IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF DELAWARE

KAREN SMITH-LEVERING, Plaintiff, v. JO ANNE B. BARNHART, Commissioner of Social Security Defendant.	)	Civil Action No. 02-1301-KAJ

MEMORANDUM OPINION

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September 27, 2004

JORDAN, District Judge

I. INTRODUCTION

Karen Smith-Levering ("Plaintiff") brings this action for review of the Commissioner of Social Security's ("Commissioner") decision to deny supplemental security income ("SSI") and disability insurance benefits (DIB) to Plaintiff under Titles II and XVI, respectively, of the Social Security Act (the Act).[1] (*See* Docket Item ["D.I."] 1; D.I. 6 at 29) Presently before the Court are Plaintiff's Motion for Summary Judgment (D.I. 9) and the Commissioner's Cross-Motion for Summary Judgment. (D.I. 11) The Court has jurisdiction to review the Commissioner's decision under 42 U.S.C. § 405(g). For the reasons that follow, Plaintiff's Motion for Summary Judgment will be denied and Defendant's Cross-Motion for Summary Judgment will be granted.

II. BACKGROUND

A. MEDICAL HISTORY

Plaintiff was born on December 18, 1968. (D.I. 6 at 86.) She has a high school education and has completed three years of college. (*Id.* at 109.) Among other things, she has worked in the past as a teacher, personal care attendant, billing dispute analyst, and customer service representative. (*Id.* at 25, 104.) Plaintiff claims that she is "disabled" under the regulations because of nerve damage, severe muscle spasms, back fusion and a herniated disc. (*Id.* at 103.)

According to the record, the first signs of Plaintiff's alleged disability stem from a car accident in August 1998. (*Id.* at 103, 149.) On August 12, Plaintiff was treated in

[1] 42 U.S.C. §§ 401-433, 1381-1383f.

the emergency department at St. Francis Hospital, complaining of whiplash resulting from the accident. (*Id.* at 149.) Dr. Lisa A. Bennett diagnosed Plaintiff with an acute cervical strain/spasm. (*Id.*)

In November 1998, Plaintiff was allegedly re-injured in another car accident. (*Id.* at 170.) She was treated at 1st Choice Health Care by Kevin McDermott, D.C. (*Id.*) According to Dr. McDermott's assessment on November 12, Plaintiff showed signs of cervical disc degeneration, cervicobrachial syndrome, cervicocranial syndrome, cervical myofascitis and cervical strain. (*Id.* at 172-73.) During her follow-up visits, Plaintiff complained of continued pain and stiffness in her neck and lower back. (*Id.* at 154-60.) Dr. McDermott insisted that she apply moist heat to the affected areas to ease her symptoms. (*Id.*)

On July 26, 1999, Plaintiff was seen by an orthopedic surgeon, Ali Kalamchi, M.D., complaining of lower back, left buttock, and leg pain. (*Id.* at 231.) As noted by Dr. Kalamchi, x-rays of Plaintiff's lumbar spine showed a bilateral L5 defect with a Grade I Spondylolisthesis. (*Id.*) During a follow-up on August 23, 1999, Dr. Kalamchi noted that Plaintiff's MRI showed marked degenerative changes at the L5-S1 with pseudo-herniation and neural forminal stenosis and a possible tear at L4-5. (*Id.* at 230.) According to a report dated September 27, 1999, Plaintiff continued to have lower back pain to such an extent that she had to go to the emergency room. (*Id.*) On the same visit, Dr. Kalamchi noted that Plaintiff exhibited a good range of motion (ROM) of her lumbar spine with pain on extension and rotation. (*Id.*) According to Dr. Kalamchi, Plaintiff's neck symptoms were not related to her lower back problems. (*Id.*) On October 15, 1999, Plaintiff was seen at the Community Rehab Center by Christopher E.

Kay, M.P.T. Upon examination, Plaintiff exhibited generalized weakness and pain throughout lower extremities, palpable tenderness and spasms throughout throacic spine paraspinals, and decreased functional status. (*Id.* at 201.)

On November 10, 1999, Plaintiff underwent surgery at Christiana Care Health Services. She had a diagnosis of spondylolisthesis at the L5 level with mechanical low back pain at L4 to S1. (*Id.* at 203.) Plaintiff's surgeon, Dr. Kalamchi, performed a Gill laminectomy of L5 followed by spinal fusion and instrumentation L4 to S1 with right iliac bone graft. (*Id.* at 203-05.) The operation was deemed a success and Plaintiff was discharged on November 13. (*Id.* at 203.)

