IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF DELAWARE

GERALD COULBOURNE, Plaintiff, v. KENNETH S. APFEL, Commissioner of Social Security Administration, Defendant.	:	Civil Action No. 00-370-JJF

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MEMORANDUM OPINION

July 26, 2001

Wilmington, Delaware

Farnan, District Judge.

Presently before the Court is an appeal pursuant to 42 U.S.C. § 405(g), filed by Plaintiff, Gerald Coulbourne, seeking review of the final administrative decision of the Commissioner of the Social Security Administration ("the Administration") denying Plaintiff's claim for continued disability insurance benefits ("DIB") under Title II of the Social Security Act, 42 U.S.C. § 401-433 (the "Act"). Plaintiff has filed a Motion For Summary Judgment (D.I. 12) requesting the Court to reverse the findings of the Commissioner and reinstate Plaintiff's benefits, or in the alternative, to remand this case to the Administrative Law Judge. In response to Plaintiff's Motion, Defendant has filed a Cross-Motion For Summary Judgment (D.I. 10) requesting the Court to affirm the Commissioner's decision. For the reasons set forth below, Defendant's Motion For Summary Judgment will be denied and Plaintiff's Motion For Summary Judgment will be granted. The decision of the Commissioner dated May 21, 1998 will be reversed and remanded to the Administrative Law Judge for further findings and/or proceedings consistent with this Memorandum Opinion.

BACKGROUND

I. Procedural Background

Based on a previous decision by the Social Security Administration, Plaintiff had been receiving disability benefits due to an affective disorder and alcoholism since 1983. (Tr. 51-54). By a notice dated June 12, 1996, Plaintiff was advised that his disability benefits would be terminated on January 1, 1997, pursuant to Public Law 104-121 which prohibits an award of benefits to a disability claimant when drug addiction or alcoholism is a material, contributing factor to the claimant's disability. (Tr. 51-54).

Plaintiff appealed the Administration's decision to revoke his benefits alleging that he was disabled as a result of mental illness, frequent hospitalizations, depression and a left arm impairment. (Tr. 64-71). Upon review, the Social Security Administration concluded that Plaintiff was no longer disabled and denied Plaintiff's appeal. (Tr. 55-56). Thereafter, Plaintiff requested a hearing before an Administrative Law Judge ("A.L.J.").

On April 21, 1998, the A.L.J. conducted a redetermination hearing. (Tr. 25-50). On May 21, 1998, the A.L.J. issued a decision denying Plaintiff's request to continue his disability benefits. (Tr. 10-19). The A.L.J. found that Plaintiff had bipolar disorder and residual effects of a left arm fracture which were severe impairments. However, the

A.L.J. found that Plaintiff could perform a reduced range of "medium" work and that a sufficient number of jobs existed in the local and national economy meeting Plaintiff's residual functional capacity. Accordingly, the A.L.J. concluded that Plaintiff was no longer disabled within the meaning of the Social Security Act.

Following the unfavorable decision, Plaintiff filed a timely Request For Review Of Hearing Decision. On March 3, 2000, the Appeals Council denied Plaintiff's request. (Tr. 3-5). Accordingly, the decision of the A.L.J. denying Plaintiff's continued claim to benefits became the final decision of the Commissioner. 20 C.F.R. § 404.981.

After completing the process of administrative review, Plaintiff filed the instant civil action pursuant to 42 U.S.C. § 405(g), seeking review of the A.L.J.'s decision denying his claim for continued disability benefits. In response to the Complaint, Defendant filed an Answer and the Transcript of the proceedings at the administrative level.

Thereafter, Plaintiff filed a Motion For Summary Judgment and Opening Brief in support of the Motion. In lieu of an Answering Brief, Defendant filed a Cross-Motion For Summary Judgment requesting the Court to affirm the A.L.J.'s decision. The motions have been fully briefed, and therefore, this

matter is ripe for the Court's review.

II. Factual Background

A. Plaintiff's Medical History, Condition and Treatment

At the time of the hearing in this case, Plaintiff was a forty-four year old male with a high school diploma. Plaintiff had no past relevant work, but testified before the A.L.J. that he was employed as a janitor for Goodwill Industries performing what the vocational expert considered to be light to medium work.[1] (Tr. 31-33, 43-44).

