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

APRIL A. KNIGHT,	)	Case No. 5:09cv00033
Plaintiff	)	REPORT AND RECOMMENDATION
v.	)	
MICHAEL J. ASTRUE, Commissioner of Social Security,	)	By: Hon. James G. Welsh U. S. Magistrate Judge
Defendant	)	

The plaintiff, April A. Knight, brings this action pursuant to 42 U.S.C. § 405(g) challenging the final decision of the Commissioner of the Social Security Administration (‘the agency”) denying her claim for a period of disability insurance benefits (“DIB”) and supplemental security income ("SSI") under Titles II and XVI respectively of the of the Social Security Act, as amended ("the Act"). 42 U.S.C. §§ 416 and 423 and 42 U.S.C. §§ 1381 *et seq*. Jurisdiction of the court is pursuant to 42 U.S.C. § 405(g).

The Commissioner’s Answer was filed on September 30, 2009 along with a certified copy of the entire record”(“R.”) containing the evidentiary basis for the findings and conclusions set forth in the Commissioner’s final decision. By order of referral entered the following day, this case is before the undersigned magistrate judge for report and recommendation pursuant to 28 U.S.C. § 636(b)(1)(B).

In her appeal the plaintiff contends the conclusion of the administrative law judge (”ALJ”) that

she retained the ability to perform a range of light work [1] was based on his failure to include in his functional assessment, what she contends are the significantly limiting effects of her chronic migraine headaches, chronic extremity pain, acute mobility problems and depression. In response, the Commissioner argues that the plaintiff's evidence failed to demonstrate that she was either unable to perform her past work as a housekeeper or unable to perform a range of other work at a light exertional level and that the ALJ's relevant findings and conclusions (R.13-24; see also R.46) are supported by substantial evidence. *See Hall v. Harris*, 658 F.2d 260, 264 (4th Cir, 1981) (an individual seeking disability benefits bears the burden of proving a *disability*, as that term is defined by the statute). Each party has moved for summary judgment; no written request was made for oral argument, [2] and the case is now before the undersigned for a report and recommended disposition.

I. Summary Recommendation

As outlined herein, a thorough review of the administrative record demonstrates a substantial evidentiary basis for the ALJ's non-disability conclusion and a decisionally proper consideration and assessment of her exertional and non-exertional limitations.

II. Standard of Review

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[1] *Light work* is defined in 20 C.F.R. § 404.1567(b) and § 416.967(b) to involve lifting no more than 20 pounds at a time and with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job in this category generally requires a good deal of walking or standing, or when it involves sitting most of the time it generally involves some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities, and a job may also be considered light work if it requires "standing or walking, off and on, for a total of approximately 6 hours of an 8-hour workday" with intermittent sitting. Social Security Ruling ("SSR") 83-10.

[2] Paragraph 2 of the court's Standing Order No. 2005-2 requires that the plaintiff in a Social Security case must request oral argument in writing at the time his or her brief is filed.

The court's review in this case is limited to a determination as to whether there is substantial evidence to support the Commissioner's conclusion that the plaintiff failed to meet the statutory conditions for entitlement to a period of DIB or to SSI on or before August 7, 2008, the date of the Commissioner's final decision. "Under the . . . Act, [a reviewing court] must uphold the factual findings of the [Commissioner], if they are supported by substantial evidence and were reached through application of the correct legal standard." *Mastro v. Apfel*, 270 F.3d 171, 176 (4th Cir. 2001) (quoting *Craig v. Chater*, 76 F.3d 585, 589 (4th Cir. 1996)). This standard of review is more deferential than *de novo*. "It consists of more than a mere scintilla of evidence but may be somewhat less than a preponderance." *Mastro*, 270 F.3d at 176 (quoting *Laws v. Celebrezze*, 368 F.2d 640, 642 (4th Cir. 1966)). "In reviewing for substantial evidence, [the court should not] undertake to re-weigh conflicting evidence, make credibility determinations, or substitute [its] judgment for that of the [Commissioner]." *Id*. (*quoting Craig v. Chater*, 76 F.3d at 589). Nevertheless, the court "must not abdicate [its] traditional functions," and it "cannot escape [its] duty to scrutinize the record as a whole to determine whether the conclusions reached are rational." *Oppenheim v. Finch*, 495 F.2d 396, 397 (4th Cir. 1974). The Commissioner's conclusions of law are, however, not subject to the same deferential standard and are subject to plenary review. *See Island Creek Coal Company v. Compton*, 211 F.3d 203, 208 (4th Cir. 2000); 42 U.S.C. § 405(g).