On December 6, 1999, Dr. Kalamchi reported that Plaintiff's operative area had healed well and Plaintiff was pleased with the overall progress. (*Id.* at 226.) X-rays showed good alignment of her L4 to S1 instrumentation. (*Id.*) On January 6, 2000, Dr. Kalamchi reported, based on a discussion with Plaintiff, that "the majority of [Plaintiff's] pre-operative pains had resolved, she was only in pain when sitting for a prolonged period of time, and she was taking very little pain medication." (*Id.*) On February 24, 2000, Plaintiff reported falling and twisting her back. (*Id.*) She exhibited a limited ROM, but no sensory or motor deficits to suggest radiculopathy. (*Id.*) On March 28, 2000, an MRI of Plaintiff's thoracic spine showed a small degenerative bulge at the T9-10 level. (*Id.* at 225.) MRI of the lumbar spine showed no evidence of old or new disc herniations. (*Id.*)

On June 15, 2000, a medical consultant from the Delaware Disability Determination Service (DDS) completed a residual functional capacity assessment of Plaintiff. (*Id.* at 242-50.) The consultant reported that Plaintiff could occasionally lift

twenty pounds, frequently lift ten pounds, stand and/or walk for a total of about six hours in an eight-hour workday, sit for about six hours in an eight-hour workday provided that she periodically alternates sitting and standing, and was unlimited in her ability to push and/or pull. (*Id.* at 243.) The consultant stated that Plaintiff was limited to occasional climbing, balancing, stooping, kneeling, crouching and crawling. (*Id.* at 244.) As further noted, Plaintiff had no manipulative, visual, communicative, or environmental limitations with the exception of concentrated exposure to hazard-related activities. (*Id.* at 245-46.)

On August 7, 2000, Plaintiff underwent treatment at Papastavros' Associates Medical Imaging, L.L.C. Upon examination, a CT scan of the cervical spine showed normal results, and a CT scan of the lumbar spine showed an extradural defect at the L5-S1 level compatible with mild spondylolisthesis. (*Id.* at 262-63.) A chest x-ray was normal and a bone scan was essentially negative. (*Id.* at 261.)

On October 2, 2000, a second DDS medical consultant completed a residual functional capacity assessment of Plaintiff. (*Id.* at 275-82.) This consultant reported similar findings as the first consultant's: Plaintiff could occasionally lift twenty pounds, frequently lift ten pounds, stand and/or walk for a total of about six hours in an eight-hour workday, and was unlimited in her ability to push and/or pull (*Id.* at 276.); Plaintiff was limited to occasional climbing, balancing, stooping, kneeling, crouching and crawling (*Id.* at 277.); and Plaintiff had no manipulative, visual, communicative, or environmental limitations with the exception of concentrated exposure to hazard-related activities. (*Id.* at 278-79.)

Plaintiff was seen four times by Anthony Curci, D.O., from October 4, 2000 to April 20, 2001. (*Id.* at 286-89.) On August 7, 2001, Dr. Curci completed a residual

functional capacity questionnaire concerning Plaintiff's ability to perform work-related activities. Dr. Curci reported although Plaintiff was capable of tolerating low stress jobs, she could not sit or stand for more than one hour at a time and could only sit or stand for less than two hours in an eight-hour workday. (*Id.* at 291.) He also noted that Plaintiff could only work at a job that permitted shifting positions at will from sitting, standing or walking; that permitted unscheduled breaks; and that occasionally required lifting and carrying of less than ten pounds only. (*Id.* at 292.) Regarding Dr. Curci's reports, the administrative law judge (ALJ) specifically noted "I do not find [his] opinions to be persuasive." (*Id.* at 25.)

Plaintiff was seen eight times by Frank J.E. Falco, M.D., from October 28, 1999 to June 7, 2001. (*Id.* at 294-319.) On August 13, 2001, Dr. Falco also completed a residual functional capacity questionnaire. Dr. Falco reported that Plaintiff suffered no gait abnormalities and no muscle weakness or atrophy. (*Id.* at 357.) Plaintiff could not sit or stand for more than thirty minutes at a time and could only sit, stand, or walk for about four hours in an eight-hour workday. (*Id.* at 358.) Similarly, he noted that Plaintiff could only work at a job that permitted shifting positions at will from sitting, standing, or walking; that permitted unscheduled breaks; and that occasionally required lifting and carrying of less than ten pounds only. (*Id.* at 359.) The ALJ also found the opinions of Dr. Falco not to be entirely persuasive. (*Id.* at 25.)

