saw Andrew Vranic, M.D., a pulmonologist at UVAHS, for evaluation of her asthma and dyspnea. Jefferson reported that she had not required hospital admission for her asthma since she was a child but that she frequently experienced dyspnea with mild to moderate exertion. Her general physical exam was unremarkable. Dr. Vranic assessed her dyspnea as multifactorial, the result of deconditioning, obesity, polypharmacy, OSA, and disordered sleep. Her asthma was mild and intermittent, and COPD was considered a possible factor for both asthma and dyspnea, considering her long smoking history. Jefferson also mentioned she was being screened as a candidate for gastric bypass surgery. R. 595–96.

On April 12, Jefferson began seeing Victor Owusu-Yaw, M.D., a neurologist, to address her migraines, chronic daily headaches, and diabetic neuropathy. Her general physical

examination was unremarkable. The neurologic examination revealed normal mental status without evidence of disorientation, impaired concentration, memory disturbance, language problem, or apraxia. Her cranial nerves were all intact, and she had normal coordination. She was unable to walk on heel and toe or perform tandem walking, and she required a cane for ambulation. She had full strength throughout her body and no abnormal movements. Deep tendon reflexes were decreased, and she had diminished sensation throughout for modalities of touch, pinprick, vibration, and temperature. Dr. Owusu-Yaw began a drug regimen of Depakote and Paxil to address Jefferson's headaches. R. 653–55.

At a follow-up visit in May, Jefferson stated that since starting Depakote and Paxil she was "better by 50% with her headaches." The neurologic examination findings were the same as in her previous visit. R. 650–52. In August, the headaches remained steady in their improved state, and the neurologic examination now showed normal deep tendon reflexes throughout. R. 647–49. Further progress was noted in September, with Jefferson's headaches continuing to be 50% better and the neurologic examination showing her sensation to be normal throughout all the tested modalities. R. 643–46. In October, Jefferson complained of worsening pain in her headaches and increased neuropathy. The neurologic examination was normal and revealed the ability to walk on heel and toe and no assistance for ambulation. R. 639–42. A February 2013 visit saw Jefferson still complaining of increased headache pain and neuropathy, but neurologic examination was unremarkable. R. 635–38.

On May 9, 2012, Jefferson began seeing Larry Winikur, M.D., a pain specialist. Jefferson complained of pain all over her body, secondary to fibromyalgia syndrome. She described pain in the back of her neck that radiated down into her lower back, pain that radiated down the front and back of her legs into her knees and feet, and pain in both hands. She described the pain as

sharp, aching, burning, throbbing, stabbing, electrical shocks, tingling, numb, and weak. Sitting and standing increased her pain, and she rated her pain that day as an eight out of ten. A general physical examination revealed generally unremarkable findings, and it was noted that she had painless, full range of motion in her spine, arms, and legs; exhibited tenderness over the lumbar facet joints and paraspinal muscles; had normal stability, strength, and station in her gait; had normal motor strength, but “subjective weakness” in her extremities; and used a cane. Dr. Winikur prescribed both Neurontin and Lortab. R. 606–10.

At a July visit with Dr. Winikur, Jefferson stated that her pain was tolerable on the current drug regimen. The general physical examination revealed nothing exceptional. R. 611–14. In August, Jefferson received a transforaminal epidural steroid injection at L4-L5. R. 615–17. In September, she reported that the pain was only located in her bilateral lower lumbar back and right lower extremity. She stated the prescriptions were helping with the pain. The general physical examination was unremarkable. R. 618–22. Another epidural was administered in November. R. 623–25.

In December, Jefferson again reported pain in her bilateral lower lumbar back, this time radiating down both legs into her feet. She stated that the November epidural provided good relief for one month and that the current drug regimen was helpful in controlling her pain. The general physical examination was unremarkable. R. 626–30. Another epidural was administered in January 2013. R. 631–33.

At a February visit with the pain specialist, Jefferson complained of pain in the middle of her back that radiated down the front of her legs and into her toes. She said that Lortab gave her some relief for two to three hours and that her most recent epidural gave her three weeks of relief. The general physical examination was unremarkable. R. 688–92. Another epidural was

administered in March. R. 693–95. During an appointment in April, Jefferson reported only mild pain in her lower back radiating down the front of her legs. She stated that her current prescriptions were very effective in controlling her pain and muscle spasms. The general physical examination was unremarkable. R. 696–700.