III. Administrative History

The record shows that plaintiff protectively filed her applications on August 31, 2006, alleging a disability beginning April 19, 2006. (R.11,86,96.) In them and in her related submissions, the

plaintiff contends that she has been unable to work since April 19, 2006 due the combined effects of a speech dysfluency, persistent and diffuse upper and lower extremity pains, "nerve pain," recurrent abdominal pain, and depression. (R.86-96,122,128-130.) Her claims was denied, both initially and on reconsideration, and an administrative hearing was held on March 7, 2008. (R.11,26,49-65,68,74.) At the hearing the plaintiff was present, testified, and was represented by counsel. (R.11,26,29-44,66-67,69-73,85.) Vocational testimony was provided by Earl Glosser, Ph.D. (R.11,26,45-47,81-84.) Utilizing the agency's standard sequential evaluation process, [3] the plaintiff's claim was subsequently denied by written administrative decision dated March 27, 2008. (R.11-25.)

At the time of the ALJ's decision, the plaintiff was thirty-eight years of age;[4] her education included only nine years of schooling, [5] and her previous fifteen-year vocational history included factory work as an assembler and as a materials handler, CNA work in a nursing home, housekeeping work in various employment settings, waitress work, and some work in a press room as a "bundle girl." (R.13,24,29,32-37,45,86,90,96,118,132-151.)

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[3] To facilitate a uniform and efficient processing of disability claims, by regulation the agency has reduced the statutory definition of "disability" to a series of five sequential questions. An examiner must consider whether the individual (1) is engaged in substantial gainful activity, (2) has a severe impairment, (3) has an impairment which equals an illness contained in the agency's official Listings of Impairments found at 20 C.F.R. Part 4, Subpt. P, Appx. 1, (4) has an impairment which prevents past relevant work, and (5) has an impairment which prevents him or her from doing substantial gainful employment. 20 C.F.R. § 404.1520 and § 416.920. If an individual is found disabled or not disabled at any step, further inquiry is unnecessary. *See Hall v. Harris*, 658 F.2d 260, 264-265 (4th Cir. 1981).

[4] At this age the plaintiff is classified as a "*younger person*," and pursuant to the agency's regulations age is generally considered not to affect seriously a younger person's ability to adjust to other work. 20 C.F.R. § 404.1563(c) and § 416.920(c).

[5] Pursuant to the agency's regulations an individual with a 7th grade through the 11th grade of formal education has a limited education, meaning the individual has an ability in reasoning, arithmetic and language skills, but not enough to allow an individual to do most of the complex job duties needed in semi-skilled or skilled jobs. 20 C.F.R. § 404.1564(b)(3) and § 416.920(c)

In his written decision the ALJ summarized the plaintiff's written statements and hearing testimony, and he individually reviewed and summarized each the medical treatment exhibits then in the record. (R.13-21.) He determined that her long-standing speech disorder (stuttering), osteoarthritis, and history of tarsal tunnel syndrome (lower ankle pain) were *severe* [6] conditions within the meaning of the Act, and based on the lack of supporting objective medical evidence he determined that her alleged depressive symptoms were *non-severe*. (R.22.) He next found that her *severe* conditions, individually and collectively, were not of listing-level severity, [7] and based on his consideration of the vocational testimony and other evidence in the record he concluded that the plaintiff was functionally able to perform light work, including *inter alia* her past work in a housekeeping department. (R.22-24.) A timely request for Appeals Council review was thereafter made; [8] the request was subsequently denied, and the decision of the ALJ now stands as the Commissioner's final decision. (R.1-7.) *See* 20 C.F.R. § 404.981 and § 416-1481.