Plaintiff has had an extensive history of psychiatric conditions, drug and alcohol abuse, and related hospitalizations. Beginning in 1974, Plaintiff was hospitalized at the Delaware State Hospital following a violent outburst at his parents' home during which he threatened his step father with a butcher knife and threw his mother across a bed. (Tr. 85). At that time, Plaintiff's parents and brother informed hospital staff that they believed

[1] Plaintiff described his employment at Goodwill Industries as "sheltered work," while the vocational expert described his employment as "supported employment." However, the vocational expert acknowledged that Plaintiff's employment was not competitive and was a highly monitored setting. The vocational expert's primary reason for disagreeing with Plaintiff's characterization of his work as "sheltered employment" was based on her statement that "[s]heltered employment is at less than minimum wage." (Tr. 47).

Plaintiff needed psychiatric held since 1967 or 1968 when school authorities had informed his parents that Plaintiff was "hyperactive, a discipline problem and was highly resistant to authority." (Tr. 85).

Shortly after his February hospitalization, Plaintiff was hospitalized a second time on March 17, 1974 for again threatening the life of his stepfather and mother, taking drugs and alcohol, and kidnaping his brother with the intent to take him to Florida on an airplane. (Tr. 83). The admitting physician indicated that Plaintiff's judgment was "severely impaired" and that he was abusive and psychotic. The admitting physician gave Plaintiff a provisional clinical diagnosis of "psychosis with drug or poison intoxication (other than alcohol)." Plaintiff was treated with thorazine and released one month later with his condition noted as "improved." (Tr. 84).

Slightly more than four years later at age 25, Plaintiff was again admitted to the Delaware State Hospital. Plaintiff asked his parents to bring him to the hospital, because "his girlfriend was irritating [him], so [he] couldn't relax or sleep" for approximately one week. (Tr. 81). According to Plaintiff's past history, he was an in-patient at "St. Elizabeth's in DC January-February 1975." Plaintiff had also

been jailed for 60 days on charges for unspecified offense that were later dropped. During his mental status evaluation, Plaintiff was noted to be "attention seeking and belligerent when demands were not met for pain pills immediately." Plaintiff scratched his leg open with his fingernail in an attempt to see a physician immediately. However, Plaintiff did not have delusions or hallucinations and his orientation and memory were "intact." Plaintiff admitted alcohol abuse, but denied any drug abuse. Plaintiff's provisional clinical diagnosis stated "[m]anic depressive illness, manic type; immature personality." (Tr. 81).

The day after his release from the Delaware State Hospital, Plaintiff was civilly committed by Dr. Tonogbanua for shouting obscenities and using threatening behavior to intimidate others. Plaintiff "claimed that he was an undercover agent, restless, talkative, belligerent, antagonistic to all therapies, with marked looseness of association; grandiose." (Tr. 79). The notes from Plaintiff's mental status evaluation at that time indicated that Plaintiff "was frequently nude, as he tore up his pajamas and was residing in a seclusion room that he littered with food, and on one occassion with defecation. He was secluded due to constant stream of profane, threatening, and obscene

language directed at female patients in an intimidating manner and for no apparent reason." (Tr. 81). Plaintiff was diagnosed with manic depressive illness, manic type. (Tr. 80). Plaintiff was treated with thorazine and lithium carbonate and was transferred to an intensive treatment unit. After becoming aggressive toward several women at the hospital, Plaintiff was transferred to a more secure area of the hospital and was treated with Haldol. Plaintiff's medications were eventually adjusted and Plaintiff showed "improvement in his manic psychosis with less hyperactivity, less hostility and less flight of ideas." As a result of this improvement, Plaintiff was released on October 3, 1978.

On June 10, 1980, Plaintiff was again admitted to Delaware State Hospital. Although no records exist for a previous commitment, the record of Plaintiff's June 10, 1980 hospitalization indicates that he had been previously discharged on June 6, 1980. Plaintiff reported that he was "overtalkative, insomniac, with poor appetite, nervous, crying and shaking often" while he was at home in the intervening days. (Tr. 76). Plaintiff also reported that he was drinking everyday and not taking his medication regularly. Plaintiff had agreed to cooperate with a program at St. Francis Hospital, but when his wife took him there, he became

