IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF DELAWARE

SHARYN L. KLEITZ,	:	
	:	
Plaintiff,	:	
	:	
v.	:	Civil Action No. 98-500-### (MPT)
	:	
COMMISSIONER OF SOCIAL SECURITY,	:	
	:	
Defendant.	:	

MEMORANDUM OPINION

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Dated: October 18, 2002

Wilmington, Delaware

Thynge, U.S. Magistrate Judge

I. Introduction

Plaintiff, Sharyn L. Kleitz, brought this claim against the Government pursuant to 42 U.S.C. § 405(g). Having exhausted her administrative remedies, she seeks review of the administrative law judge's denial of disability benefits. Presently before the court are the parties' cross-motions for summary judgment. For the reasons stated below, plaintiff's motion is DENIED and defendant's motion is GRANTED.

II. Background

a. Social Security System

Under the Social Security Act, 42 U.S.C. § 423, eligible persons may apply to the Social Security Commissioner ("Commissioner") to receive disability benefits. Eligible persons are those who are "insured for disability insurance benefits ("DIB")…[have] not attained retirement age…[have] filed an application for disability insurance benefits, and [are] under a disability." *42 U.S.C. § 423(a)(1)*. In order to receive the benefits, a claimant must show they are disabled under § 423 (d)(1). That section defines disability as the "inability to engage in 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).*

The Social Security regulations require the Commissioner or an administrative law judge ("ALJ") follow a five-step process when a person requests Social Security benefits. *See 20 C.F.R. § 404.1520.* In *Plummer v. Apfel*, 186 F.3d

422, 428-29 (3d Cir. 1999), the Third Circuit explained the process mandated by the regulations. First, the Commissioner must evaluate whether a claimant is participating in "substantial gainful activity." *Plummer at 428*. If so, the Commissioner should deny disability benefits. If a claimant is unable to participate in substantial gainful activity, the Commissioner should determine if a severe impairment is the basis. *Id.* If a claimant suffers from a severe impairment, a comparison of the claimant's medical evidence "to a list of impairments presumed severe enough to preclude any gainful work," is then required. *Id.* (citing *20 C.F.R. § 404.1520(d)*). If a claimant suffers from one of the listed impairments, or its equivalent, the Commissioner should grant disability benefits. However, should the claimant not suffer from a listed impairment, the process continues. *Id.*

In step four, an ALJ must determine "whether the claimant retains the residual functional capacity to perform her past relevant work." *Id.* (citing *20 C.F.R. § 404.1520(d)*). If the ability to return to prior employment exists, the Commissioner should deny disability benefits. *Id.* The burden of proof in each of the previous steps remains with the claimant. *Id.* (citing *20 C.F.R. § 404.1520(f)*). However, the burden shifts to the Commissioner in the final step of the process. *Id.* (citing *20 C.F.R. § 404.1520(f)*). In this step, the Commissioner must show that a claimant is capable of performing other work, and upon such a showing, an ALJ should uphold the decision to deny disability benefits. *Id.*

A claimant who disagrees with any decision of the Commissioner may request reconsideration of that decision. *42 U.S.C. § 405(g).* Additionally, a claimant may request an administrative hearing in front of an ALJ. If the request is granted, and the

ALJ renders an unfavorable opinion, a claimant may appeal to the Social Security Appeals Counsel. If a claimant is dissatisfied with the decision of the Appeals Counsel, an appeal to the District Court in the jurisdiction where the claimant resides or is primarily employed is available. Id.

b. Plaintiff's Background

The plaintiff in this matter claims she became disabled and unable to work on September 1, 1992, due to lupus, a gastric ulcer, and fibromyalgia. *D.I. 18 at 1.* Plaintiff is a 41 year-old female with a high school education and past relevant work experience as a store merchandiser, assistant manager, security dispatcher, and secretary. *D.I. 10 at 19.* She claims that she has, and still suffers from numerous physical complications associated with her disability. *Id.*

Due to the above mentioned ailments, plaintiff has seen numerous doctors and has been hospitalized several times. *D.I. 10 at 20.* Plaintiff first saw Dr. Harry J. Anagnostakos, D.O., on September 11, 1992. Dr. Anagnostakos recorded her complaints of epigastric and dyspeptic symptoms, and performed an endoscopy that revealed two gastric ulcerations, severe antral gastritis, focally hemorrhagic gastritis, and duodenitis of the duodenal bulb. As s result of these findings, the doctor prescribed Pepcid, and non-sterodial anti-inflammatory medications. Another endoscopy was performed on November 5, 1992, which revealed almost complete healing of the previously diagnosed conditions. *Id.*