Michael Rawlins, M.D., performed laparoscopic Roux-en-Y gastric bypass, cholecystectomy, and a liver biopsy on May 22. R. 684–86. There is no other information about this procedure in the record.

B. Mental Impairments

Jefferson also claims a mental impairment of depression. R. 21. She has received prescriptions for antidepressants since at least March 31, 2010, from Dr. Goodnight, which remained consistent through at least February 2012. R. 375–99, 548–58, 576–84, 595–96, 602–04. She also received prescriptions for anti-anxiety drugs from March through June, R. 375–81, although unspecified anxiety did not appear in her record until a visit with Nurse Broughton in June 2011, R. 375–77. In November 2011, a diagnosis of depression was noted by Broughton, R. 545–47, and Drs. Brown and Winikur also noted depression as a diagnosis in the relevant records, R. 576–80, 606–10.

During the visits at her primary care provider, Jefferson’s general appearance was noted as pleasant, alert, and oriented, and her psychological state as appropriate. R. 372–99, 545–55. Dr. Brown recommended Jefferson see a psychiatrist for assistance in reducing the amount and types of medications prescribed. R. 602–04.

In April 2012, Dr. Owusu-Yaw observed that Jefferson had uncontrolled depression and anxiety, but that she denied any suicidal or homicidal thoughts. He began actively treating Jefferson’s depression by increasing her dosage of antidepressants. The doctor reported a normal

mental status, however, without evidence of disorientation, impaired concentration, memory disturbance, language problem, or apraxia. R. 653–55. Identical evaluations were made in May and July, but the dose of antidepressant was increased at the latter appointment. R. 647–52.

At the August visit, Dr. Owusu-Yaw said Jefferson’s depression was “not really any better” and that she complained of six to seven panic attacks a day, for which he prescribed her a sedative. Her mental status in the neurologic examination was assessed as normal. R. 643–46. Dr. Owusu-Yaw made an identical assessment in October, increased Jefferson’s Paxil prescription, and referred her to a psychiatrist. R. 639–42. Depression was noted as uncontrolled again at the February 2013 visit, at which time Jefferson was still waiting to see a psychiatrist. R. 635–38.

Dr. Winikur stated in every single visit with Jefferson from May 2012 through June 2013, that her affect was appropriate, with no depression, anxiety, or agitation. R. 606–14, 618–22, 626–30, 688–92, 696–704.

On May 3, 2012, Jefferson had her first meeting with Jane Rose, a licensed clinical social worker (“LCSW”). In that meeting, Rose made an initial diagnosis of bipolar I disorder, as well as generalized anxiety disorder. She also assigned a global assessment of functioning (“GAF”) score of 47/45.⁶ Jefferson described her mood as depressed, with low self-esteem and poor self-image, and she admitted to some suicidal ideation. Rose noted that Jefferson was oriented to person, place, time, and situation. R. 678–82. At the following appointment, on May 31, Rose’s assessment of Jefferson’s mental status again showed she was oriented to person, place, time,

⁶ GAF scores represent a “clinician’s judgment of the individual’s overall level of functioning.” American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 32 (4th ed., text rev., 2000) (“DSM-IV”). The scale is divided into 10 ten-point ranges reflecting different levels of functioning, with 1–10 being the lowest and 91–100 the highest. *Id.* Jefferson’s score of 47/45 indicates “[s]erious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).” *Id.* at 34.

and situation, but that she seemed apathetic, depressed, and anxious, with suicidal thoughts. Jefferson reported that she was agitated and “trying to keep my cool.” R. 677.

Two weeks later, Jefferson reported low energy levels, excessive worrying, and suffering from back pain. Rose noted Jefferson was appropriately oriented and had lucid speech, appropriate mood, and goal directed and relevant thoughts. R. 676. Later in June, Jefferson complained about personal problems with her mother, expressed disorganized speech, and had a depressed, anxious, and flat mood, but was appropriately oriented with coherent and relevant thoughts. R. 675.