"disruptive, loud, belligerent, was throwing things, and claiming someone was after him." The doctor at St. Francis had Plaintiff civilly committed for his seventh admission to the Delaware State Hospital. In his mental status evaluation, doctors noted that Plaintiff "was observed talking and laughing to himself. He was running up and down the corridors singing and screaming. He was standing in the shower with this clothes on. He threatened to break the nursing station window and eventually did so. He was probably hallucinating. He was combative and needed to be secluded. He was growling and calling out obscenities. Insight and judgment were impaired to a psychotic degree." (Tr. 76). Plaintiff was again placed on Haldol and Plaintiff's symptoms gradually improved. Plaintiff was released one month later with instructions to attend the mental hygiene clinic and the Day hospital. On discharge, Plaintiff was not psychotic and no delusions were noted. The discharging psychiatrist noted that Plaintiff "had gained good insight and realizes that his main problem is drinking." The discharging psychiatrist also stated that Plaintiffs acute "problems were resolved" and that he was able to drive a car, manage his own finances and work. (Tr. 77-78). Plaintiff's final diagnosis was noted as (1)manic-depressive illness, manic type; (2) explosive

personality; and (3) habitual excessive drinking. (Tr. 78).

Approximately one year later, Plaintiff was readmitted to the Delaware State Hospital for the eighth time. Plaintiff had discontinued his counseling sessions and his medication. He reported that he was "drinking heavily, three pints a day, and has been depressed because his car painting business failed." Notes from Plaintiff's mental status evaluation at that time indicated that he was alert, his memory and orientation were intact, he was cooperative with relevant and coherent thoughts. Plaintiff's memory and orientation were also intact, however his judgment was noted to be "grossly impaired." (Tr. 74). In addition, staff psychiatrists noted that although Plaintiff had a past history with mental illness, during this admission "there [was] no evidence of clear cut manic ideation or depressive episodes of psychotic proportion." (Tr. 74). Plaintiff was diagnosed with acute intoxication of alcohol and discharged three days later. Upon Plaintiff's discharge, doctors recommended an in-patient alcoholic rehabilitation program; however Plaintiff adamantly refused to enter such a program stating that he could stop drinking on his own. (Tr. 75). No medications were prescribed for Plaintiff and the staff psychiatrist expressly noted that there were no grounds to commit Plaintiff at that

time.

From 1981 until 1990, there are no records indicating that Plaintiff received any further treatment. In 1983, Plaintiff was awarded disability benefits due to a mental impairment, and alcohol and/or drug abuse.

In January 1990, Plaintiff was admitted to HCA Rockford Center for severe depression, anxiety, restlessness, inability to function, paranoia and agitation. Plaintiff reported that "[h]e was afraid of losing control." (Tr. 86). The records for Plaintiff's admission to HCA Rockford Center indicate that he was followed as an outpatient for many years, with his last visit approximately a year or two prior to his January 1990 admission. Plaintiff admitted alcohol abuse, but denied drug abuse. Plaintiff was diagnosed with bipolar disorder, manic and substance abuse. (Tr. 86). Plaintiff improved with medication and psychotherapy, and he was discharged on January 16, 1990. However, Plaintiff's prognosis was noted as "chronic."

In 1993 and 1994, Plaintiff was examined by an unidentified physician on several occasions. On November 19, 1993, Plaintiff indicated that he had not been hospitalized since January 1990, and his only current medication was Trilafon. (Tr. 90). Doctors' notes from this time period

indicate that Plaintiff continued to stay at home while his wife worked. Plaintiff indicated that he had a good appetite and a good sex life. (Tr. 89-90). Plaintiff denied racing thoughts and anything other than occasional anxiety when he failed to take his medication. (Tr. 90, 97). Plaintiff also stated that he slept well, got up late and spent the day "messing around" and drinking at a tavern. Throughout these visits, Plaintiff indicated that he was feeling okay and was "handling life well" (Tr. 92, 96-7), but he still had "issues of drinking." (Tr. 93).

On November 23, 1994, Plaintiff was again admitted to Rockford Center. Plaintiff denied a history of drug and alcohol abuse at that time, but the attending physician noted that Plaintiff had a "prominent problem" with alcohol abuse. (Tr. 99, 101). Plaintiff stated that he had not had a drink for a week, but admitted that he regularly drank ten beers a day. Plaintiff was awake, alert and fully oriented while at Rockford. Plaintiff also showed no signs of confusion, denied hallucinations and had good memory. Plaintiff became tearful when he talked about money, but indicated that his primary problems were insomnia and that he neglected himself and his hygiene. Plaintiff was diagnosed by history with bipolar disorder, depression and alcohol withdrawal. Plaintiff's

Global Assessment of Functioning Score ("GAF") for the past year was noted to be 70, but upon admission Plaintiff's GAF was noted to be 32. Plaintiff was treated with Librium to relieve his alcohol withdrawal symptoms. Plaintiff's condition again improved and he was discharged shortly thereafter.

