IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF DELAWARE

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| BEVERLY A. KOVALCIK, | : | |
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| Plaintiff, | : | |
| | : | |
| v. | : | Civil Action No. 01-742-JJF |
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| JO ANNE B. BARNHART, Commissioner of Social Security, | : | |
| | : | |
| Defendant. | : | |

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Of Counsel: James A. Winn, Esquire, Regional Chief Counsel, and Joyce M.J. Gordon, Esquire, Assistant Regional Counsel of the SOCIAL SECURITY ADMINISTRATION, Philadelphia, Pennsylvania.
Attorneys for Defendant.

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**MEMORANDUM OPINION**

September 29, 2003

Wilmington, Delaware

**Farnan, District Judge.**

Presently before the Court is an appeal pursuant to 42 U.S.C. § 405(g), filed by Plaintiff, Beverly A. Kovalcik, seeking review of the final administrative decision of the Commissioner of the Social Security Administration denying Plaintiff's application for disability insurance benefits ("DIB") under Title II of the Social Security Act, 42 U.S.C. §§ 401-433. Plaintiff has filed a Motion For Summary Judgment (D.I. 7) 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. 10) 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 February 11, 2000 will be affirmed.

## BACKGROUND

### I. Procedural Background

Plaintiff filed an application for DIB on February 9, 1999, alleging a disability onset date of December 31, 1994. (Tr. 93-95). This application was Plaintiff's second application for benefits. The application was denied initially and upon reconsideration. (Tr. 74-80). Thereafter, Plaintiff requested a hearing before an administrative law judge (the "A.L.J."). (Tr. 80). On February 11, 2000, the A.L.J. issued a decision denying

Plaintiff's application for DIB. (Tr. 13-21). Following the unfavorable decision, Plaintiff filed a timely Request For Review Of Hearing Decision. (Tr. 8-9). On September 14, 2001, the Appeals Council denied Plaintiff's request for review (Tr. 5-6), and the A.L.J.'s decision became the final decision of the Commissioner. Sims v. Apfel, 530 U.S. 103, 107 (2000).

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. In response to the Complaint, Defendant filed an Answer (D.I. 4) and the Transcript (D.I. 5) of the proceedings at the administrative level.

Thereafter, Plaintiff filed a Motion For Summary Judgment and Opening Brief in support of the Motion. In response, Defendant filed a Cross-Motion For Summary Judgment and a combined Opening and Answering Brief requesting the Court to affirm the A.L.J.'s decision. Plaintiff then filed a Reply Brief to Defendant's Cross-Motion For Summary Judgment. 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 A.L.J.'s hearing on Plaintiff's application, Plaintiff was thirty-nine years old and considered a "younger individual" under the social security regulations. 20

C.F.R. § 404.1564. Plaintiff has a high school education and past relevant work as a cashier, pharmacy clerk and salesperson. (Tr. 20).

Beginning in April 1993 through November 1997, Plaintiff treated with Nancy Murphy, M.D., a rheumatologist. (Tr. 221-244). Plaintiff reported that she had not been feeling well since September of 1993 and that she was experiencing pain in her low back that would radiate around to the abdominal area. She also reported achiness in the neck and shoulder muscles with some pain radiating into the right arm. Plaintiff complained of crampy pain in her legs, fatigue, hair loss, mouth sores, low grade fevers, and dryness of the eyes, mouth and throat. All objective testing of Plaintiff was normal except for the anti-nuclear antibody test, which was positive at a titer of 1/40. Plaintiff's physical examination revealed some muscle spasms and some tender points for fibromyalgia, but a full range of motion. Plaintiff's neurological exam was within normal limits. Dr. Murphy diagnosed Plaintiff with possible lupus, but more likely fibromyalgia.

Throughout her treatment with Dr. Murphy, Plaintiff maintained a full range of motion. Dr. Murphy's treatment notes describe Plaintiff's pain as "mild stiffness," tenderness and achiness. Dr. Murphy's treatment notes also indicate that Plaintiff's symptoms improved over time. (Tr. 240).

Plaintiff's energy levels fluctuated from poor in 1993 (Tr. 243, 238) to "mild fatigue-very active" in May 1994. (Tr. 236, 227). In May 1996, Plaintiff reported that her energy level was fair, and in August 1996 she reported "mild fatigue." (Tr. 228, 227).

As for her sleep, Plaintiff reported that she slept better with her Elavil medication. (Tr. 229, 227-243, 231). In June 1995, Plaintiff reported that she "gets good sleep." (Tr. 232)

By May 1997, Dr. Murphy's notes indicate that Plaintiff was "slowly feeling better." However, in September 1997, Plaintiff reported to Dr. Murphy that she stopped working due to muscle and joint pain. Plaintiff had worked from 1993 through 1997, although she reportedly worked fewer hours as of June 1995, because she had "personality problems [with a] manager at work." (Tr. 232).

