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medications for "eternity". What is the difference in chronic pain relief treatment?

Rule 20 is obsolete and needs updated with up-to-date chronic pain management input;

146. A May 19, 2005 a consultative examination from Arturo Sabio, M.D., for the West Virginia Disability Determination Service indicating a review of the following medical records:

- March 19, 2002 lumbar MRI, which showed mild degenerative disc disease of the T12 and L1, L1 and L2 interspaces;
- June 3, 2002 lumbar myelogram, which showed minimal anterior epidural impression of the L3-L4 and L4-L5 interspaces;
- June 3, 2002 lumbar spine CT scan, which showed mild diffuse disc bulge at L4-5 and L5-1 interspace and no mass effect;
- December 19, 2003 chest CT scan, which showed bilateral upper lob mass compatible with progressive muscle fibrosis and no evidence of malignancy;
- Dr. Pondo's consultations notes, dated May 9 and July 11, 2003, diagnosing Plaintiff with pneumoconiosis;
- April 22, 2003 bronchoscopy results, which showed no interbronchial lesions, but inflammatory changes; and
- Results from the specimen from the bronchial washing and bronchial biopsy, which showed fibrosis, chronic inflammation, and foreign material consistent with anthracosis and silicosis.

Dr. Sabio's examination revealed:

- GENERAL APPEARANCE: Well-developed, well-nourished, alert and oriented to time, place and person. The patient

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ambulates with a normal gait, without ambulatory aids. The patient is stable at station. There is no lurching or unpredictability in gait. The patient is able to hear and understand conversational voices spoken at normal volume levels. Visual fields are normal by gross confrontation testing.

- VITAL SIGNS: In stocking feet, this 48-year old male is 5 feet, 5 inches tall and weighs 162 pounds. Blood pressure is 126/84, pulse rate 72 per minute and regular and respirations are 22 per minute and unlabored. Visual acuity is 20/30 on the right side and 20/30 on the left, without corrective lenses. The patient is right-handed. He refused a chaperone during the examination.
- HEENT: The head is normocephalic. the pupils are equal and round and reactive to light and accommodation. The extraocular movements are intact. The sclerae are nonicteric. The fundi showed no diabetic or hypertensive retinopathic changes. The tympanic membranes are normal; the nares are patent without discharge. the oropharynx is normal. No intraoral lesions found.
- NECK: The neck is supple. There is no stiffness, no thyromegaly, no lymphadenopathy, or masses palpable. The carotids are 2/2 without bruits. There is no jugular venous distension.
- CARDIOVASCULAR: Cardiovascular examination reveals a regular heart rate and rhythm, without murmurs, gallops or rubs. There are normal S1 and S2 heart sounds. The point of maximal impulse is in the fifth intercostal space, left midclavicular line.
- CHEST: The chest is symmetrical. There is no increased AP diameter of the chest. The patient had rhonchi all over. He had frequent sighing breaths. He had a frequent dry cough. He did not have rales and there was no wheezing appreciated. The patient did not have cyanosis.
- EXTREMITIES: Palpation of the shoulders, elbows, wrists, and hands showed no tenderness, redness, effusion,

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swelling, heat, or any other signs of acute inflammation. There are no Heberdon nodes, Bouchard nodes, or rheumatoid nodules found. Palpation of the hips, knees, and ankles showed no tenderness, redness, effusion, or signs of acute inflammation.

The femoral pulses are 2/2 and symmetrical, without bruits. The dorsalis pedis and posterior tibial arteries have strong and symmetrical pulses. The capillary refill is normal.

Muscle development is symmetrical on both sides in the upper and lower extremities. No venous insufficiency, no varicose veins, and no stasis ulcers are found. There is no clubbing or cyanosis.

- SPINE: There is tenderness over the second and third thoracic vertebrae, tenderness over the lumbar 2<sup>nd</sup>, 3<sup>rd</sup> and L5-S1 vertebrae. The patient did not have kyphosis or scoliosis.
- RANGE OF MOTION: The cervical spine allows 60 degrees of flexion, 75 degrees of extension, lateral flexion is 45 degrees bilaterally, and rotation is 80 degrees bilaterally. Shoulder abduction is 180 degrees bilaterally; forward flexion is 180 degrees bilaterally; adduction [sic] is 50 degrees bilaterally; internal rotation is 40 degrees bilaterally and external rotation is 90 degrees bilaterally. Elbow flexion is 150 degrees bilaterally, extension is 0 degrees bilaterally, supination is 80 degrees bilaterally and pronation is 80 degrees bilaterally. Wrist dorsiflexion is 60 degrees bilaterally; palmar flexion is 70 degrees bilaterally; radial deviation is 20 degrees bilaterally and ulnar deviation is 30 degrees bilaterally. All the joints of the hands allow 90 degrees of flexion and 0 degrees of extension. The ~~straight leg raising~~ is 45 degrees bilaterally, restricted by pain in the lumbar spine. The lumbar flexion is only 30 degrees forward and 10 degrees laterally to either side, and he refused to go any further because of pain and stiffness in his back. The hips allow 100 degrees of flexion and 30 degrees of

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extension bilaterally. The knees allow 150 degrees of flexion and 0 degrees of extension bilaterally. The ankles allow 20 degrees of dorsiflexion and 40 degrees of plantar extension bilaterally.

- **NEUROLOGICAL:** The patient is alert and oriented to time, place and person. Cranial nerves II through XII were grossly normal. Sensory function to light touch and pinprick is intact throughout. The motor strength is graded 5/5 in the bilateral upper extremities and 5/5 in the bilateral lower extremities.

The mid-arm circumference is 28 centimeters bilaterally. The mid-forearm circumference is 27 centimeters bilaterally. The mid-calf circumference is 38 centimeters bilaterally. The hand grips are measured at 35 KGF on the right and 36 KGF on the left. This is normal for this right-handed individual.

The deep tendon reflexes were normal. The Babinski reflex is negative bilaterally. The patient is able to walk on the heels, on the toes and heel-to-heel in tandem. He is able to stand on either leg separately. He is able to squat fully. Fine manipulation movements were normal.

. . .

- **SUMMARY:** This 48-year old male relates a history of shortness of breath of six years duration. He used to work for almost 20 years in the coal mine, and he has a chronic cough with frequent wheezing. On the examination, the patient was noted to have a [sic] asymmetrical chest. He had frequent sighing breaths, and he had frequent dry cough. The patient also had rhonchi all over. There was not wheezing. He did not have rales. He did not have edema. His sighing breaths were carefully masked after he was trying to take deep breaths because of hypoxemia. The patient did not have cyanosis.

He complains of low back pain since 2000. He hurt his back while he was pulling a miner cable. He has had numerous workups, and he was found to have degenerative

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disk disease and diffuse bulging of the disks at the L4-L5, L5-S1 level with no significant mass effect. On the examination, the patient was able to walk with a fluid gait. He did not have any hitches in this gait and there was no lurching or unpredictably [sic] of the gait. The patient did not require any ambulatory aids. There is tenderness over the spinous process of the T2 and T3 vertebrae and tenderness over the L2-L3 and L5-S1 vertebrae. There was no kyphosis or scoliosis. The patient had restriction of straight leg raising to 45 degrees bilaterally because of pain in the lumbar spine. The lumbar flexion was only 30 degrees forward and 10 degrees laterally to either side. He flatly refused to go any further because of the pain in the lumbar spine. The patient is able to talk on the heels, on the toes and heel-to-toe in tandem. He is able to stand on either leg separately. He is able to squat fully. Fine manipulation movements were normal. The patient had a normal neurological examination. There was no muscle atrophy or weakness.

The patient has a history of testicular cancer, treated with orchilectomy. He did not have any recurrence of the cancer. There was no tenderness. There was no adenopathy noted in the inguinal areas or in the axillary and supraclavicular areas. The patient appears to be doing well from the previous orchilectomy and radiation;

147. A May 19, 2005 Medical Source Statement of Ability to do Work-Related Activities (Physical) from Dr. Sabio indicating ability to occasionally lift or carry twenty pounds, frequently lift or carry ten pounds, stand or walk for at least two hours in an eight-hour workday, and limited pushing or pulling in his lower extremities, no opinion offered regarding ability to sit, no climbing, occasional crouch, crawl, and stoop and frequent balance

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and kneel, no manipulative, visual, or communicative limitations, due to breathing problems, limited exposure to dust, fumes, odors, chemicals, and gases, but not to temperature extremes, vibrations, humidity, wetness and hazards;

148. A May 19, 2005 ventilatory function test from Tri-State Occupational Medicine indicating Shinaberry's effort was good and the pulmonary function study was normal;

149. A June 30, 2005 Physical Residual Functional Capacity Assessment from Dr. Sharp indicating ability to occasionally lift or carry ten pounds or less, frequently lift or carry ten pounds or less, stand or walk for at least two hours in an eight-hour workday, sit for a total of about six hours in an eight-hour work day with periodic alternate sitting and standing to relieve pain or discomfort, and push/pull was limited in his lower extremities, occasionally limited in his ability to climb ramps and stairs, balance, kneel, and crawl, could never climb ladders, ropes, scaffolds, stoop, or crouch, no manipulative or visual limitations, communicative limitation was noted as a one percent hearing loss, ~~unlimited exposure to noise and vibrations, avoid concentrated~~ exposure to extreme cold and heat, avoid moderate exposure to

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wetness, humidity or hazards, avoid all exposure to fumes, odors, dusts, gases, and poor ventilation.

