

findings only to establish that they are supported by substantial evidence, we also must assure that [his] ultimate conclusions are legally correct.” Myers v. Califano, 611 F.2d 980, 982 (4th Cir. 1980).

The court may neither undertake a de novo review of the Commissioner’s decision nor re-weigh the evidence of record. Hunter v. Sullivan, 993 F.2d 31, 34 (4th Cir. 1992). Judicial review of disability cases is limited to determining whether substantial evidence supports the Commissioner’s conclusion that the plaintiff failed to satisfy the Act’s entitlement conditions. See Laws v. Celebrezze, 368 F.2d 640, 642 (4th Cir. 1966). Evidence is substantial when, considering the record as a whole, it might be deemed adequate to support a conclusion by a reasonable mind, Richardson v. Perales, 402 U.S. 389, 401 (1971), or when it would be sufficient to refuse a directed verdict in a jury trial. Smith v. Chater, 99 F.3d 635, 638 (4th Cir. 1996). Substantial evidence is not a “large or considerable amount of evidence,” Pierce v. Underwood, 487 U.S. 552, 565 (1988), but is more than a mere scintilla and somewhat less than a preponderance. Perales, 402 U.S. at 401. If the Commissioner’s decision is supported by substantial evidence, it must be affirmed. 42 U.S.C. § 405(g); Perales, 402 U.S. at 401.

“Disability” is the “inability 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). The “[d]etermination of eligibility for social security benefits involves a five-step inquiry.” Walls v. Barnhart, 296 F.3d 287, 290 (4th Cir. 2002). This inquiry asks whether the claimant (1) is working; (2) has a severe impairment; (3) has an impairment that meets or equals the requirements of a listed impairment; (4) can return to his or her past relevant work; and if not, (5) whether he or she can perform other work. Heckler v.

Campbell, 461 U.S. 458, 460-462 (1983); Johnson v. Barnhart, 434 F.3d 650, 654 n.1 (4th Cir. 2005) (citing 20 C.F.R. § 404.1520). If the Commissioner conclusively finds the claimant “disabled” or “not disabled” at any point in the five-step process, he does not proceed to the next step. 20 C.F.R. §§ 404.1520(a)(4), 416.920(a)(4). Once the claimant has established a prima facie case for disability, the burden then shifts to the Commissioner to establish that the claimant maintains the residual functional capacity (“RFC”),¹ considering the claimant’s age, education, work experience, and impairments, to perform alternative work that exists in the local and national economies. 42 U.S.C. § 423(d)(2)(A); Taylor v. Weinberger, 512 F.2d 664, 666 (4th Cir. 1975).

II.

Cox was born in 1958 (Administrative Record, hereinafter “R.” 61), and at the time of the ALJ’s decision was considered a “younger individual” under the Act. 20 C.F.R. §§ 404.1563(b), 416.963(b). Cox has an eleventh grade education and worked as a farm laborer prior to his alleged onset date. (R. 21, 75, 638-40.) Cox alleges a disability onset date of November 15, 2003² due to injuries to his kidneys, back and arm, and depression. (R. 19, 641-52.) His application for benefits was rejected by the Commissioner both initially and again upon reconsideration. (R. 19.) An administrative hearing was convened before an Administrative

¹ RFC is a measurement of the most a claimant can do despite his limitations. See 20 C.F.R. §§ 404.1545(a), 416.945(a). According to the Social Security Administration:

RFC is an assessment of an individual’s ability to do sustained work-related physical and mental activities in a work setting on a regular and continuing basis. A ‘regular and continuing basis’ means 8 hours a day, for 5 days a week, or an equivalent work schedule.

Social Security Regulation (SSR) 96-8p. RFC is to be determined by the ALJ only after he considers all relevant evidence of a claimant’s impairments and any related symptoms (e.g., pain). See 20 C.F.R. §§ 404.1529(a), 416.929(a).

² Cox originally claimed a disability onset date of March 29, 2004. (R. 19.) At the administrative hearing, he amended his alleged onset date to November 15, 2003. (R. 19, 641-42, 645.)

