IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF DELAWARE

KAY MACLARY,	:	
	:	
Plaintiff,	:	
	:	
v.	:	Civil Action No. 00-729-JJF
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JOANNE BARNHART,[1] Commissioner of Social Security,	:	
	:	
	:	
Defendant.	:	

Gary C. Linarducci, Esquire of GARY C. LINARDUCCI, New Castle, Delaware.
Attorney for Plaintiff.

Colm F. Connolly, Esquire, United States Attorney, and Paulette K. Nash, Esquire, Assistant United States Attorney, of the OFFICE OF THE UNITED STATES ATTORNEY, Wilmington, Delaware.
Of Counsel: James A. Winn, Esquire, Regional Chief Counsel, and Robert W. Flynn, Esquire, Assistant Regional Counsel of the SOCIAL SECURITY ADMINISTRATION, Philadelphia, Pennsylvania.
Attorneys for Defendant.

MEMORANDUM OPINION

July 15, 2002

Wilmington, Delaware

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[1] Jo Anne Barnhart became the Commissioner of Social Security, effective November 14, 2001, to succeed Acting Commissioner Larry G. Massanari, who succeeded Commissioner Kenneth S. Apfel. Pursuant to Federal Rule of Civil Procedure 25(d)(1) and 42 U.S.C. § 405(g), Jo Anne Barnhart is automatically substituted as the defendant in this action.

Farnan, District Judge.

Presently before the Court is an appeal pursuant to 42 U.S.C. §§ 405(g) and 1383(c), filed by Plaintiff, Kay Maclary, seeking review of the final administrative decision of the Commissioner of the Social Security Administration denying Plaintiff's claims for Supplemental Security Income ("SSI") under Title XVI of the Social Security Act, 42 U.S.C. §§ 1381-1383 (the "Act") and Disability Insurance Benefits ("DIB") under Title II of the Act, 42 U.S.C. §§ 401-433. Plaintiff has filed a Motion For Summary Judgment (D.I. 15) requesting the Court to enter judgment in her favor. In response to Plaintiff's Motion, Defendant has filed a Cross-Motion For Summary Judgment (D.I. 18) requesting the Court to affirm the Commissioner's decision. For the reasons set forth below, Defendant's Motion For Summary Judgment will be granted and Plaintiff's Motion For Summary Judgment will be denied. The decision of the Commissioner dated July 6, 1998 will be affirmed.

BACKGROUND

I. Procedural Background

Plaintiff has filed three applications for DIB and SSI benefits. Plaintiff's first application was filed on June 4, 1989, alleging a disability onset date of May 1, 1989. Plaintiff's first application was denied, and Plaintiff did not appeal.

Plaintiff's second application for DIB and SSI benefits was filed on July 1, 1994. Plaintiff alleged that she was disabled as of November 30, 1993, due to left leg and low back impairments. (Tr. 102). Plaintiff's second application was denied initially and upon reconsideration. Plaintiff did not request a hearing or seek further review of this denial.

Plaintiff's third application for DIB and SSI benefits is the subject of the instant appeal. Plaintiff filed this application on June 4, 1996 (Tr. 60, 63), alleging that she was disabled as of March 3, 1989 (Tr. 64), due to chronic pain syndrome, sciatica, allergies (Tr. 116), and a mental impairment (Tr. 97-98). Plaintiff's application was denied initially (Tr. 77-80) and upon reconsideration. (Tr. 92-95).

Plaintiff appealed the denial of her application and an administrative law judge (the "A.L.J.") conducted a hearing on Plaintiff's claims. By decision dated July 6, 1998, the A.L.J. denied Plaintiff's claims for DIB and SSI benefits. (Tr. 7-23). Following the unfavorable decision, Plaintiff filed a timely Request For Review Of Hearing Decision. On June 23, 2000, the Appeals Council denied Plaintiff's request. (Tr. 4-5).

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 her claim for DIB and SSI benefits. In response to the Complaint,

Defendant filed an Answer (Tr. 19) and the Transcript (D.I. 10) 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. Thereafter, Plaintiff filed a Reply Brief. Accordingly, this matter is fully briefed and ripe for the Court's review.