In October 1997, Plaintiff filed her first application for DIB. In that application, Plaintiff reported that she experienced every kind of pain 80-100 percent of the time, and that her pain was only relieved "somewhat" by sitting, moving, medication and warm, dry weather.

In November 1997, Plaintiff reported to Dr. Murphy that she was denied disability payments. She stated that her medications were not making any difference in her complaints of pain. Dr. Murphy referred Plaintiff for a second opinion for the management

of her condition, because of her stated non-responsiveness to multiple trials of medication. (Tr. 221).

Between January 1998 and June 1998, Plaintiff underwent a variety of x-rays, an MRI and a CT-scan. Plaintiff's MRI showed no disc herniation or significant posterior bulge, and all of her x-rays and CT-scan were normal. Plaintiff visited a dermatologist in January 12, 1998, for a rash. The dermatologist recommended that Plaintiff avoid outdoor exposure, but did not place any physical restrictions on Plaintiff.

In February 1998, Plaintiff's primary care physician, Kevin O'Hara, M.D., recommended physical therapy to alleviate Plaintiff's complaints of low back and right hip pain. In response, however, Plaintiff stated that she did not want physical therapy. (Tr. 309). Plaintiff also reported that her pain was "much less now." In March 1998, Dr. O'Hara diagnosed Plaintiff with low back pain syndrome and recommended back exercises. (Tr. 308).

In April 1998, Plaintiff treated with Peter Rocca, M.D. on referral from Dr. O'Hara and Dr. Murphy. (Tr. 327-328). Plaintiff complained of pain and swelling in her hands and thumb, and to a lesser extent, in her knees, hips and low back. Plaintiff also reported that she was not employed, but bowled once a week. (Tr. 325, 327). After examining Plaintiff, Dr. Rocca reported that Plaintiff was in no acute distress and the

"only abnormality" was the presence of multiple soft tissue tender points. (Tr. 328). His initial impression was fibromyalgia, "[r]ule out systemic lupus," and a future goal of obtaining Plaintiff's prior medical record to better define her clinical problems. (Tr. 328). With regard to medications, Dr. Rocca observed that Plaintiff had taken numerous medications in the past, but that more recently she had been given tolmetin, Plaquenil, carisoprodol, Elavil and Darvocet as needed. Dr. Rocca also reported that Plaintiff took the Darvocet "very infrequently." (Tr. 326).

Plaintiff was next seen by Dr. Rocca on May 29, 1998. Dr. Rocca reported that Plaintiff had "poorly localized musculoskeletal pain" and tender points, but no definite synovitis. (Tr. 325). At that time, Dr. Rocca discontinued Plaintiff's Plaquenil medication and renewed her prescription for Darvocet. Dr. Rocca asked Plaintiff to return in three months, but she failed to return until nearly six months later on November 12, 1998.

At her November 12 visit, Plaintiff reported no significant change in her condition. She said that she felt worse without the Plaquenil and went back on it without any doctor's direction. Plaintiff's physical examination was repeated, but unchanged. Dr. Rocca performed several laboratory studies and all were normal, except for a "mildly elevated" sedimentation rate of 37

millimeters per hour. Dr. Rocca asked Plaintiff to increase her Elavil and to exercise aerobically. (Tr. 325).

Plaintiff's fourth and last visit with Dr. Rocca was on February 15, 1999. Plaintiff reported additional joint and muscle pain and stated that she did not engage in any aerobic exercises, despite Dr. Rocca's recommendation. Plaintiff complained bitterly of sharp pain in her left elbow. A physical examination was repeated, and Dr. Rocca reported that Plaintiff's condition was unchanged from her first, second and third visits. Dr. Rocca's impressions included "[d]efinite fibromyalgia, doubtful systemic lupus." (Tr. 326). Dr. Rocca asked Plaintiff to again increase her Elavil and repeated his recommendation that Plaintiff engage in an aerobic exercise program. (Tr. 326).

On November 5, 1999, Dr. Rocca completed a Lupus Residual Functional Capacity ("RFC") Assessment for Plaintiff. Dr. Rocca indicated that Plaintiff did not meet the diagnostic criteria for lupus. (Tr. 189-190). Dr. Rocca stated that Plaintiff had oral ulcers, photosensitivity, a rash on her cheeks, a positive test for ANA, and gastrointestinal complaints. Although Dr. Rocca noted that Plaintiff had swelling, tenderness and warmth, he did not specify which joints were affected as required by the RFC form.

