IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF DELAWARE

SHAJUAN GOODEN,	:	
	:	
Plaintiff,	:	
	:	
v.	:	Civil Action No. 01-570 JJF
	:	
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 Judith M. Kinney, 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 Victor J. Pane, Esquire, Assistant Regional Counsel of the SOCIAL SECURITY ADMINISTRATION, Philadelphia, Pennsylvania.
Attorneys for Defendant.

MEMORANDUM OPINION

July 18, 2002

Wilmington, Delaware

---

[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) filed by Plaintiff, Shajaun Gooden, 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"). Plaintiff has filed a Motion For Summary Judgment (D.I. 11) 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. 14) 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 September 20, 2000 will be affirmed.

BACKGROUND

I. Procedural Background

Plaintiff filed her application for SSI benefits on October 5, 1999, alleging disability since December 1998 due to fibromyalgia[2] and depression. Plaintiff's application was denied

[2] Fibromyalgia refers to pain in the fibrous connective tissue components of muscles, tendons, ligaments and other "white" connective tissue. A diagnosis of fibromyalgia is based on an individuals' subjective symptoms (e.g. pain, poor sleep, anxiety, fatigue and irritable bowl symptoms), after testing has

initially and on reconsideration. (Tr. 64-65).

Plaintiff appealed the denial of her application and an administrative law judge (the "A.L.J.") conducted a hearing on Plaintiff's claim. By decision dated September 20, 2000, the A.L.J. denied Plaintiff's claim for SSI benefits. (Tr. 13-21). Following the unfavorable decision, Plaintiff filed a timely Request For Review Of Hearing Decision. (Tr. 9). On June 12, 2001, the Appeals Council denied Plaintiff's request. (Tr. 5-6).

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 SSI benefits. In response to the Complaint, Defendant filed an Answer (D.I. 7) and the Transcript (D.I. 8) of the proceedings at the administrative level.

Thereafter, Plaintiff filed a Motion For Summary Judgment and Opening Brief (D.I. 11) in support of the Motion. In response, Defendant filed a Cross-Motion For Summary Judgment and a combined Answering Brief and Opening Brief (D.I. 15) requesting the Court to affirm the A.L.J.'s decision. To date, Plaintiff

---

excluded an underlying systemic or autoimmune disorder. The condition does not include tissue abnormalities or inflammation, and the prognosis for the condition is favorable with treatment. Treatment includes supportive measures like reassurance and explanation of the benign nature of fibromyalgia, stretching exercises, local applications of heat, gentle massage, low-dose tricyclic antidepressants at bedtime, and aspirin or other mild non-narcotic analgesic agents. The Merck Manual, 481-482 (17th ed. 1999).

has not filed a Reply Brief.

II. Factual Background

A. Plaintiff's Medical History, Condition and Treatment

At the time the A.L.J. issued his decision, Plaintiff was twenty-nine years old making her a "younger individual" under the Social Security Regulations. 20 C.F.R. § 416.963(b)(2001). Plaintiff has a ninth grade education and a driver's license. She has worked as a hairstylist, assembler and fast food restaurant cook. (Tr. 44). Plaintiff receives welfare payments (Tr. 45), and has a Medicaid card entitling her to medical care at no charge. (Tr. 93).

Plaintiff is single with five children. (Tr. 170). At the time of the administrative hearing in this case, Plaintiff had five year old twins, an eight year old, a ten year old, and a twelve year old. (Tr. 51).

On January 4, 1999, Plaintiff was seen by Dr. Mayda Melendez at the St. Francis Family Practice Center. Plaintiff complained of leg pain and pelvic pain. Upon physical examination, Dr. Melendez noted tenderness of the frontal medial area and tightness with deep palpation. Dr. Melendez noted that Plaintiff has a family history of Lupus. Dr. Melendez ordered Anaprox for Plaintiff's pelvic and leg pain and further lab work to test for Lupus, specifically: ANA, ESR, RA and CSE. Plaintiff's ANA test was positive in a 1:160 dilution, but her other autoantibodies

were negative along with serum component levels. (Tr. 159-169). Thyroid function studies conducted on Plaintiff were normal and antibodies to double-stranded DNA were negative.