On December 22, 1992, plaintiff saw Dr. Kelly Fanto, M.D. *D.I. 10 at 21.* Dr. Fanto performed an EMG examination of plaintiff's upper extremities, which disclosed 1+ fibrillations in the right abductor pollicis brevis. Normal somatosensory evoked

potentials of the lower extremities were found. Dr. Fanto diagnosed plaintiff with systemic lupus erythematosus, and myofascial pain syndrome involving the neck, the right upper extremity, upper back, lower back, and right lower extremity. The doctor prescribed plaintiff Percocet, Norpramin, physical therapy, and aquatic exercises. *Id.*

Plaintiff next was seen by Michael H. Mark, M.D., on January 22, 1993. *D.I. 10 at 20.* He recorded a history of lupus, and plaintiff's complaints of right arm and lower leg pain. The doctor reported unremarkable motor systems, characterized by no focal weakness, no loss of power or muscle bulk, normal deep tendon reflexes, and normal gait, station and coordination. Dr. Mark recorded evidence of cervical radiculopathy suggested by an EMG, and severe right/myofascial pain syndrome and prescribed Valium. Subsequently on February 22, 1993, the doctor indicated that plaintiff's pain appeared musculoskeletal in nature. *Id.*

On March 11, 1993, plaintiff returned to Dr. Fanto. *D.I. 10 at 21.* The doctor recorded a history of systemic lupus erythematosus, and migraine headaches. Dr. Fanto reported that plaintiff was functionally independent in all daily activities, though plaintiff needed to rest when performing some household duties. Upon examination, the doctor found tenderness, normal upper extremity strength and sensation, a somewhat decreased sensation over the dorsum and lateral right foot, normal reflexes, and that plaintiff could walk heel to toe without difficulty. X-rays revealed minimal degenerative changes in the cervical and lower back. *Id.*

Plaintiff saw Dr. Fanto again on April 26, 1993. *D.I. 10 at 21.* The doctor reported that serology tests failed to show the current existence of systemic lupus erythematosus. Dr. Fanto found tenderness over plaintiff's lower extremities, upper

trapezius, and cervical, thoracic, and lumbar paraspinals. The doctor also diagnosed plaintiff with a history of systemic lupus erythematosus and fibromyalgia. Plaintiff was prescribed Percocet for her current ailments. *Id.*

On May 8, 1993, a medical consultant diagnosed plaintiff with systemic lupus erythematosus, in remission and lower back pain. *D.I. 10 at 21.* The consultant also reported that plaintiff could perform medium work.[1] *Id.*

About a month later, on June 17, 1993, Dr. Fanto recorded that plaintiff's overall symptoms had improved. *D.I. 10 at 22.* The examination revealed diffuse tenderness over the upper trapezius, cervical paraspinals, and back and chest regions and the fibromyalgia diagnosis was reiterated. *Id.*

Less than a month after her last visit with Dr. Fanto, plaintiff saw Fahim Khafar, M.D., on June 22, 1993. *D.I. 10 at 21.* This doctor performed a pulmonary function study on plaintiff. Dr. Khafar made findings consistent with chronic obstructive pulmonary disease. *Id.*

On September 20, 1993, Dr. Fanto recognized that plaintiff was having increased leg and lower back pain. *D.I. 10 at 22.* The doctor reported tenderness over plaintiff's body, and that a straight leg raising test was painful. However, sensation testing and deep tendon reflexes at the ankles and knees were normal. Dr. Fanto diagnosed plaintiff with fibromyalgia and a history of systemic lupus erythematosus. *Id.*

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[1] The determination that plaintiff could perform medium work was part of the Residual Physical Functional Capacity Assessment done by the medical consultant. It is a standard assessment which uses set factors to determine a claimant's current ability to perform work. Here, the medical consultant found that plaintiff could: occasionally lift up to 50 pounds; frequently lift up to 25 pounds; stand or walk with normal breaks about 6 hours in an 8-hour work day; sit with normal breaks for about 6 hours in an 8-hour work day; and that plaintiff could push or pull (including operation of hand and/or foot controls) in an unlimited capacity other than as shown for lifting and/or carrying. *D.I. 10 at 230.*

