

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF DELAWARE

JOCELYN E. STEVENS,)
)
 Plaintiff,)
)
 v.) Civil Action No. 02-1330-SLR
)
 JO ANNE B. BARNHART,)
 Commissioner of Social Security,)
)
 Defendant.)

John S. Grady, Esquire, Grady & Hampton, P.A., Dover, Delaware.
Counsel for Plaintiffs.

Colm F. Connolly, United States Attorney, Leonard P. Stark,
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Counsel: James A. Winn, Regional Chief Counsel, Robert W. Flynn,
Assistant Regional Counsel, Social Security Administration,
Philadelphia, Pennsylvania.

MEMORANDUM OPINION

Dated: November 14, 2003
Wilmington, Delaware

ROBINSON, Chief Judge

I. INTRODUCTION

Plaintiff Jocelyn E. Stevens filed this action against Jo Anne Barnhart, Commissioner of Social Security ("Commissioner"), on July 24, 2002. (D.I. 3) Pursuant to 42 U.S.C. § 405(g), plaintiff seeks judicial review of the final decision by the Commissioner denying her claim for disability insurance benefits ("DIB") and supplemental security income ("SSI") under Titles II and XVI of the Social Security Act, 42 U.S.C. §§ 401-433, 1381-1383f. Currently before the court are the parties' cross-motions for summary judgment. (D.I. 16, 20) For the following reasons, the court denies plaintiff's motion and grants the Commissioner's motion.

II. BACKGROUND

A. Procedural History

On January 31, 2000, plaintiff filed an application for DIB and SSI. (D.I. 21 at 1) Plaintiff alleged that she was disabled as of July 1, 1999 due to low back pain, arthritis in her right knee and hand, uncontrolled blood pressure, and a heart condition. (Id.) The state denied plaintiff's original application on August 11, 2000 and her application on reconsideration on October 19, 2000. (D.I. 12 at 25-28, 31-35)

Plaintiff requested a hearing before an administrative law judge ("ALJ"). (Id. at 37, 38) On November 13, 2001, the ALJ

conducted a hearing where plaintiff, her daughter, and an independent vocational expert testified. (Id. at 494) On December 27, 2001, the ALJ issued a decision denying plaintiff's claim. (Id. at 9) In considering the entire record, the ALJ found the following:

1. Claimant meets the nondisability requirements for a period of disability and disability insurance benefits set forth in Section 216(I) of the Social Security Act and is insured for benefits through the date of this decision.
2. Claimant has not engaged in substantial gainful activity since the alleged onset of disability.
3. Claimant's arthritis and heart disease are considered "severe" based on the requirements in the Regulations 20 C.F.R. §§ 404.1520(b) and 416.920(b); her depression is nonsevere.
4. These medically determinable impairments do not meet or medically equal one of the listed impairments in Appendix 1, Subpart P, Regulation No. 4.
5. Claimant's allegations regarding her limitations are not totally credible for the reasons set forth in the body of the decision.
6. Claimant has the following residual functional capacity: the full range of medium work, limited by her need to only occasionally climb ladders/ropes/scaffolds, balance, stoop, kneel, crouch, crawl as well as avoid concentrated exposure to hazards, such as dangerous machinery and unprotected heights.
7. Claimant is able to perform her past relevant work as a claims clerk, registrar, psychiatric aide and barmaid/restaurant manager.
8. Claimant was not under a "disability" as defined in the Social Security Act, at any time through the date of the decision.

(Id. at 19-20) In making these findings, the ALJ reviewed the plaintiff's medical records from 1997 through 2001, noting the specific diagnoses of each physician and specialist who examined plaintiff. He also considered plaintiff's responses to a Daily Activities Questionnaire. Accordingly, the ALJ denied plaintiff's claim for DIB and SSI under Sections 2169(i), 223, 1602 and 1614(a)(3)(A) of the Social Security Act.

On January 31, 2002, plaintiff appealed the ALJ's decision. (Id. at 491) The Appeals Council denied plaintiff's request for review on May 17, 2002. As a result, the ALJ's decision became the final decision of the Commissioner under 20 C.F.R. § 404.981. Plaintiff now seeks review before this court pursuant to 42 U.S.C. § 405(g).

B. Facts Evinced at the Administrative Law Hearing

At the time of the ALJ hearing in 2001, plaintiff was a forty-eight year old female. (Id. at 12) She graduated from high school and worked in a variety of positions, including registrar, psychiatric aide, hairdresser, and barmaid/restaurant manager. (Id. at 19) Plaintiff alleges that her disability began in July 1999, around the time she was relieved from her employment as a clerk due to significant work absence. (Id. at 497) After being laid-off, plaintiff collected unemployment benefits while looking for other employment. (Id.) Plaintiff, however, did not secure other employment and continued receiving

unemployment benefits. (Id.)

Plaintiff was evicted from her home because she was unable to pay her rent. (Id. at 510) Plaintiff, consequently, moved in with her daughter. She presently occupies an attic room in her daughter's house. Plaintiff testified that she spends the majority of her days resting, but that she does leave the house for medical appointments. (Id. at 511) She also stated that she occasionally goes shopping at the grocery store with her daughter. Plaintiff's daughter substantiated this testimony and added that plaintiff may assist at times with light dusting and cooking. (Id. at 514) Plaintiff's daughter likewise testified that plaintiff is not able to help care for her two grandchildren, but instead relies on them to aid her with household chores. (Id. at 513)

Regarding plaintiff's medical condition, plaintiff testified that she suffers from degenerative disk disease, degenerative joint disease, a left valve problem, uncontrolled blood pressure, and depression. (Id. at 497, 505) She also testified that she has osteoarthritis in her knees, hips, feet, toes, fingers, and neck. (Id. at 506) Additionally, plaintiff stated that she has a hole in her esophagus and experiences internal bleeding in her stomach. (Id. at 497) Plaintiff further claimed that her primary problem was back pain. To this end, she stated that on a scale of one to ten, her back pain was always a ten. (Id.)

Because of her back injuries, plaintiff testified that she alternates sitting and standing, but that she is unable to do either for more than fifteen or twenty minutes. (Id. at 499) In fact, she explained that she must lean forward in a chair to sit to alleviate pressure on her lower back. Plaintiff also testified that it hurts to bend, to climb a flight of stairs, and to raise her leg.