Dr. Sharp noted Shinaberry had pneumoconiosis, which was progressive, that had caused a chronic cough and for which he would be under the constant care of a pulmonologist. Dr. Sharp also noted that Shinaberry had injuries to his lumbar, cervical and thoracic spine, which limited his physical abilities to lift, carry and bend. In Dr. Sharp's determination, "[h]is functional ability would be sedentary with limitations, under the optimal conditions. Not Pocahontas County;" and

150. A December 18, 2006, Office of Workers' Compensation Division of Coal Mine Workers' Compensation award of permanent, total disability due to "functional limitations imposed as a direct result of occupational pneumoconiosis."

**VI. DISCUSSION**

A. Standard of Review

In Hays v. Sullivan, 907 F.2d 1453, 1456 (4th Cir. 1990), the Fourth Circuit held that, in reviewing an administrative finding of ~~no disability, the Court is limited to determining whether~~ "the findings of the Secretary are supported by substantial evidence and whether the correct law was applied." In Smith v. Schweiker, 795

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F.2d 343, 345 (4<sup>th</sup> Cir.1986), the Fourth Circuit held that “[o]ur scope of review is specific and narrow. We do not conduct a de novo review of the evidence, and the Secretary’s finding of non-disability is to be upheld, even if the court disagrees, so long as it is supported by substantial evidence.”

In Richardson v. Perales, 402 U.S. 389, 401 (1971) (quoting Consolidated Edison Co. v. NLRB, 305 U.S. 197, 229 (1938)), the Supreme Court defined substantial evidence as “such relevant evidence as a reasonable mind might accept to support a conclusion.” In Hays, the Fourth Circuit elaborated on this definition, stating that substantial evidence “consists of more than a mere scintilla of evidence but may be somewhat less than a preponderance. If there is evidence to justify a refusal to direct a verdict were the case before a jury, then there is ‘substantial evidence.’” 907 F.2d at 1456 (quoting Laws v. Celebrezze, 368 F.2d 640, 642 (4th Cir. 1968)). In Coffman v. Bowen, 829 F.2d 514, 517 (4th Cir. 1987), the Fourth Circuit held that a reviewing court must also consider whether the ALJ applied the proper standards of law. “A factual finding by the ALJ is not binding if it was reached by means of an improper standard or misapplication of the law.” Id.

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**B. Credibility Analysis**

Shinaberry objects to the report and recommendation and argues that the Magistrate Judge Kaul erred in accepting the weight the ALJ assigned to the report of Dr. Landis when making his credibility analysis.

In Shively v. Heckler, 739 F.2d 987, 989 (4th Cir.1984) (citing Tyler v. Weinberger, 409 F.Supp. 776 (E.D.Va.1976)), the Fourth Circuit held that "[b]ecause he had the opportunity to observe the demeanor and to determine the credibility of the claimant, the ALJ's observations concerning these questions are to be given great weight." In Craig v. Chater, 76 F. 3d 585 (4<sup>th</sup> Cir. 1996), the Fourth Circuit developed a two-step process to determine whether a person is disabled by pain or other symptoms. Craig requires:

1) For pain to be found to be disabling, there must be shown a medically determinable impairment which could reasonably be expected to cause not just pain, or some pain, or pain of some kind or severity, but *the pain the claimant alleges she suffers*. The regulation thus requires at the threshold a showing by objective evidence of the existence of a medical impairment "which could reasonably be expected to produce the actual pain, in the amount and degree, alleged by the claimant." Cf. Jenkins, 906 F.2d at 108 (explaining that 42 U.S.C. § 423(d)(5)(A) requires "objective

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medical evidence of some condition that could reasonably be expected to produce the pain alleged"). *Foster*, 780 F.2d at 1129 . . . .

2) It is only after a claimant has met her threshold obligation of showing by objective medical evidence a medical impairment reasonably likely to cause the pain claimed, *that the intensity and persistence of the claimant's pain, and the extent to which it affects her ability to work, must be evaluated*, See 20 C.F.R. §§ 416.929(c)(1) & 404.1529(c)(1). Under the regulations, this evaluation must take into account not only the claimant's statements about her pain, but also "all the available evidence," including the claimant's medical history, medical signs, and laboratory findings, *see id.*; any objective medical evidence of pain (such as evidence of reduced joint motion, muscle spasms, deteriorating tissues, redness, etc.). See 20 C.F.R. §§ 416.929(c)(2) & 404.1529(c)(2); and any other evidence relevant to the severity of the impairment, such as evidence of the claimant's daily activities, specific descriptions of the pain, and any medical treatment taken to alleviate it. See 20 C.F.R. § 416.929(c)(3) & 404.1529(c)(3). (Emphasis added).

Id. at 594.

Here, the ALJ determined that the diagnosis of coal worker's pneumoconiosis and degenerative disc disease of the lumbosacral spine satisfied the first step of the two-prong test in Craig. The ALJ then proceeded to the second step of the two-prong test to

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determine the intensity and persistence of the pain and its limitations, if any, on Shinaberry's ability to work.

Pursuant to 20 C.F.R. § 404.1529, the ALJ reviewed Shinaberry's statements about his pain and limitations, his medical history, medical signs and laboratory findings, objective medical evidence of pain, his daily activities, his specific descriptions of the pain, and the medical treatment taken to alleviate it. During his review, the ALJ noted that, in 2000, Shinaberry applied for compensation benefits as a result of an injury to his back, and further noted that Shinaberry originally had reported to his safety director at work that he had injured his back at home while lifting a Subaru motor.

Later, however, Shinaberry told his treating physician, Dr. Sharp, that he had hurt his back either at work, pulling on a mine cable, or at home while lifting a motor. On April 19, 2000, Dr. Sharp examined Shinaberry due to increased low back pain and inability to bend over and, later, in a letter to Workers' Compensation, reported that Shinaberry told him he pulled his back ~~while lifting a motor, but continued to work, then injured his back~~ pulling a cable in the coal mine. On May 9, 2000, Shinaberry told Dr. Douglas that "while pulling a cable at the mines, he began to

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notice minor low back pain, presumed he had pulled a muscle, finished work that day, went home and then did some additional lifting at home. "

Even though, for Social Security purposes, it is not relevant exactly how Shinaberry injured his back, his inconsistent statements about how that injury occurred give rise to a credibility question. They also suggest a possible motive for an attempt to magnify the gravity of Shinaberry's limitations.

The record is clear that the ALJ reviewed all of the evidence of record prior to making his credibility determination. He reviewed Dr. McClung's report, and noted that Shinaberry remained active and that his pain relief ended after he did some tree trimming, drove a car for two hours, or performed other activities. He "tried to hunt" but "couldn't walk a mile." Dr. Landis found that Shinaberry's range of motion measurements did not pass the validity criteria, and that Shinaberry restricted his range of motion due to subjective pain. Dr. Fahim, the Medical Director of a pain management center, noted that Shinaberry's responses to the examination were exaggerated. Dr. Sabio noted that, during range of motion testing, Shinaberry "flatly refused to go any further because of pain in the lumbar spine."

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Shinaberry accurately notes that he was found to be totally and permanently impaired by the Office of Workers' Compensation, Division of Coal Mine Workers' Compensation. This determination, however, does not preclude him from all work because it was based solely on the diagnosis of pneumoconiosis and not on his back impairment or a combination of the two impairments. Moreover, after reviewing the opinion of Dr. Renn, the Magistrate Judge determined that Shinaberry was not totally disabled from all work. As noted earlier in this opinion, Dr. Renn's report from 2004 stated:

[Plaintiff] should not return to any type of work where he is exposed to coal mine dust owing to the presence of complicated coalworkers' pneumoconiosis. He is totally and permanently impaired owing to both simple and complicated coalworkers' pneumoconiosis . . . .From the medical records, catalogued above, it is evident that he has exercise-induced hypoxemia. He would be unable to perform heavy manual labor for extended periods of time.