Plaintiff returned to Dr. Fanto on October 11, 1993. *D.I. 10 at 21.* The doctor recorded plaintiff's history of systemic lupus erythematosus and fibromyalgia, as well as her reports of pain. At this visit, plaintiff told Dr. Fanto that she was doing better through both her exercise and medication. At this time plaintiff was taking Flexeril, Ambien, Fioricet, Premarin, E.S. Tylenol, Percocet, and a Proventil Inhaler. Dr. Fanto, who previously diagnosed plaintiff with fibromyalgia, found no significant tenderness on palpation of the joint lines or the patella area, and no pain on compression or subluxation with manipulation of the patella. The doctor did report, however, that plaintiff was tender in the quadriceps, hamstrings, and the anterior tibialis on palpation. *Id.*

Plaintiff was also hospitalized four times from July 1995 to November 1995. *D.I. 10 at 22.* She was hospitalized from June 27, 1995 to July 4, 1995, with severe obstipation and constipation. Plaintiff was again hospitalized in July 1995, and October 1995, for nausea, malnutrition, abdominal pains, vomiting, diarrhea, and dehydration. From November 14, 1995 to November 17, 1995, she was hospitalized for headaches, weakness, generalized aching and dehydration. *Id.*

On November 28, 1995, plaintiff saw Dr. Anagnostakos again. *D.I. 10 at 22.* The doctor performed an endoscopy which revealed a normal esophagus, a "much improved" mild focal hemorrhagic gastritis, "a beefy red" antral gastritis, and two prior healed ulcerations. Dr. Anagnostakos prescribed Prilosec, and Cytotec. *Id.*

On February 15, 1996, plaintiff saw Dr. Peter J. Coveleski, D.O. *D.I. 10 at 22.* The plaintiff this time complained of increased pain in her left heel. The doctor diagnosed her with chronic pain syndrome and prescribed Neurontin. *Id.*

Plaintiff next saw Maria J. Watson, M.D. on March 27, 1996. *D.I. 10 at 22.* The doctor recorded a history of lupus, but otherwise recorded no unremarkable physical conditions of plaintiff. Although Dr. Watson found some joint tenderness of the ankle and wrists, she found no active synovitis, full range of motion of all the joints, and diffuse tender points in the back. The doctor diagnosed plaintiff with fibromyalgia and a history of lupus. Plaintiff returned to Dr. Watson on April 17, 1996. *Id.* The doctor reported that the fibromyalgia had been active. *D.I. 10 at 23.* On May 20, 1996, plaintiff complained of diarrhea, spinning and ringing of the ears. Dr. Watson reported muscle tenderness and an otherwise unremarkable physical examination. The doctor reiterated her diagnosis of fibromyalgia and a history of lupus. *Id.*

Plaintiff was again hospitalized from June 12, 1996 to June 14, 1996. *D.I. 10 at 23.* This time plaintiff was hospitalized for acute severe dehydration, hypotension, nausea, vomiting, and chronic diarrhea. She was discharged in excellent condition. *Id.*

On June 25, 1996, plaintiff again saw Dr. Watson. *D.I. 10 at 23.* She complained of headaches and pain in her joints and muscles. The doctor reported an unremarkable physical examination except for some multiple tender points and pain over the muscles. Dr. Watson prescribed Medrol, Parafon Forte, Premarin, Fioricet, Percocet, Prilosec, Propulcid, Cytotec, Xanax, Levsin, Neurontin, and Compazine. *Id.*

On July 18, 1996, Robert C. Deckman, M.D., hospitalized plaintiff for dehydration, weakness and near syncope. *D.I. 10 at 23.* The doctor recorded a history of peptic ulcers, lupus, headaches, dizziness, lightheadedness, weakness, anorexia, weight loss, nausea, occasional vomiting, diarrhea and myalgias. Laboratory studies and a head CAT scan were normal. Plaintiff responded well to steroid treatment and

was discharged in excellent condition with a diagnosis of possible vasculitis or auto-immune connective tissue disease, symptoms associated with orthostasis, and a non-healing ulcer. *Id.*

On October 18, 1996, Dr. Coveleski issued a report in which he stated that he had treated plaintiff since 1993 and that she could not work due to fibromyalgia, lupus, depression, colitis, significant stomach ulcerations, and migraine headaches. *Id.* On February 3, 1998, Dr. Anagnostakos made an additional report in which he opined that plaintiff was disabled which was submitted for the first time to the Appeals Council. *D.I. 18 at 13.*