B. PLAINTIFF'S TESTIMONY

On August 15, 2002, a hearing was held before the ALJ at which Plaintiff testified. (*Id.* at 35-70.) According to Plaintiff, she was experiencing mid-back pain, neck pain, and low back pain that radiated down her left leg. (*Id.* at 52-53.) She alleged

left shoulder pain, sever migraine headaches, right knee pain, and jaw pain. (*Id.* at 53.) She also testified that she was depressed with suicidal visions, appetite disturbance, sleep disturbance, concentration problems, and a short attention span. (*Id.* at 54.)

Regarding daily activities, Plaintiff testified that she could take care of herself for the most part, but needs help with her shoes and socks. (*Id.* at 49-52.) She drives approximately ten times per week. (*Id.* at 40.) She is allegedly able to read and sew (*Id.* at 51-52.) ; she can dust and cook with the help of her husband (*Id.* at 49.) ; she attends church several times a month (*Id.* at 51.) ; she goes grocery shopping with her husband; and she visits her family and friends (*Id.*).

Plaintiff also testified as to her functional abilities. She claimed that she could walk two blocks, stand for thirty minutes, sit for an hour, and lift approximately four pounds. (*Id.* at 57.) Finally, Plaintiff mentioned that she needs a cane for ambulation. (*Id.* at 58.)

III. PROCEDURAL HISTORY

On April 3, 2000, Plaintiff filed for DIB and SSI, alleging disability since November 10, 1999. (*Id*. at 86-90, 361-66.) The application was denied initially on June 16, 2000, and again upon reconsideration on October 12, 2000. (*Id*. at 71-81, 367-73.) Following the August 15, 2001 hearing mentioned earlier, the ALJ issued a decision on August 30, 2001, finding that Plaintiff had the residual functional capacity to perform a significant range of unskilled "sedentary"[2] jobs with a sit or stand option that do not involve significant pushing, pulling, and reaching with the left non-dominant hand and arm; that do not involve significant stooping and crouching; and that only involve one-to-two step work tasks, low to moderate levels of stress and frustration, and minimal interaction with the public and co-workers. (*Id.* at 25.) Accordingly, the ALJ held that Plaintiff was not "disabled" for purposes of eligibility for SSI or entitlement to DIB. (*Id.*) Plaintiff requested review of this decision, but was denied by the Appeals Council on May 21, 2002. (*Id.* 8-9.) Plaintiff appealed the ALJ's decision, as the final decision of the Commissioner, to this Court.

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[2]Sedentary work is defined under the regulations as involving:

> lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

20 C.F.R. §§ 404.1567(a), 416.967(a) .

IV. STANDARD OF REVIEW

This Court reviews a decision of the Commissioner to determine whether the decision is supported by substantial evidence in the record. 42 U.S.C. § 405(g); 5 U.S.C. § 706(2)(E); *see also Richardson v. Perales*, 402 U.S. 389, 390 (1971); *Monsour Med. Ctr. v. Heckler*, 806 F.2d 1185, 1190 (3d Cir. 1986). The Court is limited in its review to determining whether the Commissioner's decision is supported in the record by substantial evidence and whether the correct legal principles have been applied. 42 U.S.C. §§ 405(g), 1383(c); *Monsour Medical Ctr. v. Heckler*, 806 F.2d 1185, 1190 (3d Cir. 1990). The Supreme Court has defined "substantial evidence" as "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Perales*, 402 U.S. at 427. It is less than a preponderance of evidence and more than a mere scintilla. (*Id.*)

The standard of review in this Court when deciding an appeal from the Commissioner is not *de novo*. *See Limerick Ecology Action v. United States Nuclear Regulatory Commission*, 869 F.2d 719, 753 (3d Cir. 1989). The Court is obliged, therefore, to affirm the decision of the Commissioner if the weight of the evidence substantially supports the decision, regardless of whether the Court may have decided the case differently if it were before it on first impression. *Richardson*, 402 U.S. at 401; *Monsour*, 806 F.2d at 1191.