(Emphasis added). Dr. Renn also indicated that Shinaberry only used a nebulizer "as needed," and that he had last used it three days earlier and that he had fished and hunted. Dr. Renn further noted that ~~Shinaberry had stopped woodworking, and that "[h]is usual~~ activities are shopping with his wife, reading the newspaper, doing some yard work and watching television." According to Dr. Renn,

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Shinaberry had normal spirometry and lung volume, moderately reduced diffusing capacity partially corrected toward normal when alveolar volume was considered, and normal resting arterial blood gases for his age.

In Kesling v. Secretary, 491 F.Supp. 569 (N.D.W.V. 1980), the Court held:

The medical evidence of record substantiates the presence of medically determinable physical ailments, but does not necessarily substantiate the degree of severity claimed thereby by Plaintiff. [FN\*]

FN\* In this regard, the Court notes that Plaintiff has been awarded federal black lung benefits. The only medical evidence of record which would appear to substantiate entitlement to black lung benefits is the results of a single pulmonary function study which result in qualifying values for MVV and FEV1. The Court further recognizes that entitlement to black lung benefits does not necessarily establish total disability under title II of the social Security Act.

Social Security Ruling ("SSR") 06-3p provides:

Because the ultimate responsibility for determining whether an individual is disabled under Social Security law rests with the Commissioner, we are not bound by disability decisions by other governmental and nongovernmental agencies. In addition, because other agencies may apply different rules and standards than we do for determining whether an individual is disabled, this may limit the

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relevance of a determination of disability made by another agency.

The Magistrate Judge determined that the ALJ did not "rely" solely on the opinion of Dr. Landis but, pursuant to 20 C.F.R. § 404.1527, had reviewed and considered all of the evidence of record. Regarding that review, 20 C.F.R. provides:

(d) *How we weigh medical opinions.* Regardless of its source, we will evaluate every medical opinion we receive. Unless we give a treating source's opinion controlling weight under paragraph (d)(2) of this section, we consider all of the following factors in deciding the weight we give to any medical opinion

(1) *Examining relationship.* Generally we give more weight to the opinion of a source who has examined you than to the opinion of a source who has not examined you.

(2) *Treatment relationship.* Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source's opinion on the issue(s) of the nature and severity

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of your 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, we will give it controlling weight. When we do not give the treating source's opinion controlling weight, we apply the factors listed in paragraphs (d)(2)(I) and (d)(2)(ii) of this section, as well as the factors in paragraphs (d)(3) through (d)(6) of this section in determining the weight to give the opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion.

(I) *Length of the treatment relationship and the frequency of examination.* Generally, the longer a treating source has treated you and the more times you have been seen by a treating source, the more weight we will give to the treating source's medical opinion. When the treating source has seen you a number of times and long enough to have obtained a longitudinal picture of your impairment, we will give the source's opinion more weight than we would give it if it were from a non treating source.

(ii) *Nature and extent of the treatment relationship.* Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source's medical opinion. We will

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look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories.

(3) *Supportability.* The more a medical source presents relevant evidence to support an opinion particularly medical signs and laboratory findings, the more weight we will give that opinion. . . .

(4) *Consistency.* Generally, the more consistent an opinion is with the record as a whole, the more weight we will give to that opinion.

After examining Shinaberry, Dr. Landis, an orthopedic surgeon, noted that, despite complaints of back pain on all ranges of motion, Shinaberry was able to sit on the examining table with both legs straight out in front of him and bend forward without having a significant increase in back pain. In addition to his examination, and before stating his diagnosis of simple strain/sprain type injury to the lower back superimposed on some mild degenerative changes, Dr. Landis reviewed a great deal of objective medical evidence. Significantly, he noted that ~~Shinaberry's range of motion measurements did not meet the validity~~ criteria and felt that it was inappropriate to assess impairment using range of motion guidelines. Dr. Landis did allow Shinaberry

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a minor 5% whole-man impairment, but further determined that Shinaberry was not temporarily totally disabled and "certainly capable of performing at least light to sedentary type work."

It is correct that Dr. Landis evaluated Shinaberry only for his back impairment, not his lung impairment. His opinion, however, is consistent with the evidence of record as a whole regarding Shinaberry's back impairment, and is substantially supported not only by the evidence of record but also by his own examination. Therefore, the Magistrate Judge did not err when he determined that the ALJ had properly given Dr. Landis' opinion greater weight.

The ALJ determined:

The claimant has two well-documented impairments: coal worker's pneumoconiosis and degenerative disc disease of the lumbosacral spine. Both of these impairments cause significant work-related functional limitations. But it seems that secondary gain in the form of workers' compensation (Exhibits 3D and 6D) has driven the claimant to magnify the gravity of his limitations. The evidence as a whole establishes that the severity of the claimant's impairments does not preclude all substantial gainful employment.

After careful review of all of the evidence, the Magistrate Judge determined that the record contained substantial evidence to support the ALJ's credibility determination and the Court agrees.

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C. Listing 3.02 C-3, Table III,A

Shinaberry objects to the Magistrate Judge's report and recommendation and contends that the ALJ erred in determining that he failed to meet the criteria set forth in Listing 3.02(C)(3). The Commissioner contends that the ALJ was correct in concluding that the record did not contain substantial evidence to support a finding that Shinaberry's pulmonary impairment met the requirements of Listing 3.02(C)(3).

Listing 3.02(C) provides:

C. Chronic impairment of gas exchange due to clinically documented pulmonary disease. With:

1. Single breath DLCO (see 3.00F1) less than 10.5 ml/min/mm Hg or less than 40 percent of the predicted normal value. (Predicted values must either be based on data obtained at the test site or published values from a laboratory using the same technique as the test site. The source of the predicted values should be reported. If they are not published, they should be submitted in the form of a table or nomogram); or

2. Arterial blood gas values of  $PO_2$  and simultaneously determined  $PCO_2$  measured while at rest (breathing room air, awake and sitting or standing) in a clinically stable condition on at least two occasions, three or more weeks apart within a 6-month period, equal to or less than the values specified in the applicable table III-A or III-B or III-C:

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Table III-A  
[Applicable at test sites less than 3,000 feet  
above sea level]

Arterial PCO <sub>2</sub> (mm. Hg) and	Arterial PO <sub>2</sub> equal to or less than (mm. Hg)
30 or below	65
31	64
32	63
33	62
34	61
35	60
36	59
37	58
38	57
39	56
40 or above	55

As the Magistrate Judge noted, the requirements of the listing at issue are very strict. Under "Methodology," the Regulations provide:

The individual should then perform exercise under steady state conditions, preferably on a treadmill, breathing room air, for a period of 4 to 6 minutes at a speed and grade providing an oxygen consumption of approximately 17.5 ml/kg/min (5 METS). . . . If the claimant fails to complete 4 to 6 minutes of steady

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state exercise, the testing laboratory should comment on the reason and report the actual duration and levels of exercise performed. This comment is necessary to determine if the individuals' test performance was limited by lack of effort or other impairment (e.g., cardiac, peripheral vascular, musculoskeletal, neurological.) . . . . The exercise report should contain representative ECG strips taken before, during and after exercise; resting and exercise and grade settings . . . ; and the duration of exercise . . . . The altitude of the test site, its normal range of blood gas values, and the barometric pressure on the test date must be noted.

As noted above, on January 29, 2004, Shinaberry had a treadmill stress test at Charleston Area Medical Center. The report notes that he was tested at two miles per hour and achieved his target heart rate and tolerated the test well, without complications. His post-test readings were pH 7.38, pCO<sub>2</sub> 36, pO<sub>2</sub> 57, HCO<sub>3</sub> 20, B.E. -3.6, and O<sub>2</sub> Sat. 89.

Because the initial review of the study indicated that the numbers in the January 29, 2004 report appeared to meet Listing 3.02(C)(3), the ALJ requested that Dr. Gomez, a Disability Determination Service medical consultant physician, review the report to determine whether the readings satisfied the criteria of Medical Listing 3.02C.

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Dr. Gomez reviewed the January 29, 2004 report and determined that the Arterial Blood Gas readings of pCO<sub>2</sub> 33 and pO<sub>2</sub> 84 (resting) did not meet the listing, and further indicated that he was unable to determine whether the Arterial Blood Gas readings of pCO<sub>2</sub> 36 and pO<sub>2</sub> 57 (exercise) met the Listing "since report does not give for how long patient exercised." Dr. Gomez further indicated that the May 19, 2004 PFS and DLCO readings also did not meet the listing. Thus, Dr. Gomez found that the record did not contain any test results that met the criteria of a listing.