Despite her complaints, plaintiff testified that she does not take any medications to alleviate her back pain. (Id. at 501) Plaintiff explained that she previously tried both Celebrex and Vioxx, but that neither successfully reduced her pain. (Id. at 508) Plaintiff also testified that she received a caudal injection in her tailbone on one occasion, but that it lasted for only twenty-four hours. (Id. at 502) She explained that her neurosurgeon did not recommend another injection because the first one lasted only for a short duration. (Id.) She further stated that her neurosurgeon suggested surgery, but that the surgeon did not consider it to be a viable option given her osteoarthritis, degenerative disk disease, and bulging discs. (Id.) As a result of these diagnoses, she stated that she takes a hot shower daily to manage her pain.

Concerning other medications, plaintiff testified that she takes Zoloft for her depression, Norvasc for her left valve problem, and Lipitor for her hypercholesterolemia. (Id. at 505)

Plaintiff stated that these medicines, however, cause her to experience nausea, cramping in her stomach, sleepiness, and drowsiness. (Id. at 509)

C. Vocational Evidence

During the administrative hearing, the ALJ called Mr. Bruce Martin as a vocational expert. (Id. at 516) Mr. Martin opined as to the exertional and skill requirements of plaintiff's prior jobs. He explained that her past work ranged from the sedentary exertional level to the medium exertional level. (Id. at 516-17) The ALJ asked the vocational expert whether the job base for medium work would be significantly reduced for an individual capable of performing medium work, but who could only occasionally kneel, crouch, crawl, stoop, and climb and who must avoid concentrated exposure to machinery. (Id. at 517) Mr. Martin testified that the job base would not be reduced for an individual with such limitations. On cross-examination, plaintiff's attorney asked Mr. Martin whether there would be work in the economy for plaintiff if her medical condition caused significant pain. Mr. Martin opined that there would not be any work in the economy. Plaintiff's attorney also inquired whether significant pain impairs a person's efficiency in performing a job. Mr. Martin indicated that such pain would have the effect of inhibiting work performance.

D. Medical Evidence

On May 12, 1999, John F. Madden, M.D., a physician at Christiana Care Emergency Room, reported that plaintiff complained of a headache and chest pain and stated that she had not taken her blood pressure medications for a few weeks. (Id. at 132) Dr. Madden found that plaintiff's heart sounded normal but for a murmur, her chemistries were normal, and she had no motor or sensory deficits. (Id. at 135) Plaintiff's electrocardiogram did not reveal any abnormal sinus rhythm or non-specific abnormalities. (Id. at 141, 146) Dr. Madden diagnosed plaintiff with acute hypertension and prescribed Ziac and Adalat as treatment. (Id. at 147)

On May 12, 1999, Tim Parsons, M.D., a physician at The Family Medicine Center, reported that plaintiff complained of high blood pressure, nausea, dizziness, tingling in her right hand, and a severe frontal headache. (Id. at 407) Dr. Parsons noted that plaintiff denied any changes in her speech, vision, sensation, or strength. He found that plaintiff's breathing was clear, her heart was normal but for a murmur, and her neurological, motor, and sensory functions were normal. Dr. Parsons recommended an echocardiogram to evaluate plaintiff's heart murmur, administered Procardia in the office to immediately lower her blood pressure, and provided samples of Adalat for plaintiff to take home to treat her blood pressure.

On June 3, 1999, Dr. Parsons reported that plaintiff

complained of having headaches and neck pain over the course of three to four days, but denied blurry vision, chest pain, and fever. (Id. at 411) Dr. Parsons found that plaintiff's chest, blood pressure, and neurological function were normal. He also found that her heart was also normal but for a murmur. Dr. Parsons recommended ibuprofen for plaintiff's pain.

On June 7, 1999, Michael J. Pasquale, M.D., a cardiologist at Christiana Care Health Services, performed an electrocardiogram on plaintiff. (Id. at 149) Dr. Pasquale found that her ventricles, atria, and valves were normal and that she did not suffer from pericardial effusion. Dr. Pasquale, therefore, reported that plaintiff showed no significant abnormalities.

On June 23, 1999, Kimberly Gallagher, M.D., a physician at The Family Medicine Center, reported that plaintiff complained of a nagging cough lasting more than three weeks, chest pressure, and difficulty breathing. (Id. at 264) Dr. Gallagher found that plaintiff's ears, throat, and chest were normal, but that plaintiff had grey-pink turbinates in her nose. She diagnosed plaintiff with rhinitis and prescribed Zyrtec and an Albuterol inhaler.

On July 4, 1999, Robert T. Chrzanowski, M.D., a physician at Kent General Emergency Room, reported that plaintiff complained of head pain and nausea but denied vomiting, visual changes,

weakness, lack of strength, fever, chills, and head trauma. (Id. at 150) Dr. Chrzanowski noted that plaintiff's blood pressure was intact, her ears, throat, and chest were clear, her heart sounded normal, and that her vital signs, sensations, motor strength, reflexes, and mental status were normal. He diagnosed plaintiff with acute head pain and administered Demerol and Phenergan.

On July 16, 1999, Matthew O'Brien, M.D., a physician at The Family Medical Center, examined plaintiff as part of a follow-up visit for treatment of plaintiff's blood pressure. Dr. O'Brien noted that plaintiff complained of diffuse moderate headaches, but denied visual changes, chest pain, shortness of breath, fever, chills, nausea, vomiting, and diarrhea. (Id. at 261) Dr. O'Brien found that plaintiff's chest and heart were normal but for a heart murmur and that she had a good pulse and sensation.

On August 15, 1999, Leo Burns, M.D., and Marcia B. Robitaille, M.D., physicians at Christiana Care Emergency Room, reported that plaintiff complained of severe chest pressure and shortness of breath over the span of four days. (Id. at 152, 154) Drs. Burns and Robitaille found that plaintiff did not suffer from respiratory distress, her heart sounded normal but for a murmur, and she had no motor or sensory deficit. (Id. at 155) Plaintiff's electrocardiogram did not reveal any abnormal sinus rhythm or non-specific abnormalities. (Id. at 161) Drs.

Burns and Robitaille diagnosed plaintiff with non-specific chest pain due to a problem in the chest wall. They also concluded that plaintiff's pain was unrelated to any serious heart or lung disease. (Id. at 162) Drs. Burns and Robitaille dispensed Percocet to treat plaintiff's condition.