In connection with the hearing on her disability claim, Plaintiff requested an evaluation from Dr. Rocca in late November

1999. Plaintiff's counsel sent this evaluation to the A.L.J. with a cover letter indicating that Dr. Rocca "prefers not to give any specific functional limitations," but "has indicated that [Plaintiff] would be unable to perform even a low-stress job." (Tr. 373). Dr. Rocca described his clinical findings as "tender points" and checked "yes" in response to a question asking if emotional factors contributed to Plaintiff's pain. (Tr. 374). Dr. Rocca checked off other boxes indicating that Plaintiff had nonrestorative sleep, chronic fatigue, morning stiffness, muscle weakness, and subjective swelling. (Tr. 374). Dr. Rocca indicated that Plaintiff had constant severe pain bilaterally in all areas indicated on the form and that the pain was precipitated by stress, fatigue, static positions and changing weather. He also checked the box indicating that Plaintiff's pain was severe enough to interfere with her attention and concentration "frequently." With regard to Plaintiff's capacity for sitting, standing, walking, performing repetitive reaching, handling and figuring, Dr. Rocca provided a response of "unknown." However, Dr. Rocca did opine that plaintiff could occasionally lift up to ten pounds. Dr. Rocca checked "yes" in response to whether Plaintiff suffered good and bad days, but responded "unknown" to the question asking for an estimate of how many days Plaintiff would be absent from work due to pain.

B. Plaintiff's Responses To Disability Questionnaires

In October 1997, Plaintiff completed a daily activities questionnaire and a pain questionnaire for disability determination services. (Tr. 118-129). Plaintiff reported that she did not need any help with her personal care (Tr. 122), but that she woke up stiff every morning. She reported that she cleaned the house, washed laundry, and cooked dinner resting in between the chores for up to an hour. (Tr. 118). Plaintiff indicated that her hobby was bowling and that she bowled using a light ball once a week for three hours. (Tr. 120). Plaintiff also reported that she read books for a half hour at a time, approximately two books a week, and watched television.

In November 1998, Plaintiff completed a personal pain questionnaire, a fatigue questionnaire and a daily activities questionnaire in connection with her DIB claims. Plaintiff reported sharp, severe, constant pain and aching. (Tr. 172). Plaintiff stated that her medications did not alleviate her pain completely, but that they did lessen her pain. She stated that she did not like taking pain killer because the side effects made her unable to do anything and she "need[s] to be there for my kids." (Tr. 176). Plaintiff also reported that she could walk for twenty minutes before resting for five to ten minutes. She reported that she visited family and friends monthly, and that she did not drive "if [she] could help it."

Plaintiff reported that she gets help with cooking, cleaning and food shopping from her children and her husband. (Tr. 174). She reported that she sleeps seven hours a night and can perform "light duties" consisting of fifteen or twenty minute tasks followed by a period of rest. (Tr. 175). With regard to her daily activities Plaintiff reported that she does some light cleaning and shopping, watches television, plays cards, reads for an hour a day and watches her husband and friends bowl weekly. (Tr. 184-186).

C. Consultative Opinions and Examinations

On January 22, 1998, a state agency physician completed a functional capacity assessment of Plaintiff. The state agency physician opined that Plaintiff had unlimited pushing and pulling capacity, and that Plaintiff could occasionally lift twenty-pounds, frequently lift ten pounds and stand, walk or sit for six hours a day. (Tr. 282-289). The state agency physician also found that Plaintiff could climb, balance, stoop, kneel, crouch and crawl occasionally and that she had no manipulative limitations.

On April 8, 1999, a second consultative report was completed by a state agency physician. The second state agency physician found the same functional limitations as the first reviewing physician. This physician also responded to Plaintiff's symptoms indicating that they were "possibly" related to a medically

determinable impairment, but that the severity of her symptoms was disproportionate. In reaching these conclusions, the second reviewing physician noted the medical impressions of Drs. Rocca and Murphy, and also noted that Plaintiff bowled once a week and was told to perform aerobic exercises. This reviewing physician opined that Plaintiff could perform light exertional work and that this level of work complied with the activity level recommended by Dr. Rocca. (Tr. 336).