II. Factual Background

A. Plaintiff's Medical History, Condition and Treatment

At the time of the filing of this appeal, Plaintiff was forty-two years old. Plaintiff completed high school at a technical school and received a cosmetology license. Plaintiff also took one year of preparatory college courses.

Plaintiff is single and has no children. Plaintiff lives alone and receives food stamps and $123.00 per month from state assistance based on need.

In the past, Plaintiff worked as a mail clerk for City Bank, delivered flowers, and was a presser machinist for a dry cleaners. She was last employed as a cashier at Acme Super Market and has not been employed since March 3, 1989.

At twelve years of age, Plaintiff had pins placed in both hips for a slipped femoral capital epiphysis. These pins were partially removed from each hip when Plaintiff was 16 years old

and 35 years old.

Plaintiff alleges that she was in excellent health until she was involved in an industrial accident in December 1984. (Tr. 141). Plaintiff stepped into an open drain at her workplace and injured her left foot. Through Workers' Compensation proceedings, Plaintiff was found to have a 15% partial permanent impairment to her left foot. (Tr. 141).

Plaintiff alleges that she became disabled on March 3, 1989 (Tr. 64). However, Plaintiff's medical records indicate that she did not seek medical care until nearly four years later in December 1992. At that time, Plaintiff reported to her family physician, Edward Richman, M.D., with complaints of left shoulder pain. (Tr. 165).

During subsequent visits, Plaintiff continued to complain of shoulder and back pain. Dr. Richman diagnosed Plaintiff with low back strain (Tr. 149), cervical arthritis (Tr. 153), chronic pain in her hips (Tr. 153-154), chronic pain in her spine (Tr. 156), and muscle spasms in her back, which were exacerbated by changes in the weather (Tr. 148). Although Plaintiff had appointments with Dr. Richman on March 25, 1993 and April 23, 1993, Plaintiff did not keep those appointments. (Tr. 162-163). Plaintiff returned to Dr. Richman on May 6, 1993 complaining of right ankle pain after stepping into a ditch. (Tr. 162). On July 29, 1993, Plaintiff again saw Dr. Richman complaining of gastritis and

stress. (Tr. 157).

On July 30, 1993, Plaintiff was examined by Dr. Anthony B. Glassman at the request of Dr. Richman. Dr. Glassman noted that an electrodiagnostic evaluation of Plaintiff's lower left extremity showed only a "minimal involvement" of the L5 and S1 nerve roots. Dr. Glassman further noted that "[m]ultiple Gallium and triple phase bone scans as well as plain radiographs were negative" for any abnormalities. (Tr. 141). Dr. Glassman found that Plaintiff had a muscular build, normal cervical, thoracic and lumbar curvatures, good range of motion in her cervical and lumbar spines, and normal straight leg raise ("SLR") tests.[2] (Tr. 142). Plaintiff also had 5/5 strength and normal reflexes in her upper and lower extremities. Plaintiff was able to heel and toe walk[3] and her gait was not antalgic.[4] (Tr. 141-142). Dr. Glassman diagnosed Plaintiff with chronic myofascial pain

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[2] The straight leg raise test ("SLR") is used to detect nerve root pressure, tension or irritation. A positive SLR requires the reproduction of pain at an elevation of less than 60 degrees. A positive SLR is said to be the most important indication of nerve root pressure. Andersson and McNeill, Lumbar Spine Syndromes, 78-79 (Springer-Verlag Wein, 1989).

[3] Difficulty with heel walking is indicative of L5 nerve root damage and difficulty with toe walking is indicative of S1 nerve root damage. Andersson & McNeill, Lumbar Spine Syndromes, supra at 78-79.

[4] An antalgic gait is "a limp adopted so as to avoid pain on weight bearing structures (as in hip injuries), characterized by a very short stance phase." Dorland's Illustrated Medical Dictionary 721 (29th ed. 1996).

involving the cervical, thoracic and lumbar spines and stressed that Plaintiff should exercise to help alleviate her complaints. (Tr. 142).