After reviewing all this, the Magistrate Judge concluded:

The Disability Determination Service (DDS) determined that the claimant had no impairment or combination of impairments that meets, or is equivalent to, the criteria of any of the listed impairments described in Appendix 1 of the regulations at 20 CFR, part 404, Subpart P. This conclusion by the DDS's expert medical consultants is consistent with the evidence and is accorded substantial evidentiary weight under Social Security Rules 96-60. No treating or examining physician has mentioned findings identical, or equivalent in severity, to the criteria of any listed impairment. Dr. Gomez, the DDS consulting physician carefully considered the arterial blood gas study reference by claimant's counsel (Exhibits 22F and 20F) and he concluded that, due to an absence of information regarding the length of time that the claimant exercised during the test, he could not determine whether the requirements of Medical Listing 3.02C had been met. The undersigned is not in the position to

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presume, as claimant's counsel wishes, 'that exercise was done at less than five (5) METS.' (Exhibit 22F, p.1) Dr. Gomez further considered a pulmonary function studies (PFS) test and DLCO readings and opined that neither met the requirements of the appropriate Medical Listing (Exhibit 20F). Accordingly, after having reviewed the records, the undersigned finds that the claimant has not had impairments that meet or equal the requirements of any section of Appendix 1.

The Magistrate Judge also noted that, pursuant to 20 CFR § 416.927(f)(2)(I), the ALJ is not required to accept the December 18, 2006, Office of Workers' Compensation Division of Coal Mine Workers' award of permanent, total disability due to "functional limitations imposed as a direct result of occupational pneumoconiosis" because, as noted earlier, pursuant to 20 CFR § 416.927(f)(2)(I), ALJs "are not bound by any findings made by State agency medical or psychological consultants, or other program physicians or psychologists" and must only "consider findings of State agency medical and psychological consultant or other program physicians or psychologists as opinion evidence, except for the ultimate determination about whether you are disabled."

As discussed earlier, Social Security Ruling ("SSR") 06-3p provides that the ultimate responsibility for determining whether an individual is disabled under Social Security law rests with the

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Commissioner and that, because other agencies may apply rules and standards that are different from Social Security's regulations when determining whether an individual is disabled, their relevance may be limited.

The record is clear that the ALJ considered and relied on all of the evidence of record in determining that Shinaberry was not totally disabled from all work. The evidence considered included:

1. A June 9, 2004, independent medical evaluation from Dr. Renn, stating that:

[Plaintiff] should not return to any type of work where he is exposed to coal mine dust owing to the presence of complicated coalworkers' pneumoconiosis. He is totally and permanently impaired owing to both simple and complicated coalworkers' pneumoconiosis . . . From the medical records, catalogued above, it is evident that he has exercise-induced hypoxemia. He would be unable to perform heavy manual labor for extended periods of time;

and

2. A June 30, 2005, Physical Residual Functional Capacity Assessment from Dr. Sharp, Shinaberry's treating physician, indicating "[h]is [Shinaberry's] functional ability would be sedentary with limitations, 'under the optimal conditions.' Not Pocahontas County".

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The Magistrate Judge correctly determined that the ALJ had reviewed all of the medical evidence of record prior to concluding that Shinaberry did not meet any listing, and that the ALJ was correct in his decision to have a Disability Determination Service medical consultant physician review the January 29, 2004 blood gas study. Therefore, the Court agrees with the Magistrate Judge's determination that the record contains substantial evidence to support the ALJ's decision that Shinaberry failed to meet the criteria of a listing.

**D. Hypothetical to Vocational Expert**

Shinaberry contends that, even though the Magistrate Judge determined that the vocational expert's findings were not totally consistent with the ALJ's hypothetical, he erred in accepting the ALJ's determination that Shinaberry could perform work as a general office clerk or surveillance system monitor. The Commissioner contends that the ALJ properly relied upon the testimony of the vocational expert in determining that Shinaberry retained the residual functional capacity to perform a significant number of jobs in the national economy.

The ALJ asked the following hypothetical:

- Q. Please assume you are dealing with an individual the same age as the claimant who has the same educational background and

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past work experience. Further assume that the claimant retains residual functional capacity for sedentary work, with the following additional limitations. Standing at least tow hours, push-pull limited in the lower extremities, no ladders, ropes, scaffolds, stooping, or crouching, occasional climbing stairs, ramps, balancing, kneeling and crawling, avoid all exposure to fumes, odors, dust, gases, and poor ventilation, avoid even moderate exposure to extreme cold or heat. I take that since I'm at the sedentary level, he could not perform his past work. Is that correct?

A. No, sir.

Q. Could this individual perform any other job that exists in the local, regional, or national economy?

A. Under the conditions that you have set forth, yes.

Q. Could you please identify the job, their census number?

A. Yes, sir. He could do various assembly kinds of jobs performed at the sedentary, unskilled level. There's some 48,000 of those within the national economy, some 1700 of those within the region with the two regions being West Virginia and Virginia. The census number on that is 896. He could also do the work of a surveillance system monitor position. There's some 13,000 of those in the national economy, just under 500 of those in the region, with the region being Virginia and West Virginia. The census number on that is 395. He could do the work of, of a general office clerk. There's some 86,000 of those jobs in the national economy, some 2400 of those within the region. The census number on that is 582, 586. That's examples of work that he might do.

Q. Did you, did you describe them as how the [sic] describe them in the Dictionary of Occupational Terms?

A. Yes, sir.

Q. Now there are the additional requirement to avoid frequent background noise. Does that change anything?

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A. Possibly in the assembly positions. There are, is other work going on that would probably be at a moderate level.

Q. Now if same hypothetical, if you add the additional requirement that the individual be able to lay down on occasion several times a day, would those jobs be still available?

A. No Sir.

Shinaberry's attorney then asked the VE:

Q. In regard to the job that you listed Mr. Pearis, first in regard to the assembly job, out of the 58,000 national, 1700 regionally, would any of those jobs involve work in environments that may have dust, fumes, or other odors?

A. Well they all would have dust, but there's a moderate amount of dust, fumes, odors as we sit now. Reaching to a level as to be, well I don't know what his tolerance level is.

Q. Would there be more than what would be in the room that we are in today?

A. More than likely yes?

Q. Can you separate out a number from the numbers that you've given that would eliminate those jobs that would have-

A. I could not do that.

Q. Are assembly jobs generally done on a production basis?

A. Under some circumstances they might be. Generally though it's they're either coming down a line and you work at the rate of the line. In other situations in which the material is brought to you, you work it from there. Now like sewing, now like jobs that are piece work.

Q. It does require, would require that individual to be at that line to complete the work process?

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- A. Certainly, certainly.
- Q. So, if the individual had to leave to use any nebulizer for 20 minute treatments during the day, would that interfere with their ability to do that job?
- A. Certainly.
- Q. In regard to the job that you listed as surveillance system monitor and the 13,000 in the national economy and 500 in the region, are any of those government jobs?
- A. Surely.
- Q. Okay and would you be able to separate out of a portion of those that are government jobs from the numbers that you gave us today?
- A. No. I might add that for the most part those are considered to be government jobs, but I'm sure that they - - I say I'm sure. My best guess would be that they're not and this is probably one of the most under reported chops [sic] that I think we see, every Wal-Mart, every K-Mart, every bank, every - -
- Q. Government jobs generally require civil service testing?
- A. Some of them certainly would, yeah.
- Q. Would some of those jobs require a high school education?
- A. Not that I know of. Not that I'm aware of.
- Q. [INAUDIBLE] the job that you listed as a general office clerk, with 86, 000 in the national economy and 2400 in the region, what would be example of jobs [sic] duties that, that individual would have to perform?
- A. Some times they have to prepare documents of one kind or another. Sometimes they put labels on mailings, that kind of thing.

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- Q. Would that individual have to, would it require the using of any type of office equipment? {INAUDIBLE} answering the telephone, using a computer?
- A. Possibly, Not the computer, no, not generally. Copy machine maybe, sure.
- Q. If an individual had the ability as set forth at exhibit 8F which is a full scale IQ of 75, a vocabulary in the fourth grade range, and math in the eighth grade range, comprehension in the fifth grade range, would that individual have moderate difficulties in social functioning, moderate difficulties in concentration and memory, if their judgment was moderately impaired, and they had moderate limitations in their ability to understand and remember detailed instructions would that individual be able to do that job as a general office clerk?
- A. That's quite a mouthful. My head, I'm not sure if I can sort all of that quite as quickly as you gave it to me. These, let me just try and answer it this way. These are basically routine kind of low level jobs. Most of them require less than a sixth grade education. I'm not going to say they all do, but generally they're the routine, the repetitive, the easier kinds of jobs.
- Q. But if the individual had moderate difficulties in maintaining concentration, and moderate difficulties in social functioning?
- A. Okay, let me again. I get hung up on the word moderate. I'm not exactly sure what you mean. So let me try and say that if moderate means that they would have difficulty on the job, they would not be able to perform the essential functions of the job then they would not be able to do that.
- Q. Okay. If an individual had, with right arm dominant and they were limited in reaching in odd direction with the right arm, the right dominant arm and they were also limited in handling with the right arm, would that individual be able to do any of the jobs that you've listed?