After the second consultative opinion, the Disability Determination Service requested that Plaintiff undergo a consultative physical examination. Plaintiff was examined by Irwin Lifrak, M.D. Plaintiff reported to Dr. Lifrak that she slept seven to eight hours per night and that she did not nap during the day. She alleged intense pain throughout her body and believed that she could walk two blocks, climb three to four steps, sit for thirty minutes, stand for ten minutes and lift five pounds with either hand. (Tr. 350). Upon examination of Plaintiff, Dr. Lifrak opined that Plaintiff was in no acute physical distress. Plaintiff was ambulated with a normal station and gait, walked on her heel and toes, got on and off the examining table without assistance, could perform tandem gait and hand manipulation requiring fine and gross dexterity without any difficulty. Prior to conducting the range of motion tests, Dr. Lifrak instructed Plaintiff repeatedly to immediately relay any

undo pain or discomfort. (Tr. 351). Testing revealed that Plaintiff had a reduced lumbosacral spine range of muscle, but no paravertebral muscle spasm. (Tr. 351). Plaintiff's detailed range of motion examination revealed no significant anomalies and Plaintiff's neurological exam was normal. (Tr. 353-360). Dr. Lifrak's impressions were complaints of fatigue, complaints of pain and reported episodes of abdominal discomfort.

After Dr. Lifrak's examination, a third consultative opinion was completed in August 1999. The third reviewing physician opined that Plaintiff had the same exertional level and functional limitations as the previous reviewing physicians. In support of his opinion, the third reviewing physician noted Plaintiff's normal gait, station, and her ability to get on and off the examining table during her examination with Dr. Lifrak. The reviewing physician also noted Plaintiff had good grip strength, dexterity and range of motion, as well as no muscle weakness in the upper and lower extremities. Like the second reviewing physician, the third reviewing physician opined that it was possible that Plaintiff's symptoms were from a medically determinable impairment, but that the severity of these symptoms was disproportionate. (Tr. 344).

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

On November 18, 1999, the A.L.J. conducted a hearing on Plaintiff's application for benefits. At the hearing, Plaintiff

was represented by counsel. Plaintiff testified that she worked part-time, but she had to stop working due to increased pain and fatigue. Plaintiff testified that she smokes a pack of cigarettes a day, and that she drives on rare occasions. Plaintiff testified that she spends most of her day in a reclining chair watching television. She testified that she has to lay down almost all of the day, but that she does prepare dinner, vacuum and clean with the help of her children for approximately two hours a day. She testified that she could not sit long and that she would have to get up and stretch every half hour due to joint stiffness. (Tr. 37-38). She testified that she could stand no more than 5 minutes, but that she grocery shops and walks around the store for half an hour. She testified that she could pour a gallon of milk with some difficulty, because of pain in her hands. Plaintiff testified that the pain in her hands started around the same time as her diagnoses.

The A.L.J. also heard the testimony of a vocational expert. The A.L.J. asked the vocational expert to consider a hypothetical individual with Plaintiff's age, education and past work experience. He limited the hypothetical individual as follows:

> Sedentary residual functional capacity. Indoor work. No exposure to temperature extremes. Moderate difficulty reaching, handling, and fingering as opposed to severe which would severely compromise the ability to reach, handle, finger. Simple routine operations . . . not requiring sustained concentration and attention. . . [A]ttention and concentration can be readily summoned as necessary to complete the requisite

transaction or task.

(Tr. 48). In response to this hypothetical, the vocational expert responded that such an individual could perform the jobs of telephone quotation clerk, information clerk brokerage services, order clerk food and beverage, and that these jobs existed in significant numbers in the national and local economy.

The A.L.J. then asked the vocational expert to include all of Plaintiff's subjective testimony regarding her complaints and opine as to whether such an individual could still perform the identified jobs. The vocational expert opined that none of the jobs previously identified would be available. (Tr. 50). At the close of the hearing, the A.L.J. left the record open for Dr. Rocco to submit his RFC assessment. Thereafter, Plaintiff submitted Dr. Rocca's November 18, 1999 assessment which did not give any specific functional limitations.

In his decision dated February 11, 2000, the A.L.J. concluded that Plaintiff had not engaged in substantial gainful activity since December 31, 1994. The A.L.J. found that Plaintiff had severe fibromyalgia and lupus, but that she did not have an impairment meeting or equaling a listed impairment. The A.L.J. also concluded that Plaintiff's testimony regarding the severity of her impairment and the effect on her functional abilities was not credible. The A.L.J. found that while Plaintiff was unable to perform her past relevant work, she

retained the residual functional capacity for the full range of sedentary work reduced by restrictions to indoor jobs not involving temperature extremes and unskilled jobs not requiring more than one to two step tasks or sustained concentration or attention. The A.L.J. also found that Plaintiff was able to perform the jobs of telephone clerk, information clerk and order clerk, and that significant numbers of these jobs existed in the national and regional economies. Accordingly, the A.L.J. concluded that Plaintiff was not under a disability within the meaning of the Act, and therefore, not entitled to benefits.