Law Judge (“ALJ”) on December 9, 2005. (R. 634-67.) Following the hearing, Cox was referred to Robert Smith, Ph.D., for an independent consultative psychological evaluation. (R. 24, 398-405.) The Psychological Evaluation Report has been incorporated into the record. (R. 398-405.) In an opinion dated July 24, 2006, the ALJ found that Cox has degenerative disc disease/osteoarthritis, history of right arm injury with surgery to repair biceps tendon rupture, history of skin cancer, and history of hematoma to the kidney, which qualify as severe impairments pursuant to 20 C.F.R. §§ 404.1520(c), 416.920(c). (R. 27.) The ALJ also found that Cox has the RFC to perform a limited range of light work; specifically, that he can frequently lift and carry 10 pounds, occasionally lift and carry 20 pounds, and sit, stand or walk for six hours in an eight hour workday. (R. 27.) The ALJ held that Cox can occasionally climb ramps/stairs and stoop, frequently balance, kneel, crouch and crawl, but cannot perform jobs that require climbing ladders, ropes or scaffolds, and that he should refrain from jobs that involve direct prolonged exposure to sunlight. (R. 27.) Although Cox’s impairments prevent him from performing his past relevant work, the ALJ found there are a significant number of jobs in the national economy that he could perform. (R. 28.) Thus, the ALJ found Cox not to be disabled under the Act. (R. 28.) The Appeals Council denied Cox’s request for review and this appeal followed. (R. 7-10.)

III.

Cox argues that the ALJ erred by failing to take into account the cumulative effects of his physical and mental impairments. Specifically, Cox contends that he suffers from chronic pain and depression, which preclude his ability to perform work in the national economy.

A.

With respect to his physical impairments, Cox has a history of skin cancer, which he had surgically removed in 2001. (R. 125-44.)

On May 30, 2002, Cox presented to the Wythe Community Hospital emergency room complaining of severe pain in his right arm after it was caught between a fencepost and a bull. (R. 245-49, 275.) Dr. Paul Morin diagnosed Cox with a biceps tendon rupture. (R. 262.) An MRI revealed a contusion involving the short head of the biceps muscle, with no evidence of disruption of the tendon. (R. 264.) On June 25, 2002, Dr. Morin performed a surgical exploration of the right bicep with repair of the torn muscle belly. (R. 243-44, 250-51, 254-59.) Following physical therapy (R. 232-39), Cox had a good range of motion and 5/5 strength bilaterally; he was released to work on September 9, 2002 but was limited to lifting no more than 35 pounds with only his right arm. (R. 267.) On October 15, 2002, this restriction was lifted and Cox was released to full duty work. (R. 267.) Cox was not treated for this arm injury again until the summer of 2003, when he complained of increased discomfort after bailing hay. (R. 153.) At that time, Cox had good grip, strength, and range of motion (R. 152-53), and there was no evidence of re-injury except for inflammation. (R. 153.) Drs. Torok and Morin recommended strengthening exercises with high repetitions of low weight. (R. 152-53.)

On April 7, 2003, Cox presented to Wayne D. Horney, M.D., with complaints of back pain following an incident at work in which a cow backed into him and pushed him through a fence. (R. 166, 182.) Dr. Horney noted Cox suffered from a low back contusion and a kidney contusion. (R. 166, 182.) On April 17, 2003, Cox reported that he was not doing well and was still experiencing pain in the left lower back and flank region. (R. 169.) Dr. Horney prescribed Vicodin and diagnosed him with a kidney hematoma. (R. 169.) A CT scan of Cox's abdomen

and pelvis taken on April 23, 2003, showed no significant abnormality aside from a tiny nonobstructing right renal calculus. (R. 147, 173, 359.) By April 24, 2003, Cox's condition had improved. (R. 172.) He was instructed to continue treating his back with rest and heat, take Vicodin as needed for pain, and return to the clinic as needed. (R. 172.) Cox did not seek treatment for this issue for nearly one year. On March 29, 2004, Cox presented to Dr. Horney complaining again of significant pain in the left flank region, as well as pain radiating down to his left heel. (R. 178.) Dr. Horney noted the initial CT scan showed no evidence of permanent damage to his kidney. (R. 178.) He advised Cox not to work and to continue taking Vicodin as needed (R. 178), and he referred Cox to a urologist, Dr. Elkins, for his hematuria.¹ (R. 183.) Another CT scan of Cox's abdomen and pelvis taken on April 9, 2004 revealed two nonobstructing calculi in the right kidney, but was otherwise normal. (R. 149, 156.) A bladder cytoscopy proved to be normal as well. (R. 156.) Cox did not show up for a follow up appointment with Dr. Elkins. (R. 159.) However, he continued to complain of back pain to Dr. Horney and took Vicodin for pain. (R. 186, 188, 190, 192, 193, 268, 312, 314, 317.)