On March 15, 1995, Plaintiff was readmitted to the Delaware State Hospital following an argument with his wife upon his return from a bar. (Tr. 105). Plaintiff admitted past drug use, but denied current drug use. With regard to alcohol consumption, Plaintiff admitted a continuing problem with alcohol. Plaintiff reported that he drank 6 beers a day. Plaintiff stated that he had been "doing fine" since his last admission to Delaware State Hospital. Plaintiff was unkempt, but cooperative at the time of admission. However, Plaintiff became agitated and hysterical at one point, crying and screaming that he wanted to die. Plaintiff denied any hallucinations or having suicidal or homicidal thoughts. Plaintiff was alert and oriented. His memory was good, but his insight and judgment were poor. When his condition improved, Plaintiff was discharged. Upon discharge, Plaintiff was diagnosed with bipolar disorder and alcohol abuse. Plaintiff's GAF score was again noted to be 70 over the past

year and 70 upon discharge. Plaintiff's prognosis was guarded due to his history of substance abuse. (Tr. 108).

In April 1996, Plaintiff was evaluated by Mary Wolf, M.A. in connection with his desire to continue to receive disability benefits. Dr. Wolf's notes indicate that Plaintiff admitted to long-term alcohol abuse. Specifically, Dr. Wolf noted that Plaintiff drank a six pack of beer one to two times per week, which Plaintiff described as "moderate" drinking. Plaintiff denied the use of alcohol since 1995, after a DUI arrest. (Tr. 109). Plaintiff's current and past GAF scores were assessed at 55. Dr. Wolf diagnosed Plaintiff with alcohol dependence.

A few days later Plaintiff was examined at the Northeast Treatment Centers-Delaware Care facility. (Tr. 114-117). Plaintiff's primary problem was identified as alcohol abuse, and his denial of an alcohol problem. Plaintiff stated that his wife used excessive drinking as an excuse to leave him, but Plaintiff claimed that his wife was "jealous of the time he spent with male friends bonding at the tavern." (Tr. 115).

After receiving the notice that his disability benefits would be discontinued, Plaintiff was examined by two physicians, Alfonso Garbayo, M.D. and Patricia Lifrak, M.D.

During his examination with Dr. Garbayo, Dr. Garbayo noted that Plaintiff was causal in appearance, cooperative, aloof, and suspicious. Plaintiff's speech was observed to be normal, coherent and relevant. (Tr. 119). Dr. Garbayo noted that Plaintiff's affect was appropriate, and he was alert and oriented with adequate concentration and intact memory and attention span. However, Dr. Garbayo reported that Plaintiff had poor impulse control and poor judgment. Dr. Garbayo diagnosed Plaintiff with bipolar disorder and alcohol abuse in remission. Dr. Garbayo remarked that Plaintiff's condition was "stable" and that his GAF score was sixty-five. (Tr. 121).

During his examination with Dr. Lifrak in October 18, 1996, Plaintiff complained that he "sometimes" felt restless and easily stressed. Plaintiff denied any emotional complaints and stated that he was able to cope well. Plaintiff stated that, although he was receiving disability benefits, he worked part-time as a package store clerk for a year and a half until he was laid off. Plaintiff denied any attendance problems at work and indicated that he had no difficulties performing his job or getting along with co-workers and supervisors. (Tr. 126). Dr. Lifrak reported that Plaintiff denied hallucinations and suicidal behavior, any

history of alcohol withdrawal symptoms or substance abuse. Plaintiff also denied the consumption of alcohol since January 1995. Plaintiff also stated that his heaviest alcohol use was in from 1971 to 1973, when he was 18 to 22 years old and drinking six beers per weekend. Plaintiff also denied any current medical problems. Plaintiff reported that he enjoyed watching television, listening to music, going to the beach and camping. (Tr. 127). Plaintiff described his mood as "fairly good." (Tr. 129-130). Based on her observations, Dr. Lifrak reported that Plaintiff was fully oriented, cooperative, friendly and well-groomed with good personal hygiene. Plaintiff's speech was normal and his activity level was normal with no signs of tension, anxiety, restlessness or hyperactivity. Plaintiff's attention span was normal and he was able to focus and remain on task. Plaintiff's affect was also noted as normal, with his thought process logical and no evidence of looseness of association, delusions, or hallucinations. Plaintiff's memory, abstract reasoning and ability to perform calculations were also intact. Dr. Lifrak reported that Plaintiff's insight and judgment were fair during the interview, and his current and past GAF scores were 70. Dr. Lifrak diagnosed Plaintiff with bipolar disorder, in full remission, and alcohol and cannabis abuse in sustained