Because plaintiff failed to specify the exertional and non-exertional requirements of her past work, the ALJ sought the input of a vocational expert ("VE"), Dr. Ryan. *D.I. 10 at 26.* Plaintiff did provide that her past work as a store merchandiser had required her to carry up to 10 pounds and sometimes up to 20 pounds while her security dispatcher job was mostly sedentary. This work is consistent with "light work" as described in 20 C.F.R. 404.1567(b). The VE testified that plaintiff could return to her prior job as a security dispatcher, as this was a job in which plaintiff would not be exposed to dust, chemicals, fumes, noxious odors, and allows frequent access to the bathroom. *Id.*

c. Procedural History

Plaintiff applied for DIB on February 24, 1993, *D.I. 10 at 68-70*, pursuant to Title II of the Act *42 U.S.C. §§ 401-433*. After denial of her application initially and upon reconsideration, plaintiff filed a timely request for a hearing before an administrative law judge. *D.I. 16 at 1*. A hearing was held on October 9, 1996, *D.I. 16 at 1*, where the ALJ

concluded plaintiff was not disabled on or prior to her date last insured[2], December 31, 1999. *D.I. 18 at 2*. After the ALJ decision, plaintiff filed a request for review and provided additional evidence to the Appeals Council. *D.I. 16 at 2*. On June 26, 1998, the Appeals Council denied plaintiff's request for review of the ALJ's decision. *D.I. 18 at 2*. Accordingly, the ALJ's decision became the final decision of the Commissioner, pursuant to 20 C.F.R. § 404.981 (2000). Plaintiff now seeks judicial review of the Commissioner's final decision. 42 U.S.C. § 405(g).

d. ALJ's Decision

In his decision**,** the ALJ explained the prior history of plaintiff's application for benefits, and incorporated findings from the administrative hearing. *D.I. 10 at 24*. The ALJ determined plaintiff was not disabled and could return to past relevant work. *Id. at 25-7*. As to disability, the ALJ concluded that plaintiff's allegations of disability could not be supported by the evidence in the record. *Id. at 25*. The ALJ first noted inconsistencies within the evidence. For instance, while plaintiff alleged that she had lost the range of motion in her hands, feet, legs, neck, and back on April 15, 1994, a doctor subsequently reported that plaintiff had full range of motion of all her joints on March 27, 1996. Also, although plaintiff alleged in her July 27, 1993 Disability Report on Reconsideration that her husband would sometimes have to help with her personal needs, a March 11, 1993 doctor's report considered plaintiff to be "functionally independent in all her activities of daily living." *Id*.

[2] As mentioned above, a DIB claimant must be disabled continuously for a period of at least twelve months to be considered for DIB. The last date insured is the last day that a DIB claimant was working during the period.

The ALJ supported the notion of plaintiff's ability to function in her daily activities with two reasons. *D.I. 10 at 25*. First, plaintiff alleged no difficulties with respect to "reading, writing, answering, hearing, speaking, understanding, breathing, seeing, walking, sitting, or with the use of her hands," in the above mentioned Disability Report on Reconsideration. Second, plaintiff offered no evidence that she required a need for assistive devices. *Id*. Although the ALJ believed plaintiff suffered some discomfort, "[w]hen considered in combination" these factors conclude that plaintiff "does not suffer from symptoms or limitations of a disabling intensity" to prevent her from performing sedentary work. *D.I. 10 at 25-6*.

In his determination that plaintiff was not disabled, the ALJ also considered the opinion of Dr. Coveleski, who stated that plaintiff could not work. *D.I. 10 at 26*. The doctor's opinion was given little weight [3] because the ALJ concluded the "opinion was expressed in a conclusory report unsupported by any medical signs or laboratory findings, and is inconsistent with the other substantial evidence on the record," which could not prevent the finding that plaintiff "retained the residual functional capacity for sedentary work." *Id.*

The ALJ then determined that plaintiff could also perform her past relevant work as a security dispatcher. *D.I. 10 at 2*. Based on the VE's testimony that plaintiff could perform sedentary work, the ALJ concluded plaintiff's past relevant work as a security dispatcher was sedentary work that she could perform. Accordingly, the ALJ determined that plaintiff was not disabled, and a period of disability may not be

[3] See 20 C.F.R. 404.1527(d)(3) - (4); Social Security ruling 96-2p.

established based on the application filed on February 24, 1993. *Id*.