**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 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, which can be expected to result in death, or which

has lasted or can be expected to last, for a continuous period of not less than 12 months. 42 U.S.C. § 423(d)(1)(A). 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." 20 C.F.R. § 404.1505. In order to qualify for disability insurance benefits, the claimant must establish that he or she was disabled prior to the date he or she was last insured. 20 C.F.R. §§ 404.131, Matullo v. Bowen, 926 F.2d 240, 244 (3d Cir. 1990). 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 his or 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. Specifically, the A.L.J. must find 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. At this step, the A.L.J. often seeks the assistance of a vocational expert. Id. at 428.

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

By her Motion, Plaintiff contends that the A.L.J.'s decision is not supported by substantial evidence. Specifically, Plaintiff contends that the A.L.J. (1) failed to properly evaluate Plaintiff's subjective complaints of pain; (2) erred in rejecting the opinion of Plaintiff's treating physician, Dr. Rocca; and (3) posed a deficient hypothetical to the vocational expert.

Plaintiff contends that the A.L.J. failed to properly evaluate her subjective complaints of pain, because the A.L.J. indicated that objective findings did not support her complaints and her daily activities did not support her allegations of pain. Plaintiff contends that numerous courts have recognized that fibromyalgia is an elusive disease of uncertain origin and its symptoms are entirely subjective including pain all over, fatigue, sleep disturbances, stiffness and multiple tender spots (at least 11 of 18 fixed locations). Plaintiff further maintains that Plaintiff's sporadic daily activity is insufficient to discredit her testimony of disabling pain.

Plaintiff is correct concerning the clinical aspects of fibromyalgia. Courts have recognized that the causes of fibromyalgia are unknown and the disease is incurable. See e.g. Wilson v. Apfel, 1999 WL 993723, *1, n.1 (E.D. Pa. Oct. 29, 1999) (citing Sarchet v. Chater, 78 F.3d 305, 306 (7th Cir. 1996).

Courts have also recognized that its symptoms are entirely subjective and that there are no current laboratory tests that can gauge the severity of the condition. Id. However, courts have also recognized that a diagnosis of fibromyalgia does not necessarily equate with a finding of disability under the Act. Id.

A plaintiff's subjective complaints of pain must be consistent with the objective medical evidence concerning the plaintiff's impairment. 20 C.F.R. § 404.1529. Once an A.L.J. concludes that a medical impairment could reasonably cause the alleged symptoms, the A.L.J. is required to evaluate the intensity and persistence of the pain, and the extent to which it affects the claimant's ability to work. Id. This determination necessarily requires the A.L.J. to gauge the credibility of the claimant. Id.; Morrow v. Apfel, 2001 WL 641038, *9 (D. Del. Mar. 16, 2001); Wilson, 1999 WL 993723 at *3.

An A.L.J.'s credibility determinations are generally entitled to great weight and deference. Fargnoli v. Massanari, 247 F.3d 34, 43 (3d Cir. 2001). The A.L.J. may discredit a claimant's complaints of disabling pain if "he affirmatively addresses the claim in his decision, specifies the reasons for rejecting it and has support for his conclusion in the record." Hirschfeld v. Apfel, 159 F. Supp. 2d 802, 811 (E.D. Pa. 2001); see also Mason v. Shalala, 994 F.2d 1058, 1067 (3d Cir. 1993).

Because of the subjective nature of fibromyalgia, "the credibility of a claimant's testimony regarding her symptoms takes on substantially increased significance in the A.L.J.'s evaluation of the evidence." Brunson v. Barnhart, 2002 WL 393078, *16 (E.D.N.Y. Mar. 14, 2002). In evaluating the claimant's complaints of pain in the context of a diagnosis of fibromyalgia, the A.L.J. may also consider such factors as (1) whether the record contains a detailed clinical documentation of the claimant's symptoms, and (2) whether the physicians who diagnosed the claimant with fibromyalgia reported on the severity of his or her condition. Id.

In this case, the A.L.J. found that Plaintiff's subjective complaints were not entirely credible. The Court concludes that substantial evidence supports the A.L.J.'s determination. Although Plaintiff was diagnosed with fibromyalgia by her treating physicians, those physicians did not report on the severity of her condition, and to the extent that they noted the severity of her condition, their notes are inconsistent with Plaintiff's testimony of disabling pain both at the hearing and in her disability application forms and questionnaires. For example, throughout her four years of treatment with Dr. Murphy, Plaintiff reported her pain in terms of "mild stiffness," tenderness and achiness. Dr. Murphy's treatment notes also indicate improvements in Plaintiff's condition. However, these

treatment notes stand in contrast to Plaintiff's reports of pain in her disability applications in which Plaintiff reported pain of every kind 80 to 100 percent of the time.