On September 23, 1999, Dr. O'Brien reported that plaintiff appeared for another follow-up visit for her blood pressure condition. (Id. at 259) Dr. O'Brien noted that plaintiff denied having a headache, shortness of breath, chest pain, fever, chills, nausea, vomiting, diarrhea, and polyphagia. Dr. O'Brien found that plaintiff's chest and heart were normal and she enjoyed a full range of motion in all extremities. He noted a mildly thickened right toenail and prescribed an over-the-counter antifungal.

On January 31, 2000, Dina Esterowitz, M.D., a physician at Kent General Hospital Emergency Room, reported that plaintiff complained of numbness and tingling in her right hand and right toes. (Id. at 169) Dr. Esterowitz found that plaintiff was in no acute distress, her heart and lungs sounded normal, she was alert, and her sensations and motor strength were normal. Dr. Esterowitz diagnosed plaintiff with transient numbness.

On February 10, 2000, Dr. O'Brien reported that plaintiff complained of a bad headache and tingling in her hands and feet, but denied fever, chills, nausea, vomiting, diarrhea, chest pain,

and shortness of breath. (Id. at 247) Dr. O'Brien found that plaintiff's blood pressure was elevated, so he immediately prescribed Adelaide. Dr. O'Brien otherwise noted that plaintiff's breathing was clear, her heart was normal, and she had a full range of motion in all extremities. Dr. O'Brien further noted that plaintiff expressed difficulty in obtaining her medications. Dr. O'Brien urged plaintiff to return to The Family Medicine Center if she was unable to obtain her medicines in the future. He also prescribed ongoing treatment with Adelaide for plaintiff's high blood pressure.

On March 1, 2000, Dr. O'Brien reported that plaintiff complained of intermittent right arm numbness and tingling, irregular sleep habits, and feelings of depression. (Id. at 432) He likewise indicated that plaintiff denied chest pain, shortness of breath, fever, chills, nausea, vomiting, and diarrhea. Dr. O'Brien found that plaintiff's chest and heart were normal and she was alert and oriented. Dr. O'Brien maintained Adelaide and added Hydrodiuril for plaintiff's high blood pressure. He also prescribed Zoloft to treat plaintiff's depression.

On March 15, 2000, Dr. O'Brien reported that plaintiff complained of blood pressure problems and right leg and right arm numbness. (Id. at 435) Upon examination, he found that plaintiff's heart and lungs were normal, she exhibited a full range of motion in all extremities, her reflexes and sensation

were symmetric throughout, and she walked with a normal gait. Dr. O'Brien diagnosed plaintiff with hypercholesterolemia.

Dr. O'Brien filed a disability form on behalf of plaintiff with the Delaware Health and Social Services Agency. Dr. O'Brien stated that plaintiff suffered from uncontrolled hypertension, depression, and lumbosacral strain. (Id. at 382) Dr. O'Brien reported that plaintiff was unable to perform her usual occupation and that he would not permit plaintiff to perform any other work on a full time basis. He likewise opined that plaintiff would be unable to return to work for two months.

On April 3, 2000, Dr. O'Brien reported that plaintiff complained of a variety of issues including dyspnea in climbing a flight of stairs, right extremity numbness and tingling, and increased urinary retention that she perceived was caused from taking Zoloft. (Id. at 438) Dr. O'Brien found that plaintiff had clear lungs, a regular heart, normal extremities, and normal mood and affect. Dr. O'Brien also noted that plaintiff's blood pressure was excellent. He recommenced continuing treatment with Adelaide and Hydrodiuril. To manage plaintiff's urinary retention, Dr. O'Brien reduced plaintiff's dose of Zoloft.

On April 7, 2000, David Ramos, M.D., a cardiologist at Cardiology Consultants P.A., reported that plaintiff had no chest discomfort with exercise and that her stress test for ischemia was negative. (Id. at 206) Dr. Ramos also reported that

plaintiff's gated dual isotope myocardial perfusion study showed a small amount of ischemia, no areas of myocardial infarction, normal left ventricular wall motion and thickening with normal calculated left ventricular ejection. (Id. at 207)

On April 11, 2000, Dr. Esterowitz reported that plaintiff complained of chest pain, nausea, and shortness of breath, but denied vomiting or diaphoresis. (Id. at 180) Dr. Esterowitz found that plaintiff had no acute distress, her heart and lungs were clear, and she was alert. Plaintiff's chest x-ray was negative. (Id. at 186) Her electrocardiogram, however, showed acute ischemia. Dr. Esterowitz diagnosed plaintiff with acute unstable angina and prescribed aspirin and nitroglycerin. (Id. at 181)

On April 11, 2000, Harjinder Grewal, M.D., a cardiologist at Kent General Hospital, was consulted about plaintiff's heart condition. Dr. Grewal reported that plaintiff complained of pain in the center of her chest that radiated to her left shoulder and neck regions. (Id. at 194) He also reported that plaintiff complained of shortness of breath. Dr. Grewal found that plaintiff's lungs were clear, her heart sounded normal, and her nervous system appeared intact. (Id. at 196) Dr. Grewal diagnosed plaintiff with mild non-obstructive coronary artery disease, controlled hypertension, and a history of hyperlipidemia. (Id. at 197)

On April 12, 2000, Mark Zolnick, M.D., a cardiologist at Christiana Heart Center, performed a coronary arteriography, left heart catherization, and left ventriculography on plaintiff.

(Id. at 176) Dr. Zolnick concluded that plaintiff suffered from non-obstructive coronary artery disease. He also indicated that this condition was treatable with medication. (Id. at 177)

On April 18, 2000, Dr. O'Brien reported that plaintiff continued to complain of right extremity tingling. (Id. at 441) Dr. O'Brien noted that plaintiff also claimed that she felt "off balance" from taking Zoloft. Dr. O'Brien found that plaintiff's breathing was clear, her heart was normal, she enjoyed a full range of motion in all her extremities, and she walked with normal gait. Dr. O'Brien likewise found that plaintiff's right arm and right leg showed decreased sensation. A cardiac catherization revealed normal left ventricle function. He noted that plaintiff's blood pressure was stable, but that it fluctuated widely. Dr. O'Brien diagnosed plaintiff with idiopathic peripheral neuropathy, prescribed Plavix, and ordered an MRI of plaintiff's neck and lumbar spine.