On August 30, 1993, Plaintiff reported back to Dr. Richman complaining of right hip pain. At that time, Dr. Richman noted that overall Plaintiff's neck and back pain were better, and Plaintiff was more active. (Tr. 156). Plaintiff continued to complain of right hip pain caused by the pins that were implanted in her hips when she was a child. These pins were removed in October 1993, and Dr. Richman reported that Plaintiff's hip complaints improved.

In subsequent visits with Dr. Richman, Plaintiff continued to complain of low back and neck pain. However, Plaintiff did not join an exercise club as her doctors advised. (Tr. 153). Plaintiff also complained of an ankle sprain and headache, but an x-ray of Plaintiff's right foot was negative. (Tr. 151).

On January 12, 1995, Plaintiff was examined by Bradley Grayum, M.D., a neurologist. Dr. Grayum reported that Plaintiff was in no apparent distress. She had normal muscle strength, tone and bulk. Plaintiff's deep tendon reflexes and sensations were noted to be normal. Dr. Grayum reported that Plaintiff was well-coordinated and could heel/toe walk without difficulty. Although Dr. Grayum stated that Plaintiff had chronic pain, he opined that her neurological examination was "relatively benign"

and that she had no significant nerve injury and needed no further diagnostic testing. (Tr. 167-168).

On November 22, 1995, Plaintiff presented to the emergency room of Silverside Medical Center with complaints of back pain caused when she tried to help her father from falling. Plaintiff was diagnosed with acute thoracic-lumbar sprain/strain. (Tr. 169).

On May 28, 1996, Plaintiff returned to the emergency room of Silverside Medical Center complaining of back pain after she changed her bed linens. Plaintiff was diagnosed with a lumbo-sacral strain. (Tr. 171, 186). An x-ray of Plaintiff's lumbar spine taken at that time stated: "Disc space narrowing is present from L4 through S1. Hypertrophic spurring is present involving the entire lumbar spine anteriorly. Mild degenerative changes are noted involving the facets at the L5-S1 level." (Tr. 172, 187).

On October 1, 1993, Plaintiff was seen by a neurologist, William Sommers, D.O. Dr. Sommers reported that Plaintiff was "a cooperative woman in no acute distress." (Tr. 174). Although Plaintiff's neck was supple, Dr. Sommers noted that her cervical range of motion was cautious and reduced by 10-20%. (Tr. 174). Dr. Sommers stated that Plaintiff "cautiously bends at the waist and is able to approximate her fingertips no closer than eight to ten inches to her toes." (Tr. 174). Dr. Sommers found that

Plaintiff had normal muscle mass and tone, normal fine movements, no localized weakness and good coordination. Dr. Sommers also found that Plaintiff's sensation was decreased. Dr. Sommers tentatively diagnosed Plaintiff with peripheral polyneuropathy and suspected that there may be some superimposed radiculopathy. Although Dr. Sommers laid out a plan for the treatment and reevaluation of Plaintiff, the medical records indicate that Plaintiff did not return to Dr. Sommers.

On January 14, 1997, Plaintiff underwent a CT Scan. (Tr. 176). The CT Scan revealed a small broad disc bulge at L3-4, but no spinal stenosis, impression on thecal sac or significant neuroforaminal encroachment. The CT Scan further revealed a moderate sized broad disc bulge at L4-5 causing moderate right neuroforaminal encroachment and minimal left neuroforaminal encroachment. In addition, the CT Scan revealed a central disc protrusion at L5-S1 with moderate degenerative changes. An electromyogram performed on Plaintiff was normal and showed that Plaintiff had no evidence of lumbosacral radiculopathy, peripheral polyneuropathy or entrapment neuropathy. (Tr. 178, 248).

On October 14, 1997, Plaintiff was evaluated by a social worker at Children and Families First. (Tr. 249-252). During her evaluation, Plaintiff admitted to a history of marijuana, intravenous cocaine and methamphetamine drug abuse. (Tr. 252).