Similarly, Dr. Rocca's treatment notes indicate that while Plaintiff complained of persistent pain, she was in "no acute distress." (Tr. 325). Dr. Rocca also did not provide any detailed clinical documentation of Plaintiff's condition. For example, Dr. Rocca reported that Plaintiff had soft tissue points, but he did not define the area or number. Similarly, Dr. Rocca completed an RFC Assessment in November 1999 and stated that Plaintiff had swelling, tenderness and warmth, but he did not identify the affected joints. Dr. Rocca also did not place any limitations on Plaintiff and could not identify any such limitations as a result of Plaintiff's condition in his assessment of Plaintiff's RFC. See e.g. Tennant v. Apfel, 224 F.3d 869, 870 (8th Cir. 2000) (affirming A.L.J.'s determination that plaintiff's complaints of disabling fibromyalgia were not credible where there was a lack of objective medical evidence, inconsistencies between plaintiff's allegations and her daily activities, and absence of physician ordered limitations).

The observations of Plaintiff's treating physicians are also consistent with the observations made by Dr. Lifrak during his consultative examination of Plaintiff. Plaintiff reported to Dr. Lifrak that she experienced severe pain throughout her entire

body. Prior to his range of motion examination, Dr. Lifrak instructed Plaintiff to notify him immediately if she experienced any undo pain or discomfort during the examination and he would cease the examination. However, Dr. Lifrak was able to complete the examination of Plaintiff and his notes do not indicate that Plaintiff complained of pain requiring him to stop the examination.

In addition to the contradictions between the reports of Plaintiff's doctors and her testimony and responses to questionnaires regarding her pain, there is also inconsistencies in the record regarding Plaintiff's complaints of fatigue. Plaintiff reported fatigue to her physicians, but Dr. Murphy's reports indicate that Plaintiff's energy levels improved. Similarly, Dr. Murphy's notes suggest that Plaintiff was sleeping well. This again contradicts Plaintiff's statements in her pain questionnaire in which she indicated that she slept poorly and awoke often from pain. Plaintiff's reports of disruptive sleep and fatigue are also inconsistent with her testimony that she slept at least seven to eight hours a night and did not take any naps during the day time hours. Hirschfeld, 159 F. Supp. 2d at 811 (upholding A.L.J.'s determination that plaintiff's claim of disabling pain was not credible where, among other inconsistencies, plaintiff testified that she had difficulty sleeping, but reported elsewhere that she slept ten to twelve

hours each night and napped during the day). Given the inconsistencies in Plaintiff's reports of pain, and the lack of detail from her examining physicians concerning her condition, the Court cannot conclude that the A.L.J.'s credibility determination was erroneous. Id. at 811-812 (affirming A.L.J.'s decision discounting plaintiff's credibility and allegation of disabling fibromyalgia where plaintiff's doctors did not report on severity of her condition or effects it had on plaintiff and plaintiff's testimony was inconsistent and contradictory with her daily activities).

Plaintiff criticizes the A.L.J. for referring to the fact that Plaintiff did not have lupus in his assessment of Plaintiff's credibility. Plaintiff contends that she was never diagnosed with lupus, but that her pain stems only from fibromyalgia. However, the record indicates that Plaintiff informed several doctors, including Drs. Rocca and Lifrak that she had been previously diagnosed with lupus (Tr. 350, 327), and Plaintiff based her disability application in part on her alleged affliction with lupus. (Tr. 101, 103, 136, 138, 166). That Plaintiff continued to assert a diagnosis to examining physicians and disability services which she now concedes was never made by any treating physician provides further evidence to support the A.L.J.'s finding that Plaintiff's complaints were not credible.

As for Plaintiff's daily activities, Plaintiff also contends

that the A.L.J. erred in relying on her activities to discount her credibility. Plaintiff contends that light activity does not necessarily mean that she is capable of working.

Plaintiff is correct that the ability to perform daily chores does not necessarily mean that she can engage in substantial gainful activity. However, a Plaintiff's daily activities are relevant to the A.L.J.'s assessment of her pain. Wilson, 1999 WL 993723 at *3 (citing Polaski v. Heckler, 739 F.2d 1320, 1322 (8th Cir. 1984). In this case, the record indicates that despite her complaints of pain, Plaintiff continued to bowl once a week for three hours for quite some time. Plaintiff also suggested that her pain was so severe that she could not concentrate, but her daily activities suggest that she reads approximately two books a week. Further, Plaintiff's treating physicians continually recommended that Plaintiff engage in an exercise program as a way to treat her condition, thereby suggesting that Plaintiff's pain was not as debilitating as she now alleges.