remission. Dr. Lifrak reported that although Plaintiff's condition affected his ability to function in the past, his symptoms were under control and his prognosis was only poor if he failed to follow treatment recommendations. (Tr. 130).

In response to a residual functional capacity questionnaire, Dr. Lifrak noted that Plaintiff's ability to relate to other people; ability to engage in daily living activities and ability to perform complex and repetitive tasks were "mildly" limited. (Tr. 131-132). Plaintiff's ability to work in frequent contact with others and perform varied tasks were "moderately" limited. Plaintiff's ability to engage in personal habits and interests; comprehend and follow instructions, work with minimal contact with others, and perform simple tasks were not impaired. (Tr. 131-132).

A year and a half later, Plaintiff was seen by Anis Ahmed, M.D. Dr. Ahmed noted that Plaintiff's symptoms were in remission and that his condition was stable with his medication. Dr. Ahmed assessed Plaintiff's ability to function in a regular work setting and opined that Plaintiff had a "good" ability to understand, remember and carry out simple instructions, maintain attention and attendance, and perform at a consistent pace. (Tr. 147-149). Dr. Ahmed opined that Plaintiff had a "fair" ability to remember work-

like procedures; sustain an ordinary routine without supervision; work in proximity with others; make simple work related decisions; complete a normal workday and workweek without interruption and deal with normal work stress. Dr. Ahmed further opined that Plaintiff's activities of daily living were "slightly" limited and he had "moderate" difficulties in maintaining social functioning. Dr. Ahmed also opined that Plaintiff "seldom" had deficiencies in concentration, persistence or pace resulting in failure to complete tasks in a timely manner, and he had "repeated" episodes of deterioration or decompensation in work or work-like settings based on his past history, but was "currently stable." (Tr. 149).

B. The A.L.J.'s Decision

In his Opinion dated May 21, 1998, the A.L.J. concluded that, based on the medical evidence and giving the Plaintiff "the benefit of the doubt," Plaintiff had bipolar disorder and residuals of a left arm fracture which are severe impairments, but which did not meet or equal the criteria for the impairments listed in Appendix 1, Subpart P, 20 C.F.R. § 404.1594(f)(2). Assessing Plaintiff's credibility, the A.L.J. concluded that Plaintiff's subjective complaints of complete mental and exertional functional incapacity were "less than

fully credible." (Tr. 15). Specifically, the A.L.J. observed that Plaintiff's bipolar disorder was in remission since he stopped drinking and, in any event, the disorder was controlled by medication. With regard to his left arm impairment, the A.L.J. observed that Plaintiff was not on any medication for the left arm and had no treatment or surgeries to address his alleged left arm impairment. To the extent that Plaintiff complained of arthritis, the A.L.J. noted that Plaintiff had not had any treatment for arthritis, and Plaintiff's alleged arthritis had not been documented by acceptable medical techniques. (Tr. 16). In addition, the A.L.J. found that Plaintiff's arthritis was contradicted by his testimony that he had no limitations sitting, walking, or standing, and that he was able to lift 50 pounds.

In assessing Plaintiff's residual functional capacity ("RFC"), the A.L.J. concluded that Plaintiff had an RFC for a reduced range of medium work. To this effect, the A.L.J. found that based on Plaintiff's testimony, Plaintiff could not lift or carry more than 25 pounds frequently and 50 pounds occasionally. The A.L.J. also found that Plaintiff could sit, stand and walk for eight hours in an eight hour day. However, the A.L.J. found that Plaintiff had slightly limited ability to perform push and pull functions using his left upper

extremity, and moderate limitations in his ability to work in coordination or in proximity with others, to accept instructions, respond to criticism from supervisors, maintain socially appropriate behavior and respond to changes in the work setting. Based on the testimony of the vocational expert, the A.L.J. further concluded that Plaintiff could perform such jobs as cleaner at the medium exertional level, assembler at the light exertional level and inspector at the sedentary exertional level and that a significant number of such jobs were available in the national and local economies. In addition, the A.L.J. concluded that his findings were consistent with the claimants current work for Goodwill Industries as a janitor approximately 25-28 hours a week. Accordingly, the A.L.J. concluded that Plaintiff was no longer disabled and was no longer eligible for disability benefits. (Tr. 17).