On April 24, 2000, Dr. Grewal reported that plaintiff visited to discuss the results of her carotid doppler scan. (Id. at 198) Dr. Grewal noted that plaintiff complained of both pain in her left thigh on walking and swelling of her left thigh following her heart catherization. Dr. Grewal noted that

plaintiff, nevertheless, denied any history of chest pain, shortness of breath, rapid heart beat, or dizziness. Dr. Grewal found that plaintiff's heart was normal and that her lungs were clear. He confirmed his previous diagnosis of mild non-obstructive coronary artery disease. (Id. at 199)

On April 28, 2000, Lawrence Narun, M.D., a cardiologist, reviewed plaintiff's electrocardiogram. He concluded that plaintiff's left ventricle cavity size, systolic function, atrial size, and valve function were all normal and that she did not have pericardial effusion. (Id. at 201) Dr. Narun noted, however, that plaintiff suffered mild concentric left ventricle hypertrophy.

On May 2, 2000, Dr. Grewal reported that plaintiff stated that she was in good health and did not have any history of chest pain, shortness of breath, rapid heart beat, or dizziness. (Id. at 400) Dr. Grewal found that plaintiff's heart was normal but for a heart murmur, her lungs were clear, and her legs showed no edema. A carotid doppler scan showed mild stenosis of the left internal carotid artery. Dr. Grewal maintained his diagnosis of mild non-obstructive coronary and carotid artery disease, controlled hypertension, and a history of hyperlipidemia.

On May 4, 2000, Dr. O'Brien reported that plaintiff complained of general achiness, but denied chest pain, shortness of breath, nausea, vomiting, diarrhea, fever, chills, headache

and vision change. (Id. at 445) Dr. O'Brien also reported that plaintiff said she was able to climb a flight of stairs without stopping. He found that plaintiff had a clear chest, normal heart, and symmetric reflexes and sensation. Dr. O'Brien further reported that plaintiff's blood pressure was well-controlled with Adelaide and Hydrodiuril. He prescribed Vioxx to treat plaintiff's symptoms.

On June 2, 2000, Dr. O'Brien reported that plaintiff felt much better as a result of weight loss, but still complained of intermittent right extremity tingling. (Id. at 448) He found that plaintiff's lungs were clear, her heart and extremities were normal, and her blood pressure and hypercholesterolemia were improved. Dr. O'Brien strongly encouraged plaintiff to continue a diet and exercise program. He prescribed Lamisil to plaintiff.

On June 26, 2000, R.P. Dushuttle, M.D., reported that plaintiff complained of intermittent arm and leg numbness. (Id. at 359) Dr. Dushuttle did not find any neuro, motor, or sensory deficit of any kind or weakness in plaintiff's lumbar spine. He noted that plaintiff showed mild tenderness in her trapezius muscle, but that she still was able to enjoy a full range of motion. Dr. Dushuttle diagnosed plaintiff with sciatica secondary to advanced degenerative disease of the L5-S1 disc. Dr. Dushuttle discontinued plaintiff's Vioxx prescription and prescribed a non-steroidal anti-inflammatory.

On July 7, 2000, John Moghtader, M.D., a physician at Kent General Emergency Room, reported that plaintiff complained of chest, neck, and arm pain lasting twenty-four hours, but denied any pressure, radiation of pain to her back or abdomen, fever, chills, nausea, and vomiting. (Id. at 210) Plaintiff's lungs were clear and her heart and pulse were normal. Dr. Moghtader noted that laboratory tests, a chest x-ray, and an electrocardiogram were unremarkable. Dr. Moghtader consulted with Dr. Narun regarding plaintiff's catherization and Dr. Narun shared that she suspected plaintiff's condition was not cardiac, but instead due to gastrointestinal problems. (Id. at 211) Consequently, Dr. Moghtader diagnosed plaintiff with acute chest pain.

On July 17, 2000, Pamela Johnson, M.D., a physician at The Family Medicine Center, reported that plaintiff complained of a toothache and intermittent sharp chest pain on her left side with some radiation to her neck and jaw. (Id. at 451) Dr. Johnson indicated that plaintiff denied indigestion, fever, back pain, shortness of breath, and diaphoresis. Dr. Johnson found that plaintiff's lungs were clear, her heart was normal, she showed a full range of motion in all her extremities, and she walked with a normal gait. She offered to change plaintiff's antidepressant from Zoloft, but plaintiff requested that she continue her Zoloft therapy. Dr. Johnson recommended that plaintiff continue to

stretch and exercise.

On July 18, 2000, Dr. Dushuttle reported that plaintiff complained of numbness in her right extremities. (Id. at 360) Dr. Dushuttle noted that plaintiff discontinued taking Predisone because she was concerned about weight gain. Dr. Dushuttle found tenderness in plaintiff's lumbar spine, but also noted that her reflexes were symmetrical and that she did not have muscle atrophy. Dr. Dushuttle again diagnosed plaintiff with sciatica secondary to advanced degenerative disease of the L5-S1 disc. He recommended that plaintiff take Sterapred and indicated to plaintiff that he wished to refer her for epidural injections. Dr. Dushuttle concluded again that surgery was not an option unless the pain grew intolerable.

On July 31, 2000, Maria C. Mancuso, M.D., a physician at The Family Medicine Center, reported that plaintiff complained of constant upper and lower extremity pain and numbness in her left thigh. (Id. at 244) Dr. Mancuso noted that plaintiff claimed that her pain subsided by lying in the fetal position. Dr. Mancuso found that plaintiff was not under respiratory distress, she did not have any problems with her heart, and her mood was normal. Dr. Mancuso also noted that plaintiff had a full range of motion in both her left upper and lower extremities and good range of motion in her right upper and lower extremities. Dr. Mancuso indicated that she planned to refer plaintiff to a

neurosurgeon for further evaluation. Dr. Mancuso recommended that plaintiff continue taking Vioxx, Prednisone, and Soma for her conditions. (Id. at 245)

Dr. Mancuso filed a disability form on plaintiff's behalf with the Delaware Health and Social Services Agency. (Id. at 489) She stated that plaintiff suffered from bulging discs at the C4-5, C5-6, and L5-S1 positions. Dr. Mancuso indicated that plaintiff was not able to perform her usual occupation and that she would not permit plaintiff to perform any other work on a full time basis. Dr. Mancuso also indicated that plaintiff would likely not be able to work for more than twelve months and noted that plaintiff needed to be evaluated by a neurosurgeon.