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A. That individual would be limited in performing his job, but if that's what you're, again what you're saying and then it would certainly create some difficulty. And again if gets back to whether or not an individual can perform the essential elements of the job.

Q. Would this job require reaching?

A. The jobs do require, the jobs do require reaching, handling, fingering and most of them on a rather frequent basis.

At the fifth step of the sequential evaluation, "the burden shifts to the [Commissioner] to produce evidence that other jobs exist in the national economy that the claimant can perform given his age, education, and work experience." In Hunter v. Sullivan, 993 F.2d 31, 35 (4<sup>th</sup> Cir. 1992), the Fourth Circuit held that the ALJ must consider the claimant's RFC, "age, education, and past work experience to see if [he] can do other work." In Koonce v. Apfel, 166 F.3d 1209 (4<sup>th</sup> Cir 1999), the Fourth Circuit held that an ALJ has "great latitude in posing hypothetical questions" and need only include limitations that are supported by substantial evidence in the record. In Lee v. Sullivan, 945 F.2d 689 (4<sup>th</sup> Cir. 1991), the Fourth Circuit noted that a requirement introduced by claimant's counsel in a question to the VE "was not sustained by the evidence, and the vocational expert's testimony in response to the question was without support in the record."

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Pursuant to 20 C.F.R. §§ 404.1566(e), 416.966(e), an ALJ may rely on VE testimony to help determine whether other work exists in the national economy that the claimant can perform. In Walker v. Bowen, 889 F.2d 47, 50 (4<sup>th</sup> Cir. 1989), the Fourth Circuit held that "[t]he purpose of bringing in a vocational expert is to assist the ALJ in determining whether there is work available in the national economy which the particular claimant can perform." In English v. Shalala, 10 F.3d 1080, 1085 (4<sup>th</sup> Cir.1993) (citing Walker v. Bowen, 876 F.2d 1097, 1100 (4<sup>th</sup> Cir.1989)), the Fourth Circuit held that, when "questioning a vocational expert in a social security disability insurance hearing, the ALJ must propound hypothetical questions to the expert that are based upon a consideration of all relevant evidence of record on the claimant's impairment."

Moreover, in Edwards v. Bowen, 672 F. Supp. 230, 235 (E.D.N.C. 1987), the court held that if the ALJ poses a hypothetical question that accurately reflects all of the claimant's limitations, the VE's response to the question is binding on the Commissioner. Thus, the reviewing court must consider whether the hypothetical question "could be viewed as presenting those impairments the claimant alleges." English v. Shalala, 10 F.3d 1080, 1085 (4<sup>th</sup> Cir. 1993).

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The Magistrate judge determined that the ALJ had propounded a hypothetical presenting all of Shinaberry's impairments that were substantially supported by the record. Shinaberry correctly noted that the VE had stated some of the assembler jobs could involve background noise. On November 11, 2003, James E. Bland, M.D., indicated that "the four frequency totals of 100 in the right ear and 105 in the left ear would obtain a 0% wholeman impairment award. One percent would be indicated for any speech discrimination deficits, making a total bilateral wholeman impairment award of 1.0%." Significantly, on June 30, 2005, Dr. Sharp completed a Physical Residual Functional Capacity Assessment that indicated a 1% hearing loss and further reflects that Shinaberry's exposure to noise and vibration could be unlimited. Based on this evidence of record, the Magistrate judge correctly determined that the jobs listed by the VE would not be rejected due to background noise.

Regarding Shinaberry's alleged mental limitations, Dr. Joseph determined that his full scale IQ was in the Borderline Range. However, she also indicated that Shinaberry's motor activity was calm, posture was appropriate, eye contact was average, language usage was average, speed of speaking was normal, content was relevant, conduct during the interview was cooperative, no

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psychomotor disturbances were noted, affect was flat, insight was adequate, immediate memory was normal, recent memory was mildly impaired, remote memory was normal, judgment was considered moderately impaired, concentration only mildly impaired, and socialization and interaction were considered normal. Daily activities reported by Shinaberry included making the bed, dusting, cooking meals, putting groceries away, taking out the garbage, walking to the mailbox, driving a car, going grocery shopping, and managing his own finances. He fished a little and liked to play cards. Furthermore, she determined that Shinaberry's psychological prognosis was fair, that he could manage benefits, and that his socialization was within normal limits.

As noted earlier, when questioned about the clerk jobs, the VE testified that these were "basically routine kinds of low level jobs. Most of them require less than a sixth grade education. I'm not going to say they all do, but generally they're the routine, the repetitive, the easier kinds of jobs" that might require the use of a telephone or copy machine, but not a computer."

Shinaberry has provided no evidence that he is incapable of handling the simple, routine clerk jobs listed by the VE. Certainly, Dr. Sharon Joseph's evaluation offers him no support in

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that regard. Thus, after reviewing the evidence in the record, the Magistrate Judge correctly determined that the record contained substantial evidence to support the ALJ's reliance on the VE's testimony regarding the simple, routine clerk jobs, 86,000 in the national economy and 2,400 in the regional economy.

Regarding the possibility of a surveillance system monitor job, Shinaberry contends that at least some of these are government jobs that might require civil service testing. Even though the VE was unable to separate the government surveillance system monitor jobs from the non-government surveillance system monitor jobs, he testified that, while he could not provide exact numbers, he believed most of the surveillance system monitor jobs were not government jobs. To support his position, the VE noted that every Wal-mart, K-mart and bank probably has surveillance system monitor positions, and further noted that even actual government jobs would not require a high school education, or, generally, even a civil service test.

The Magistrate Judge relied on the recent case of Quesenberry v. Astrue, 2007 WL 2965042 (W.D.Va.) (slip copy), to further support the VE's testimony. In Quesenberry, the VE testified that "although the DOT listed the job of surveillance system monitor as a

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government job, that information is not accurate today because many private companies now install surveillance systems." Id at \*5.<sup>1</sup> Additionally, in Wilcox v. Barnhart, 2004 WL 1733447 (D.N.H. 2004) (not reported in F. Supp. 2d), the court disagreed with the claimant's argument that the DOT identified surveillance system monitors as government service jobs, stating:

A more close examination, however, reveals that the DOT's industry designation shows 'in what industries the occupation was studied but does not mean that it may not be found in others.' *Dictionary of Occupational Titles*, XXI (4<sup>th</sup> ed., rev. Vol I 1991). Therefore, industry designations are to be regarded as indicative of industrial location, but not necessarily restrictive.

Id.<sup>2</sup>

Therefore, the Magistrate Judge determined that, even if the limitation regarding dust eliminated the entire 1,700 regional assembly jobs (58,000 nationally), Shinaberry retained the residual functional capacity to perform the general office clerk jobs (2,400/ 86,000) and surveillance system monitor jobs (500/13,000).

Significantly, in formulating his question, the ALJ relied

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<sup>1</sup>Quesenberry is attached to this Order adopting the Magistrate Judge's Report and Recommendation.

<sup>2</sup>Wilcox is attached to this Order adopting the Magistrate Judge's Report and Recommendation.

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mainly on Shinaberry's own treating physician's opinion that he could perform a limited range of sedentary work. Therefore, the Magistrate Judge determined that the record contains substantial evidence to support the ALJ's hypothetical question and that the hypothetical accurately reflected all of the limitations substantially supported by the record. The Court agrees.

**VII. CONCLUSION**

After careful examination of his objections, it appears to the Court that Shinaberry's objections have not raised any issues that were not thoroughly considered by Magistrate Judge Kaul in his report and recommendation. Moreover, after an independent de novo consideration of all matters now before it, the Court is of the opinion that the Report and Recommendation accurately reflects the law applicable to the facts and circumstances before the Court in this action. The Court, therefore,

**ORDERS** that Magistrate Kaul's Report and Recommendation be accepted in whole and that this civil action be disposed of in accordance with the recommendation of the Magistrate. Accordingly,

1. The defendant's motion for Summary Judgment (Docket No. 12) is **GRANTED**;

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2. The plaintiff's motion for Summary Judgment (Docket No. 9) is **DENIED**; and
3. This civil action is **DISMISSED WITH PREJUDICE** and **RETIRED** from the docket of this Court.