State agency physician, Michael J. Hartman, M.D., found that Cox was capable of performing light work in his assessment dated December 15, 2004. (R. 208-13.) Specifically, Dr. Hartman found that Cox was capable of frequently lifting and carrying 10 pounds; occasionally lifting and carrying 20 pounds; and sitting, standing and walking about 6 hours in an 8 hour workday, with occasional stooping and climbing ramps or stairs, but never climbing ladders, ropes or scaffolds. (R. 210.) Dr. Frank Johnson affirmed this assessment on April 1, 2005. (R. 212.)

¹ Hematuria is defined as blood in the urine. Dorland's Illustrated Medical Dictionary 1807 (30th ed. 2003).

In June, 2005, an MRI of the lumbar spine revealed spinal stenosis at L4-5, marked neural foraminal stenosis at the L4-5 left neural foramen, degenerative disc disease and facet arthritis. (R. 318.) An x-ray of the lumbosacral spine revealed mild deformity of upper plates of L4 and 5 with minimal spurring without disc space narrowing, which appeared old and may have related to past trauma. (R. 320.) On June 15, 2005, Dr. Horney filled out a Medical Evaluation form for the Commonwealth of Virginia Department of Social Services, indicating Cox was unable to work for an unknown period of time as a result of lumbar disc disease, spinal stenosis, and depression. (R. 315-16.) Dr. Horney noted that Cox was limited in his ability to lift objects greater than 10 pounds, sit or stand for more than one hour, walk greater than 50 feet and climb more than four to six steps. (R. 316.) However, he indicated that Cox could participate in various vocational preparation programs five days a week for four hours each day. (R. 316.)

An August 6, 2005 CT of the abdomen and pelvis, which was taken after Cox experienced some rectal bleeding (see R. 348-54, 373-75), revealed a small, low-density lesion in the right kidney suggestive of a cyst. (R. 384.) Another CT taken on September 2, 2005 was negative aside from a few small nonobstructing intrarenal stones on the right. (R. 372.)

On a Clinical Assessment of Pain form completed on December 7, 2005, Dr. Horney noted that Cox's pain was present to such extent as to be distracting to adequate performance of daily activities or work. (R. 381.) He also indicated that physical activities increase Cox's pain and medication limits his effectiveness in the workplace due to distraction, inattention, and drowsiness. (R. 381.) On a Physical Capacities Evaluation form, Dr. Horney opined that Cox was able to lift and carry up to twenty pounds occasionally, but was unable to sit, stand, or walk for more than an hour at a time; sit or stand for more than four hours in an eight-hour period; or walk for more than two hours in an eight-hour period. (R. 382.)

Cox did not present to Dr. Horney again for his back pain until February 22, 2006. (R. 473-74.) Records reveal that Cox had done some work a few days earlier helping with an outside building, which aggravated his back pain. (R. 473.) Dr. Horney prescribed Flexeril 10 mg (R. 473), but after Cox reported it made him “feel funny,” he prescribed Orphenadrine. (R. 457.) Cox continued to take Vicodin for pain. (R. 438, 440, 445-46, 452-56, 458-59, 462-69, 471-72, 475, 477-79, 481.) Records submitted to the Appeals Council include an MRI taken on August 21, 2006, which reveals L4-5 moderate to severe left neural foramen stenosis and moderate spinal canal stenosis, secondary to diffuse disc bulge, end plate osteophytic disease and left worse than right facet joint degenerative arthropathy. (R. 435.) Another MRI taken on November 20, 2007 shows degenerative changes of the lower L-spine with severe narrowing of the left neural foramen and moderate to severe stenosis of the central spinal canal at L4-5 secondary to a combination of disc bulge and facet joint arthropathy. (R. 592.) To correct this problem, Cox underwent L4-5 decompression surgery in February, 2008.² (R. 514-91.)

B.