On August 3, 2000, I.L. Lifrak, M.D., J.D., examined plaintiff on behalf of the Delaware Disability Determination Service. (Id. at 219) Dr. Lifrak reported that plaintiff complained of severe pain extending throughout her entire vertebral column, pain in her right upper and lower extremities, and periodic episodes of dull chest pain. Plaintiff also stated that she was able to walk with the aide of any assistive device, able to climb stairs, sit for periods of up to fifteen minutes, stand for periods of up to fifteen minutes, and lift weights of up to approximately five pounds with her right hand and ten pounds with her left hand. (Id. at 220) Dr. Lifrak found that plaintiff was not in any physical distress. He noted that she

walked with a gait that exhibited a mild degree of limp favoring her right side. Dr. Lifrak also found that plaintiff was able to climb on and off the examining table without assistance, to walk on both her heels and toes, and to maneuver her hands with dexterity. Dr. Lifrak documented that plaintiff had a grip strength of fifty pounds with her right hand and seventy-five pounds with her left hand. He further found that plaintiff's chest and heart were normal, she had no gross deformities of either her upper or lower extremities, she had no asymmetrical muscle atrophy or joint effusion, and her muscle tone in her lower extremities was normal. (Id. at 221) Despite her muscle condition, he, nevertheless, found that plaintiff's range of motion in her cervical and lumbosacral spine was reduced and she showed muscle spasm in these regions. Finally, Dr. Lifrak reported that plaintiff's cardiac catheterization showed only a mild degree of coronary artery disease and that Doppler flow studies revealed only a mild degree of stenosis of the left internal carotid artery. (Id. at 222)

On August 10, 2000, Dr. Dushuttle reported that plaintiff complained of continued leg pain and crunching in her lumbar spine. (Id. at 360) Dr. Dushuttle did not find neuro, motor, or sensory deficit and noted that plaintiff's reflexes were symmetrical. He recommended that plaintiff consult a neurosurgeon, consider the possibility of epidurals, and continue

treatment with non-steroidal anti-inflammatories. Dr. Dushuttle, however, did not suggest surgical intervention.

On August 10, 2000, M. Burk, M.D., a physician for the Delaware Health and Social Services Agency, reviewed plaintiff's records. (Id. at 227) Dr. Burk found that plaintiff was able to occasionally lift fifty pounds, frequently lift and/or carry twenty-five pounds, stand and/or walk about six hours in an eight-hour workday, sit for a total of about six hours in an eight-hour workday, and push and/or pull in an unlimited fashion. He also found that plaintiff did not have any postural limitations associated with climbing, balancing, stooping, kneeling, crouching, or crawling. Dr. Burk further found that plaintiff did not have any manipulative or visual limitation. He recommended that plaintiff avoid exposure to extreme heat and cold, fumes, odors, dusts, gases, poor ventilation, machinery, and heights.

On August 25, 2000, Lisa Dockter, M.D., a family physician at The Family Medicine Center, reported that plaintiff complained of neck and back pain and pain running down the backs of her legs with numbness in her right foot and right arm. (Id. at 241) Dr. Dockter found that plaintiff's chest and heart were normal but for the presence of a heart murmur. Dr. Dockter diagnosed plaintiff with an ischemic heart. She prescribed additional medications to treat plaintiff's conditions.

On September 11, 2000, Karen Canter, M.D., a family physician at The Family Medicine Center, reported that plaintiff consulted her about her medications due to a fainting episode that she experienced over the Labor Day holiday weekend. (Id. at 238) Specifically, Dr. Canter noted that plaintiff complained that she felt faint and fell to the floor after jumping off her sofa quickly to answer the door. Dr. Canter noted that plaintiff denied chest pain, abdominal pain, urination difficulty, constipation, and diarrhea. Dr. Canter found that plaintiff's chest, heart, reflexes, and sensations were normal. Dr. Canter slightly adjusted plaintiff's medications.

On September 19, 2000, Dr. Canter reported that plaintiff complained of intermittent visual blurriness, numbness in her right extremities, and feelings of weakness, dizziness, and light-headedness. (Id. at 464) She noted that plaintiff sat slumped over on the end of the exam table and propped herself up with both arms in a tripod style. Dr. Canter further noted that plaintiff refused to stand or walk because she feared falling. Dr. Canter found that plaintiff's breathing was clear, her heart was normal, she had a full range of motion in all extremities, and she exhibited a normal, but slow, gait. Dr. Canter recommended that plaintiff go to the hospital for a CT head scan, MRI/MRA of her brain, and carotid ultrasound.

On September 20, 2000, Janicia Thomas, M.D., a physician at

Kent General Emergency Room, reported that plaintiff complained of numbness and tingling on her right side. (Id. at 272) Dr. Thomas noted that plaintiff denied any chest pain, difficulty breathing, nausea, vomiting, fever, change in her vision or hearing, and dizziness. She also indicated that plaintiff expressed concern about her blood pressure. Dr. Thomas found that plaintiff's heart and lungs were normal and she was able to move all of her extremities. A CAT scan of plaintiff's head was negative. Dr. Thomas diagnosed plaintiff with weakness.

On October 17, 2000, Vinod Keterie, M.D., a physician for the Delaware Health and Social Services Agency, reviewed plaintiff's medical records. (Id. at 274) Dr. Keterie reported that plaintiff was able to occasionally lift fifty pounds, frequently lift twenty-five pounds, stand and/or walk about six hours in an eight-hour workday, sit about six hours in an eight-hour workday, and push and/or pull in an unlimited fashion. (Id. at 275) Dr. Keterie also found that plaintiff was able to frequently climb a ladder/rope/scaffold, frequently balance, and occasionally stoop, kneel, crouch, and crawl. (Id. at 276) Dr. Keterie concluded that plaintiff did not have any environmental limitations, except that she should avoid machinery and heights. (Id. at 278)

On October 25, 2000, Bikash Bose, M.D., a neurosurgeon at Neurosurgery Consultants, P.A., conducted a neurological

consultation with plaintiff. (Id. at 350) Dr. Bose reported that plaintiff complained of numbness in the left side of her body, headaches, and pain in her lower back, buttocks, and in the region between her shoulder blades. Dr. Bose noted that plaintiff told him that she injured her back and neck in a fall twenty years ago and has experienced problems since that time. He found that plaintiff's neurological functions were within normal ranges, her upper and lower extremities showed full motor strength, and she was able to walk on her toes without difficulty though experienced pain when walking on her heels. Dr. Bose reported that he reviewed the MRI, MRA, and CT scan of plaintiff's brain and MRI of plaintiff's lumbar and cervical spine. He concluded that plaintiff has advanced degenerative disc disease at the L5-S1 disc and has bulging discs at the C4-5 and C5-6 levels. Dr. Bose recommended epidural steroids, Daypro, stretching, and exercise. He did not recommend surgery.