IV. Medical Evidence

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[6] Quoting *Brady v. Heckler*, 724 F.2d 914, 920 (11th Cir. 1984), the Fourth Circuit held in *Evans v. Heckler*, 734 F.2d 1012, 1014 (4th Cir. 1984), that "an impairment can be considered as '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 the individual's ability to work, irrespective of age, education, or work experience." *See also* 20 C.F.R. § 404.1520(c) and § 416.920(c).

[7] The Listing of Impairments ("the listings") is in appendix 1 of subpart P of part 404 of 20 C.F.R. For each of the major body systems it describes impairments that the agency considers to be severe enough to prevent an individual from doing any gainful activity, regardless of his or her age, education, or work experience. 20 C.F.R. § 404.1525 and § 416.925.

[8] Along with her request for Appeals Council review the plaintiff submitted three additional medical treatment exhibits (R.4,404-432); however, none was *new* or related to a period before the date of the ALJ's decision. *Wilkins v. Secretary*, 953 F.2d 93, 96 (4th Cir. 1991) (the Appeals Council must consider evidence submitted to it only "if the additional evidence is (a) new, (b) material, and (c) relates to the period on or before the date of the ALJ's decision") (quoting *Williams v. Sullivan*, 905 F.2d 214, 216 (4th Cir. 1990)). *Wilkins* further defines evidence to be new "if it is not duplicative or cumulative" and evidence to be material "if there is a reasonable possibility that the new evidence would have changed the outcome." *Id.* at 96.

In this case the plaintiff's medical records begin with a Rockingham Memorial Hospital ("RMH") emergency room visit on January 17, 2005 for a reported fourth episode of acute right lower quadrant pelvic pain within the preceding year. (R.245-256.) Based on X-rays, a uterine fibroid diagnosis was made, and she was given a prescription for Vicodin ES to relieve her pain. (R.246.) Two months later, the persistence of this pain and discomfort resulted in an RMH admission on March 4 for a complete hysterectomy and bilateral oopharectomy. (R.208-223.) Her subsequent hospital course was routine, and she was released on the third post-operative day. (R.208.)

The later treatment records of her primary care physician, G. W. Harper, M.D., show that on September 26, October 27 and November 15 of the same year she saw G. W. Harper, M.D., for treatment of pain-related complaints, including heel pain,"off and on" low back pain, and lower abdominal pain. (R.372-378.) Dr. Harper noted at the time that the plaintiff appeared to be depressed and uneasy ("dysphoric") and that his clinical examinations disclosed no neurologic or other physiologic abnormality. (R.372-373,374,377.)

On November 16, one day after she had seen Dr. Harper, the plaintiff sought emergency room treatment at RMH for the second time. (R.235-244.) On that occasion, she complained of ongoing acute abdominal pain for the past three weeks; however, neither the clinical nor the radiographic studies disclosed any abdominal abnormality, and she was released "in good condition." (R.236-237.) Still complaining of ongoing abdominal pain, two days later the plaintiff again sought treatment from Dr. Harper. (R.270-271.) Yet again, he found her to be in no acute distress and to have no medically significant abnormality.

Following a five-month absence of any medical care, in April 2006 the plaintiff sought treatment from Gregory Shilling, D.P.M., for what she described as long-standing chronic foot pain along and a recently developed extremity numbness and swelling. (R.321.) Based on his testing, Dr. Shilling concluded that the plaintiff had a bilateral tarsal tunnel condition, a right heel bone spur, and bilateral plantar fasciitis (an inflammation of the heel): he treated her podiatric condition with a three-week series of steroid injections and released her to return to work without limitations. (R.321-324,326-327.)

