IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF DELAWARE

VERNELL R. LESTER,	:	
	:	
Plaintiff,	:	
	:	
v.	:	Civil Action No. 02-225-JJF
	:	
JO ANNE BARNHART, Commissioner of Social Security,	:	
	:	
Defendant.	:	

Gary C. Linarducci, Esquire of GARY C. LINARDUCCI, New Castle, Delaware.
Of Counsel: Eva I. Guerra of THE LAW OFFICES OF EVA I. GUERRA, Bloomfield, Michigan.
Attorneys for Plaintiff.

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

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, Vernell R. Lester, seeking review of the final administrative decision of the Commissioner of the Social Security Administration denying Plaintiff's application for a period of disability and disability insurance benefits under Title II of the Social Security Act, 42 U.S.C. §§ 401-433. Plaintiff has filed a Motion For Summary Judgment (D.I. 17) requesting the Court to enter judgment in Plaintiff's favor or in the alternative to remand this matter to the A.L.J. for a decision free of errors. In response to Plaintiff's Motion, Defendant has filed a Cross-Motion For Summary Judgment (D.I. 20) requesting the Court to affirm the Commissioner's decision. For the reasons set forth below, Defendant's Motion For Summary Judgment will be denied and Plaintiff's Motion For Summary Judgment will be granted to the extent that it requests the Court to remand this matter. The decision of the Commissioner dated May 4, 2000 will be reversed and this matter remanded for further findings and/or proceedings consistent with the Court's decision.

BACKGROUND

I. Procedural Background

Plaintiff initially filed an application for a period of Disability insurance benefits on January 6, 1996. (Tr. 16). The application was denied, and Plaintiff did not file a Request For

Reconsideration. No prior application has been reopened in this case. With respect to Plaintiff's current application, the protective filing date is December 10, 1997. Plaintiff alleges a disability onset date of January 2, 1992. (Tr. 31). However, for purposes of the instant application, Plaintiff must establish that she became disabled prior to March 31, 1996, the date that she last met the disability insured status requirements under Title II of the Act. 42 U.S.C. §§ 414(a), 423(a)(1), 423(c)(1).

Plaintiff's current application was denied initially and on reconsideration. (Tr. 58). Thereafter, Plaintiff requested a hearing before an administrative law judge (the "A.L.J."). (Tr. 30-53). On May 4, 2000, the A.L.J. issued a decision denying Plaintiff's application for a period of disability and disability insurance benefits. (Tr. 16-24). Following the unfavorable decision, Plaintiff filed a timely Request For Review Of Hearing Decision. (Tr. 12). On January 25, 2002, the Appeals Council denied Plaintiff's request for review (Tr. 7-8), 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 a period of disability and disability insurance benefits. In response to the Complaint, Defendant filed an Answer (D.I. 15)

and the Transcript (D.I. 16) 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. Thereafter, Plaintiff 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

As of the date she was last insured, Plaintiff was fifty one years old. Plaintiff has a high school education and past relevant work as a secretary and inspector of equipment. (Tr. 82, 71).

On March 3, 1991, Plaintiff was injured in a motor vehicle accident. At that time, Plaintiff treated with Craig D. Sternberg, M.D. for complaints of constant, achy pain in the lower back radiating up the back, with constant sharp, achy pain and soreness in the neck area. Tenderness and some areas of spasm were present, but Plaintiff's muscle strength, sensation, reflexes, straight leg raising and gait were unimpaired. Plaintiff was diagnosed with "neck pain with acute cervical

strain and sprain, paraspinal muscle spasm, right trapezius muscle spasm, thoracic strain and sprain and lumboscacral strain and sprain." (Tr. 181). Plaintiff was prescribed medication and referred for physical therapy. (Tr. 180-182). Plaintiff did not work for three weeks, and after that time, Dr. Sternberg observed that Plaintiff no longer suffered from spasms. (Tr. 176-177). However, upon returning to work, Plaintiff still reported that she was in pain, so she was prescribed medication and eventually told to continue out of work. (Tr. 174, 177).