For the next four sessions, lasting through August, Jefferson was noted to be appropriately oriented, with an appropriate mood and goal-directed and coherent thoughts. She attested to severe panic attacks and complained more about her relationship with her parents, financial woes, and problems sleeping. R. 670–73. Rose noted that Jefferson’s speech in an October session was fragmented, disorganized, and blunted, and that her mood was depressed, anxious, and flat. Her orientation and thoughts were appropriate, as they were in prior sessions. Jefferson complained more about financial issues and her parents, and she also signed off on a treatment plan with the goal of improving her coping skills. R. 668–69.

In the two subsequent sessions, Rose’s assessment of Jefferson’s mental status matched her earlier findings of appropriate orientation, lucid speech, appropriate mood, and goal-directed and relevant thoughts. She continued to discuss her relationship with her parents, as well as her abusive ex-husband. R. 666–67. At a session later in November, she was noted to have fragmented and disorganized speech and a depressed and anxious mood, and she continued to discuss her tense relationship with her mother. R. 665.

At four appointments from December 2012 through March 2013, Rose again assessed Jefferson's mental status as appropriately oriented, with lucid speech, appropriate mood, and goal-directed and relevant thoughts. Jefferson mentioned that she knew if she could stop taking some of her medications, her overall health and well-being would improve. She also reported that she got a dog, which seemed to be helping her feel less depressed and anxious. R. 659–63. At the May 16 appointment, Jefferson's mood was recorded as depressed and anxious because another boy allegedly molested her son and the police were investigating. R. 657.

C. Jefferson's Statements

In a function report that Jefferson submitted to the state agency on September 15, 2011, she reported that, since she sustained her injuries, a typical day started with her helping get her seven year-old son ready for school. After that, she would go back to bed, have lunch, and then take an afternoon nap. When her son came home from school, she would spend time with him, assisting with food and homework, until bedtime. Jefferson reported that she received help from her family with her son and around the house. R. 263–70.

Jefferson also reported that she had difficulty dressing, bathing, toileting, feeding herself, and attending to other hygiene tasks, but did not require any assistance. She also claimed she could prepare simple foods, but family members performed yard and house work for her. She claimed to go outside at least twice a day to get her son on and off the school bus, and she could walk, drive a car, and otherwise get around on her own for short periods of time. Jefferson also stated that she usually received assistance from family when she went grocery shopping, but was able to pay bills, handle a savings account, and use a checkbook herself. *Id.*

Jefferson stated that her hobbies and interests include watching television, listening to music, and spending time with friends and family. She stated that she talks on the phone and

sends messages online, occasionally receives visitors, and attends church whenever possible. She also reported that she does not always need someone to accompany her locally, but always needs someone else to come along to doctor's appointments and travel out of town. *Id.*

Jefferson described limitations to her physical abilities caused by her injuries. She could stand for five minutes at a time, reach at arm's length, and walk short distances, but she could not squat or lift anything over ten pounds and could only bend a little from the waist. She reported being able to pay attention for only about a half hour before getting sleepy and claimed to have difficulty with memory and understanding, but she also stated that she could follow spoken instructions and was able to get along with authority figures. *Id.*

In a pain questionnaire, dated September 15, 2011, Jefferson stated that her pain was all over her body, and that it lasted "every day, all day and night." She also claimed that "most all activity" made it worse and that sometimes medication, heat, cold, rest, and lying down helped relieve the symptoms. R. 281–82. On a fatigue questionnaire, completed on the same date, Jefferson claimed she was tired all the time and had difficulty completing tasks, like cooking and cleaning, without having to stop and rest. She also claimed to need twelve hours of sleep a day and to spend most of her time resting. R. 284–85.

At the July 10, 2013, hearing before ALJ Peltzer, Jefferson testified that the pain medication she took did not help at all and that she could sleep only two to three hours a night because of her pain. She also attested to using a walker recently and stated that she previously had used crutches most of the time. R. 53–57.

Jefferson testified that her neuropathy caused her to drop objects and that her fibromyalgia often was so bad she could not even let people hug her or pat her on the back. She stated that her pain was constant and that she was unable to relieve it except temporarily in a hot

shower. She also claimed that she had to alternate between sitting and standing and that she could walk only the distance from the handicapped parking space into a building. R. 60–62.