On February 5, 1999, Plaintiff reported to Dr. Melendez again complaining of bilateral leg and hip pain and joint swelling of the hands and wrists. Upon physical examination, Dr. Melendez noted tenderness over the femur area and the frontal medial area with deep palpation. Dr. Melendez ordered additional tests for Plaintiff, including a Lupus antic, a Lupus profile, and a rheumatoid factor. (Tr. 149). Plaintiff's test for the lupus anticoagulant revealed a normal result, which excluded the presence of a lupus anticoagulant. (Tr. 156).

At the request of Dr. Melendez, Plaintiff was evaluated by Dr. Russell Labowitz, a Board-certified rheumatologist, on September 14, 1999. Dr. Labowitz noted that Plaintiff complained of pain in her inner thighs since August 1998 and that the pain became more severe in January 1999. Plaintiff reported that she had been experiencing more fatigue and pain in her left third and fourth fingers. She also complained of pain in her knees and upper arms. Upon physical examination of Plaintiff, Dr. Labowitz found that Plaintiff's peripheral joints were "entirely normal," there was no active synovitis, and "there was full range of motion in all joints tested." (Tr. 170). Dr. Labowitz noted "some tenderness in both thighs, but no atrophy or

fasciculations." (Tr. 170-171). Dr. Labowitz also detected no muscular weaknesses and an examination of Plaintiff's axial skeleton was normal. A general systemic examination of Plaintiff was also normal. (Tr. 171). Dr. Labowitz noted the results of the tests previously performed on Plaintiff and suggested that Plaintiff take Relafen twice a day. Dr. Labowitz also showed Plaintiff quadricep strengthening exercises. Dr. Labowitz concluded by noting that "there is no evidence of multisystem disease, but the patient may have a connective tissue disease based on the positive ANA and strong family history." (Tr. 171).

On October 26, 1999, Peter V. Rocca, M.D. dictated a report for his evaluations of Plaintiff on April 8, 1999 and May 3, 1999. (Tr. 172). During her April 8 examination, Plaintiff complained of pain in her thighs, low back, left groin and hands. Dr. Rocca noted that Plaintiff had laboratory tests on April 15 which revealed a negative anti-rola Smith hepatitis panel, normal BUN and creatinine, unremarkable CBC, a sedimentation rate of 10, a negative anti-Smith RNP and double stranded DNA, and serum complements within normal limits. (Tr. 172). In her May 3 re-evaluation, Dr. Rocca noted that Plaintiff was accompanied by her aunt. Plaintiff stated that she was still in a "fair amount" of pain and that she was waking up during the night with back pain. Plaintiff also informed Dr. Rocca that she was taking Anaprox BS 2-3 times a day which was "helping somewhat." (Tr. 172). Dr.

Rocca repeated a physical examination on Plaintiff and noted that she had a "full range of motion of all joints without any synovitis, effusion, nodules or impaired range of motion." (Tr. 173). During this visit, Dr. Rocca informed Plaintiff that she had a benign condition known as fibromyalgia that would not result in crippling or deformity. Dr. Rocca also advised Plaintiff to incorporate an aerobic exercise program into her daily routine and gave her a prescription for Cyclobenzaprine to take at bedtime. Dr. Rocca reported that at the conclusion of Plaintiff's visit, Plaintiff's aunt "produced a form for me to fill out for her disability." (Tr. 173). Dr. Rocca stated:

> I refused to do this because I did not believe that this patient was disabled and unable to work. I asked the patient to return to see me on August 2, 1999 in follow up but she failed to do so.

(Tr. 173).

On November 3, 1999, Plaintiff reported to Dr. Labowitz complaining of achiness in her hands and feet. Dr. Labowitz assessed Plaintiff with undetermined connective tissue disorder. (Tr. 147).