In April 1991, x-rays of Plaintiff revealed degenerative changes in the lumbar and dorsal spine and mild degenerative changes in the cervical spine. (Tr. 173, 185). In July 1991, Plaintiff underwent an MRI of the lumbar spine. The MRI revealed degenerative changes at C2-C6 and L5-S1, small central disk bulging at C3 through C6 with a more diffuse bulge and possible herniation at C6-C7, and a small herniated disc on the left at L5-S1, compressing the passing left S1 nerve root. With regarded to the herniated disc at the left L5-S1 level, the reviewing physician recommended clinical correlation, because Plaintiff complained of right-sided rather than left-sided pain. (Tr. 157-158).

Plaintiff underwent a second MRI in October of 1991. This MRI indicated the presence of a small central disk herniation indenting the anterior dural sac at C4-C5, spondylosis and a

right paracentral disk herniation at C6-C7 narrowing the right lateral recess and right C6-C7 intervertebral foramen, spondylosis and a diffuse disk bulge at C5-C6 laterizing toward the right, and a mild diffuse disk bulge flattening the anterior dural sac at C3-C4. (Tr. 143).

In November 1991, Dr. Sternberg referred Plaintiff to Otto R. Medinilla, M.D. for an evaluation. Dr. Medinilla noted that Plaintiff was not in acute distress and that her general physical examination revealed no gross abnormalities. Plaintiff demonstrated normal mental status, and the cranial nerves III through XII were normal. Dr. Medinilla noted that Plaintiff had weakness of the right grip, but no weakness of the triceps, biceps, deltoids or legs. Plaintiff's sensation was normal, and there was no tenderness to palpation. Plaintiff had a full range of motion in all directions. In his recommendations and conclusions, Dr. Medinilla noted a right cervical radiculopathy that could be related to the spondylosis and small disc herniation at the C5-C6 and C6-C7 levels. (Tr. 141-142). Plaintiff was given the option of undergoing a myelogram to determine if surgery was indicated or was advised that she could continue nonsurgical measures for six more weeks. Plaintiff opted for continued nonsurgical measures, and Dr. Medinilla recommended that Plaintiff be reevaluated within one month.

On November 25, 1991, Plaintiff saw Dr. Sternberg for a

follow-up visit. Dr. Sternberg recommended that Plaintiff follow Dr. Medinilla's recommendations and was told that she could continue to see her chiropractor, Kristina Hollstein, D.C. Plaintiff was to return for a follow-up with Dr. Sternberg in six weeks. (Tr. 137-138).

Plaintiff's first documented medical appointment after her alleged onset date of disability, January 2, 1992, was approximately three weeks later on January 27, 1992. Plaintiff returned to Dr. Sternberg at this time and his notes indicated the continuation of her previous symptoms. Plaintiff complained of pain and tenderness, particularly in the right trapezius. However, Plaintiff's compression and distraction tests, straight leg raising, strength, sensation and reflex testing were normal. Plaintiff transferred independently and her gait was not antalgic.

In February 1992, Plaintiff was treated with trigger point injection. (Tr. 133-134). She continued physical therapy and cervical traction at home, and was told that she could continue to see her chiropractor. On February 24, 1992, Plaintiff's chiropractor placed her out of work. At the end of February, Plaintiff reported to Dr. Sternberg for a follow-up visit. Plaintiff reported a "nice improvement in symptoms" after her chiropractor placed her out of work. (Tr. 128). Upon physical examination, Dr. Sternberg also noted improvement in Plaintiff's

condition, noting less tightness, swelling and tenderness. (Tr. 128).

Although Dr. Sternberg opined that Plaintiff no longer needed trigger point injections, Plaintiff received two injections in March by Dr. Sternberg. (Tr. 126, 133). At a subsequent visit with Dr. Sternberg, Plaintiff reported continuing discomfort in the neck and low back, but indicated no numbness or tingling in the upper extremities and no symptoms in the lower extremities. (Tr. 119-120). Dr. Sternberg noted that Plaintiff had been traveling a lot to Pennsylvania to care for her ill mother, thereby limiting her chiropractic care. Dr. Sternberg prescribed Orudis and recommended that Plaintiff continue on Pamelor. Dr. Sternberg also indicated that Plaintiff would not need another trigger point injection at that visit. (Tr. 120).