Jefferson also discussed the help she received from family, especially her aunt, in performing daily tasks like preparing food. Jefferson claimed that she was unable to dress or bathe without assistance and that her aunt helped quite a bit with cooking and cleaning around the house. She also alleged that she was able to get in and out of chairs by herself, but could not pick something up off the ground if she dropped it. She also stated that she could shop for groceries on her own, but that her aunt took care of it for her most of the time. R. 63–64, 66–67.

D. Medical Opinions

The only medical opinions in the record come from the state agency Disability Determination Services (“DDS”) physicians and psychologists. On initial review, Josephine Cader, M.D., provided two assessments of Jefferson’s physical RFC. For Jefferson’s DIB claim, Dr. Cader found that as of June 30, 2011, Jefferson could perform a limited range of light work consisting of lifting ten pounds occasionally and frequently, standing or walking for two hours in an eight-hour workday, and sitting for six hours in an eight-hour workday. She also found that Jefferson was limited to occasionally performing postural activities. R. 99–100. On October 3, 2011, Dr. Cader assessed Jefferson’s then-current functioning for her SSI claim, and found that she could perform a full range of light work, lifting twenty pounds occasionally and ten pounds frequently, standing or walking for six hours, and sitting for six hours. R. 109–10.

On reconsideration, Alan D. Entin, Ph.D, found that Jefferson had an affective disorder that was a medically determinable impairment, but was not severe. Dr. Entin noted that Jefferson was prescribed medication for depression by her primary care doctor, but treatment notes documented normal findings, and Jefferson had not been hospitalized for depression. He also

noted her activities of daily living. R. 120. Paula Nuckols, M.D., determined that Jefferson could perform a full range of light work and that she was limited to occasionally engaging in postural activities. R. 122–23.

IV. Discussion

Jefferson alleges three specific errors by the ALJ that she claims warrant a reversal or remand. *See* Pl.’s Br. 3–4, ECF No. 20. She first claims that the facts clearly demonstrate that her alleged mental impairment of depression is severe. *Id.* at 5-6. Next, Jefferson argues that the ALJ should have found her per se disabled by a listed impairment, either because of her back injuries or her diabetic neuropathy. *Id.* at 7. Finally, Jefferson argues the ALJ’s determination of the RFC is too “permissive,” *id.* at 8, and leads, therefore, to the incorrect conclusion that she could perform work in the national economy, *id.* at 9–10. Because I find that substantial evidence supports the ALJ’s determinations, I must disagree with Jefferson’s arguments.

A. The Severity of the Alleged Mental Impairment

Jefferson contends that the ALJ erred by not finding her mental impairment of depression to be severe. The regulations state, an “impairment is not severe if it does not significantly limit [the claimant’s] physical or mental ability to do basic work activities.” 20 C.F.R. §§ 404.1521(a), 416.921(a). With regard to a claimant’s mental functioning, “basic” work activities are things such as following simple instructions, responding appropriately to other people, and coping with changes in a routine work setting. *Id.* §§ 404.1521(b), 416.921(b).

An impairment should be labeled “not severe only if it is a *slight abnormality* which has such a *minimal effect* on the individual that it would not be expected to interfere” with a claimant’s work activities. *Evans v. Heckler*, 734 F.2d 1012, 1014 (4th Cir. 1984) (internal quotation marks omitted); *see also Waller v. Colvin*, No. 6:12cv63, 2014 WL 1208048, at *7

(W.D. Va. Mar. 24, 2014). This is not a difficult hurdle for the applicant to clear. *See Albright v. Comm'r of Soc. Sec.*, 174 F.3d 473, 474 n.1 (4th Cir. 1999); *Carr v. Comm'r of Soc. Sec.*, No. 4:10cv25, 2011 WL 1791647, at *9 (W.D. Va. May 11, 2011). Still, this Court must affirm the ALJ's severity finding if she applied the correct legal standard and if her conclusion is supported by substantial evidence in the record. *See Meyer*, 662 F.3d at 704.