V. DISCUSSION

A. INTRODUCTION

The Act defines disability in terms of the effect an impairment has on a person's ability to function in the work place. 42 U.S.C. § 1382c(a)(3)(A), (3)(B); *Heckler v. Campbell*, 461 U.S. 458, 460 (1983). The responsibility for determining whether Plaintiff is disabled under the Act is reserved to the Commissioner. 20 C.F.R. §§ 404.1527(e), 416.927(e). The five-step sequential process for evaluating disability claims requires the Commissioner to consider, in sequence, whether a claimant (1) is working; (2) has a severe impairment; (3) has an impairment that meets or equals the requirements of a listed impairment; (4) can return to his past relevant work, and (5) if not, whether he can perform other work in the national economy. 20 C.F.R. §§ 404.1520, 416.920. Here, the ALJ, in accord with the Commissioner's order, determined that Plaintiff was not working, had a severe impairment that did not meet or equal a listed impairment, and could not return to her past employment. (*Id.* at 28.) At step five of the sequential evaluation process, however, the ALJ found that Plaintiff could perform other work in the national economy. (*Id.* at 25.) Thus, the ALJ concluded that Plaintiff was not "disabled" under the Act. (*Id.* at 28.)

B. THE WEIGHT ACCORDED TO THE OPINIONS OF DRS. CURCI AND FALCO

Plaintiff first argues that the ALJ failed to give proper weight to the residual functional capacity evaluations performed by Drs. Curci and Falco. (D.I. 9 at 12.) Specifically, Plaintiff claims that the ALJ erred by "revoking" controlling weight from these physicians without properly balancing the factors set forth in 20 C.F.R. §§

404.1527(d)(2), 416.927(f)(2)(I). (*Id.* at 11-12.) This argument, however, is without merit and fails to consider the record as a whole.

Under the treating physician's rule, the regulations require that the ALJ give controlling weight to a "treating" physician's opinion only if the ALJ "find[s] that a treating source's opinion of the issue(s) of the nature and severity of [the claimant's] impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in [the] case record." 20 C.F.R. §§ 404.1527(d)(2), 416.927(d)(2). If a treating physician's opinion is not given controlling weight, the ALJ must apply several factors in determining the weight to give the opinion, including 1) the length of the treatment relationship with the claimant and the frequency of examination, 2) the nature and extent of the treatment relationship, 3) the supportability of the medical opinion, 4) the consistency of the opinion with the record as a whole, and 5) the specialization of the physician. (*Id.*) Under the regulations, the ALJ must provide "good reasons" in his or her decision for the weight given to the opinion of a claimant's treating physician. (*Id.*)

As noted by Defendant (D.I. 12 at 14), there is a valid argument that Drs. Curci and Falco should not be considered "treating" physicians in this case. A treating physician as defined by the regulations, is one who has an ongoing treatment relationship with a patient. 20 C.F.R. §§ 404.1502, 416.902. Here, Drs. Falco and Curci saw Plaintiff four and eight times, respectively, during a period of almost two years in which Plaintiff claimed she was disabled. (*See* D.I. 6 at 256-74, 286-89, 294-319.) Medical opinions based on treatment relationships occurring on a relatively infrequent basis may not warrant controlling weight in determining a case.

Nevertheless, even if Drs. Curci and Falco are considered treating physicians, Plaintiff's argument fails because the record shows that the ALJ gave proper weight to their opinions and provided "good reasons" for doing so. *See* 20 C.F.R. §§ 404.1527(d)(2), 416.927(d)(2). Initially, the ALJ said, "I do not find the opinions of [Drs. Curci and Falco] . . . to be persuasive." (*Id.* at 25.) In making this determination, the ALJ first stated that "Dr. Falco's treatment records reflect that he saw [Plaintiff] relatively infrequently." (*Id.*) The record shows that, as noted above, Plaintiff was examined by Dr. Falco no more than eight times during a period of almost two years. (*Id.*)