When she saw Dr. Harper for a "six-month follow-up" in May 2006, she reported that her pelvic pain had "improved," that Dr. Shilling's treatment of her foot pain had "helped," and that she was continuing to experience persistent upper and lower back pain. (R.367.) On examination, Dr. Harper found no physical change in her condition; he noted that she continued to appear depressed and uneasy; he discontinued Paxil (which the plaintiff reported made her feel like a zombie), and he updated her medication regime. (R.367-369.)

Over the next one and one-half years, Dr. Harper's office records show that the plaintiff was seen by him on seven separate occasions either for medication management or treatment. Although she reported additional problems with extremity pain, swelling and discomfort, during this period Dr. Harper found that her overall physical condition remained essentially unchanged. (R.353-366,385-394.)

On July 30 2006, less than two months after being treated by Dr. Shilling with a series of steroidal injections, the plaintiff went to the RMH emergency room with renewed complaints of

"sharp" pains in her feet, "tingling" upper legs and into her arms and hands, difficulty speaking, and a thought process that was "a little off." (R.224-234.) No physiologic basis either for her pain or her "tingling" sensation could be identified, and she was advised to follow-up as necessary with her podiatrist. (R.225, 231.)

With similar complaints, including "extreme" left lower extremity pain, a sensation of "needles" in her arms and legs and "slurred" speech, seventeen days later (on August 16, 2006), the plaintiff again sought emergency room care, this time through University of Virginia Medical Center ("UVAMC"). (R.307-311.) On this occasion she was admitted to the hospital, and over the next two days extensive neurologic and other interdisciplinary diagnostic testing and laboratory studies were done. (R.257-306,312-320.) Once again, no physiologic basis for her complaints was identified, and she was discharged on a pain medication and advised to follow-up with her primary care provider in one to two weeks. (R.257-260.)

A subsequent brain MRI by the Neuromuscular Clinic at UVAMC similarly disclosed no neurologic basis her complaints or other significant abnormality. (R.336-341.) Although a neurologic assessment in October 2007 at Medical College of Virginia reported that the plaintiff had some mild muscle group weakness, it too documented no significant change in her medical condition. (R.396-399.)

V. Discussion

The plaintiff's basic contention on appeal is that the ALJ's assessment of her residual functional capacity failed to include limitations related to her headaches, depression, and lack of mobility. By failing to included her testimony and statements about the adverse functional impact of these conditions in the hypothetical question posed to the vocational witness, she argues, the ALJ's decision contains reversible error.

A.

A review of the decision, however, simply does not support this contention. The ALJ outlines in considerable detail the plaintiff's statements and testimony about the nature of her various health-related problems and their attendant exertional and non-exertional limitations, including *inter alia* her description of chronic back and lower extremity pain, her upper and lower extremity weakness, her limited hand function, her difficulty with walking and standing activities, her throbbing "non-stop" nerve pain, her depression which "ma[de] it hard" for her to do normal activities, her chronic fatigue, and her belief that her health was generally continuing to deteriorate over time. (R.13-16,21,23.) And contrary to the plaintiff's contention on appeal, the ALJ also took note of the fact that some of the plaintiff's medical records mentioned her depression, alleged lower extremity weakness and ambulatory problems, and chronic pain. (R.22-23.)

Moreover, in determining that the plaintiff's testimony concerning her condition generally lacked credibility and that she retained the ability to perform a range of light work, the ALJ made the individualized functional assessments and explanations required by Social Security Ruling ("SSR") 96-7p. He considered the objective medical evidence, including an extensive neurologic work-up at UVAMC and multiple diagnostic study results that failed to reveal any physiologic basis for the

plaintiff's statements about the nature and extent of her pain, weakness and related functional difficulties. (R.16-20.) He took note of the state agency reviewers' summaries and functional assessments, and he related them to the plaintiff's inconsistent statements. (R.19.) He observed that her allegedly disabled condition was inconsistent with her work and her pursuit of unemployment benefits since her alleged onset date. (R.23.) He mentioned that she had required no psychiatric evaluation or treatment and had required only "limited . . . and conservative" medical treatment. (R.22-23.) In addition, he observed that the medical record contained only "minimal relatively benign objective findings" and that no medical source had opined that the plaintiff lacked the functional capacity to perform a range of work activity at a light exertional level. (*Id*.)