On October 31, 2000, Dr. Mancuso reported that plaintiff complained of numbness in her right extremities and loss of balance, but denied a headache, fever, chills, nausea, and vomiting. (Id. at 469) Dr. Mancuso also reported that plaintiff claimed to have fallen down steps the previous day. Dr. Mancuso found that plaintiff's heart and chest were normal, she exhibited a full range of motion in all extremities, she walked with a normal gait, her back and neck were not tender, her reflexes and

gross sensation were symmetric, and she did not experience dizziness when standing. Dr. Mancuso diagnosed plaintiff with anemia and with an L5-S1 disc derangement. Dr. Mancuso offered plaintiff an epidural steroid injection with the intention of decreasing her pain to facilitate an active therapeutic exercise program.

On November 20, 2000, John Coll, D.O., a neurosurgeon at The Center for Neurology, Neurosurgery and Pain Management, PA, examined plaintiff. (Id. at 351) Dr. Coll reported that plaintiff complained of dizziness, poor balance, intermittent headaches, chronic chest pain, and neck and back pain. Dr. Coll noted that plaintiff denied tetinitus, hearing loss, double vision, visual field loss, speech or swallowing difficulty, nausea, bladder dysfunction, fever, weakness, palpitations, and symptoms of anxiety or depression. Dr. Coll found no neck or spinal tenderness and a full range of cervical motion. He reported that plaintiff's lungs were clear, her heart was normal, and that she was alert and well-orientated. He also noted that she had normal motor tone in all extremities, her muscles were of good consistency in all four limbs, and she did not have any swelling or tenderness in her extremities. Dr. Coll further reported that plaintiff experienced decreased sensation in her right thigh, but otherwise showed normal sensation to pin, touch, vibration, and proprioception. Finally, he reported that

plaintiff had a normal gait with no difficulty in toe, heel, or tandem walking. Dr. Coll concluded that plaintiff's balance difficulties were not caused by neurologic illness.

On December 5, 2000, Elva Pearson, M.D., a psychiatrist at Physiatrist Associates, P.A., examined plaintiff. (Id. at 373) Dr. Pearson reported that plaintiff became tearful during the examination because of frustration from her pain. She also noted that plaintiff stood with a normal lumbar posture, exhibited symmetric deep tendon reflexes at her knees, ankles, and medial hamstrings, displayed decreased sensation in her left lower extremity, and showed normal strength. Dr. Pearson diagnosed plaintiff with an L5-S1 disc derangement. Dr. Pearson suggested that plaintiff receive an epidural steroid injection to decrease her pain and thereby enable a therapeutic exercise program.

On December 13, 2000, Dr. Pearson administered a lumbar/caudal epidural steroid injection to plaintiff. (Id. at 375) She followed up with plaintiff regarding the success of the treatment on December 27, 2000. (Id. at 376) Dr. Pearson reported that plaintiff complained of pain in her right buttock and decreased range of motion in her lumbar spine. She determined that no further injections were reasonable given the short-lived results of her first injection. Dr. Pearson recommended that plaintiff consider a surgical fusion.

On December 21, 2000, Dr. Mancuso reported that plaintiff

complained of pain in her coccyx with sitting and numbness in her right extremities that intensified with sitting. (Id. at 473) Dr. Mancuso also reported that plaintiff claimed to feel poor equilibrium and an intermittent "pulse" behind her right ear, but denied ear pain. Dr. Mancuso further reported that plaintiff claimed to feel off balance when standing and when walking. She noted that plaintiff discontinued taking Zoloft because she did not find that it helped her feelings of depression. Dr. Mancuso found that plaintiff's heart and lungs were normal and she showed a full range of motion throughout all extremities. She indicated that plaintiff had a normal gait and symmetric reflexes and sensation. Dr. Mancuso noted, however, that plaintiff showed elevated blood pressure. As a result, Dr. Mancuso increased plaintiff's dosage of Accupril.

On January 22, 2001, Dr. Mancuso reported that plaintiff complained of sinus problems, but denied fever and chills. (Id. at 477) Dr. Mancuso noted that plaintiff stated that she felt less depressed following treatment with Zoloft. Dr. Mancuso found that plaintiff's breathing was clear and her heart was normal. She also found that plaintiff showed a full range of motion in all extremities, symmetric sensation throughout her body, and a normal gait. Dr. Mancuso noted Dr. Pearson presented plaintiff with the option of having a spinal fusion in light of the failed spinal injections.

On March 1, 2001, Dr. Mancuso reported that plaintiff complained of low back pain and stated that her Vioxx prescription offered no relief. (Id. at 481) Dr. Mancuso found that plaintiff had normal breathing, a normal heart rate and rhythm, full motor strength, brisk reflexes, intact sensation, and a normal gait.

On June 11, 2001, Dr. Mancuso reported that plaintiff complained of back pain. (Id. at 333) She found that plaintiff displayed normal breathing, a regular heart rate and rhythm, and normal reflexes. She also noted that plaintiff's depression appeared improved.

On July 10, 2001, J. Rafeal Yanez, M.D., a neurosurgeon, examined plaintiff at the request of Dr. Mancuso. (Id. at 311) Dr. Yanez reported that plaintiff was uncomfortable during the examination and that she sat bent over without an ability to straighten her back. Dr. Yanez also noted that plaintiff complained of severe pain in her left lower back and pain in her left leg that radiated to her big toe of one week's duration. He found that plaintiff's lumbar lordosis was lost and that her back was totally flat and quite tender. Dr. Yanez recommended that plaintiff have an immediate lumbosacral spine x-ray, total skeletal bone scan, and MRI of her lumbosacral area.