ALJs use "a special technique" to evaluate the severity of an alleged mental impairment. 20 C.F.R. §§ 404.1520a(a), 416.920a(a). First, the ALJ evaluates the applicant's symptoms and medical records to determine whether she has a "medically determinable mental impairment." *Id.* §§ 404.1520a(b), 416.920a(b). If she does, the ALJ then rates the applicant's resulting "degree of functional limitation" in four areas: activities of daily living; social functioning; concentration, persistence, or pace; and episodes of decompensation.⁷ *Id.* §§ 404.1520a(c)(3), 416.930a(c)(3); *see also id.* pt. 404, subpt. P, app. 1 § 12.00(C). "Non-severe" mental impairments cause no more than "mild limitations" in the first three areas and no episodes of decompensation. *Id.* §§ 404.1520a(d)(1), 416.920a(d)(1). As always, the ALJ must analyze all of the relevant evidence, articulate her rationale for crediting certain evidence, make required factual findings, and adequately explain the grounds for her conclusions at this stage. *See Bill Branch Coal Corp. v. Sparks*, 213 F.3d 186, 190 (4th Cir. 2000).

In this case, the ALJ found that Jefferson had a medically determinable mental impairment of depression. The evidence in the Administrative Record supports this finding. For example, Jefferson's primary care provider diagnosed her with depression in November 2011, R. 547, and prescribed an antidepressant (and sometimes anti-anxiety medication), since at least

⁷ Limitations in the first three areas are measured on a five-point scale: none, mild, moderate, marked, or extreme. 20 C.F.R. §§ 404.1520a(c)(4), 416.920a(c)(4). Limitation in the fourth area is measured by the number of episodes of decompensation a person has experienced. *Id.*

March 2010, *see* R. 398. Furthermore, this diagnosis was supported by Dr. Brown, R. 604, and Dr. Owusu-Yaw, R. 654.

The ALJ thoroughly discussed the evidence relating to Jefferson's depression, and she explained her severity analysis. R. 21–24. The ALJ noted that the vast majority of Jefferson's mental health treatment came through psychotherapy sessions with LCSW Rose. She discussed Ms. Rose's treatment notes, identifying the varying instances of depressive and normal symptoms and Jefferson's reports of family, social, and financial stressors. Although Jefferson had been prescribed Paxil, an anti-depressant, the ALJ observed that Jefferson had not seen a psychiatrist. The ALJ also found, "on many medical visits, [Jefferson's] mental functioning has been normal." R. 23. The Administrative Record supports this conclusion. Dr. Owusu-Yaw reported, "mental status is normal without evidence of disorientation, impaired concentration, memory disturbance, language problem or apraxia." *Id.* This finding matches Dr. Owusu-Yaw's and other physicians' treatment notes, which consistently documented normal mental status findings. *See, e.g.*, R. 584 (Drs. Tarasi and Johnson), 636 (Dr. Owusu-Yaw), 699 (Dr. Winikur). Additionally, the ALJ noted that Jefferson's social activities and interactions, travels, and activities of daily living suggested that her depression caused no more than mild limitations. R. 23–24.

Jefferson contends that ALJ Peltzer erred by giving "no weight" to the clinical records of Ms. Rose, including the GAF score of 47/45 recorded by Rose during her initial session. Pl.'s Br. 6, ECF No. 20. Jefferson argues that Rose's findings are corroborated by treatment notes of other medical providers. Specifically, she relies on Dr. Owusu-Yaw's diagnosis of depression, which he noted was "uncontrolled." R. 654. The problem with this argument, as discussed above and noted by the ALJ, R. 23, is that the physicians who assessed Jefferson's mental status found it to be

normal. Additionally, Ms. Rose, a licensed clinical social worker, is considered an “other source[.]” SSR No. 06-03p, 2006 SSR LEXIS 5, at *4. “Information from these ‘other sources’ cannot establish the existence of a medically determinable impairment However, information from such “other sources” may be based upon special knowledge of the individual and may provide insight into the severity of the impairment(s) and how it affects the individual’s ability to function.” *Id.* at *5; *see also* 20 C.F.R. §§ 404.1513(d), 416.913(d). Presented with evidence of normal mental examination findings, but also findings of some depressive symptoms, the ALJ acted within her realm of discretion in weighing this contradictory evidence.