STANDARD OF REVIEW

Pursuant to 42 U.S.C. § 405(g), findings of fact made by the Commissioner of Social Security are conclusive, if they are supported by substantial evidence. Accordingly, judicial review of the Commissioner's decision is limited to determining whether "substantial evidence" supports the decision. Monsour Medical Ctr. v. Heckler, 806 F.2d 1185,

1190 (3d Cir. 1986). In making this determination, a reviewing court may not undertake a de novo review of the Commissioner's decision and may not re-weigh the evidence of record. Id. In other words, even if the reviewing court would have decided the case differently, the Commissioner's decision must be affirmed if it is supported by substantial evidence. Id. at 1190-91.

The term "substantial evidence" is defined as less than a preponderance of the evidence, but more than a mere scintilla of evidence. As the United States Supreme Court has noted substantial evidence "does not mean a large or significant amount of evidence, but rather such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Pierce v. Underwood, 487 U.S. 552, 555 (1988).

With regard to the Supreme Court's definition of "substantial evidence," the Court of Appeals for the Third Circuit has further instructed, "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 . . . or if it really constitutes not evidence but mere conclusion." Kent v. Schweiker, 710 F.2d 110, 114 (3d Cir. 1983). Thus, the

substantial evidence standard embraces a qualitative review of the evidence, and not merely a quantitative approach. Id.; Smith v. Califano, 637 F.2d 968, 970 (3d Cir. 1981).

DISCUSSION

In his Motion For Summary Judgment, Plaintiff contends that the decision of the A.L.J. denying Plaintiff disability benefits is not supported by substantial record evidence. Specifically, Plaintiff contends that (1) the A.L.J. erred in concluding that the Plaintiff had a medical improvement related to his ability to work; (2) the A.L.J. erred in making a medical determination that Plaintiff's psychiatric condition was in remission following cessation of alcohol use and rejecting the opinions of Plaintiff's treating psychiatrist; and (3) the hypothetical proposed to the vocational expert did not contain all of Plaintiff's limitations found by his treating physician and was otherwise inadequate. The Court will consider each of Plaintiff's arguments in turn.

I. Whether The A.L.J. Erred In Concluding That The Plaintiff Had A Medical Improvement Related To His Ability To Work

By his Motion, Plaintiff contends that the A.L.J. erred in concluding that he had a medical improvement related to his ability to work under 20 C.F.R. § 404.1594. Specifically, Plaintiff contends that the A.L.J. failed to appropriately assess whether he had a medical improvement according to the

criteria set forth in 20 C.F.R. § 404.1594(c)(2)(iv), because the A.L.J. did not consider the "longitudinal history of the [Plaintiff's] impairments, including the occurrence of prior remission, and the prospect of future worsening." (D.I. 13 at 8-11).

In response to Plaintiff's argument, the Commissioner contends that "Plaintiff's argument is premised upon a misunderstanding of social security law." (D.I. 11 at 18). Specifically, the Commissioner contends that "Plaintiff's disability benefits were terminated in 1997 not because he showed medical improvement, but pursuant to an Act of Congress articulated in Public Law 104-121, which amended the Social Security Act to eliminate benefits for disability caused by alcohol and drug addiction." (D.I. 11 at 18). Thus, according to the Commissioner, Plaintiff was no longer entitled to receive disability benefits regardless of any medical improvement by Plaintiff. Stated another way, the Commissioner contends that a finding of medical improvement was not necessary to the denial of Plaintiff's claim. (D.I. 11 at 18).

In reply, Plaintiff contends that a review of the A.L.J.'s decision confirms that the A.L.J. terminated Plaintiff's benefits "only due to a medical improvement" and

not pursuant to an application of Public Law 104-121, because the A.L.J. made no findings concerning the effects of Plaintiff's alcoholism on his disability. Because the A.L.J. relied on the medical improvement provision, Plaintiff further contends that the A.L.J. was required to consider both the individual's prior and current condition. According to Plaintiff, the A.L.J. erred because he did not discuss Plaintiff's prior psychiatric history and only considered Plaintiff's current condition in a limited and abbreviated fashion.