The notes from the social worker's evaluation indicate that Plaintiff was defensive about her use of prescription medication, which "should have no benefit at all at this time." (Tr. 252). Plaintiff was referred to Dr. Kratsa to review the appropriateness of the medications she was taking. However, the record indicates that Plaintiff did not treat with Dr. Kratsa. The record also indicates that Plaintiff attended five counseling sessions, cancelled one appointment and was a "no-show" for four appointments. Plaintiff did not return for counseling after her disability hearing was held. (Tr. 249).

On October 20, 1997, Plaintiff reported to the Medical Center of Delaware complaining of intermittent low back pain and left leg pain. On October 22, 1997, Plaintiff was examined by Anthony Salvo, M.D. Plaintiff complained of back discomfort with intermittent radiating pain. To assist Plaintiff in receiving public assistance benefits, Dr. Salvo completed a form indicating that Plaintiff was not able to currently work and stating that Plaintiff had not worked since May 1996.

Dr. Salvo referred Plaintiff to Anne C. Mack, M.D. for evaluation. Dr. Mack examined Plaintiff and reported that Plaintiff complained of pain and decreased range of motion in her neck, low back and hips. (Tr. 235-236). Dr. Mack noted that Plaintiff had an antalgic gait on her left side (Tr. 236). Dr. Mack's impressions included low back pain with evidence of

lumbosacral strain. (Tr. 237). Dr. Mack also noted that Plaintiff had no herniated discs and an electromyogram study performed on Plaintiff was negative.

On November 5, 1997, Plaintiff reported to Dr. Salvo for a check-up. At that time, Dr. Salvo noted that Plaintiff had limited range of motion, but did not indicate to what extent her motion was limited. On November 19, 1997, Plaintiff again reported to Dr. Salvo complaining of headache pain and anxiety.

On November 23, 1997, Plaintiff presented to the Medical Center of Delaware with complaints of acute onset of back pain after pushing a shopping cart several blocks. A CT Scan of Plaintiff was initially interpreted to be negative. (Tr. 277, 279). However, upon further evaluation, Plaintiff's CT Scan was interpreted to suggest a herniated disc at the L4-5 area. (Tr. 281).

Two days later, Plaintiff was re-examined by Dr. Mack. Dr. Mack reported that Plaintiff complained of decreased sensation and lumbar flexion. Dr. Mack indicated that Plaintiff's SLR test was negative and that she had no lumbosacral spine tenderness. Dr. Mack diagnosed Plaintiff with low back pain with evidence of lumbosacral strain and sprain, and post-surgery hip pain. (Tr. 225).

On November 28, 1997, Plaintiff returned to the Medical Center of Delaware complaining of back pain. Plaintiff was

diagnosed with a low back strain. (Tr. 270).

On December 9, 1997, Plaintiff underwent an MRI lumbar spine without contrast. The MRI indicated that Plaintiff had no herniated discs or spinal stenosis, but that Plaintiff did have a small central bulging disc at L5-S1 and mild degenerative disc disease at the L4-5 and L5-S1 levels. (Tr. 246, 303).

On December 17, 1997, Plaintiff was again examined by Dr. Salvo. Plaintiff complained of poor sleep due to increased back pain. (Tr. 300). Dr. Salvo reported that Plaintiff's back range of motion was limited and diagnosed her with chronic pain. (Tr. 299).

On January 8, 1998, two weeks before Plaintiff's hearing for social security disability benefits, Plaintiff reported to Dr. Salvo. At that time, Plaintiff was walking with a cane. Dr. Salvo indicated that Plaintiff's low back was tender and that she had some decreased range of motion.