The ALJ discussed at length Ms. Rose’s treatment notes, but she dismissed the GAF score because the score, which suggested severe limitations, was overwhelmingly contradicted in later psychotherapy sessions, *e.g.*, R. 676, concurrent physician’s notes, *e.g.*, R. 609, and Jefferson’s earlier Function Report, *see* R. 263-70. R. 23. Thus, the ALJ reasonably refused to credit the one-time application of the GAF by a non-acceptable medical source in light of the rest of the evidence. *See Craig*, 76 F.3d at 590. I cannot find this decision to be in error.

With this discussion of the Administrative Record in mind, the ALJ analyzed the functional limitations attributable to Jefferson’s depression and found them to be mild. Although the ALJ did not explicitly analyze each area of functioning, a close reading of her opinion shows that she considered all areas. For example, regarding activities of daily living, the ALJ noted that Jefferson was capable of at least rudimentary daily tasks such as bathing, getting dressed, and preparing simple foods. R. 23. As to social functioning, the ALJ favorably cited Jefferson’s ability to maintain relationships with family, attend church when possible, and use of the telephone and online messaging. R. 23. Finally, with regard to concentration, persistence, or pace, the ALJ noted the multiple records from doctors about Jefferson’s psychological state,

awareness, and function, as well as her own professed ability to follow written and spoken instructions. R. 23–24. Finally, the ALJ accurately concluded that the Administrative Record contained no evidence of any episodes of decompensation. R. 23–24. The ALJ also observed that the DDS psychologist determined that Jefferson did not have a severe mental impairment. *See Gordon v. Schweiker*, 725 F.2d 231, 235 (4th Cir. 1984) (holding that an ALJ may rely on the opinion of a consulting medical professional where it is consistent with the record.) Concurring with this opinion, the ALJ determined that Jefferson did not have a severe mental impairment. Considering the Administrative Record as a whole and the ALJ’s explanation, I find that this determination is supported by substantial evidence.

B. Listed Impairments

Jefferson also argues that the ALJ erred by not finding that her back injury or diabetic neuropathy met or medically equaled a listed impairment. Pl. Br. 7. Although Jefferson claims that ALJ Peltzer did not fully explain why these listings were not met, *id.*, her brief does not present any evidence to indicate the ALJ’s conclusion was incorrect.⁸ The ALJ did, in fact, discuss why she found that Jefferson’s impairments did not meet Listings 1.04 or 11.14, which pertain to disorders of the spine and peripheral neuropathies, respectively. R. 24–25. Furthermore, a review of the Administrative Record shows these determinations to be supported by substantial evidence.

There is no evidence of nerve root compression or spinal arachnoiditis, as required to meet the criteria for Listings 1.04(A) and (B), respectively. Although there is evidence of stenosis, which is necessary to meet the criteria for listing 1.04(C), the ALJ correctly found that the Administrative Record does not show that this condition resulted in pseudoclaudication or that Jefferson required assistance “that limits the functioning of both upper extremities” (e.g., a

⁸ At oral argument, Jefferson’s counsel conceded the Listings argument.

walker) in order to ambulate, *see* 20 C.F.R. pt. 404, subpt. P, app. 1 § 1.04(C) (citing *id.* § 1.00(B)(2)(b)). R. 24. While not perfectly consistent, the record frequently notes no limitations to Jefferson's range of motion or strength, a normal walking gait, and no assistance for ambulation. *See, e.g.*, R. 635–38.

As to Listing 11.14, the ALJ accurately determined that the record failed to show that Jefferson had either sensory or motor aphasia resulting in ineffective speech or communication or significant and persistent disorganization of motor function in two extremities. R. 25.

For the foregoing reasons, I find that the ALJ's determination that Jefferson's severe impairments do not meet or medically equal Listings 1.04 or 11.14 is supported by substantial evidence.