In relevant part, Section 105 of Public Law 104-121 of the Contract With America Advancement Act of 1996 provides:

> An individual shall not be considered to be disabled for purposes of this subchapter if alcoholism or drug addiction would (but for this subparagraph) be a contributing factor material to the Commissioner's determination that the individual is disabled.

42 U.S.C. § 423(d)(1)(C). Pursuant to this amendment, claimants who had been receiving disability benefits due to alcoholism prior to March 29, 1996, had their benefits terminated as of January 1, 1997. See e.g. Torres v. Chater, 125 F.3d 166, 171 (3d Cir. 1997).

Application of this amendment to a claimant requires a two step analysis. McCall v. Apfel, 47 F. Supp. 2d 723, 728 (S.D. W. Va. 1999). First, the A.L.J. must determine whether

the claimant is disabled. Id.; see also 20 C.F.R. 404.1535(a). If the A.L.J. finds that the claimant is disabled, then the A.L.J. must determine whether alcoholism is a contributing factor to the claimant's disability. McCall, 47 F. Supp. at 728; see also 20 C.F.R. 404.1535(a), (b).

Whether a claimant has shown medical improvement sufficient to terminate disability benefits under 42 U.S.C. § 423(f) is a separate inquiry from the inquiry necessitated by the termination of benefits due to alcoholism under 42 U.S.C. 423(d)(1)(c). See e.g. Hamblin v. Apfel, 2001 WL 345798 (6th Cir. Mar. 26, 2001). To make a determination of medical improvement under Section 423(f), the A.L.J. must consider "all the evidence available in the individual's case file, including new evidence concerning the individual's prior or current condition which is presented by the individual or secured by the Commissioner of Social Security." 42 U.S.C. § 423(f). Expanding on the statutory criteria for medical improvement, the regulations require the A.L.J. to carefully consider "the longitudinal history of the impairments, including the occurrence of prior remission, and the prospect of future worsening. Improvement in such impairments that is only temporary will not warrant a finding of medical improvement." 20 C.F.R. § 404.1594(c)(2)(iv).

To determine whether the A.L.J.'s analysis was appropriate in this case, the Court must first consider the threshold question raised by the parties' respective arguments, specifically, which section of 42 U.S.C. 423 did the A.L.J. rely on for his conclusion that Plaintiff was longer disabled. After thoroughly reviewing the A.L.J.'s decision and the transcript of the hearing before the A.L.J. in light of the record evidence in this case, the Court agrees with Plaintiff that the A.L.J.'s conclusions rested on medical improvement under 42 U.S.C. § 423(f) and not alcoholism as a material contributing factor under 42 U.S.C. § 423(d)(1)(C). Although the A.L.J. mentioned that Plaintiff's disability benefits were terminated pursuant to Public Law 104-121 in his statement regarding the procedural history of this case, none of the A.L.J.'s finding or conclusions were directed to the inquiry necessitated by Public Law 104-121 and its related regulations. The Court's conclusion is supported by the A.L.J.'s statutory references. Indeed, nowhere in the A.L.J.'s opinion does he refer to 20 C.F.R. § 404.1535, the regulation guiding the analysis under Section 423(d)(1)(C). Moreover, the A.L.J. expressly stated and concluded that the claimant "experienced a work-related medical improvement." (Tr. 14, 17) (emphasis added).

Although the A.L.J. discussed Plaintiff's drinking to some extent, the Court cannot conclude that the A.L.J. considered whether Plaintiff's alcoholism was a "contributing factor material to his disability." Indeed, the A.L.J. did not perform the two step analysis required by Section 423(d)(1)(C) and never made any of the findings required by 42 U.S.C. 423(d)(1)(C) and its related regulation, 20 C.F.R. § 1535, that alcoholism was, in fact, a material contributing factor to Plaintiff's disability. To the contrary, rather than addressing the question of whether Plaintiff's alcoholism was still a material contributing factor to his disability, the A.L.J. assumed this by virtue of Plaintiff's previous award of disability. (Tr. 14). Stated another way, the A.L.J. did not reevaluate whether Plaintiff's alcoholism was still a material contributing factor to his disability, which would have been the appropriate analysis if the A.L.J. was relying on Section 423(d)(1)(C). Rather, the A.L.J. stated that "[t]he claimant's bipolar disorder has been in remission concomitant with the claimant's abstinence from alcohol. Accordingly, regarding the claimant's mental limitation, he has experienced a work-related medical improvement (20 CFR 404.1594(f)(3)(4))." (Tr. 14). With respect to his findings, the A.L.J. stated that "[t]he claimant has experienced a work-