The Clerk of Court is directed to enter a separate judgment order. Fed.R.Civ.P. 58.

The Clerk of the Court is directed to transmit copies of this Order to counsel of record.

DATED: March 7, 2008.

/s/ Irene M. Keeley  
IRENE M. KEELEY  
UNITED STATES DISTRICT JUDGE

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Quesenberry v. Astrue  
W.D.Va.,2007.

United States District Court, W.D. Virginia,  
Abingdon Division.

Thomas E. QUESENBERRY, Plaintiff,

v.

Michael J. ASTRUE, Commissioner of Social  
Security,<sup>FN1</sup> Defendant.

FN1. Michael J. Astrue became the  
Commissioner of Social Security on  
February 12, 2007, and is, therefore,  
substituted for Jo Anne B. Barnhart as the  
defendant in this suit pursuant to Federal  
Rule of Civil Procedure 25(d)(1).

Civil Action No. 1:06cv00116.

Oct. 10, 2007.

Deborah K. Garton, Hensley, Muth, Garton &  
Hayes, Bluefield, WV, Michael F. Gibson, Gibson,  
McFadden & Ash, Princeton, WV, for Plaintiff.  
Sara Bugbee Winn, United States Attorneys Office,  
Roanoke, VA, for Defendant.

**MEMORANDUM OPINION**

PAMELA MEADE SARGENT, United States  
Magistrate Judge.

\*1 In this social security case, this court affirms the  
final decision of the Commissioner denying benefits.

*I. Background and Standard of Review*

The plaintiff, Thomas E. Quesenberry, filed this  
action challenging the final decision of the  
Commissioner of Social Security, ("Commissioner"  
) , denying plaintiff's claim for disability insurance  
benefits, ("DIB"), under the Social Security Act, as  
amended, ("Act"), 42 U.S.C.A. § 423 (West 2003

& Supp.2007). Jurisdiction of this court is pursuant  
to 42 U.S.C. § 405(g). This case is before the  
undersigned magistrate judge upon transfer  
pursuant to the consent of the parties under 28  
U.S.C. § 636(c)(1).

The court's review in this case is limited to  
determining if the factual findings of the  
Commissioner are supported by substantial  
evidence and were reached through application of  
the correct legal standards. See *Coffman v. Bowen*,  
829 F.2d 514, 517 (4th Cir.1987). Substantial  
evidence has been defined as "evidence which a  
reasoning mind would accept as sufficient to  
support a particular conclusion. It consists of more  
than a mere scintilla of evidence but may be  
somewhat less than a preponderance." *Laws v.*  
*Celebrezze*, 368 F.2d 640, 642 (4th Cir.1966). "If  
there is evidence to justify a refusal to direct a  
verdict were the case before a jury, then there is "  
substantial evidence." " *Hays v. Sullivan*, 907  
F.2d 1453, 1456 (4th Cir.1990) (quoting *Laws*, 368  
F.2d at 642).

The record shows that Quesenberry filed his  
application for DIB on or about June 25, 2003,  
(Record, ("R."), at 85-88), alleging disability as of  
April 14, 2001, due to lower back problems and  
lumbar disease. (R. at 85, 102.) The claim was  
denied initially and upon reconsideration. (R. at  
32-34, 38, 40-42.) Quesenberry then timely  
requested a hearing before an administrative law  
judge, ("ALJ"). (R. at 44.) The ALJ held an initial  
hearing on August 16, 2005, at which Quesenberry  
was not represented by counsel. (R. at 406-35.) The  
ALJ kept the matter open, however, and on June 5,  
2006, the hearing was reconvened, at which time  
Quesenberry was represented by counsel. (R. at  
436-80.)

By decision dated August 18, 2006, the ALJ denied  
Quesenberry's claim. (R. at 14-29.) The ALJ found  
that Quesenberry met the nondisability insured  
status requirements of the Act for disability

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purposes through at least the date of the decision. (R. at 27.) The ALJ determined that Quesenberry had not engaged in substantial gainful activity since the alleged onset of disability. (R. at 27.) The ALJ also found that Quesenberry had medically determinable severe impairments but that Quesenberry's impairments, considered either singly or in combination, did not meet or equal the criteria of any impairments listed at or medically equal to one listed at 20 C.F.R. Part 404, Subpart P, Appendix 1. (R. at 28.) The ALJ found that Quesenberry's allegations regarding his symptoms and complaints of pain were not fully credible. (R. at 28.) In addition, the ALJ determined that since the alleged onset of disability, and through the date of his decision, Quesenberry retained the residual functional capacity to perform light work.<sup>FN2</sup>(R. at 28.) The ALJ determined that Quesenberry could stand and/or walk for a total of four to six hours, sit for a total of six hours and stand, sit or walk for one hour at a time in a typical eight-hour workday. (R. at 28.) Due to Quesenberry's limitations, the ALJ noted that he must be allowed a sit/stand option. (R. at 28.) Further, the ALJ determined that Quesenberry could occasionally reach, including overhead reaching, climb, balance, kneel, crouch, crawl, stoop and bend. (R. at 28.) Thus, the ALJ found that Quesenberry was unable to perform any of his past relevant work. (R. at 28.) Based on Quesenberry's age, education, work history and residual functional capacity and the testimony of a vocational expert, the ALJ determined there was a significant number of unskilled jobs in the national and regional economies that Quesenberry could perform, including jobs as a parking lot attendant, a nonpostal mail sorter and an office helper. (R. at 27.) Thus, the ALJ found that Quesenberry had not been disabled at any time through at least the date of the ALJ's decision and was not entitled to DIB benefits. (R. at 28-29.) See 20 C.F.R. § 404.1520(g) (2007).

FN2. Light work involves lifting items weighing up to 20 pounds at a time with frequent lifting or carrying of items weighing up to 10 pounds. See 20 C.F.R. § 404.1567(b) (2007). Furthermore, a job is considered light work when it requires a

good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. See 20 C.F.R. § 404.1567(b) (2007). If someone can perform light work, he also can perform sedentary work. See 20 C.F.R. § 404.1567(b) (2007).

\*2 After the ALJ issued his decision, Quesenberry pursued his administrative appeals but the Appeals Council denied review, thereby making the ALJ's decision the final decision of the Commissioner. (R. at 6-10.) See 20 C.F.R. § 404.981 (2007). Thereafter, Quesenberry filed this action seeking review of the ALJ's unfavorable decision. The case is before this court on Quesenberry's Motion For Judgment On The Pleadings filed July 10, 2007, and on the Commissioner's Motion For Summary Judgment filed August 8, 2007.

## II. Facts

Quesenberry was born in 1964, which classifies him as a "younger person" under 20 C.F.R. § 404.1563(c) (2007). (R. at 85.) According to the record, Quesenberry has a 12th-grade education. (R. at 108.) In addition, Quesenberry has past relevant work experience as a dishwasher/dish room assistant supervisor, an automobile mechanic, a maintenance man for a realty company and a maintenance man for a maintenance company. (R. at 103, 114-19.) Quesenberry had an initial hearing on August 16, 2005, at which he was not represented by counsel. (R. at 406-35.) The ALJ kept the matter open, however, and on June 5, 2006, the hearing was reconvened, at which time Quesenberry was represented by counsel. (R. at 436-80.)

At Quesenberry's first hearing before the ALJ on August 16, 2005, he testified that he worked from approximately 1995 to 2001 at Virginia Tech as a dish room supervisor. (R. at 416.) Quesenberry testified that he stopped working at Virginia Tech because of his back. (R. at 416.) At Virginia Tech, Quesenberry lifted items weighing up to 100 pounds. (R. at 417.) Quesenberry also testified that he worked as an automobile mechanic for most of

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his life and that he worked as a carpenter's helper and a brick mason's helper. (R. at 418.) Quesenberry noted that he worked as an automobile mechanic from 1988 to 1994, and that he worked on brakes, tune-ups, tires, state inspections, transmission work and various other tasks. (R. at 418.) Quesenberry testified that he left his job as an automobile mechanic because of his back pain and immobility. (R. at 418.)

Quesenberry testified that he was hospitalized overnight at Montgomery Regional Hospital, ("MRH"), in February 2005 for stomach problems. (R. at 418-19.) Quesenberry further noted that he was hospitalized in 2004 for pneumonia, and on another occasion in 2004, for addiction problems. (R. at 418.) Quesenberry then stated that he was hospitalized for psychiatric reasons, unrelated to addiction or substance abuse, on one or two different occasions about 10 or 15 years previously. (R. at 419.)