On July 25, 2001, Dr. Yanez diagnosed plaintiff with advanced degenerative disc disease involving the L5-S1 disc based

upon an examination of plaintiff's lumbar spine. (Id. at 312) Dr. Yanez noted that the examination showed that the remainder of plaintiff's intervertebral discs were well maintained, her vertebral bodies were normal in height and alignment, and there was no evidence of a compression fracture or subluxation. Dr. Yanez also reported that an MRI of plaintiff's lumbar spine showed advanced degenerative disc disease and a mild L5-S1 bulging disc with no herniation or spinal stenosis.

On July 30, 2001, plaintiff was the driver of an automobile involved in a two-car automobile accident. (Id. at 364) She was treated at Kent General Emergency Room for her injuries. The staff reported that plaintiff complained of lower back pain. (Id. at 366) The staff found that plaintiff did not have chest pain, her heart was normal, and her neuro and sensory functions were normal. The staff also found that plaintiff showed paralumbar tenderness, but x-rays of plaintiff's lower spine showed no new changes. The staff diagnosed plaintiff with a lumbar sprain and administered Tylenol for pain.

On August 3, 2001, Dr. Yanez reported that plaintiff complained of lower back pain and leg pain. (Id. at 308) Dr. Yanez found that plaintiff walked with an antalgic gait, but that her reflexes, sensory, and motor abilities were normal. He also noted that plaintiff was stiff and sore in her lumbosacral and gluteal areas and, as a result, experienced difficulty in moving

her back and raising her legs. Dr. Yanez further indicated that a bone scan did not reveal any abnormalities, but that a lumbosacral spine x-ray showed degenerative disc disease concentrated at the L5-S1 disc. Finally, Dr. Yanez reported that an MRI did not show any abnormalities, but did reveal bulgings in the L5-S1 region of her spine. Dr. Yanez recommended that plaintiff be treated at a pain management clinic.

On September 6, 2001, Dr. Mancuso again filed disability forms on behalf of plaintiff with the Delaware Health and Social Services. (Id. at 490) She stated that plaintiff suffered from bulging discs and spine degeneration. Dr. Mancuso indicated that plaintiff was unable to sit for more than fifteen to twenty minutes and that she was unable to twist, lift, or bend as part of work experiences. Dr. Mancuso concluded that plaintiff was unable to work at her occupation. She also stated that she would not permit plaintiff to perform other work on a full time basis and that plaintiff's illness would likely last more than twelve months.

III. STANDARD OF REVIEW

"The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, [are] conclusive." 42 U.S.C. § 405(g) (2003). The court will set aside the Commissioner's denial of plaintiff's claim only if it is "unsupported by substantial evidence." 5 U.S.C. § 706(2) (E)

(2003). The Supreme Court held that

“substantial evidence is more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.” Accordingly, it “must do more than create a suspicion of the existence of the fact to be established.... It must be enough to justify, if the trial were to a jury, a refusal to direct a verdict when the conclusion sought to be drawn from it is one of fact for the jury.”

Universal Camera Corp. v. NLRB, 340 U.S. 474, 477 (1951) (quoting NLRB v. Columbian Enameling & Stamping Co., 306 U.S. 292, 300 (1939)).

The Supreme Court also has embraced this standard for determining the availability of summary judgment pursuant to Federal Rule of Civil Procedure 56.

The inquiry performed is the threshold inquiry of determining whether there is the need for a trial – whether, in other words, there are any genuine factual issues that properly can be resolved only by a finder of fact because they may reasonably be resolved in favor of either party.

Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 250 (1986)

(internal citations omitted). Thus, in the context of judicial review under § 405(g),

“[a] single piece of evidence will not satisfy the substantiality test if the [Commissioner] ignores, or fails to resolve, a conflict created by countervailing evidence. Nor is evidence substantial if it is overwhelmed by other evidence – particularly certain types of evidence (e.g., that offered by treating physicians) – or if it really constitutes not evidence but mere

conclusion.”

Brewster v. Heckler, 786 F.2d 581, 584 (3d Cir. 1986) (quoting Kent v. Schweiker, 710 F.2d 110, 114 (3d Cir. 1983)).

“Despite the deference due to administrative decisions in disability benefit cases, ‘appellate courts retain a responsibility to scrutinize the entire record and to reverse or remand if the [Commissioner]’s decision is not supported by substantial evidence.’” Morales v. Apfel, 225 F.3d 310, 317 (3d Cir. 2000) (quoting Smith v. Califano, 637 F.2d 968, 970 (3d Cir. 1981)). “A district court, after reviewing the decision of the [Commissioner] may, under 42 U.S.C. 405(g) affirm, modify, or reverse the [Commissioner]’s decision with or without a remand to the [Commissioner] for rehearing.” Podedworny v. Harris, 745 F.2d 210, 221 (3d Cir. 1984).

IV. DISCUSSION

A. Standards for Determining Disability

“Disability” is defined in the Social Security Act as an 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) (2003). A claimant is considered unable to engage in any substantial gainful activity

only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work.

42 U.S.C. § 423(d) (2) (A) (2003). The Commissioner makes this determination based upon a regulation promulgated by the Social Security Administration that sets out a five-step sequential evaluation process. See 20 C.F.R. § 404.1520, 416.920. The Third Circuit outlined the process in Plummer v. Apfel, 186 F.3d 422 (3d Cir. 1999).

In order to establish a disability under the Social Security Act, a claimant must demonstrate there is some "medically determinable basis for an impairment that prevents him from engaging in any 'substantial gainful activity' for a statutory twelve-month period." A claimant is considered unable to engage in any substantial activity "only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy."

The Social Security Administration has promulgated regulations incorporating a sequential evaluation process for determining whether a claimant is under a disability. In step one, the Commissioner must determine whether the claimant is currently engaging in substantial gainful activity. If a claimant is found to be engaged in substantial activity, the disability claim will be

denied. In step two, the Commissioner must determine whether the claimant is suffering from a severe impairment. If the claimant fails to show that her impairments are "severe", she is ineligible for disability benefits.

In step three, the Commissioner compares the medical evidence of the claimant's impairment to a list of impairments presumed severe enough to preclude any gainful work. If a claimant does not suffer from a listed impairment or its equivalent, the analysis proceeds to steps four and five. Step four requires the ALJ to consider whether the claimant retains the residual functional capacity to perform her past relevant work. The claimant bears the burden of demonstrating an inability to return to her past relevant work.