Plaintiff contends that this case is similar to the circumstances in Brunson v. Barnhart, 2002 WL 393078 (E.D.N.Y. Mar. 14, 2002) and Morrow v. Apfel, 2001 WL 641038 (D. Del. Mar. 16, 2001). In these cases, the plaintiffs were diagnosed with fibromyalgia, and the respective courts concluded that the A.L.J. failed to properly evaluate the plaintiffs' subjective complaints

of pain. In Brunson, however, the A.L.J. clearly erred, because he mischaracterized the testimony of the plaintiff. The plaintiff in Brunson testified that she is "unable to do shopping, cooking or housekeeping" and the A.L.J noted these assertions in his decision, but then stated incorrectly that the plaintiff was not credible because she cleans her house, cooks, does laundry and shops with her son in law. In this case, however, the A.L.J. did not distort Plaintiff's testimony concerning her daily activities.

Although the Morrow decision is more closely akin to the circumstances of the instant case than Brunson, the Court is not bound by that decision and the Court believes it is factually distinguishable. In Morrow, the A.L.J. concluded that the plaintiff's complaints of pain were not credible, but the severity and intensity of the plaintiff's complaints were fully documented by her examining physicians and Plaintiff's examining physicians noted numerous restrictions in completing residual functional capacity questionnaires related to the plaintiff. Id. at *10 (concluding that A.L.J.'s credibility analysis was not supported by substantial evidence where treating physicians concurred regarding plaintiff's limitations and agreed that her pain was severe enough to result in significant concentration deficits and absences from work). Unlike Morrow, in this case, the severity and intensity of Plaintiff's pain are not documented

by Plaintiff's treating physicians to the degree asserted by Plaintiff. As the Court observed, Dr. Murphy noted primarily "stiffness and tenderness," and Dr. Rocca found that Plaintiff was in "no acute distress." Further, Dr. Rocca completed a questionnaire regarding Plaintiff's residual functional capacity but declined to give any opinions as to any limitations Plaintiff may have as a result of her condition. Indeed, contrary to restricting Plaintiff's activities, Drs. Rocca, Murphy and O'Hara recommended that Plaintiff engage in an exercise program, with Dr. Rocca specifically recommending aerobic exercise.

While the Court may have assessed Plaintiff's credibility differently, the Court's decision cannot rest on a de novo review of the evidence. Wilson, 1999 WL 993723 at *5 (recognizing that court cannot "decide the facts anew, reweigh the evidence or substitute its own judgment to decide whether a claimant is or is not disabled"). Because the Court finds that substantial evidence exists to support the A.L.J.'s finding regarding Plaintiff's credibility and the A.L.J. properly evaluated Plaintiff's credibility and subjective complaints of pain in light of the applicable law, the Court cannot conclude that the A.L.J.'s assessment was erroneous. See Harris v. Barnhart, 2002 WL 31500912, * 10 (D. Del. Oct. 31, 2002) (upholding A.L.J.'s credibility analysis in fibromyalgia case where plaintiff reported chronic drowsiness but only mentioned drowsiness once to

her physician, doctors recommended exercise and plaintiff maintained ability to groom herself and do some cooking and grocery shopping, though less frequently than before her illness); Frazier v. Apfel, 2000 WL 288246, *6-8 (E.D. Pa. 2000) (upholding A.L.J.'s credibility analysis in fibromyalgia case where plaintiff went out socially with her husband weekly, traveled and handled the finances for two households); Wilson, 1999 WL 993723, * 3-4 (E.D. Pa. Oct. 29, 1999) (upholding A.L.J.'s credibility analysis in fibromyalgia case where plaintiff could walk for two blocks, perform daily activities and groom herself); see also Johnson v. Barnhart, 268 F. Supp. 2d 1317 (M.D. Fla. 2002) (upholding A.L.J.'s decision denying benefits in fibromyalgia case where plaintiff routinely visited friends and attended church and objective medical findings were all within normal limits including normal range of motion).

Plaintiff next contends that the A.L.J. erred in rejecting the residual functional capacity assessment completed by Plaintiff's treating physician, Dr. Rocca. In this questionnaire, which consisted primarily of "check the box" answers, Dr. Rocca opined that Plaintiff's pain was severe enough to frequently interfere with her attention or concentration and that she was incapable of performing even low stress jobs due to constant pain.

The opinion of a treating physician is entitled to

controlling weight when it is supported by medically acceptable clinical and laboratory diagnostic techniques and is consistent with the other evidence in the record. Russum v. Massanari, 2002 WL 775240, *5 (D. Del. April 12, 2002). However, the A.L.J. may reject such an opinion, if he or she adequately explains the reasons for doing so on the record. Id.