Cox’s appeal focuses primarily on his mental impairments. Cox first complained of depression³ to Dr. Horney on September 27, 2002, after he was out of work and his wife left him. (R. 274.) Dr. Horney prescribed 10 mg of Lexapro and noted at his next office visit on October 28, 2002, that Cox felt better. (R. 273.) In follow up visits, Dr. Horney indicated that Cox’s situational depression had improved and that “he is quite optimistic.” (R. 270, 272.) On October 1, 2003, Cox complained of being increasingly depressed after running out of his Lexapro

² The undersigned notes that the record does not include evidence reflecting Cox’s post-op condition, and Cox does not present new evidence in support of a sentence six remand under 42 U.S.C. § 405(g). See Borders v. Heckler, 777 F.2d 954, 955 (4th Cir. 1985).

³ Prior to 2002, records reveal Cox was counseled for anger management and alcohol abuse from 1990-92 at Mount Rogers Mental Health Services (R. 292-303), and that he presented to Wythe Community Hospital on August 26, 1990 complaining of anxiety. (R. 333.)

prescription ten days earlier. (R. 174.) Dr. Horney noted that he had a mildly depressed affect and mood but was not suicidal or tearful. (R. 174.) He continued Cox on Lexapro. (R. 174.) Cox returned on November 21, 2003 and stated his depression had worsened secondary to losing his job. (R. 176.) According to Dr. Horney, Cox was neither suicidal nor delusional and his depression remained unchanged. (R. 176.) Cox did not complain of depression again until May 27, 2004, at which time he stated his depression had worsened, as he was out of work and living in a trailer without running water or electricity. (R. 186.) Dr. Horney increased his Lexapro dose to 20 mg per day. (R. 186.) On June 28, 2004, Cox related to Dr. Horney that he could not tolerate the increased dosage; thus, Cox reduced it on his own. (R. 188.) Cox reported that he was doing better under the decreased dosage on July 26, 2004. (R. 190.) There were no additional complaints of depression during Cox's visits to Dr. Horney's office on August 30, 2004 and October 28, 2004. (R. 193, 268-69.)

Following a review of the records, state agency psychologist Julie Jennings, Ph.D., opined on December 14, 2004 that Cox suffers from depressive disorder but is not restricted in his activities of daily living, has no difficulty maintaining concentration, persistence or pace, and has only mild difficulty in maintaining social functioning. (R. 195-207.) This opinion was reviewed and affirmed by R.J. Milan, Jr., Ph.D., on April 1, 2005. (R. 195.)

On February 10, 2005, notes reveal Cox was "still complaining of some degree of depression although he states the Lexapro is helping." (R. 312.) He reported feeling more depressed than normal on October 11, 2005, and Dr. Horney once again increased his daily dose of Lexapro to 20 mg. (R. 391.) A few weeks later, on November 18, 2005, Cox presented to Mount Rogers Community Service Board and asked to see a crisis worker. (R. 392-94.) He expressed recent suicidal ideation but denied actual intent. (R. 394.) The Preadmission

Screening Form indicated a diagnosis of major depressive disorder, recurrent, severe, without psychosis. (R. 392-96.) Notes reveal he was not an imminent danger to himself or others and was able to care for himself. (R. 396.) He did not meet the criteria for inpatient hospitalization, and a crisis appointment was scheduled for November 30, 2005. (R. 394.) There is no evidence in the record to suggest Cox ever returned for follow-up treatment beyond this initial consultation.

On November 29, 2005, Cox was referred by his attorney to Belinda D. Overstreet, Ph.D., for a psychological evaluation. (R. 361-69.) Dr. Overstreet noted that Cox's behavior during the interview was unremarkable, that he had good eye contact, and that he appeared to be alert, cooperative, and responsive. (R. 362.) Cox was well-oriented; his thought processes were goal-directed; and there was no evidence of any perceptual abnormalities. (R. 362.) Cox's insight and judgment were generally good, and Dr. Overstreet deemed him competent to manage his own funds. (R. 362.) Though Cox reported having suicidal ideation with a lethal plan, he had neither the intent nor the means with which to harm himself. (R. 363.)

Dr. Overstreet administered a Personality Assessment Inventory (PAI) to Cox and found his responses to be "consistent with an individual who may be responding with some element of exaggeration of complaints or problems." (R. 364.) Dr. Overstreet diagnosed Cox with major depressive disorder (moderate), generalized anxiety disorder, and cannabis abuse—rule out dependence.⁴ (R. 367.) She assessed his Global Assessment of Functioning (GAF) as 55.⁵ She opined that Cox's prognosis is guarded. (R. 369.) In a Medical Assessment of Ability to do

⁴ Cox admits he uses marijuana on a regular basis. (R. 366, 666; see also R. 399.)