II. Legal Standards

a. Summary Judgment Standard

Under Rule 56 of the Federal Rules of Civil Procedure, summary judgment is appropriate when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of law." *Fed. R. Civ. P. 56(c).* Summary judgment should not be granted if the dispute involves a material fact.[4] "By its very terms, this standard provides that the mere existence of some alleged factual dispute between parties will not defeat an otherwise properly supported motion for summary judgment; the requirement is that there be no genuine issue of material fact." *Anderson, 477 U.S. at 247-48.* There is a genuine issue of fact when "the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Id. at 248* (citations omitted). Additionally, summary judgment is appropriate "against a party who fails to make a showing sufficient to establish the existence of an [essential element]...on which that party will bear the burden of proof at trial…since a complete failure of proof concerning an essential element of [that]...party's case necessarily renders all other facts immaterial." *Celotex Corp. v. Catrett, 477 U.S. 317, 322-23; 91 L. Ed. 2d 265; 106 S. Ct. 2548 (1986).*

The party moving for summary judgment bears the burden of showing that there

[4] "Only disputes over facts that might affect the outcome of the suit under the governing law will properly preclude the entry of summary judgment." *Anderson et. al. v. Liberty Lobby, Inc., et. al., 477 U.S. 242, 248; 91 L. Ed. 2d 202; 106 S. Ct. 2505 (1986).*

is no genuine issue of material fact. *Id. at 323.* A moving party can meet its burden if the party "point[s] out to the district court that there is an absence of evidence to support the nonmoving party's case." *Id. at 325.* On the other hand, "a party opposing a properly supported motion for summary judgment 'may not rest upon the mere allegations or denials of his pleadings, but…must set forth specific facts showing that there is a genuine issue for trial.'" *Id. at 321* (citing *Catrett v. Johns-Manville Sales Corp., 756 F.2d 181, 184 (1985)*).

When reviewing a motion for summary judgment, a court must evaluate the facts in a light most favorable to the nonmoving party drawing all reasonable inferences in that party's favor. *Anderson, 477 U.S. at 255.* The court should grant the motion "unless the evidence be of such a character that it would warrant the jury in finding a verdict in favor of that party." *Id. at 251.* In deciding a motion the court should apply the evidentiary standard of the underlying cause of action. *Id. at 251-52.*

> In every case, before the evidence is left to the jury, there is a preliminary question for the judge, not whether there is literally no evidence, but whether there is any upon which a jury could properly proceed to find a verdict for the party producing it, upon whom the *onus* of proof is imposed…The mere existence of a scintilla of evidence in support of the plaintiff's position will be insufficient.

Id. at 251.

b. Jurisdiction

District Court review of an ALJ's decision regarding disability benefits is limited in scope. 42 U.S.C. § 405(g) provides "[a]ny individual, after any final decision of the Commissioner of Social Security made after a hearing to which he was a party…may obtain review of such decision by a civil action." A decision of the Commissioner becomes final when the Appeals Council affirms an ALJ decision, denies review of an

ALJ decision, or when a claimant fails to pursue the available administrative remedies. *Aversa v. Secretary of Health & Human Services, 672 F. Supp. 775, 777 (D. N.J. 1987); see also 20 C.F.R. § 404.905.* This court has jurisdiction to review the case under § 405(g) because the Commissioner's decision became final when the Appeals Council declined to review the ALJ's denial of benefits.

c. Standard Applicable to ALJ's Decision

A district court's review of an ALJ's decision is limited to whether the decision was supported by substantial evidence. *Jesurum v. Sec'y of the United States Department of Health & Human Servs., 48 F.3d 114, 117 (3d Cir. 1995)* (citing *Brown v. Bowen, 845 F.2d 1211 (3d Cir. 1988)*). If the decision is so supported, the court is bound by those factual findings. Substantial evidence "means such relevant evidence as a reasonable mind might accept as adequate to support the conclusion."[5] Substantial evidence is less than a preponderance, but more than a scintilla. *Jesurum, 48 F.3d at 117.* The review of whether the ALJ established substantial evidence is limited to the evidence which was actually presented to him. *Matthews v. Apfel 239 F. 3D 589, 593-95 (3d Cir. 2001)).*

III. Discussion

a. ALJ's Denial of Benefits

When deciding whether plaintiff is entitled to disability benefits, an ALJ should consider both subjective complaints of pain, and the plaintiff's medical records.

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[5]The Court applied this standard by analogy from decisions addressing the meaning of substantial evidence in the context of the *National Labor Relations Act § 10(e). Richardson v. Perales, 402 U.S. 389, 401; 28 L. Ed. 842; 91 S. Ct. 1420 (1971* (citing *Consolidated Edison Co. v. NLRB, 305 U.S. 197, 229 (1938)*).