The ALJ next questioned Quesenberry regarding Dr. Ae-Sik Kim's specific limitations, and Quesenberry noted that Dr. Kim informed him not to "lift-what was it-I think she said 10 pounds or was it 40 pounds?"(R. at 420.) He further noted that Dr. Aikin told him that he would "probably be disabled doing any kind-moderate to mild work ..." and that he could lift items weighing up to 10 pounds. (R. at 420.) Quesenberry stated that he could stand for maybe an hour, and could walk up to half a mile if necessary. (R. at 421.) Quesenberry further noted that he could sit for about an hour or two before he had to move around, that he could lift a 24-pack of soft drinks, that he had to get on his hands and knees to pick items off the floor, that he could push a grocery cart that was one-half full, could open doors and jars, could dress himself and could climb a flight of stairs. (R. at 421-22.) Quesenberry testified that he did not believe he could perform the job of a security guard that would allow for a sit/stand option, but he was not sure. (R. at 422-23.)

\*3 Quesenberry stated that he shared responsibility of taking care of his three-year-old daughter and sometimes did light cooking. (R. at 423.) Quesenberry also stated that if necessary he could

sweep, mop, wash clothes and go grocery shopping. (R. at 424.) In response to questioning by the ALJ concerning whether Quesenberry could work a job where he did not have to lift much and where he could move around at will, Quesenberry stated that his pain kept him from working all day. (R. at 427.) Quesenberry testified that he already had undergone one back surgery, and that he was informed by Dr. Weaver that another surgery would not be helpful. (R. at 427.) Quesenberry stated that he did not know how to explain himself and that is why he believed that he needed an attorney. (R. at 427.)

Ann Marie Cash, a vocational expert, also testified at Quesenberry's hearing. (R. at 428-33.) Cash described Quesenberry's past work as a dish washroom supervisor as medium,<sup>FN3</sup> semi-skilled work, according to the Dictionary of Occupational Titles, ("DOT"). (R. at 430.) Cash noted, however, that Quesenberry's work as a dish washroom supervisor, would be considered heavy <sup>FN4</sup> work as described by Quesenberry at the hearing. (R. at 430.) Cash classified Quesenberry's past work as an automobile mechanic as medium, skilled work, according to the DOT. (R. at 430.) Cash testified that Quesenberry possessed no transferable skills from his work as an automobile mechanic. (R. at 430-31.) The ALJ then asked Cash to consider a hypothetical individual of the same, age, education, background and experience as Quesenberry who would be able to perform light work and stand or walk at least two hours, but less than six hours, in a typical eight-hour workday. (R. at 431.) The ALJ asked Cash to assume further that the hypothetical individual would be able to sit for six or more hours in a typical eight-hour workday. (R. at 431.) The ALJ also noted that the hypothetical individual would have some loss of lumbar lordosis and some restriction on the range of motion in the back, but the individual would be able to perform work that required occasional climbing of ramps and stairs. (R. at 431.) The ALJ noted that the hypothetical individual would not be able to perform work that required climbing ladders, ropes or scaffolds, and would be unable to perform work that required more than occasional balancing, kneeling, crouching, crawling, stooping and bending. (R. at 431.) The ALJ also noted that the hypothetical individual would have some limitations in reaching

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overhead and no limitations on handling, fingering or feeling. (R. at 431.) Lastly, the ALJ pointed out that the individual would have no visual, communicative or environmental limitations. (R. at 431.) Cash testified that such an individual would be able to perform jobs existing in significant numbers in the national economy including those of a receptionist/information clerk at the light and sedentary FN5 levels of exertion, a general office clerk, at the light and sedentary levels of exertion and a security worker at the light level of exertion. (R. at 432.)

FN3. Medium work involves lifting items weighing up to 50 pounds at a time with frequent lifting or carrying of items weighing up to 25 pounds. See 20 C.F.R. § 404.1567(c) (2007). If an individual can perform medium work, he also can perform light and sedentary work. See 20 C.F.R. § 404.1567(c) (2007).

FN4. Heavy work involves lifting items weighing up to 100 pounds at a time with frequent lifting or carrying of items weighing up to 50 pounds. See 20 C.F.R. § 404.1567(d) (2007). If an individual can perform heavy work, he also can perform medium, light and sedentary work. See 20 C.F.R. § 404.1567(d) (2007).

FN5. Sedentary work involves lifting items weighing up to 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers and small tools. See 20 C.F.R. § 404.1567(a) (2007).

\*4 The ALJ next asked Cash to assume that the state agency residual functional capacity evaluation was accurate and supported by objective medical evidence. (R. at 433.) Cash testified that such an individual would be unable to perform any of Quesenberry's past relevant work. (R. at 433.) The ALJ closed the hearing by noting that the record would remain open for 30 days and a supplemental hearing would be held if Quesenberry obtained a representative. (R. at 434.)

After Quesenberry obtained counsel, a supplemental hearing before the ALJ was held on June 5, 2006. (R. at 436-80.) Quesenberry's counsel moved to strike the record of Quesenberry's August 16, 2005, hearing, and the motion was denied by the ALJ. (R. at 438.)

Quesenberry testified that in May 2005 he was hospitalized because of a pancreatitis attack resulting in no specific limitations. (R. at 447.) He stated that he was subsequently hospitalized for pancreatitis in March, April and May 2006. (R. at 463-64.) Likewise, Quesenberry stated that he had undergone back surgery in the past resulting in no long-term limitations. (R. at 447.) Quesenberry testified, however, that Dr. Kim told him he could not lift items weighing more than 40 pounds and could not stand or sit for long periods. (R. at 447.) The ALJ pointed out that Quesenberry had to sit for at least 35 minutes as he rode to the supplemental hearing and that he had to sit for an hour and a half to ride to the previous hearing. (R. at 447-48.) Quesenberry estimated that he could probably sit for at least an hour, but later testified that he could sit comfortably for only 30 to 40 minutes. He testified that he could stand comfortably for 40 minutes to one hour and walk comfortably for about 20 minutes. (R. 458-59.) Quesenberry also testified that he had seen Dr. Frazier, an orthopedic surgeon, who imposed no limitations. (R. at 448.) Quesenberry testified that he could stand for an hour if necessary, walk 100 yards without feeling pain, walk up to one-half mile if necessary, lift a 24-pack of soft drinks, bend with his knees, squat, push a lawnmower, reach above his shoulders, open jars, dress himself, climb a flight of stairs if necessary and drive a car. (R. at 449-52.) Quesenberry also noted that he could cook if necessary and could take a bath or shower by himself. (R. at 453-55.) Quesenberry opined that he could not perform a job where he had to work for eight hours because of his back pain. (R. at 452-53.)

Quesenberry noted that he had a magnetic resonance image, ("MRI"), performed in March 2006 that showed a herniated disc. (R. at 459-60.) Quesenberry testified that he was restricted from lifting or carrying items weighing more than 40 or 50 pounds and from sitting or standing for prolonged

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periods. (R. at 461.) Quesenberry also stated that he previously had taken Percocet for pain, but that he no longer takes the medication because he ultimately became addicted to it. (R. at 462-63.)

\*5 Quesenberry testified that he saw a psychologist in 2004 for drug addiction. (R. at 448.) He noted that during one of his hospital visits, a doctor mentioned that an antidepressant might benefit him, but he never followed up on the suggestion. (R. at 465-66.) Quesenberry stated that he has been very depressed, was easily frustrated, sometimes threw things, had considered suicide, had trouble socializing and had crying spells at least three or four times a week. (R. at 466-68.) Quesenberry also stated that he had not gone back to visit Dr. Kim because he was ashamed of his previous medication addiction. (R. at 469.) Quesenberry noted that he saw psychologist Teresa Jarrell who did not recommend that he see a psychiatrist or another psychologist. (R. at 470.)

Olen Dodd, a vocational expert, also testified at Smith's supplemental hearing. (R. at 471-79.) Dodd classified Quesenberry's past work as an automobile mechanic as medium, skilled work. (R. at 472.) Dodd classified Quesenberry's work as a dish room supervisor as a kitchen helper as medium, unskilled work. (R. at 472.) Dodd noted that Quesenberry's past work as an automobile mechanic would contain transferable skills, such as mechanical skills, ability to read and understand technical manuals and math aptitude. (R. at 472-73.) The ALJ then asked Dodd to consider a hypothetical individual of the same, age, education, background and experience as Quesenberry who would be able to sit, stand or walk for an hour at a time or for a total of four to six hours in a typical eight-hour workday and who would be able to perform light work. (R. at 473.) The ALJ asked Dodd to assume further that the hypothetical individual could occasionally climb, balance, kneel, crouch, crawl, bend and stoop and would have an unlimited ability to handle and manipulate items, with the exception of some limitation in reaching overhead. (R. at 473.) The ALJ also noted that the hypothetical individual would have no environmental limitations. (R. at 473.)