On November 5, 1999, Dr. Melendez completed a Medical Certification for Plaintiff. Dr. Melendez indicated that Plaintiff was unable to work at her usual occupation and would be unable to work for two months. Dr. Melendez also indicated that she was not permitted to perform any other work on a full-time basis. (Tr. 151). However, Dr. Melendez also noted that

Plaintiff would need "more evaluation and diagnostic work up to determine a definitive diagnosis." (Tr. 151).

On January 7, 2000, Plaintiff returned to Dr. Labowitz complaining of continued pain in her left upper arm. Plaintiff also complained that her left lower leg gave out on two occasions and that she had stiffness in her hands and fingers. Dr. Labowitz's diagnosis remained undetermined connective tissue disorder. (Tr. 195-196).

On February 15, 2000, Plaintiff reported to St. Francis Hospital complaining of chronic pain, migraines, excessive sleeping, and occasional dizziness when standing up and sitting up. Plaintiff also indicated that she was no longer enjoying normal activities. Dr. Mansilla's assessments of Plaintiff included: (1) arthritis, (2) depression, (3) migraines, and (4) postural hypertension. Plaintiff was told to increase her water intake and was prescribed Elavin (50 mg) to treat her depression and help her chronic pain. (Tr. 205).

On February 22, 2000, Plaintiff called the St. Francis Family Practice Center and spoke with the Telephone Triage Center. Plaintiff complained of thigh pain when she put weight on her leg. Plaintiff was given an appointment with Dr. Mansilla for the next day.

During her visit with Dr. Mansilla, Plaintiff complained that her left thigh was swollen and painful. In examining

Plaintiff, Dr. Mansilla noted that Plaintiff's thigh was swollen and tender. Dr. Mansilla indicated that the "myopathy was secondary to probable connective tissue disorder." (Tr. 203). Dr. Mansilla ordered (1) CR ESR, (2) continued pain medications, (3) a follow up with a rheumatologist in one month, and (4) a follow up with Dr. Mansilla. (Tr. 203).

On April 25, 2000, Plaintiff returned to Dr. Labowitz complaining of anxiety, depression and her legs giving out. Dr. Labowitz diagnosed Plaintiff with undetermined connective tissue disorder, depression and anxiety.

Plaintiff next reported to Dr. Mansilla on May 15, 2000, with complaints of muscle pain and leg swelling. Upon physical examination, Dr. Mansilla noted that Plaintiff had pain in her left thigh and left arm with use. Dr. Mansilla opined that Plaintiff's myositis was secondary to connective tissue disorder. Dr. Mansilla ordered Plaintiff to stop taking Percocet, increase her intake of Elavin to 75 mg, and start a physical therapy program. (Tr. 199).

On July 25, 2000, Plaintiff returned to Dr. Labowitz complaining of sleeplessness and arthritic pain. Dr. Labowitz noted that Plaintiff's dorsal spine was tender. Dr. Labowitz's diagnosis remained the same, undetermined connective tissue disorder, depression and anxiety.

On August 2, 2000, Dr. Labowitz completed a Residual

Functional Capacity Assessment ("RFC") form for Plaintiff. Dr. Labowitz reported that Plaintiff could lift/carry less than ten pounds occasionally, stand/walk less than two hours in an eight hour work day, and remain at a work station performing sedentary work for two hours. (Tr. 207). Dr. Labowitz indicated that Plaintiff's ability to push/pull was limited in the upper extremities and the lower extremities, but he did not indicate that nature or degree of Plaintiff's limitations. Dr. Labowitz opined that Plaintiff could never climb, balance, stoop, kneel, crouch or crawl. Dr. Labowitz also opined that Plaintiff had limitations in the repetitive use of her hands, fingering (fine manipulation), reaching all directions (overhead), feeling (skin receptors), hearing and speaking. Dr. Labowitz based this opinion on Plaintiff's "chronic arthritis in hands and wrists." (Tr. 208). Based on Plaintiff's complaints, Dr. Labowitz described Plaintiff's pain as moderate to severe. However, when asked for his opinion regarding Plaintiff's pain, Dr. Labowtiz circled "moderate." (Tr. 209). Dr. Labowitz also found that the effects of Plaintiff's limitations on her ability to stand, sit, lift, move arms/legs, move legs/feet, concentrate, deal with stress, deal with others, and complete a day's work were moderate. (Tr. 210). Dr. Labowitz indicated that Plaintiff had no known psychiatric or non-exertional conditions that would effect her ability to work except for "mild depression and