Wimbley v. Massanari, 2001 WL 761210 (D. Del. 2001). The ALJ must give the plaintiff's complaints of pain serious consideration, even if those complaints are not supported by the medical evidence. However, "when a claimant's subjective complaints of pain indicate a greater severity of impairment than the objective medical evidence supports, the ALJ can give weight to factors such as physicians' reports and claimant's daily activities. Additionally, the ALJ may properly look at the claimant's stated daily activities to assess credibility." *Id.*

When reviewing a decision, the district court must defer to the ALJ's determinations on the credibility of the witnesses and on whether the claimant has satisfied the burden of proof. *Murry v. Apfel, 1999 U.S. App. Lexis 28911 (9th Cir. 1999); Davis v. Califano, 439 F. Supp. 94, 98 (E.D. Pa. 1977).* "Great deference is given [to the ALJ's] judgment as fact-finder, since he actually heard the witnesses' testimony and observed their demeanor. 'Most particularly, the administrative law judge to whom the Secretary delegated fact finding responsibilities, must decide issues of credibility and appropriate weight to be given the exhibits.'" *Davis, 439 F. Supp. at 98.* "A finding that a witness is not credible must be set forth with sufficient specificity to permit the court to engage in an intelligible review of the record." *Hanratty v. Chater, 1997 U.S. Dist. LEXIS 15488 (W.D.N.Y. 1997).*

Plaintiff contends the ALJ erred in determining she was not entitled to DIB and proposes two arguments in support of this proposition. *D.I. 16 at 15*. Firstly, plaintiff contends the ALJ's decision was not based on substantial evidence. *Id. at 16.* Secondly, plaintiff argues that the ALJ did not give appropriate consideration of Dr. Coveleski's opinion in making the disability determination. *Id. at 18.*

1. Substantial Evidence Determination

In determining whether substantial evidence existed as to plaintiff's disability allegations, the ALJ considered plaintiff's medical background and the testimony of a VE. *D.I. 10 at 26.* As mentioned above, a plaintiff claiming DIB must show they meet a listing impairment in step three of the administrative process. An ALJ must compare the claimant's injuries with those listed in 20 C.F.R. Pt. 404, Subpt. P, App. 1.

Here, plaintiff claims to meet a listed impairment under 5.00 of Subpt. P, App. 1., and more specifically under 5.06. *D.I. 16 at 16.* 5.00 is the general listing for digestive disorders. *20 C.F.R. Pt. 404, Subpt. P, App. 1.* This section maintains that disorders of the digestive system are "complications [which] must be shown to persist on repeated examinations despite therapy for a reasonable presumption to be made that a marked impairment will last for a continuous period for at least 12 months. *Id.* 5.06 pertains specifically to chronic ulcerative or granulomatous colitis. It maintains that chronic ulcerative or granulomatous colitis must be "demonstrated by endoscopy, barium enema, biopsy, or operative finding." *Id.*

The ALJ must give controlling weight to a DIB claimant's treating physician where the treating physician's opinion is well-supported by medical evidence not inconsistent with other substantial evidence in the record. *20 C.F.R. § 404.1527(d)(2).* The Commissioner may reject, or accord less weight to a treating physician's opinion if other evidence in the record contradicts the treating physician's opinion. *Id.* When a treating physician's opinion conflicts with a non-treating physician's opinion, the Commissioner, with good reason, may choose which opinion to credit. *Morales v. Apfel, 225 F. 3d 310, 317 (3d Cir. 2000).* When considering the treating physician's opinion,

the Commissioner may not make "speculative inferences from medical reports" and may "reject "a treating physician's opinion outright only on the basis of contradictory medical evidence" and not due to the Commissioner's own judgment or speculation. *Id.* The opinion of any physician is not determinative as to the issue of disability under the Act; that determination is expressly reserved to the Commissioner. *20 C.F.R. § 404. 1527(e)(1).*

The medical records in this matter support the ALJ's finding that plaintiff's alleged disability was not supported by substantial evidence. The ALJ noted his decision was not "to imply that she [plaintiff] does not suffer from some discomfort, but her symptoms are not inconsistent with her ability to perform sedentary work." *D.I. 10 at 26.* This court agrees with the ALJ's determination that plaintiff was not disabled, and thus not eligible for DIB based on the evidence of record presented to the ALJ and this court.

As mentioned above, plaintiff claims to be significantly disabled due to systemic lupus erythematosus, a gastric ulcer and fibromyalgia. *D.I. 18 at 1.* However, the medical records show no continuous presence of these disabilities. Plaintiff saw or was evaluated by eight medical professionals. None of these professionals' reports support the continuous period of disability which plaintiff alleges.