In April 1992, Plaintiff underwent another MRI. This MRI confirmed the presence of degenerative disk disease, a left sided herniation at L5-S1, and a left disk bulge at L4-L5. In June and July 1992, Plaintiff returned to Dr. Sternberg for another follow-up. Plaintiff reported pain in the neck mainly on the right side and discomfort in the low back area. Plaintiff reported no pain radiating into the upper or lower extremities and no tingling in the upper right extremities.

In her August 1992 visit with Dr. Sternberg, Plaintiff

reported some improvement with the use of Relafen, but she continued to report sharp pain in the middle back area going into the left low back area. A physical examination of Plaintiff at this time revealed some increased tenderness and some spasm in the midparaspinal musculature on the left side. Plaintiff exhibited a range of motion within functional limits for her cervical and lumbosacral spine, but some tenderness.

At her September 1992 visit with Dr. Sternberg, Plaintiff reported discomfort in the left neck and low back, radiating into the left hip. Plaintiff also complained of swelling in her left knee. Upon physical examination, Dr. Sternberg noted tenderness, tightness and some spasm remaining in the left paraspinal musculature. However, Dr. Sternberg continued to document that Plaintiff's sensation, strength, reflexes, straight leg raising and other objective tests were normal. (Tr. 103-104).

With regard to her left knee, Dr. Sternberg noted that crepitus was present, but that Plaintiff maintained a full range of motion. X-rays taken of Plaintiff's left knee in October of 1992 showed no abnormalities. (Tr. 101).

In early November 1992, Plaintiff's chiropractor referred her to Leo W. Raisis, M.D., an orthopedic surgeon for evaluation of her left knee pain. Dr. Raisis diagnosed severe pattellofemoral arthralgia and administered a local injection. Dr. Raisis stated that Plaintiff should respond well to

nonoperative treatment. (Tr. 196).

In late November 1992, Plaintiff returned to Dr. Sternberg. She continued to complain of pain in the mid and lower back and neck, but denied numbness, weakness and bowel or bladder dysfunction. Plaintiff did not report any knee problems to Dr. Sternberg at this time. Upon physical examination, Dr. Sternberg noted tenderness in the spinal areas, but no spasms. Plaintiff's compression distraction, straight leg raising, strength, sensation, reflex and other objective tests remained normal. Plaintiff's gait was not antalgic and she was able to transfer independently. (Tr. 97). Based on the record, it appears that this visit was Plaintiff's last treatment with Dr. Sternberg.

Between November 1992 and April 1993, there is no documentation that Plaintiff had any further medical visits. Plaintiff's last recorded medical visit prior to her date last insured was with Dr. Medinilla. Plaintiff returned to Dr. Medinilla at the advice of her attorney. Dr. Medinilla noted that Plaintiff was not in any acute distress. He found her neck to be nontender with almost a full range of motion in the cervical spine and no focal weakness, atrophy or fasciculation. Plaintiff demonstrated mild general weakness in the left upper extremity and reduced grip strength in the right hand, but no sensory deficits and symmetrical reflexes. Dr. Medinilla concluded that Plaintiff had cervical muscle strain. He noted

that some of her symptoms could be related to spondylosis and osteoarthritis, but he no longer believed a myelogram was needed. Dr. Medinilla advised Plaintiff to continue with nonsurgical measures.

For the next three years, there is no contemporaneous evidence of medical treatment in the record. Nine days after Plaintiff's date last insured, on April 8, 1996, the record indicates that Plaintiff was newly injured in a slip and fall accident. Plaintiff treated with Frank J.E. Falco, M.D. Dr. Falco indicated that Plaintiff had neck and left shoulder and arm pain and that she aggravated her previous back and knee pain as a result of the fall. He specifically noted that Plaintiff described her neck, left shoulder and arm discomfort differently than what she previously experienced. (Tr. 201-203).