C. The RFC Determination

Finally, Jefferson argues that the ALJ's RFC determination was overly "permissive," and therefore was "flawed, and not based on substantial evidence." Pl.'s Br. 8. Jefferson argues that the RFC "should be more restrictive . . . because the ALJ's determination is simply not based upon any actual evidence in the record." *Id.* at 9. A claimant's RFC is a factual finding "made by the Commissioner based on all the relevant evidence in the [claimant's] record," *Felton-Miller v. Astrue*, 459 F. App'x 226, 230–31 (4th Cir. 2011) (per curiam), and it must reflect the combined limiting effects of impairments that are supported by the medical evidence or the claimant's credible complaints, *see Mascio v. Colvin*, 780 F.3d 632, 638–40 (4th Cir. 2015). The ALJ's RFC assessment "must include a narrative discussion describing" how specific medical facts and nonmedical evidence "support[] each conclusion" in her RFC finding, *Mascio*, 780 F.3d at 636, and why she discounted any "obviously probative" conflicting evidence, *Arnold v. Sec'y of*

Health, Educ. & Welfare, 567 F.2d 258, 259 (4th Cir. 1977); *see also Reid v. Comm’r of Soc. Sec.*, 769 F.3d 861, 865 (4th Cir. 2014).

The ALJ found that Jefferson could perform light work consisting of lifting ten pounds frequently and twenty pounds occasionally; standing or walking for four hours and sitting for six hours in an eight-hour workday; never climbing ladders, ropes, and scaffolds, kneeling, and crawling; and occasionally climbing stairs, operating foot controls, balancing, stooping, and crouching. R. 26. Additionally, Jefferson was limited to occasional exposure to environmental hazards. *Id.*

Here, Jefferson primarily alleges limitations in functioning that are caused by the combined effects of her impairments and her pain and depression. Pl.’s Br. 9–10. She contends that the RFC should have included a limitation for being off task 10% of the time. Although Jefferson casts this argument as a challenge to the ALJ’s hypothetical to the VE and determination that she can perform other work, the argument actually goes to the ALJ’s RFC determination.

The ALJ found Jefferson’s report of disabling symptoms not entirely credible. R. 28. The regulations set out a two-step process for evaluating a claimant’s allegation that she is disabled by symptoms, including pain, caused by a medically determinable impairment. *Fisher v. Barnhart*, 181 F. App’x 359, 363 (4th Cir. 2006) (citing 20 C.F.R. § 404.1529). The ALJ must first determine whether objective medical evidence⁹ shows that the claimant has a medically determinable impairment that could reasonably be expected to cause the kind and degree of pain

⁹ Objective medical evidence is any “anatomical, physiological, or psychological abnormalities” that can be observed and medically evaluated apart from the claimant’s statements and “anatomical, physiological, or psychological phenomena [that] can be shown by the use of medically acceptable diagnostic techniques.” 20 C.F.R. §§ 404.1528(b)–(c), 416.928(b)–(c). “Symptoms” are the claimant’s description of his or her impairment. *Id.* §§ 404.1528(a), 416.928(a).

alleged. 20 C.F.R. §§ 404.1529(a), 416.929(a); *see also Craig*, 76 F.3d 594. If the claimant clears this threshold, then the ALJ must evaluate the intensity and persistence of the claimant's pain to determine the extent to which it affects her physical or mental ability to work. SSR 96-7p, 1996 WL 374186, at *2 (July 2, 1996); *see also Craig*, 76 F.3d at 595.

The latter analysis often requires the ALJ to determine “the degree to which the [claimant's] statements can be believed and accepted as true.” SSR 96-7p, at *2, *4. The ALJ cannot reject the claimant's subjective description of her pain “solely because the available objective medical evidence does not substantiate” that description. 20 C.F.R. §§ 404.1529(c)(2), 416.929(c)(2). Rather, she must consider all the relevant evidence in the record, including the claimant's other statements, her treatment history, any medical-source statements, and the objective medical evidence. 20 C.F.R. §§ 404.1529(c), 416.929(c).

The ALJ must give specific reasons, supported by relevant evidence in the record, for the weight assigned to the claimant's statements. *See Mascio*, 780 F.3d at 639; *Eggleston v. Colvin*, No. 4:12cv43, 2013 WL 5348274, at *4 (W.D. Va. Sept. 23, 2013) (citing SSR 96-7p, at *4). A reviewing court will defer to the ALJ's credibility finding except in those “exceptional” cases where the determination is unclear, unreasonable, contradicts other findings of fact, or is based on an inadequate reason or no reason at all. *Bishop v. Comm'r of Soc. Sec.*, 583 F. App'x 65, 68 (4th Cir. 2014) (per curiam) (citing *Edelco, Inc. v. NLRB*, 132 F.3d 1007, 1011 (4th Cir. 1997)); *see also Mascio*, 780 F.3d at 640.