Firstly, there is no substantial evidence that plaintiff suffers from a gastric ulcer. On September 11, 1992, as a result of endoscopy, Dr. Anagnostakos diagnosed plaintiff with gastric ulcerations, severe antral gastritis, focally hemorrhagic gastritis, and duodenitis of the duodenal bulb. *D.I. 10 at 20.* Plaintiff took her prescribed medications and on November 5, 1992, another endoscopy revealed almost complete healing of the previously diagnosed conditions. *Id.* Subsequent reports mentioning plaintiff's ulcers

merely referred to them as healed. *Id. at 22-3.* In fact, the only mention of symptoms which may possibly relate to a gastric ulcer was made by Dr. Deckman on July 18, 1996, four years after the ulcer actually existed. *Id. at 23.* Plaintiff's allegations that she suffers from a gastric ulcer are not supported by substantial evidence, and thus should not be considered in a determination that plaintiff is severely disabled.

All of plaintiff's other doctors' reports involve or relate to either systemic lupus erythematosus and fibromyalgia.[6] Neither of these ailments appear consistent throughout plaintiff's period of disability. Plaintiff was first diagnosed with systemic lupus erythematosus on December 22, 1992, pursuant to an EMG examination. *D.I. 10 at 21.* No other diagnosis made pursuant to testing of plaintiff yielded similar results. *Id. at 20-2.* In fact, subsequent treating physicians only recorded a history of systemic lupus erythematosus. *Id.* Furthermore, the medical consultant who evaluated plaintiff in May 1993 determined that plaintiff's systemic lupus was in remission. *Id. at 22.* Due to the lack of substantial evidence supporting plaintiff's claim of continuous suffering of systemic lupus erythematosus, the court finds this physical condition to be inadequate proof of a severe disability.

Plaintiff's argument for fibromyalgia does have some merit. The eight medical professionals who treated or evaluated plaintiff also reported that some of plaintiff's physical conditions were associated with fibromyalgia. *D.I. 10 at 20-3*. However, the

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[6] Systemic lupus erythematosus is a chronic inflammatory condition caused by an auto immune disease. An auto immune disease occurs when the body's tissues are attacked by its own immune system. People with lupus have unusual antibodies in their blood that are targeted against their own body tissues. Fibromyalgia chronically causes pain, stiffness, tenderness of the muscles, tendons and joints without detectable inflammation. Patients with fibromyalgia may suffer undue fatigue, sleep disorders, and irritable bowel syndrome. *Medicine.Net.com.*

record indicates that these professionals reported that plaintiff experienced improvement throughout the disability period. *Id.*

Dr. Fanto evaluated plaintiff on six occasions. While on five of these occasions the doctor reported that plaintiff was experiencing pain associated with fibromyalgia, the reports also show that plaintiff was improving through treatment. *D.I. 10 at 20-3.* On a March 11, 1993 visit, Dr. Fanto reported that although plaintiff had some tenderness and pain, plaintiff was functionally independent in all daily activities, could walk heel to toe without difficulty, and that plaintiff had minimal degenerative changes in her lower back and cervical area. *Id. at 21.* It was not until her April 26, 1993 visit with Dr. Fanto that plaintiff was diagnosed fibromyalgia which was treated only with Percocet. *O*n June 17, 1993, Dr. Fanto related plaintiff's complaints with fibromyalgia, but noted that, overall, plaintiff's symptoms improved. *Id. at 22. D.I. 10 at 21.* Also, on September 20, 1993, while plaintiff complained of tenderness over her body and pain in straightening her leg, the doctor commented that sensation testing and deep tendon reflexes at the ankles and knees were normal. *Id.* Plaintiff's last visit with Dr. Fanto on October 11, 1993 yielded similar results and plaintiff even told Dr. Fanto that she was doing much better through the prescribed medication and exercise. *Id. at 22.*

The record indicates that plaintiff saw Dr. Mark once on January 22, 1993. *D.I. 10 at 20.* There, Dr. Mark reported complaints of plaintiff's physical symptoms, but also, noted unremarkable motor systems, characterized by no focal weakness, no loss of power or muscle bulk, normal deep tendon reflexes, and normal gait, station and coordination. *D.I. 10 at 20.*

On May 8 1993, plaintiff was evaluated by a medical consultant. *D.I. 10 at 21.*

The consultant, who determined plaintiff's systemic lupus was in remission, also determined that she could perform medium work. A medium work determination at this point shows that plaintiff was able to perform work greater than that of her previous employment as a security dispatcher. Plaintiff also saw Dr. Khafar only once on June 22, 1993. This doctor made no findings associated with fibromyalgia. *Id.*

Dr. Anagnostakos prepared two more reports concerning plaintiff's condition other than his September 11, 1992 evaluation. *D.I. 10 at 22.* On November 28, 1995, Dr. Anagnostakos performed an endoscopy which revealed a normal esophagus, a "much improved" mild focal gastritis, "a beefy red" antral gastritis, and two prior healed ulcerations. *Id.* The doctor's other report was made after the ALJ's determination.