anxiety." (Tr. 209). Dr. Labowitz opined that Plaintiff would be absent from work more than three days per month. (Tr. 210). When asked to describe the objective findings and tests results that formed the basis for his evaluation, Dr. Labowitz cited Plaintiff's positive ANA 1:80 dilution. (Tr. 211).

On August 15, 2000, Dr. Mansilla completed an RFC assessment for Plaintiff. Dr. Mansilla reported that Plaintiff could lift/carry ten pounds occasionally and stand/walk less than two hours in an eight hour day. Dr. Mansilla assessed Plaintiff's pain to be moderate or severe and noted that Plaintiff's depression was stable. (Tr. 214). Dr. Mansilla also opined that Plaintiff would be absent more than three days per month as a result of her medical problems. (Tr. 215). When asked to support his opinions with objective medical evidence and testing, Dr. Mansilla cited Plaintiff's sedimentation rate, positive ANA, homogeneous ANA pattern, and neurological exam showing 4/5 muscle strength, which is slightly reduced muscle strength. (Tr. 216).

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

On August 16, 2000, the A.L.J. conducted a hearing on Plaintiff's SSI claim. At the hearing, Plaintiff testified that she has pain "basically everywhere" and "basically, all the time." (Tr. 45-46). Plaintiff testified that she is taking prescription pain medication which helps with the pain, but makes her sleepy. (Tr. 47). Plaintiff also testified that she has

five children and that she takes care of them. Plaintiff testified that she gets her children off to school and goes back to sleep from nine or ten in the morning until two or three in the afternoon. She testified that she stays up with the children for "a minute" and then she goes back to sleep until five or six at night. From five or six to nine in the evening, Plaintiff testified that she helps the children with their homework and then she goes back to bed for the evening.

Plaintiff's friend, Carrie Shreves, also testified at the hearing. She testified that she is also disabled and that Plaintiff has the same symptoms she has. (Tr. 56). Ms. Shreves testified that she helps Plaintiff get her children dressed and off to school on a frequent basis.

In addition to the testimony of Plaintiff and Ms. Shreves, the A.L.J. also heard the testimony of a vocational expert, Margaret Preno. 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 body areas indicated by plaintiff, headaches, back pain, leg pain, hand pain, swelling in her hands and feet, and drowsiness due to her medications. (Tr. 58-59). Assuming the nonexertional limitations were severe, the vocational expert opined that the

hypothetical individual would not be competitive in the local or national economy. (Tr. 59). However, if these limitations were moderate in nature, the vocational expert testified that the individual could perform some sedentary work. Specifically, the vocational expert noted that Plaintiff could be (1) a surveillance monitor with 45,000 jobs available in the national economy; (2) an information clerk with 14,500 jobs in the national economy and 40 jobs in the local economy; and (3) a cashier with 132,000 jobs in the national economy and 100 in the local economy.

In his decision dated September 20, 2000, the A.L.J. concluded that Plaintiff was unable to perform her past relevant work as a hairstylist, because the job requires prolonged standing or walking. The A.L.J. found that Plaintiff "has fibromyalgia and a possible connective tissue disorder, impairments that are 'severe' within the meaning of the Regulations but not severe enough to meet or equal one of the impairments listed in Appendix 1, Subpart P, Regulations No. 4." (Tr. 15). The A.L.J. also concluded that Plaintiff's allegations regarding the severity of her impairments and symptoms and their effect on her functional abilities were not credible and not consistent with the medical record. The A.L.J. concluded that Plaintiff had the residual functional capacity to lift ten pounds of weight, stand or walk for at least limited periods (two hours