⁵ The Global Assessment of Functioning, or GAF, scale ranges from 0 to 100 and considers psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Diagnostic & Statistical Manual of Mental Disorders 32 (4th ed. 1994). A GAF of 51-60 indicates that an individual has "[m]oderate symptoms . . . OR moderate difficulty in social, occupational or school functioning . . ." Id. at 34.

Work-Related Activities (Mental), Dr. Overstreet stated that Cox had an unlimited/very good ability to understand, remember, and carry out complex job instructions, but his social functioning is likely to limit his ability to function in a work setting. (R. 369-71.) Dr. Overstreet further noted Cox is able to use judgment and maintain concentration but is seriously limited in his ability to relate to co-workers, follow work rules, deal with the public, and demonstrate reliability, and he has no useful ability to relate predictably in social situations. (R. 370-71.)

Following the administrative hearing on February 7, 2006, the ALJ referred Cox to Robert W. Smith, Ph.D., for an independent consultative psychological evaluation. (R. 398-405.) In his report, Dr. Smith noted Cox's form and content of thought were within normal limits, and his judgment, math skills and abstraction skills were grossly intact. (R. 400.) Dr. Smith found Cox's answers on the PAI test contained "some exaggeration of complaints and problems." (R. 401.) Dr. Smith diagnosed Cox with major depressive disorder, recurrent, moderate, and tagged his GAF at 60.⁶ (R. 401.) In a Medical Source Statement of Ability to do Word-Related Activities (Mental) form, Dr. Smith found that Cox has an unlimited capacity to maintain gainful employment, notwithstanding mild limitations in his ability to respond appropriately to pressures or changes in a normal work setting and to understand, remember, and carry out complex job instructions. (R. 403-05.)

IV.

Cox claims that the ALJ erred by failing to analyze the cumulative effects of his impairments, focusing specifically on his chronic pain and depression. On that score, Cox argues that the ALJ should not have rejected the medical assessment completed by Belinda Overstreet, Ph.D., on December 6, 2005. Cox contends that Dr. Overstreet's report proves that

⁶ See footnote 5, *supra*.

his depressive symptoms are likely to limit his ability to function in a work setting, and the VE testified that a hypothetical individual with characteristics consistent with Dr. Overstreet's assessment could not perform work in the national economy. These mental limitations coupled with his chronic pain render him disabled, according to Cox. After reviewing the record, the undersigned disagrees and finds that substantial evidence supports the Commissioner's decision that Cox is not disabled from all work.

First, clinical findings do not support the level of pain Cox claims to suffer. When faced with conflicting evidence contained in the record, it is the duty of the ALJ to fact-find and to resolve any inconsistencies between a claimant's alleged symptoms and his ability to work. Smith v. Chater, 99 F.3d 635, 638 (4th Cir. 1996); accord Melvin v. Astrue, No. 606cv32, 2007 WL 1960600, at *1 (W.D. Va. July 5, 2007). Accordingly, the ALJ is not required to accept Cox's testimony that he is disabled by pain; instead, the ALJ must determine through an examination of the objective medical record whether Cox has proven an underlying impairment that could reasonably be expected to produce the symptoms alleged. Craig v. Chater, 76 F.3d 585, 592-94 (4th Cir. 1996) (stating the objective medical evidence must corroborate "not just pain, or some pain, or pain of some kind or severity, but the pain the claimant alleges she suffers."). The ALJ must determine whether Cox's testimony about his symptoms is credible in light of the entire record. Credibility determinations are in the province of the ALJ, and courts normally ought not interfere with those determinations. See Hatcher v. Sec'y of Health & Human Servs., 898 F.2d 21, 23 (4th Cir. 1989); Melvin, 2007 WL 1960600, at *1; SSR 95-5p.