On January 15, 1998, Dr. Salvo completed a Physical Residual Functional Capacity ("RFC") Questionnaire for Plaintiff. (Tr. 253-256). Dr. Salvo indicated that Plaintiff had chronic back and leg pain and depression and anxiety. Dr. Salvo opined that Plaintiff was able to sit for fifteen minutes and stand for ten minutes at a time. Plaintiff could stand/walk for a total of two hours and sit for a total of two hours during an eight hour work day. (Tr. 254). Dr. Salvo further opined that Plaintiff was

able to occasionally lift/carry up to ten pounds, had restricted overhead reaching and was unable to stoop or crouch. Dr. Salvo estimated that Plaintiff's impairments were likely to cause her to miss more than four days of work per month (Tr. 256) and that Plaintiff would be incapable of performing even low stress jobs. (Tr. 254).

A second RFC Questionnaire was completed by William R. Irby, M.D., a rheumatologist. (Tr. 309). Dr. Irby did not examine Plaintiff, but reviewed her medical records. Dr. Irby opined that Plaintiff's medical history indicated that she had a lumbosacral sprain, bulging disc at L4-5 and degenerative disc disease (Tr. 311). Dr. Irby opined that due to Plaintiff's musculoskeletal complaints she was able to frequently lift twenty pounds, and stand/walk for up to four hours during an eight hour work day. Dr. Irby opined that Plaintiff had unlimited ability to sit, was able to occasionally climb, balance, kneel and crawl. Dr. Irby also opined that Plaintiff could never stoop or crouch and that she had limited ability to push/pull. Because of Plaintiff's medications, Dr. Irby opined that Plaintiff should avoid working at heights or moving machinery.

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

On January 20, 1998, the A.L.J. conducted a hearing on Plaintiff's DIB and SSI claims. At the hearing, Plaintiff testified that she takes pain medication daily and that she can

function to an acceptable extent when she is taking her medication. (Tr. 330). Plaintiff testified that she prefers to sit or lay down, but that she knows she is supposed to do more exercise. (Tr. 331). Plaintiff testified that she does her own housework, watches TV, reads and visits with friends and family as often as possible. Plaintiff also testified that she has severe anxiety which affects her breathing and her memory. (Tr. 334). Plaintiff further testified that she was seeing a counselor since October of 1997.

In addition to Plaintiff's testimony, the A.L.J. also heard the testimony of a vocational expert, William T. Slaven, III. The A.L.J. asked the vocational expert to consider a hypothetical individual with Plaintiff's vocational characteristics and the ability to perform sedentary work. The A.L.J. also asked the vocational expert to assume that this individual has nonexertional impairments, specifically pain in the lower and upper back, left leg, left hip, left foot and neck. The A.L.J. also stated that the hypothetical individual would have panic attacks. (Tr. 338-339). Assuming the nonexertional limitations were severe, the vocational expert opined that the hypothetical individual could not perform any work at all. (Tr. 339). However, if these limitations were mild to moderate in nature, the vocational expert testified that the individual could perform some of the unskilled clerical positions in sedentary work, such

as telephone quotation clerk, charge account clerk and information clerk. (Tr. 339).

In a follow-up letter to the A.L.J., the vocational expert stated that if Dr. Salvo's RFC assessment was accepted, the Plaintiff would be unable to perform sedentary work. In reaching this conclusion, the vocational expert noted that Dr. Salvo opined that Plaintiff would miss more than four days of work per month due to pain. The vocational expert further opined that if Dr. Irby's RFC assessment was accepted, Plaintiff could perform unskilled sedentary work.

In his decision dated July 6, 1998, the A.L.J. concluded that Plaintiff was unable to perform her past relevant work as a mail opener, cashier, driver and machine worker. The A.L.J. found that Plaintiff "has musculoskeletal complaints with complaints of anxiety and depression, but not an impairment or combination of impairments listed in, or medically equal to one listed in Appendix 1, Subpart P, Regulations No. 4." (Tr. 22). The A.L.J. also concluded that Plaintiff's allegations of total disability were not credible and not consistent with the medical record. The A.L.J. concluded that Plaintiff had the residual functional capacity to perform the full range of sedentary work. Specifically, the A.L.J. concluded that Plaintiff's pain, depression and anxiety would not interfere with her ability to perform the jobs listed by the vocational expert. (Tr. 21).