The ALJ also concluded that Dr. Falco's opinion regarding Plaintiff's ability to sit, stand and walk no more than four hours a day was inconsistent with the other evidence of record. (*Id.*) First, the medical evidence of record provides evidence in support of this finding. Dr. Falco himself indicated that Plaintiff had no gait abnormalities, no muscle weakness or atrophy, and no side effects from medication. (*Id.* at 357.) Furthermore, Plaintiff showed positive results during ROM testing even before surgery. (*Id.* at 230.) After "successful" surgery, Plaintiff reported that she was pleased with her overall progress, x-rays showed good realignment of her lumbar region, and Plaintiff only needed a "little" amount of pain medication. (*Id.* at 226.) State-agency medical consultants reported that Plaintiff could sit, stand, or walk at least six hours in an eight-hour day. (*Id.* at 243.) Finally, within several months of surgery, a CT scan of the cervical spine showed "normal" results and CT scan of the lumbar spine showed only "mild" spondylolisthesis. (*Id.* at 262-63.)

Moreover, Plaintiff's testimony provides evidence inconsistent with Dr. Falco's opinions. Contrary to Dr. Falco's reports, Plaintiff testified that she could still care for

her own personal needs, she still drove a car at least ten times a week, and she was able read, sew, dust, and cook on a daily basis. (*Id.* at 40, 49, 51-52.) She also stated that she could still go shopping, visit her friends, and attend church at least several times a month. (*Id.* at 49-52.) This evidence is inconsistent with Plaintiff's alleged inability to sit, stand, or walk. Accordingly, the ALJ was justified in finding that "Dr. Falco's functional assessment suggests that [Plaintiff] is capable of performing sedentary work when considered in reference to the other medical evidence in the record and [Plaintiff's] testimony and written statements for the record." (*Id.*)

The ALJ also properly considered Dr. Curci's opinions in light of the five factors set forth in the regulations. As to the supportability of his opinions, the ALJ clearly established that "Dr. Curci's treatment records do not reflect symptoms of a severity or frequency that would prevent the [Plaintiff] from performing work." (*Id.*) When asked to provide medical support, Dr. Curci provided no evidence of clinical findings or objective signs to support a determination that Plaintiff could not perform even sedentary work. The ALJ also noted that "Dr. Curci [] reported that [Plaintiff] could never lift any weight when [Plaintiff's] daily activities show that she is capable of lifting at least light items." (*Id.*) Plaintiff herself acknowledged that she was capable of lifting at least four pounds. (*Id.* at 57.) Furthermore, she was able to care for her own personal needs and, with some assistance, go grocery shopping. (*Id.* at 49, 57.) This testimony is inconsistent with Dr. Curci's finding that Plaintiff was not able to lift any weight at all.

C. DEFENDANT'S DUTY TO FURTHER DEVELOP THE RECORD

Plaintiff also argues that Defendant must give controlling weight to Dr. Curci's opinion because of her failure to develop evidence pursuant § 404.1512(e)(1). (D.I. 9 at

13.) Plaintiff's complaint is in regard to the following statement concerning the supportability of Dr. Curci's clinical findings made by the ALJ: "When asked to identify the clinical findings and objective signs, Dr. Curci did not provide any information." (*Id.* at 290.)

Contrary to Plaintiff's argument, however, Defendant is only required to develop the record under 20 C.F.R. §§ 404.1512(e)(1), 416.912(e)(1) when "the evidence we receive from your treating physician or psychologist or other medical source is inadequate for us to determine whether you are disabled." Here, whether or not Dr. Curci's opinions are based on clinical findings and objective signs, there is still adequate evidence to determine whether the Plaintiff is disabled. As noted above, residual functional capacity evaluations performed by state-agency medical consultants, Plaintiff's testimony about her daily activities, and the medical record as a whole provide more than a scintilla of evidence that Plaintiff is capable of performing sedentary work subject to the limitations provided by the ALJ. Accordingly, the ALJ was not required to develop the record any further and was justified in giving the opinions of Drs. Falco and Curci less than controlling weight.

VI. CONCLUSION

Accordingly, for the reasons set forth herein, the Commissioner's Motion (D.I. 16) will be granted and Plaintiff's Motion will be denied (D.I. 14). An appropriate order will follow.

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ORDER

For the reasons set forth in the Memorandum Opinion issued on this date,

IT IS HEREBY ORDERED that Plaintiff's Motion for Summary Judgment (D.I. 9) is DENIED, and the Commissioner's Cross-Motion for Summary Judgment (D.I. 12) is GRANTED.

Kent A. Jordan
UNITED STATES DISTRICT JUDGE

September 27, 2004
Wilmington, Delaware