An MRI of Plaintiff's right knee was taken in May 1996 and revealed a tear of the posterior horn of the right medial meniscus. Dr. Falco referred Plaintiff for an orthopedic evaluation with William Newcomb, M.D. Dr. Newcomb's initial treatment notes indicate that Plaintiff reported that she had not had any problems with her right knee before the slip and fall accident. (Tr. 199).

In June 1996, Plaintiff's chiropractor referred her to William R. Atkins, M.D. Dr. Atkins performed an electromyography study. Dr. Atkins' notes indicate that Plaintiff injured both

wrists trying to catch herself in a slip and fall and her neck, mid and low back and right knee. (Tr. 233). The electromyography report recorded results that were consistent with left C5-C6 radiculopathy, but indicated that these findings were "still in a relatively acute phase." The electromyography also revealed no evidence of peripheral polyneuropathy or myopathy. (Tr. 234).

In July 1996, Plaintiff underwent an MRI of the cervical spine. The MRI indicated an increase in Plaintiff's cervical spondylosis, but also showed that Plaintiff's previous disk herniations had resolved. (Tr. 232).

In July 1996, Plaintiff also underwent right knee arthroscopy with Dr. Newcomb. Dr. Newcomb's treatment notes from August 1996 indicate that he wanted to "clear up some history." Dr. Newcomb said that Plaintiff did have some discomfort in her knee prior to her April slip and fall, but that the symptoms were "relatively minor." Dr. Newcomb also stated that "to the best of [Plaintiff's] knowledge she did not have a cartilage tear" at that time, and that after the fall "she had significantly increased symptoms" which necessitated the surgery. (Tr. 212). In February 1997, Dr. Newcomb opined that Plaintiff did not need any additional surgery for her knee. (Tr. 211).

In March 1997, Plaintiff visited Dr. Newcomb for increased pain in her left wrist. Plaintiff indicated that this had become

a problem since her fall in April 1996. Dr. Newcomb referred Plaintiff to David T. Soma, M.D., who performed a left wrist arthroscopy and partial synovectomy of the radial carpal and mid-carpal joints in July 1997. Dr. Soma's operative notes indicate that Plaintiff's bilateral wrist injuries were the post-traumatic result of her April 1996 fall. In October 1997, Plaintiff reported to Dr. Soma with increased neck pain. Dr. Soma noted that Plaintiff injured her neck in the same fall that injured her wrists. He recommended that she continue to see her chiropractor.

In 1997, Plaintiff's chiropractor drafted a letter to Plaintiff's attorney. (tr. 194-195). She indicated that she had been treating Plaintiff for her slip and fall injuries, but also mentioned Plaintiff's 1991 history. She indicated that Plaintiff was treated for a "flare-up" of her low back and leg injuries between September 5, 1995 and April 2, 1996. She stated that by April 2, 1996, Plaintiff had only "some left sacroiliac pain and discomfort, as well as low back pain," and that the left leg pain that she originally visited for in November 1995 was "improving quite nicely." Plaintiff's chiropractor also stated that Plaintiff "did not have any complaints during that [September 29, 1995 to April 2, 1996] time frame of neck pain or bilateral wrist pain." (Tr. 194). Plaintiff's chiropractor stated that "[i]t is my opinion within a reasonable medical/chiropractic probability

that this patient has sustained new injuries to the cervical, left upper extremity, and left wrist regions as well as a worsening and exacerbation of her low back, left lower extremity, and right knee conditions as a result of this slip-and-fall accident which occurred on April 9, 1996." Plaintiff's chiropractor then limited Plaintiff to the performance of light work activity involving lifting and carrying of fifteen to twenty pounds and prohibited her from performing activities using her knee like typing and kneeling. (Tr. 195).