Numerous notes in the record give the undersigned pause as to Cox's credibility regarding his level of pain and limitation. Cox testified at the administrative hearing on December 9, 2005 that he can sit for only 30 to 45 minutes, stand for 5 minutes, and walk for 15

to 20 minutes at a time. (R. 643.) Cox further claimed it hurt to lift a gallon of milk. (R. 643.) Yet office notes from Dr. Karl Lucas on September 11, 2006 reveal Cox reported having been “working in the fields.” (R. 431.) Likewise, Dr. Horney noted on February 22, 2006 that Cox had done some work “helping with an outside building.” (R. 473.) Cox testified that he had not been hunting or fishing in years due to his back problems. (R. 655.) However, the record reveals that Cox presented to Dr. Horney on August 8, 2006 complaining of left leg numbness after squatting while “fishing on the fourth.” (R. 442). Cox also stated at the administrative hearing that he “can’t make urine.” (R. 644.) Nothing in the record appears to support this claim. He further testified that the muscle in his arm “came back loose” following surgery. (R. 647.) However, the medical evidence reveals that there was no evidence of re-injury to his right bicep muscle, only inflammation. (R. 153.)

Allegations of pain and other subjective symptoms, without more, are insufficient to establish disability. Craig, 76 F.3d at 592. Both Dr. Smith and Dr. Overstreet found that Cox is prone to exaggeration of symptoms (R. 364, 401), and the objective medical evidence does not support the severity of symptoms or degree of limitation asserted by Cox. The bicep tendon rupture of Cox’s right arm was repaired surgically, and following physical therapy, he had a good range of motion and 5/5 strength bilaterally. (R. 267.) He was released to full duty work (R. 267) and when he complained of pain over six months later, he was encouraged to perform strengthening exercises with weights. (R. 153.) With respect to his kidney contusion, CT scans of Cox’s abdomen and a bladder cytoscopy were normal (R. 147, 149, 156, 173, 359), and Dr. Elkins could not find an etiology for the hematuria Cox said he was experiencing. (R. 155, 156, 157, 183, 184, 185.) Cox was treated for back pain with Vicodin, prescribed by his family physician, Dr. Horney. While Dr. Horney opined on a Medical Evaluation Form and Physical

Capacities Evaluation form that Cox is limited in his ability to lift more than 10 pounds, sit and stand for longer than an hour, and walk for more than 50 feet (R. 315; see also 382), this opinion is not supported by Dr. Horney's own clinical findings. Moreover, nothing in the record supports Cox's testimony that he can sit for only 30 to 45 minutes, stand for 5 minutes, and walk for 15 to 20 minutes at a time.

Cox argues that these physical limitations combined with his depression render him unable to engage in substantial gainful activity. With respect to his depression, Cox claims the ALJ erred by rejecting Dr. Overstreet's medical assessment dated December 6, 2005, which states that he has a seriously limited ability to follow rules, relate to co-workers, deal with stresses, and demonstrate reliability in the workplace. (R. 370-71.) Substantial evidence supports the ALJ's conclusion that Dr. Overstreet's assessment was entitled to little weight and that Cox's depression did not result in any vocationally relevant limitations.

Cox has been treated conservatively for his depression, which is described in the record as "situational" (R. 270), by his family physician, Dr. Horney. Dr. Horney prescribed 10 mg of Lexapro in September, 2002, and Cox admitted he felt better after starting the medication. (R. 273.) Although he reported that his depression was worsening in November, 2003, notes reveal he was not suicidal, and he did not complain of depression to Dr. Horney again until May, 2004. (R. 176, 186.) After Dr. Horney increased his Lexapro dose to 20 mg (R. 186), Cox said he was unable to tolerate the increased dosage and went back to taking 10 mg per day. (R. 188.) In July, 2004, Cox stated he was doing better under the decreased dosage. (R. 190.) Cox did not complain of depression again for over six months, at which time he told Dr. Horney the Lexapro was helping. (R. 312.) When Cox complained in October, 2005 of feeling more depressed than normal, Dr. Horney again increased his daily dose of Lexapro to 20 mg. (R. 391.) Dr. Horney

never recommended Cox seek additional psychological or psychiatric treatment. When Cox self-reported to Mount Rogers in November, 2005, he was not perceived to be an imminent danger to himself or others and did not meet the criteria for hospitalization. (R. 392-96.) He was scheduled to meet with a crisis worker on November 30, 2005, but never followed through with that appointment.