Based on her ability to perform sedentary work, her age, education and work experience, the A.L.J. concluded that Section 404.1569 of Regulations No. 4 and Section 416.969 of Regulations No. 16 and Rule 201.28, Table No. 2 of Appendix 2, Subpart P, Regulations No. 4, would direct a conclusion of "not disabled." (Tr. 22).

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

By her Motion, Plaintiff contends that the Commissioner's decision is not supported by substantial evidence for two reasons. First, Plaintiff contends that the A.L.J. failed to give proper weight to the opinion of her treating physician, Dr. Salvo. Second, Plaintiff contends that the A.L.J. omitted significant factors from the hypothetical question that he posed to the vocational expert. The Court will consider each of Plaintiff's arguments in turn.

A. Whether The A.L.J. Failed To Give Proper Weight To The Opinion Of Plaintiff's Treating Physician

Plaintiff contends that the A.L.J. failed to give greater weight to the opinion of Dr. Salvo, as Plaintiff's treating physician, than to Dr. Irby, as a non-treating and non-examining physician. Plaintiff contends that the A.L.J.'s acceptance of Dr. Irby's opinion over Dr. Salvo's opinion is contrary to the principles of the "treating physician doctrine."

The Court of Appeals for the Third Circuit has long adhered to the treating physician doctrine. See e.g. Mason v. Shalala, 994 F.2d 1058, 1067 (3d Cir. 1993); Podedworny v. Harris, 745 F.2d 210, 217 (3d Cir. 1984). According to this doctrine, a treating physician's opinion is entitled to significant weight. The opinions of treating physicians are entitled to more weight, because "these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of our medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations such as consultative examinations or brief hospitalizations." 20 C.F.R. § 416.927(d)(2); 20 C.F.R. § 1527(d)(2). However, the opinion of a treating physician is only given substantial weight if: (1) it is supported by medically acceptable clinical and laboratory diagnostic techniques; and (2) it is not inconsistent with other substantial evidence in the record. Fargnoli v.

Massanari, 247 F.3d 34, 42 (3d Cir. 2001). An A.L.J. may reject the opinion of a treating physician if he or she adequately explains the reasons for doing so on the record. Mason, 994 F.2d at 1067. If a treating physician's opinion is rejected, the A.L.J. must consider such factors as the length of the treatment relationship, the nature and extent of the treatment relationship, the supportability of the opinion, the consistency of the opinion with the record evidence, any specialization of the opining physician and other factors the plaintiff raises, in determining how to weigh the physician's opinion. 20 C.F.R. § 416.927(d)(2)-(6); 20 C.F.R. § 1527(d)(2)-)(6).

After considering the opinion of the A.L.J. in light of the record in this case, the Court concludes that the A.L.J. appropriately weighed Dr. Salvo's opinion, and the decision of the A.L.J. that Plaintiff is not disabled within the meaning of the Act is supported by substantial evidence. Although the A.L.J. did not reject Dr. Salvo's opinion outright, it is evident that he did not give it controlling weight. In weighing the opinion of Dr. Salvo, the A.L.J. concluded that Dr. Salvo's opinion "was not well-supported by medically acceptable clinical and laboratory diagnostic techniques as required by SSR 96-2p." (Tr. 19). The A.L.J. further concluded that Dr. Salvo's opinion "was not consistent with the objective medical evidence showing mild degenerative disk and facet disease, with no evidence of

radiculopathy, neuropathy, nerve entrapment, disk herniation, or spinal stenosis, nor was it consistent with the findings by other physicians." (Tr. 19). In making this assessment, it is evident from the A.L.J.'s opinion that he considered the treatment relationship between Plaintiff and Dr. Salvo, the supportability of Dr. Salvo's opinion in light of the record, and the consistency of Dr. Salvo's opinion in light of the medical evidence and the opinions of Plaintiff's other treating physicians.