Plaintiff continued to treat with Dr. Atkins through December of 1997. Dr. Atkins' records suggest that Plaintiff developed new disk herniations and increasing radiculopathies. (Tr. 221-222). When discussing the origin of Plaintiff's injuries, Dr. Atkins records consistently refer to Plaintiff's April 1996 slip and fall. For example, in December of 1997, Dr. Atkins stated that Plaintiff has "ongoing musculoskeletal pain and radicular symptomatology referable to the accident on 4/9/96." (Tr. 220).

In November 1999, Plaintiff's chiropractor prepared a statement describing Plaintiff's history and condition for a Disability Services representative. (Tr. 230-242). The chiropractor identified Plaintiff's 1991 injuries and stated that "we were able to prevent [Plaintiff] from surgical intervention; however symptomatology continued. She has been unable to work

since 1991." (Tr. 241). Plaintiff's chiropractor went on to describe the results of her last examination in November 1999 and rendered an assessment of Plaintiff's functional limitations. Although Plaintiff's 1997 assessment indicated that Plaintiff was limited to the performance of a light range of work involving lifting and carrying fifteen to twenty pounds, in her 1999 assessment, Plaintiff's chiropractor limited Plaintiff to lifting no more than ten pounds and restricted her standing, walking and sitting. The chiropractor also opined that Plaintiff had a number of postural, environmental and manipulative limitations. (Tr. 241-242). Plaintiff's chiropractor also completed a medical source form indicating that Plaintiff had been limited to this same degree since September 29, 1995. (Tr. 243). Plaintiff's chiropractor then concluded that "all of the injuries and diagnoses discussed in this report are directly and causally related to the trauma sustained in 1991," and that the conditions had only been exacerbated by some additional new injuries sustained in her slip and fall. (Tr. 242). Plaintiff's chiropractor opined that her prognosis was poor, that she was unable to work in her previous capacity as a secretary and was highly unlikely to be able to achieve any type of gainful employment even on a part-time basis. (Tr. 241-242). No treatment notes were provided by Plaintiff's chiropractor to support her opinion.

In December 1999, Dr. Atkins completed a questionnaire which referred to the November 1999 report from Plaintiff's chiropractor. In this questionnaire, Dr. Atkins marked "yes" in response to three questions, (1) whether he reviewed Dr. Hollstein's report, (2) whether the findings and limitations in her report were consistent with the findings derived from his examination of Plaintiff, and (3) whether he agreed with the findings and limitations stated by Dr. Hollstein.

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

On December 17, 1999, the A.L.J. conducted a hearing on Plaintiff's application for benefits. At the hearing, Plaintiff was represented by Elizabeth Strubble, an individual who was not an attorney, but who worked for a private company representing claimants. Plaintiff testified at the hearing that during her job as a secretary, she would have to leave work often due to pain, and that sitting bothered her. She testified that she had a great deal of pain in her neck and shoulders and that she was in so much pain and discomfort that she could no longer perform the duties of her work. (Tr. 37). She also testified that she had pain in her arms, upper and lower back and left knee. (Tr. 40). A vocational expert did not appear at the hearing.

In his decision dated May 4, 2000, the A.L.J. concluded that on the date her insured status expired, March 31, 1996, the medical evidence established that Plaintiff had degenerative disc

disease, but that she retained the capacity to perform her past relevant work as a secretary, which did not require her to lift up to ten pounds. Because Plaintiff's impairments did not prevent her from performing her past relevant work as of the date her insured status expired, the A.L.J. concluded that Plaintiff was not under a disability within the meaning of the Act.

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. erred in (1) finding that Plaintiff's statements were not entirely credible, (2) his

assessment of Plaintiff's residual functional capacity, and (3) his determination that Plaintiff could return to her past relevant work.