in an eight-hour day), and sit for prolonged periods. The A.L.J. concluded that these functional abilities were consistent with the full range of sedentary work and that Plaintiff's mild to moderate subjective discomfort did not result in any significant nonexertional limitations. (Tr. 18). Specifically, the A.L.J. concluded that Plaintiff retained the mental and physical RFC to perform the unskilled sedentary jobs identified by the vocational expert. (Tr. 19). Based on her RFC, age, education and work experience, the A.L.J. concluded that the Regulations would direct a conclusion of "not disabled." (Tr. 20).

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

I. Evaluation Of Social Security Disability Claims

Within the meaning of social security law, a "disability" is defined as the "inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment." 20 C.F.R. § 404.1505(a). To be found disabled, an

individual must have a "severe impairment" which precludes the individual from performing previous work or any other "substantial gainful activity which exists in the national economy." Id. The claimant bears the initial burden of proving disability. 42 U.S.C. § 423(d)(5).

In determining whether a person is disabled, the Regulations require the A.L.J. to perform a sequential five-step analysis. 20 C.F.R. § 404.1520. In step one, the A.L.J. must determine whether the claimant is currently engaged in substantial gainful activity. In step two, the A.L.J. must determine whether the claimant is suffering from a severe impairment. If the claimant fails to show that his or her impairment is severe, he or she is ineligible for benefits. Plummer v. Apfel, 186 F.3d 422, 427 (3d Cir. 1999).

If the claimant's impairment is severe, the A.L.J. proceeds to step three. In step three, the A.L.J. must compare the medical evidence of the claimant's impairment with a list of impairments presumed severe enough to preclude any substantial gainful work. Id. at 428. If the claimant's impairment meets or equals a listed impairment, the claimant is considered disabled. If the claimant's impairment does not meet or equal a listed impairment, the A.L.J.'s analysis proceeds to steps four and five. Id.

In step four, the A.L.J. is required to consider whether the

claimant retains the residual functional capacity to perform his or her past relevant work. Id. The claimant bears the burden of establishing that he or she cannot return to her past relevant work. Id.

In step five, the A.L.J. must consider whether the claimant is capable of performing any other available work in the national economy. At this stage the burden of production shifts to the Commissioner, who must show that the claimant is capable of performing other work if the claimant's disability claim is to be denied. Id. In making this determination, the A.L.J. must show that there are other jobs existing in significant numbers in the national economy, which the claimant can perform consistent with the claimant's medical impairments, age, education, past work experience and residual functional capacity. Id. In making this determination, the A.L.J. must analyze the cumulative effect of all of the claimant's impairments. It is at this step, that the A.L.J. may seek the assistance of a vocational expert. Id. at 428.

II. Plaintiff's Contentions Of Error

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 physicians, Dr. Labowitz and Dr. Mansilla. Second, Plaintiff contends that the

A.L.J. improperly substituted his own opinion for the opinion of Plaintiff's treating physicians. 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 Physicians

Plaintiff contends that the A.L.J. failed to give greater weight to the opinions of Drs. Labowitz and Mansilla, as Plaintiff's treating physician, than to Dr. Rocca, a treating physician who saw Plaintiff only twice in a one-month period. Plaintiff further contends that the A.L.J. should not have credited the opinion of Dr. Rocca that Plaintiff was not disabled.