On this treatment record, the undersigned finds that substantial evidence supports the ALJ's determination that Dr. Overstreet's assessment was entitled to little weight. The objective medical evidence simply does not support Dr. Overstreet's findings that Cox is seriously limited in making occupational and social adjustments in the workplace. (R. 370-71.) To resolve any potential ambiguity in the record with respect to a mental impairment, the ALJ ordered a consultative evaluation by Dr. Smith. Dr. Smith found that apart from mild limitations in his ability to respond to changes in work place setting and understand, remember and carry out complex job instructions, Cox has a no limitations in his ability to maintain gainful employment. (R. 403-05.) Dr. Smith's findings were consistent with the state agency psychologists, who found that Cox was only mildly limited in maintaining social functioning. (R. 205.)

As regards Cox's subjective complaints of mental limitations, a claimant's statements alone are not enough to establish a physical or mental impairment. 20 C.F.R. § 404.1528(a). Subjective evidence cannot take precedence over objective medical evidence or the lack thereof. Craig v. Chater, 76 F.3d 585, 592 (4th Cir. 1996) (quoting Gross v. Heckler, 785 F.2d 1163, 1166 (4th Cir. 1986)). Cox has admitted to smoking marijuana on a regular basis (R. 366, 666), and Dr. Smith stated that his daily use of marijuana "most likely contributes to increased lack of motivation, isolation and depressed affect." (R. 405.) Dr. Overstreet found that Cox "reports frequent occurrence of various physical symptoms and vague complaints of ill health and fatigue.

Individuals who report such symptoms also experience accompanying depressive and/or anxiety symptoms.” (R. 365.) Additionally, Dr. Overstreet noted that some of Cox’s responses were:

[C]onsistent with an individual who may be responding with some element of exaggeration of complaints or problems. This is likely to be a ‘cry for help,’ an extremely negative evaluation of his self and life in general or deliberate distortion. In addition there is some inconsistency in his responses to similar items.

(R. 364.) Indeed, inconsistency in Cox’s responses becomes evident when comparing Dr. Overstreet’s evaluation report to Dr. Smith’s. For example, Cox reported to Dr. Overstreet that he had present suicidal ideation (R. 363), but denied suicidal ideation to Dr. Smith a few months later, instead reporting homicidal ideation. (R. 400.) Cox told Dr. Overstreet that he had been having panic attacks once or twice per week for one year. (R. 363.) However, Cox did not report having panic attacks to Dr. Smith, nor did Cox complain of panic attacks to Dr. Horney. As noted above, the record supports the ALJ’s finding that Cox’s allegations regarding his limitations are not totally credible.

Substantial evidence supports the Commissioner’s decision that Cox is not disabled from all work. Cox’s complaints of pain and the degree of limitation he asserts are not supported by the objective evidence of record. Likewise, given the opinions of Dr. Smith and the state agency psychologists, the ALJ’s finding that Cox does not have a severe mental impairment is supported by substantial evidence. As such, the undersigned recommends that the Commissioner’s decision be affirmed.

V.

At the end of the day, it is not the province of the undersigned to make a disability determination. It is the undersigned’s role to determine whether the Commissioner’s decision is supported by substantial evidence, and, in this case, substantial evidence supports the ALJ’s

opinion. In recommending that the final decision of the Commissioner be affirmed, the undersigned does not suggest that Cox is totally free of any distress. The objective medical record simply fails to document the existence of any physical and/or mental conditions which would reasonably be expected to result in total disability from all forms of substantial gainful employment. It appears that the ALJ properly considered all of the objective and subjective evidence in adjudicating Cox's claim for benefits and in determining that his physical and mental impairments would not prevent him from performing any work. It follows that all facets of the Commissioner's decision in this case are supported by substantial evidence. Accordingly, the undersigned concludes that the Commissioner's decision must be affirmed and the defendant's motion for summary judgment **GRANTED**.

The Clerk is directed to transmit the record in this case to Samuel G. Wilson, United States District Judge, and to provide copies of this Report and Recommendation to counsel of record. Both sides are reminded that pursuant to Rule 72(b), they are entitled to note any objections to this Report and Recommendation within ten (10) days hereof. Any adjudication of fact or conclusion of law rendered herein by the undersigned that is 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 conclusion reached by the undersigned may be construed by any reviewing court as a waiver of such objection.

ENTER: This 25th day of September, 2009.

/s/ Hon. Michael F. Urbanski
United States Magistrate Judge