The ALJ detailed Jefferson's report of limitations. She noted Jefferson's report of pain, neuropathy, sleep problems, headaches, bowel problems, and breathing problems and what functional restrictions those conditions caused. R. 27–28. Having reviewed in detail Jefferson's treatment records, R. 14–22, the ALJ questioned the severity of her claimed limitations, R. 28.

Other than a back surgery in 2011, the ALJ found that Jefferson's treatment had been conservative, consisting of medications, a few epidural injections, and a brief stint in physical therapy. In the months following Jefferson's back surgery, Dr. Helm, who performed that surgery, determined that the most appropriate treatment of her spondylosis was weight loss. R. 459. As the ALJ noted, physical exams throughout the record documented normal findings, including for gait, extremity strength, and range of motion. R. 609, 613, 698–99. The ALJ also noted that treatment records did not support Jefferson's claims of handling limitations attributable to neuropathy, her claims of dizziness, or her claims of bowel problems. The disparities between Jefferson's report of symptoms and the treatment she received and the physical exam findings provide adequate grounds for the ALJ to question the credibility of her symptoms.

Additionally, the ALJ found that some of Jefferson's activities of daily living—presumably those the ALJ deemed credibly reported—were inconsistent with her other claimed limitations and showed that Jefferson could perform light work. R. 28–29. The ALJ noted that Jefferson traveled, drove a car, shopped in stores, and went out on her own for short periods. She could tend to her personal care, albeit with some difficulty, take care of her son, prepare simple meals, and handle her finances. She went to church when she was able, had friends and family visit, talked on the phone, watched television, and listened to music. While these cited activities are fairly limited, they are largely consistent with many of the components of the RFC.

The ALJ explained that she did not assign additional limitations caused by Jefferson's non-severe depression because Jefferson's therapy and medication regimen appeared to effectively manage her condition and she had not pursued more intensive treatment by a psychiatrist. R. 29. Additionally, in finding this impairment non-severe, the ALJ thoroughly

discussed the evidence of her mental impairment and determined that it caused no more than a mild limitation. This discussion provides adequate support for the ALJ's exclusion from the RFC of any restrictions attributable to Jefferson's depression.

The ALJ noted that the only opinions in the Administrative Record of Jefferson's functional ability were given by the DDS physicians. She gave great weight to the opinions that Jefferson could perform light work. Accounting for Jefferson's obesity, the ALJ restricted the length of time Jefferson could stand or walk and imposed greater restrictions on her postural activities than those assigned by the DDS physicians. This analysis adequately explains how the ALJ reached her conclusions, and it provides substantial evidence for the ALJ's RFC determination.

V. Conclusion

For the foregoing reasons, I respectfully recommend that the Court **DENY** Jefferson's Motion for Summary Judgment, ECF No. 19, **GRANT** the Commissioner's Motion for Summary Judgment, ECF No. 21, **AFFIRM** the Commissioner's final decision, and **DISMISS** this case from the Court's active docket.

Notice to Parties

Notice is hereby given to the parties of the provisions of 28 U.S.C. § 636(b)(1)(C):

Within fourteen days after being served with a copy [of this Report and Recommendation], any party may serve and file written objections to such proposed findings and recommendations as provided by rules of court. A judge of the court shall make a de novo determination of those portions of the report or specified proposed findings or recommendations to which objection is made. A judge of the court may accept, reject, or modify, in whole or in part, the findings or recommendations made by the magistrate judge. The judge may also receive further evidence or recommit the matter to the magistrate judge with instructions.

Failure to file timely written objections to these proposed findings and recommendations within 14 days could waive appellate review. At the conclusion of the 14 day period, the Clerk is

directed to transmit the record in this matter to the Honorable Jackson L. Kiser, Senior United States District Judge.

The Clerk shall send certified copies of this Report and Recommendation to all counsel of record.

ENTER: June 24, 2016

A handwritten signature in black ink, reading "Joel C. Hoppe". The signature is written in a cursive style with a large initial "J" and "H".

Joel C. Hoppe
United States Magistrate Judge