If the claimant is unable to resume her former occupation, the evaluation moves to the final step. At this stage, the burden of production shifts to the Commissioner, who must demonstrate the claimant is capable of performing other available work in order to deny a claim of disability. The ALJ must show there are other jobs existing in significant numbers in the national economy which the claimant can perform, consistent with her medical impairments, age, education, past work experience, and residual functional capacity. The ALJ must analyze the cumulative effect of all the claimant's impairments in determining whether she is capable of performing work and is not disabled. The ALJ will often seek the assistance of a vocational expert at this fifth step.

Id. at 427-28 (internal citations omitted).

B. Application of the Five-Step Test

In the present case, the court recognizes that the first three steps of the five-part test to determine whether a person

is disabled are not at issue: (1) the ALJ determined that plaintiff has not engaged in substantial gainful activity since the alleged onset of her disability in July 1999; (2) the ALJ qualified plaintiff's arthritis and heart disease as "severe" impairments, though noted that her depression is nonsevere; and (3) the ALJ determined that plaintiff's impairments do not meet or medically equal one of the medical impairments listed in 20 C.F.R. pt. 404, subpt. P, app. 1 that would preclude her gainful work. Plaintiff contests the ALJ's finding regarding step four in the regulatory process. Specifically, plaintiff challenges the ALJ's finding that her allegations concerning her limitations are not totally credible and that she has residual functional capacity to perform her past relevant sedentary to medium exertional work as a claims clerk, registrar, psychiatric aide and barmaid/restaurant manager. Plaintiff claims that the ALJ is supposed to reach his determination of disability based upon the medical evidence of record and not by his own medical interpretations of the amount of pain that a person likely experiences. To this end, plaintiff charges that the ALJ completely disregarded the record replete with plaintiff's complaints of pain to many physicians and specialists dating back to 1999. Plaintiff particularly claims that the ALJ should have given credibility to her testimony about her pain because Dr. Mancuso, her treating physician, supported her claims. In fact,

plaintiff notes that Dr. Mancuso even submitted two reports dated July 31, 2000 and September 6, 2001 to the Delaware Health and Human Services Agency stating that she was unable to work due to chronic pain. Plaintiff also contends that Drs. Yanez and Dushsuttle diagnosed her with a degenerative disk disease and that Dr. Pearson administered epidural shots to treat her pain.

For the court to set aside the Commissioner's conclusion that plaintiff was not under a "disability" as defined by the Social Security Act and to grant plaintiff's motion for summary judgment, plaintiff must show that the ALJ's findings are not supported by substantial evidence. The court, therefore, recognizes that the Commissioner's decision is entitled to substantial deference. The court does not find that plaintiff has met her burden such that the Commissioner's decision should be overturned.

1. ALJ's Determination that Plaintiff's Pain is Not Credible

Pursuant to the regulations, the ALJ must consider the extent to which the plaintiff's alleged symptoms can reasonably be accepted as consistent with objective medical and other evidence. 20 C.F.R. §§ 404.1529, 416.929 (2003). The ALJ noted that plaintiff claimed to suffer severe pain, yet did not take any pain medications or participate in a pain management program for relief. The ALJ also pointed out that plaintiff does not suffer any disc herniations and that neurological examinations

conducted by multiple doctors including Drs. Yanez, Bose, Coll, and Dushuttle were within normal limits. The ALJ further noted that the state agency concluded that plaintiff could sit for an unlimited time, despite plaintiff's allegations that she could not sit for more than fifteen minutes and must lie in the fetal position to relieve pressure off her back. Indeed, like the ALJ, the court finds that objective medical evidence exists to clearly contradict plaintiff's alleged symptoms.

2. Failure to Give Proper Consideration to the Treating Physician's Opinion

The ALJ may discount a treating physician's opinion where it is: (1) not well-supported by medically accepted clinical and laboratory diagnostic techniques; or (2) inconsistent with other substantial evidence in the record. 20 C.F.R. §§ 404.1527(d)(2), 416.927(d)(2) (2003). Dr. Mancuso indicated that plaintiff was unable to work merely by checking off a standard form. The Third Circuit held that form reports in which a physician's obligation is only to check a box or fill in a blank, like the one Dr. Mancuso's completed, are "weak evidence at best." See Mason v. Shalala, 994 F.2d 1058, 1065 (3d Cir. 1993). Additionally, Dr. Mancuso's acknowledged on one form that plaintiff needed to be evaluated by a neurosurgeon. As noted above, multiple neurosurgeons found no neurological, motor, or sensory deficits. Finally, the ALJ must consider whether the medical opinion relates to the physician's area of specialty under the

regulations. 20 C.F.R. §§ 404.1527(d)(5), 416.927(d)(5) (2003). As a family physician, Dr. Mancuso opined that plaintiff suffered from bulging discs and spine degeneration. Drs. Yanez, Bose, Coll, and Dushuttle opined, in contrast, that plaintiff was within normal neurological limits. The court holds that the ALJ was fully justified in placing greater weight on the diagnoses made by plaintiff's neurosurgeons than on the diagnosis made by her family physician. Based upon this evidence, the court finds that the ALJ reasonably may have concluded that plaintiff was not disabled such that she could not perform her previous work functions as a claims clerk, registrar, psychiatric aide and barmaid/restaurant manager.

V. CONCLUSION

For the reasons stated herein, the court denies plaintiff's motion for summary judgment and grants Commissioner's cross-motion for summary judgment. An appropriate order shall issue.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF DELAWARE

JOCELYN E. STEVENS,)
)
 Plaintiff,)
)
 v.) Civil Action No. 02-1330-SLR
)
 JO ANNE B. BARNHART,)
 Commissioner of Social Security,)
)
 Defendant.)

O R D E R

At Wilmington this 14th day of November, 2003, consistent with the memorandum opinion issued this same day;

IT IS ORDERED that:

1. Plaintiff's motion for summary judgment (D.I. 16) is denied.
2. Commissioner's cross-motion for summary judgment (D.I. 20) is granted.
3. The Clerk of Court is directed to enter judgment in favor of Commissioner and against plaintiff.

Sue L. Robinson
United States District Judge