After reviewing the decision of the A.L.J. in light of the record evidence in this case, the Court concludes that the A.L.J. erred in his assessment of Plaintiff's residual functional capacity. The A.L.J. chose to give "significant weight" to the opinion of Plaintiff's chiropractor, even though it is not considered an acceptable medical source entitled to controlling weight. 20 C.F.R. § 416.913(e)(3). Having chosen to credit the opinion of Plaintiff's chiropractor, the A.L.J. was left with her conclusion that Plaintiff could perform less than the full range of sedentary work due to a number of non-exertional restrictions. Of particular concern to the Court is the chiropractor's conclusion that Plaintiff could sit for less than four hours in an eight hour day. Social Security Policy 96-9p indicates that an individual's ability to perform sedentary work is eroded if the individual is unable to sit for a total of six hours in an eight hour day. SSR 96-9p. This policy also suggests that the testimony of a vocational expert may be helpful where the full range of sedentary work is eroded.

If, as Plaintiff's chiropractor opined and the A.L.J. chose to credit, Plaintiff could perform less than the full range of sedentary work, then it is questionable whether Plaintiff could

have performed her past relevant work as a secretary, which is a job generally performed in the national economy at the sedentary level. Without consulting a vocational expert on this issue, the A.L.J. concluded that Plaintiff could perform her past relevant work, even though this result is contrary to the opinion of Plaintiff's chiropractor who indicated that Plaintiff could not perform her past relevant work. In essence, the A.L.J. chose to credit the chiropractor's opinion, but then proceeded to ignore it without explaining which other evidence he was relying on to reach his conclusions regarding Plaintiff's residual functional capacity and her ability to perform her past relevant work.[1] Because the A.L.J.'s decision regarding Plaintiff's residual functional capacity and her ability to perform past relevant work appears to be at odds with the evidence which the A.L.J. expressly chose to credit, the Court believes that this matter should be remanded to the A.L.J. for further findings and/or

[1] The Court further points out that the only residual functional capacity assessment contained in the record is the assessment offered by Plaintiff's chiropractor. The A.L.J. refers to an assessment completed by a state agency physician, but that assessment is not contained in the record, and therefore, the Court cannot rely on it in evaluating the A.L.J.'s decision. Although the chiropractor's assessment is the only assessment of record, the A.L.J. was not necessarily required to accept it, particularly if it was not supported by the other medical evidence in the record. However, what the Court finds to be the error in this case is the fact that A.L.J. chose to credit that assessment, giving it "significant weight," but then ignored it when reaching his ultimate conclusions regarding Plaintiff's functional capacity.

proceedings. Accordingly, Defendant's Motion For Summary Judgment will be denied, and Plaintiff's Motion For Summary Judgment will be granted to the extent that Plaintiff requests that this matter be remanded. The decision of the Commissioner dated May 4, 2000 will be reversed and this matter will be remanded for further findings and/or proceedings.

CONCLUSION

For the reasons discussed, Defendant's Motion For Summary Judgment will be denied, and Plaintiff's Motion For Summary Judgment will be granted. The decision of the Commissioner dated May 4, 2000 will be reversed and this matter will be remanded to the Commissioner for further findings and/or proceedings.

An appropriate Order will be entered.

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF DELAWARE

VERNELL R. LESTER,	:	
	:	
Plaintiff,	:	
	:	
v.	:	Civil Action No. 02-225-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. 20) is DENIED.

2. Plaintiff's Motion For Summary Judgment (D.I. 17) is GRANTED to the extent that it requests that this matter be remanded to the Commissioner.

3. The final decision of the Commissioner dated May 4, 2000 is REVERSED and this matter is remanded to the Commissioner for further findings and/or proceedings consistent with the Court's Memorandum Opinion.

JOSEPH J. FARNAN, JR.
UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF DELAWARE

VERNELL R. LESTER, Plaintiff, v. JO ANNE BARNHART, Commissioner of Social Security, Defendant.	:	Civil Action No. 02-225-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 ORDER AND ADJUDGED that judgment be and is hereby entered against Defendant Jo Anne Barnhart and in favor of Plaintiff Vernell R. Lester.

JOSEPH J. FARNAN, JR.
UNITED STATES DISTRICT JUDGE

Dated: September 29, 2003

ANITA BOLTON
(By) Deputy Clerk