As the A.L.J. noted, Dr. Salvo did not examine Plaintiff until the fall of 1997, although she alleged a disability onset date of March 1989.[5] Indeed, the record indicates that Dr. Salvo was not Plaintiff's long-standing treating physician, and Plaintiff did not treat with Dr. Salvo until several years after her alleged onset of disability. As such, Dr. Salvo did not have as detailed a longitudinal picture of Plaintiff's condition as some of the other physicians who examined Plaintiff like Dr. Richman. 20 C.F.R. § 404.1527(d)(2); § 416.927(d)(2).

Further, as the A.L.J. noted, Dr. Salvo's opinion of Plaintiff's condition was not supported by the medical record or the opinions of other physicians who examined Plaintiff. As the A.L.J. noted in his thorough discussion of the medical evidence,

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[5] The A.L.J. also noted that Plaintiff's first medical evidence is dated December 1992, even though Plaintiff alleged a disability beginning in March of 1989.

the tests performed on Plaintiff, including x-rays, bone scans, SLRs, EMGs, MRIs and heel/toe walks, did not reveal any significant abnormalities.[6] (Tr. 141-142, 167-168, 172, 178, 187, 237, 246, 248). Plaintiff's x-rays showed only mild degenerative changes, and her electromyogram and nerve condition studies were essentially normal, with no evidence of lumbosacral radiculopathy, peripheral neuropathy or nerve entrapment. (Tr. 16).

In addition, Dr. Salvo's opinion was inconsistent with the opinions of other physicians who examined Plaintiff like Drs. Richman, Glassman, Grayum, Sommers, and Mack. Records from these physicians show that Plaintiff had mild limitations on her lumbar range of motion, but that she was in no acute or apparent distress and had normal reflexes, muscle tone, bulk and strength. (Tr. 141-142, 173-174, 224-225, 268).

As for Dr. Salvo's RFC assessment, Dr. Salvo noted in his response requiring him to identify the clinical findings and objective signs supporting his opinion, that he was awaiting the results of Plaintiff's MRI. Notably, the MRI in the record which is the closest in time to Dr. Salvo's RFC assessment, the MRI

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[6] Although Plaintiff's back complaints centered on the L5-S1 levels, her CT Scans and MRIs showed only mild degenerative changes at these levels. Further, Plaintiff's SLR which indicates nerve root pressure was negative, and she could heel/toe walk, suggesting no nerve root damage at the L5-S1 levels.

taken on December 9, 1997, indicates that Plaintiff had no herniated disc or spinal stenosis, a small central bulging disc at L5-S1 and only mild degenerative disc disease and facet disease at the levels of L4-5 and L5-S1. (Tr. 303).

Further, Dr. Salvo opined that Plaintiff had anxiety and depression that interfered with her attention span and concentration and rendered her incapable of performing even "low stress" jobs. However, as the A.L.J. noted, the medical record does not support these conclusions. Aside from her prescription for medications such as Xanax, the record indicates that Plaintiff did not receive extensive therapy or treatment for her anxiety and depression. For example, Dr. Glassman recognized that Plaintiff could benefit from anti-depressant medication, but stated that she only needed to be on a "low dose." (Tr. 142). As for therapy, Plaintiff was evaluated by a social worker, and had ten appointments. Out of the ten appointments, Plaintiff cancelled one and failed to show up for four. (Tr. 270). Moreover, the social worker who evaluated Plaintiff indicated that Plaintiff was "on a cocktail of medications which may be questionable," and cautioned Plaintiff on several occasions about her use of Xanax for anxiety. (Tr. 251-252). Given that Plaintiff's treatment for anxiety and depression and the results of her MRI and other testing are not consistent with Dr. Salvo's opinions regarding Plaintiff's condition, the Court cannot

conclude that the A.L.J. erred in finding that Dr. Salvo's assessments were entitled to less than controlling weight. Further, based on the medical and other evidence of record, including Plaintiff's tests results, the opinions of Plaintiff's other treating physicians, and the RFC assessment completed by Dr. Irby, a specialist in rheumatology[7], the Court concludes that substantial evidence supports the A.L.J.'s conclusion that Plaintiff was not disabled within the meaning of the Act.