In this case, the A.L.J. correctly recognized the treating physician doctrine, but concluded that Dr. Rocca's opinion in the RFC was not persuasive because it was inconsistent with his prior medical reports, including his prior examinations of Plaintiff and his recommendations that Plaintiff engage in an aerobic exercise program. The A.L.J. thoroughly and adequately explained his reasons for doubting Dr. Rocca's assessment. Dr. Rocca opined that Plaintiff was incapable of performing work, but declined to place any restrictions on her abilities labeling his response to questions concerning limitations and number of absences from work as "unknown." And, as the A.L.J. noted, Dr. Rocca's assessment that Plaintiff could not perform any work was at odds with his repeated recommendation that Plaintiff engage in an aerobic exercise program and with his prior reports on Plaintiff's condition. Because Dr. Rocca did not provide support for his opinion and his opinion was inconsistent with the other medical evidence of record, including his own prior recommendations and observations, the Court concludes that the

A.L.J. did not err in his treatment of Dr. Rocca's residual functional capacity assessment.

Plaintiff also contends that the A.L.J.'s questions to the vocational expert were deficient. Specifically, Plaintiff contends that the A.L.J.'s hypothetical did not accurately portray her individual physical and mental impairments, including her rate of absenteeism from work.

The A.L.J.'s hypothetical question need only contain those limitations supported by the record evidence. Plummer v. Apfel, 186 F.3d 422 (3d Cir. 1999); Chrupcala v. Heckler, 829 F.2d 1269, 1276 (3d Cir. 1987). In his hypothetical, the A.L.J. considered an individual with the ability to perform sedentary work, with the further restrictions of a moderate difficulty reaching, handling and fingering and concentration deficits which would limit the individual to simple routine operations not requiring sustained concentration. The vocational expert identified three jobs that such an individual could perform.

Plaintiff contends that this hypothetical was erroneous, because it did not take into account the limitation from Plaintiff's testimony that she would likely be absent three days per week. The A.L.J. was not required to accept this limitation, because he appropriately concluded that it was not supported by the record. Further, Plaintiff reported on numerous occasions that she was absent from her past work because she was required

to stand all day. The A.L.J. took this limitation into account by limiting Plaintiff to sedentary work. Accordingly, the Court concludes that the A.L.J.'s hypothetical was supported by the record, and therefore, not erroneous.

In sum, the Court concludes that the A.L.J.'s decision is supported by substantial evidence. Although Plaintiff suffers from pain, the record does not suggest that the pain is disabling as alleged by Plaintiff. Plaintiff's physicians noted Plaintiff's pain in terms less severe than those suggested by Plaintiff, and her physicians did not place any restrictions on her abilities. To the contrary, Plaintiff's physicians continually recommended aerobic exercise, a recommendation consistent with the A.L.J.'s finding that Plaintiff could at least perform sedentary work. The A.L.J.'s assessments are also consistent with the opinions of the reviewing state agency physicians and the consultative examination performed by Dr. Lifrak. Accordingly, the Court will grant Defendant's Motion For Summary Judgment and deny Plaintiff's Motion For Summary Judgment.

**CONCLUSION**

For the reasons discussed, the Court will grant Defendant's Motion For Summary Judgment and deny Plaintiff's Motion For Summary Judgment. The decision of the Commissioner dated February 11, 2000 will be affirmed.

An appropriate Order will be entered.

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF DELAWARE

| | | |
|---|---|---|
| BEVERLY A. KOVALCIK, | : | |
| | : | |
| Plaintiff, | : | |
| | : | |
| v. | : | Civil Action No. 01-742-JJF |
| | : | |
| JO ANNE BARNHART, Commissioner of Social Security, | : | |
| | : | |
| Defendant. | : | |

**O R D E R**

At Wilmington, this 29TH day of September 2003, 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 GRANTED.

2. Plaintiff's Motion For Summary Judgment (D.I. 7) is DENIED.

3. The final decision of the Commissioner dated February 11, 2000 is AFFIRMED.

4. The Clerk is directed to enter judgment against Plaintiff and in favor of Defendant.

JOSEPH J. FARNAN, JR.
UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF DELAWARE

| | | |
|---|---|---|
| BEVERLY A. KOVALCIK,<br><br>Plaintiff,<br><br>v.<br><br>JO ANNE BARNHART, Commissioner of Social Security,<br><br>Defendant. | : | Civil Action No. 01-742-JJF |

**JUDGMENT IN A CIVIL CASE**

For the reasons set forth in the Court's Memorandum Opinion and Order dated September 29, 2003;

IT IS ORDERED AND ADJUDGED that judgment be and is hereby entered in favor of Defendant Jo Anne Barnhart and against Plaintiff Beverly A. Kovalcik.

JOSEPH J. FARNAN, JR.
UNITED STATES DISTRICT JUDGE

Dated: September 29, 2003

ANITA BOLTON
(By) Deputy Clerk