This subsequent report should also not be considered by this Court in review of the ALJ's decision. Evidence which was not before the ALJ should not be used by the reviewing court to determine whether the ALJ's opinion was supported by substantial evidence. *Matthews, 239 F.3d at 593-95.* A district court may remand a case to the Commissioner based on claimant's evidence that was not previously before the ALJ, if claimant proves the evidence was new and material and that claimant had good cause not to previously present such evidence. *42 U.S.C. § 405(g).*

To be new, claimant must prove the evidence was not available to claimant nor in existence at the time of the administrative proceeding. *Sullivan v. Finkelstein, 496 U.S. 617, 626 (1990).* The report is not new, but rather a critique of the ALJ's opinion. *D.I. 22 at 9.* In fact, plaintiff offers no evidence why it was not presented to the ALJ other than the report being new simply because it was a review of the ALJ's decision. *Id.*

The report may be material. Material evidence is that which is "relevant and

probative". *Szubak v. Sec'y of Health and Human Servs., 745 F.2d 831, 833 (3d Cir. 1984).* The report may be "relevant and probative"; however, the evidence is similar to reports of the past and offers no new insight for this Court to consider. Furthermore, plaintiff offers no good cause for the report's untimeliness other than it being a review of the ALJ's decision. Because Dr. Anagnostakos' report was merely a reiteration of his previous opinion regarding plaintiff's alleged disability, the evidence is not new and is without good cause to be considered by this court.

Dr. Watson saw plaintiff three times from March 27, 1996 to June 25, 1996. *D.I. 10 at 22-3.* On their first meeting, the doctor found some pain and tenderness but recorded no unremarkable physical conditions. *D.I. 10 at 22.* On the second visit soon after, Dr. Watson reported that the fibromyalgia had been active. *Id.* Yet, less than a month later on the third meeting, even though Dr. Watson reiterated plaintiff's diagnosis of fibromyalgia, she reported that currently plaintiff only suffered from muscle tenderness and had an otherwise unremarkable physical examination. *Id. at 23.* Dr. Watson made the same determination on the last visit, and merely prescribed medication. *Id.*

The court also notes that plaintiff was hospitalized six times for her physical conditions. *D.I. 10 at 22-3.* On the first four instances, from approximately July 1995 to November 1995, plaintiff was hospitalized with several bowel complications, including *inter alia*, severe obstipation and constipation, to general weakness and dehydration. *Id. at 22.* Plaintiff was again hospitalized in both June and July of 1996 with similar symptoms ranging from severe internal problems associated with the bowels, as well as dehydration and weakness. *Id. at 23.* None of the hospital visits resulted in a definite

diagnosis of any problem. In fact, on the most recent occasion, Dr. Deckman released plaintiff in excellent condition from the hospital. *Id.*

The testimony of the VE also supports the ALJ's finding. Plaintiff provided that her past work as a security dispatcher job was mostly sedentary. *D.I. 10 at 26.* The VE testified that plaintiff could return to her prior job as a security dispatcher, which is consistent with "light work" as described in 20 C.F.R. 404.1567(b). *Id.*

2. Dr. Coveleski's Reports

There are two instances in this record where Dr. Coveleski evaluated plaintiff. Plaintiff saw the doctor on February 15, 1996, where he diagnosed her with chronic pain syndrome and prescribed medication. *D.I. 10 at 22.* On October 18, 1996, Dr. Coveleski issued a report stating that he was plaintiff's treating physician and that she was unable to work due to her disability. *Id. at 23.* No other doctor around this time, before or after, made any definite diagnoses of plaintiff's physical condition similar to Dr. Coveleski's. Also, unlike the other doctors treating plaintiff, Dr. Coveleski offers no tests or other information to substantiate his claims. Furthermore, although plaintiff contends that he is her treating physician, the present record shows plaintiff saw other doctors more frequently for her problems. Due to the lack of substantial evidence supporting Dr. Coveleski's bald conclusions, which are inconsistent with the other medical records, the ALJ did not err in not giving controlling weight to Dr. Coveleski's opinions.

IV. Conclusion

For the reasons discussed above, this Court finds that substantial evidence

supported the ALJ's decision to deny disability benefits. Viewing all the relevant facts most favorable to plaintiff, no reasonable jury applying the 'substantial evidence' standard could find for plaintiff. Consequently, defendant's motion for summary judgment is GRANTED, and plaintiff's motion for summary judgment is therefore DENIED. An order consistent with this opinion will follow.