B. Whether The A.L.J. Erred In Omitting Significant Factors From The Hypothetical Question Posed To The Vocational Expert

Plaintiff next contends that the A.L.J.'s hypothetical question to the vocational expert was erroneous, because it did not contain all of Plaintiff's significant functional limitations. Specifically, Plaintiff contends that the A.L.J. failed to mention (1) that Plaintiff's severe pain interferes with her attention and concentration; (2) that Plaintiff could only stand for ten minutes at a time, stand/walk for less than two hours and sit for a total of two hours in an eight hour day;

[7] Although Dr. Irby did not examine Plaintiff, his opinion is relevant to the Commissioner's determination. 20 C.F.R. § 404.1527(d), (f); 20 C.F.R. § 416.927(d), (f). As a specialist, Dr. Irby's opinion is also entitled to "more weight" than the opinion of a physician is not a specialist. 20 C.F.R. § 404.1527(d)(5); 20 C.F.R. 416.927(d)(5). As the A.L.J. noted in his opinion, Dr. Irby's assessment is consistent with the medical evidence in the record including Plaintiff's various test results and the opinions of other physicians who examined Plaintiff. Accordingly, the Court concludes that the A.L.J. appropriately considered Dr. Irby's assessment in his analysis.

and (3) that Plaintiff would be absent more than four times per month due to her pain.

A hypothetical question posed to a vocational expert "must reflect all of a claimant's impairments that are supported by the record; otherwise the question is deficient and the expert's answer to it cannot be considered substantial evidence." Chrupcala v. Heckler, 829 F.2d 1269, 1276 (3d Cir. 1987) (citations omitted). Each of the alleged omissions in the A.L.J.'s hypothetical, however, are limitations raised by Dr. Salvo in his RFC assessment. As the Court has previously discussed, however, the opinions of Dr. Salvo were not well-supported by the record, and as such, the A.L.J. was not required to adopt the limitations found by Dr. Salvo in his hypothetical question to the A.L.J. In addition, the A.L.J. concluded that Plaintiff's testimony was not entirely credible and was at times inconsistent, such that Plaintiff's testimony undermined Dr. Salvo's opinion regarding the frequency and severity of her alleged symptoms. (Tr. 14-15). Accordingly, the Court cannot conclude that the A.L.J. erred in formulating his hypothetical question.

Further, the Court concludes that substantial evidence supports the A.L.J.'s determination that Plaintiff could perform a significant number of sedentary jobs in the national economy. Using the limitations which the A.L.J. found were supported by

the record, i.e. mild to moderate nonexertional impairments, the vocational expert opined that a person with Plaintiff's educational and vocational characteristics could perform a significant number of sedentary jobs, including telephone quotation clerk, charge account clerk and information clerk. The vocational expert testified that there were 1,000 of each of these jobs available in the local economy and at least 40,000 of each of these jobs available in the national economy. Because the A.L.J.'s hypothetical included the limitations supported by the record, the vocational expert's opinion constitutes substantial evidence. Chrupcala, 829 F.2d at 1276. Accordingly, the Court concludes that the A.L.J.'s finding that Plaintiff could perform a significant number of jobs in the national economy is supported by substantial evidence.

CONCLUSION

For the reasons discussed, Defendant's Motion For Summary Judgment will be granted, and Plaintiff's Motion For Summary Judgment will be denied. The decision of the Commissioner dated July 6, 1998 will be affirmed.

An appropriate Order will be entered.

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF DELAWARE

KAY MACLARY,	:	
	:	
Plaintiff,	:	
	:	
v.	:	Civil Action No. 00-729-JJF
	:	
JOANNE BARNHART, Commissioner of Social Security,	:	
	:	
Defendant.	:	

O R D E R

At Wilmington, this 15th day of July 2002, 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. 18) is GRANTED.

2. Plaintiff's Motion For Summary Judgment (D.I. 15) is DENIED.

3. The final decision of the Commissioner dated July 6, 1998 is AFFIRMED.

JOSEPH J. FARNAN, JR.
UNITED STATES DISTRICT JUDGE