B.

Alternatively, to the extent the plaintiff's appeal can be read to suggest a failure on the part of the ALJ to assess her pain and other subjective complaints in accordance with the two-step decisional requirements of *Craig v. Chater*, 76 F.3d 585, 594 (4th Cir. 1996) (citing 20 C.F.R. § 404.1529 and § 416.929), this argument is also without merit.

Assuming *arguendo* that she met her threshold obligation to demonstrate "by objective medical evidence a condition reasonably likely to cause the pain claimed," [9] the plaintiff's subjective evidence concerning "the intensity and persistence of [her] pain, and the extent to which it affects her ability to work," [10] does not compel a second step finding favorable to her applications. As the ALJ demonstrated in his opinion, her statements concerning the level and severity of her impairments are

[9] *Hines v. Barnhart*, 453 F.3d 559, 565 n.3 (4th h Cir. 2006) (objective evidence, medical or otherwise, is "crucial to evaluating the intensity and persistence of [an individual's] pain and the extent to which it impairs her ability to work").

[10] *Craig*, 76 F.3d at 595

inconsistent with the "minimal" and "relatively benign" objective medical findings, inconsistent with the absence of any medically demonstrable basis for either her pain or extremity weakness, and her inconsistent work and pursuit of unemployment activities. 20 C.F.R. § 404.1529(c)(2-4) and § 416.929(c)(2-4).

C.

The recommendation in this case to affirm the Commissioner's final decision should not be read to suggest that the plaintiff does not suffer from pain, extremity weakness and depressive symptoms. The objective medical record certainly documents her efforts to obtain medical care for these problems. The medical record, however, also amply supports ALJ's conclusions that these and her other health-related problems are not of sufficient severity to be reasonably expected to result in a totally disabling condition.

VI. Proposed Findings of Fact

As supplemented by the above summary and analysis and on the basis of a careful examination of the full administrative record, the undersigned submits the following formal findings, conclusions and recommendations:

1. The Commissioner's final decision is supported by substantial evidence;

2. The Commissioner's final decision gave the requisite consideration to the plaintiff's statements and testimony about the nature and severity of her mobility limitations;

3. The Commissioner's final decision gave the requisite consideration to the plaintiff's statements about the nature and severity of her depressive symptoms and related limitations;

4. The Commissioner's final decision includes a proper consideration and assessment of the plaintiff's statements and testimony about her exertional and non-exertional limitations;

5. The Commissioner's final decision gave the requisite consideration to the plaintiff's statements about the nature and severity of her diffuse pain and related limitations;

6. Substantial evidence in the record supports the finding that through the date of the ALJ's decision the plaintiff was not disabled within the meaning of the Act;

7. The plaintiff has not met her burden of proving a disabling condition since her alleged disability onset date of April 19, 2006; and

8. The final decision of the Commissioner should be affirmed.

VII. Recommended Disposition

For the foregoing reasons, it is RECOMMENDED that an order be entered AFFIRMING the final decision fo the Commissioner, GRANTING JUDGMENT to the defendant, DENYING plaintiff's motion for summary judgment, and DISMISSING this case from the docket of the court.

The clerk is directed to transmit the record in this case immediately to the presiding district judge and to transmit a copy of this Report and Recommendation to all counsel of record.

VIII. Notice to the Parties

Both sides are reminded that, pursuant to Rule 72(b) of the Federal Rules of Civil Procedure, 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 to which an objection is not specifically made 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) as to factual recitals or findings as well as to the conclusions reached by the undersigned may be construed by any reviewing court as a waiver of such objections.

DATED: 4th day of May 2010.

/s/ *James G. Welsh*
United States Magistrate Judge