related medical improvement in his bipolar disorder, in that it is in remission since the claimant stopped drinking." (Tr. 17). Thus, while the A.L.J. considered Plaintiff's drinking, the Court concludes that the A.L.J.'s consideration of Plaintiff's drinking was tangential to the issue of work related improvement, in that the A.L.J. did not make any explicit findings regarding alcoholism as a material contributing factor to Plaintiff's disability.[2]

Because the A.L.J. explicitly relied on the concept of medical improvement for his decision that it was appropriate

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[2] By his Answering Brief, the Commissioner seems to suggest that the A.L.J. implicitly considered Section 423(d)(1)(C), because he found that "Plaintiff's medical condition improved since he stopped abusing alcohol." (D.I. 11 at 18). To this effect, the Commissioner contends that "a finding of medical improvement was not necessary to the denial of Plaintiff's claim." (D.I. 11 at 18). While the Commissioner is correct that a finding of medical improvement may not have been necessary to deny Plaintiff's claim if the A.L.J. had expressly found that Plaintiff's alcoholism was a material contributing factor to his illness, the fact remains that the A.L.J.'s express findings were based on medical improvement. Where as here, the A.L.J. clearly and unequivocally stated that Plaintiff experienced a work-related medical improvement, the Court declines to supplant that express finding with a finding which may be implicitly drawn from or read into the A.L.J.'s decision. See e.g. Fargnoli v. Massanari, 247 F.3d 34 (3d Cir. 2001) (holding that A.L.J. has duty to explain basis for his findings and decision). Moreover, it is the duty of the A.L.J. in the first instance, and not this Court, to determine whether Plaintiff's alcoholism is a material contributing factor to his disability. See e.g. Brown v. Apfel, 2000 WL 294816, *4 (D. Or. Mar. 21, 2000).

to discontinue Plaintiff's benefits, the A.L.J. was required to consider all of the evidence in the claimant's file, including the claimant's past history. However, as Plaintiff correctly points out, the A.L.J. failed to consider Plaintiff's extensive medical history, including his numerous hospitalizations and the circumstances and diagnoses attending those hospitalizations. In addition, the A.L.J. failed to consider the prospect of Plaintiff's condition relapsing, a notable topic in Plaintiff's medical records, including the records of Dr. Ahmed, Plaintiff's treating physician. (Tr. 146). Because the A.L.J. failed to conduct the appropriate analysis to support his findings of medical improvement, the Court concludes that the A.L.J.'s decision that Plaintiff experienced a work-related medical improvement is not supported by substantial evidence. Having concluded that the A.L.J.'s analysis was erroneous, the Court need not consider the remaining arguments offered by Plaintiff. Accordingly, the Court will remand this matter to the A.L.J. for further findings and/or proceedings consistent with this Memorandum Opinion.

CONCLUSION

For the reasons discussed, Plaintiff's Motion For Summary Judgment will be granted, Defendant's Motion For Summary

Judgment will be denied and the decision of the Commissioner dated May 21, 1998 will be reversed and remanded to the A.L.J. for further

findings and/or proceedings consistent with this Memorandum Opinion.

An appropriate Order will be entered.

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF DELAWARE

GERALD COULBOURNE,	:	
	:	
Plaintiff,	:	
	:	
v.	:	Civil Action No. 00-370-JJF
	:	
KENNETH S. APFEL, Commissioner of Social Security Administration,	:	
	:	
Defendant.	:	

O R D E R

At Wilmington, this 26 day of July 2001, for the reasons discussed in the Memorandum Opinion issued this date;

IT IS HEREBY ORDERED that:

1. Defendant's Cross-Motion For Summary Judgment (D.I. 10) is DENIED.

2. Plaintiff's Motion For Summary Judgment (D.I. 12) is GRANTED.

3. The final decision of the Commissioner dated May 21, 1998 is reversed, and the above-captioned case is remanded to the Administrative Law Judge for further findings and/or proceedings consistent with the Court's Memorandum Opinion.

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UNITED STATES DISTRICT JUDGE