An A.L.J. may reject the opinion of a treating physician if the opinion is not supported by medically acceptable clinical and laboratory diagnostic techniques and is inconsistent with other substantial evidence in the record. Fargnoli v. Massanari, 247 F.3d 34, 42 (3d Cir. 2001). If the A.L.J. rejects the opinion of a treating physician, he or she must adequately explain 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. did not err in assessing the opinions of Drs. Labowitz, Manilla and Rocca. In rejecting the RFC assessments completed by Drs. Labowitz and Manilla, the A.L.J. noted that the record evidence did not support the opinions of these physicians. As the A.L.J. noted, Dr. Labowtiz based his conclusions regarding Plaintiff's impairments on only one objective finding, a positive ANA at 1:80 dilution. Dr. Labowitz's RFC assessment is contradicted by his own physical examinations of Plaintiff. As the A.L.J. noted Dr. Labowitz's examination of Plaintiff revealed that her peripheral joints were entirely normal, there was no active synovitis, no muscular weakness, no evidence of multi-systems disease and full range of motion in all of her joints tested. (Tr. 15). Further, Dr. Labowitz acknowledged that aside from the positive ANA result, the results of other medical tests on Plaintiff were normal. Plaintiff had a negative anti-rola Smith hepatitis panel, normal BUN and creatinine, unremarkable CBC, a negative anti-Smith RNP and double stranded DNA, and normal serum complements.

Likewise, Dr. Mansilla's opinion is also contradicted by the results of Plaintiff's medical testing. Although Dr. Mansilla

cited Plaintiff's sedimentation rate, positive ANA, homogenous ANA pattern and slightly reduced muscle strength to support his opinion, Dr. Mansilla's conclusions regarding Plaintiff's physical abilities are essentially unsupported. Dr. Mansilla noted no severe motor, reflex or sensory abnormalities which would justify his assessment of Plaintiff's limitations.

Plaintiff contends that the A.L.J. erred in crediting Dr. Rocca's opinion over the opinions of Drs. Mansilla and Labowitz, because Dr. Rocca only saw Plaintiff twice in a one-month period. However, the record indicates that Plaintiff only treated with Dr. Mansilla three times, two of which were during a one-month period. Further, the record suggests that Plaintiff did not return to Dr. Rocca, although she was scheduled for a visit.

Plaintiff also suggests that the A.L.J. erred, because he accepted Dr. Rocca's conclusion that Plaintiff was not disabled. The Court disagrees with Plaintiff. The determination of disability rests with the Commissioner. Although the A.L.J. credited Dr. Rocca's opinion over the opinions of Drs. Labowitz and Mansilla, it is evident from the A.L.J.'s opinion that he did not blindly credit Dr. Rocca's assessment that Plaintiff was not disabled. Rather, the A.L.J. properly considered the results of Dr. Rocca's physical examination of Plaintiff and the results of testing on Plaintiff. Like the physical examination of Plaintiff performed by Dr. Labowitz, Dr. Rocca's physical examination

revealed a "full range of motion of all joints without any synovitis, effusion, nodules or impaired range of motion." Because the objective medical evidence supported the opinion of Dr. Rocca and contradicted the opinions of Drs. Mansilla and Labowitz, the A.L.J. was permitted to credit the opinion of Dr. Rocca and reject the opinions of Drs. Mansilla and Labowitz.

B. Whether The A.L.J. Improperly Substituted His Opinion For The Opinion Of Plaintiff's Treating Physicians

Plaintiff next contends that the A.L.J. improperly substituted his opinion regarding Plaintiff's residual functional capacity for the opinions of Plaintiff's treating physicians. Specifically, Plaintiff contends that the A.L.J. concluded that Plaintiff was able to perform a significant range of sedentary work, when the only RFC assessments in the record by Plaintiff's treating physicians, Drs. Labowitz and Mansilla, supported the conclusion that plaintiff would be precluded from performing any sedentary work in the national or local economy.

After reviewing the record, the Court disagrees with Plaintiff's contention. As the Court discussed previously, the A.L.J. was permitted to reject the opinions of Drs. Labowitz and Mansilla, because they were not supported by the record evidence. Further, there is record evidence supporting the A.L.J.'s conclusion that Plaintiff could perform a significant range of sedentary work. Two state agency physicians reviewed Plaintiff's objective medical evidence and concluded that Plaintiff was

capable of performing light work. In making this assessment, at least one of the two reviewing physicians made notes which expressly referred to the objective medical findings of the physicians whose reports were reviewed. Although the opinions of state agency physicians are not binding, the A.L.J. must consider the findings of state agency medical consultants as opinion evidence. See 20 C.F.R. § 416.927(f). In this case, the A.L.J. considered the opinions of the state agency physicians in light of the medical evidence in the record and concluded that Plaintiff was capable of performing at least sedentary work, even though the state agency physicians found Plaintiff was capable of performing light work. Porter v. Bowen, 1988 WL 102646, *2-3 (E.D. Pa. Sept. 30, 1988) (holding that A.L.J.'s conclusion that plaintiff could perform light work was supported by substantial medical evidence where state agency physicians found plaintiff capable of performing medium work and opinion of treating physician was unsupported). Where, as here, record evidence supported the A.L.J.'s determination, the Court cannot conclude that the A.L.J. impermissibly substituted his opinion for that of Plaintiff's treating physicians. Jones v. Sullivan, 954 F.2d 125, 129 (3d Cir. 1991) (holding that A.L.J. correctly determined that treating physician's opinion was not controlling where it was unsupported and noting that opinions of two state agency physicians contradicted opinions of treating physicians); Porter,

1988 WL 102646 at *2-3 (holding that A.L.J. did not substitute his opinion for that of treating physician where treating physician's opinion was unsupported and A.L.J.'s conclusion was supported by interpretation of medical tests by trained state agency physicians); see also Simpson v. Apfel, 2000 WL 387155, *2 (7th Cir. Apr. 12, 2000) (holding that A.L.J. was not "playing doctor" where his findings were supported by medical opinion of state agency physicians who reviewed claimant's medical records).

C. Whether The A.L.J.'s Decision Is Supported By Substantial Evidence

After reviewing the A.L.J.'s decision in light of the record in this case, the Court concludes that the A.L.J.'s determination that Plaintiff is not disabled is supported by substantial evidence. As discussed previously, Plaintiff's medical tests, the opinion of her treating physician Dr. Rocca, and the opinions of the state agency physicians support the A.L.J.'s conclusion that Plaintiff had a severe impairment, but that Plaintiff's impairment did not rise to the level of a listed impairment and did not preclude her from performing sedentary work. As the A.L.J. also noted, the physical examinations and clinical tests performed on plaintiff did not reveal any significant abnormalities. (Tr. 18, 156, 159-169, 170-172). Further, the A.L.J. found that Plaintiff's subjective symptoms were not fully credible and that Plaintiff's testimony regarding her limitations were consistent with the requirements of sedentary work. Van

Horn v. Schweiker, 717 F.2d 871, 873 (3d Cir. 1983) (reserving credibility determinations to A.L.J.).

Finally, in posing his hypothetical question to the vocational expert, the A.L.J. included those impairments which were supported by the record. Chrupcala v. Heckler, 829 F.2d 1269, 1276 (3d Cir. 1987) (holding that hypothetical question must contain claimant's limitations supported by the record for vocational expert's answer to be considered substantial evidence). In response to this hypothetical, the vocational expert testified that Plaintiff could perform a significant number of sedentary jobs in the national economy, including the jobs of surveillance monitor, information clerk and cashier. Accordingly, the Court concludes that the A.L.J.'s decision denying Plaintiff benefits is supported by substantial evidence, and therefore, the Commissioner's decision will be affirmed.

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 September 20, 2000 will be affirmed.

An appropriate Order will be entered.

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF DELAWARE

SHAJUAN GOODEN,	:	
	:	
Plaintiff,	:	
	:	
v.	:	Civil Action No. 01-570 JJF
	:	
JOANNE BARNHART, Commissioner of Social Security,	:	
	:	
Defendant.	:	

O R D E R

At Wilmington, this 18th 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. 14) is GRANTED.

2. Plaintiff's Motion For Summary Judgment (D.I. 11) is DENIED.

3. The final decision of the Commissioner dated September 20, 2000 is AFFIRMED.

JOSEPH J. FARNAN, JR.
UNITED STATES DISTRICT JUDGE