Dodd testified that such an individual would not be able to perform Quesenberry's past work. (R. at 473.) Dodd testified, however, that there would be jobs available in significant numbers in the national economy that such an individual could perform, including those of a parking lot attendant, a nonpostal mail sorter, an office helper, a night watchman, a merchant patroller, a gate guard, an assembly worker, a repair order clerk and a surveillance system monitor. (R. at 474-75.) Dodd noted although the DOT listed the job of surveillance system monitor as a government job, that information was not accurate today because many private companies now install surveillance systems. (R. at 476.)

Dodd next was asked to consider the same hypothetical individual, but who also was markedly limited in his abilities to understand, remember and carry out detailed or complex instructions, to maintain attention and concentration for extended periods, to perform activities on schedule, maintain regular attendance and be punctual, to perform at a consistent pace, to interact appropriately with the public and with co-workers, to respond appropriately to work pressures in a normal work setting and to respond appropriately to changes in a routine work settings. (R. at 476-77.) Dodd testified that these limitations would not individually preclude many work activities, but that, cumulatively, these limitations might preclude certain jobs. (R. at 477.) Dodd stated that he also would have to consider the positive aspects of the hypothetical individual. (R. at 477.) Quesenberry's counsel then asked Dodd to consider a hypothetical individual with mild limitations on his abilities to remember simple instructions such as locations and work-like procedures, to sustain an ordinary routine without special supervision and to make simple work-related decisions, and a moderate limitation on his ability to work with or near others without being distracted by them. (R. at 477-78.) Dodd noted that such an individual would not be able to sustain employment and would have difficulty finding employment. (R. at 479.)

\*6 In rendering his decision, the ALJ reviewed records from The Neurosurgical Center of Southwest Virginia; Carilion New River Valley

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Medical Center; Occupational Medical Services; Dr. Edgar Newman Weaver, M.D.; Dr. Chris Newell, M.D.; Bluefield Mental Health Center; Montgomery Regional Hospital; Carilion Family and Obstetric Medicine, ("CFOM"); Dr. Robert Bowers, M.D.; Dr. Michael J. Hartman, M.D., a state agency physician; Dr. F. Joseph Duckwall, M.D., a state agency physician; Joseph Leizer, Ph.D., a state agency psychologist; R.J. Milan Jr., Ph.D., a state agency psychologist; and Blacksburg Physical Therapy Associates, Inc.

The record shows that Quesenberry presented to Dr. Leslie E. Badillo, M.D., of CFOM, on July 17, 2000, complaining of lower back pain. (R. at 288-289.) Dr. Badillo noted that Quesenberry had chronic back pain, stating that he incurred a back fracture while playing football and had previously undergone back surgery due to a herniated disc. (R. at 288.) Quesenberry noted that he could not stop working because he needed the money, but that his back pain worsened when he walked continually on concrete. (R. at 288.) Dr. Badillo noted that Quesenberry had good posterior flexion, good lateral flexion, good deep tendon reflexes and that his anterior flexion was a little uncomfortable. (R. at 288.) Dr. Badillo prescribed Flexeril and Lorcet and cautioned Quesenberry on overuse of his medication. (R. at 289.)

Quesenberry presented to Dr. Kent R. Aikin, M.D., of CFOM, on October 31, 2000, for a follow-up from an emergency room, ("ER"), visit the previous day regarding a rib fracture suffered while playing football. (R. at 276.) Dr. Aikin noted that the ER physician diagnosed Quesenberry with a fracture of the right fourth rib, and that a chest x-ray suggested a possible mass in the area surrounding his left mid lung. (R. at 276.) Dr. Aikin's chest exam revealed no bruising or swelling, but tenderness over the lateral right fourth rib was noted. (R. at 276.) Dr. Aikin also noted that Quesenberry's rib and chest x-rays revealed a small nodule in the area surrounding his left mid lung as well as an essentially nondisplaced right fourth rib fracture. (R. at 276.) For treatment, Dr. Aikin suggested a rib belt, scheduled a computerized tomography, ("CT") scan and prescribed Lorcet-HD for pain. (R. at 277.) CFOM's records also contain an imaging

report from October 30, 2000, noting an acute nondisplaced fracture of the anterolateral right fourth rib and minimal pleural fluid. (R. at 278.)

On November 10, 2000, Quesenberry had a follow-up visit regarding his rib pain. (R. at 274-75.) Dr. Aikin noted gradual improvement in Quesenberry's pain and a mildly tender right chest wall. (R. at 274.) Dr. Aikin instructed Quesenberry to contact him after a scheduled CT scan and otherwise continued Quesenberry on his then-current treatment. (R. at 274.) Quesenberry's CT scan was performed on November 14, 2000, revealing several pulmonary nodules, some of which were calcified and all of which were most likely granulomata. (R. 272.) On November 28, 2000, Quesenberry presented to Dr. Aikin for treatment regarding a hunting fall and for a follow-up on his rib pain. (R. at 269-70.) Quesenberry noted that he slipped while hunting and fell on his back, re-injuring his rib. (R. at 269.) Quesenberry reported increased discomfort and tenderness in the area surrounding his right ribs. (R. at 269.) Dr. Aikin noted that his office helped Quesenberry locate a rib belt and continued Quesenberry on symptomatic treatment. (R. at 270.)

\*7 On February 2, 2001, Quesenberry stated that he had nonradiating pain in his lower back and that he felt "tight and sore." (R. at 259.) An exam of Quesenberry's lower back revealed tenderness along the right paralumbar soft tissues, while his deep tendon reflexes were  $\approx 2$  patellar bilateral,  $\approx 1$  right Achilles and  $\approx 2$  left Achilles. (R. at 259.) Dr. Aikin diagnosed low right paralumbar soft tissue strain. (R. at 259.) He ordered Quesenberry to be off work for the day and continued him on his then-current medications and symptomatic treatment. (R. at 259.) On February 14, 2001, Quesenberry noted quite a bit of pain across both sides of his lower back, presacral area and buttocks and limited flexion and extension due to discomfort. (R. at 254.) Dr. Aikin reported that Quesenberry appeared mildly uncomfortable and had tenderness in his back's soft tissue region, but that he had good strength in his legs and a normal gait. (R. at 254.) Quesenberry was diagnosed with low back strain. (R. at 254.) Dr. Aikin recommended physical therapy. (R. at 254.)

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Quesenberry was evaluated by Rony Masri, M.P.T., A.T.C., of Blacksburg Physical Therapy Associates, Inc., on February 15, 2001. (R. at 252-53.) Masri noted that Quesenberry complained of intermittent back pain for the previous 10 to 15 years, stemming from a high school football injury. (R. at 252.) Quesenberry reported his most recent exacerbation to be four or five months prior to his visit with Masri, and he described his pain as a five or six on a ten-point scale. (R. at 252.) Quesenberry described the pain as an intermittent dull, achy pain that worsened with sitting, bending and standing. (R. at 252.) He denied numbness and tingling in his lower extremities, and noted that he had previous success with physical therapy. (R. at 252.) Masri found that Quesenberry had a slow, guarded gait and a slouched, forward head posture. (R. at 252.) Quesenberry's lumbar lordosis and left lumbosacral shift was reduced when standing, and myotomal and dermatomal scans were clear. (R. at 252.) Masri also noted intact reflexes and sensation bilaterally in the lower extremities, a negative slump sitting test, negative straight leg raise tests and complaints of pulling in the low back region. (R. at 252.) Masri described Quesenberry's lumbar range of motion as follows: flexion to the mid-thigh with complaints of increased low back pain, extension 50 percent limited with reports of relief in pain and side bending two inches from the distal knee crease with no increase in symptoms. (R. at 252.) Masri noted that Quesenberry was able to ambulate on his heels and toes without reports of pain or difficulty, and that palpation revealed tenderness throughout the lumbosacral area. (R. at 252.) Masri discussed immediate and long-term goals, including correction of Quesenberry's lumbosacral shift, posture training, moist heat and electrical stimulation for symptomatic relief and the initiation of a home exercise program. (R. at 252-53.)

\*8 On February 23, 2001, Quesenberry reported no significant overall improvement in his back pain, but also reported increased back pain when standing. (R. at 249.) Dr. Aikin diagnosed low back strain. (R. at 249.) Dr. Aikin noted that Quesenberry needed a neurosurgical evaluation, referred Quesenberry to Dr. Edgar N. Weaver, M.D., a board certified neurosurgeon, and directed Quesenberry to remain off work. (R. at 221,

248-50.) On March 1, 2001, Dr. Aikin ordered Quesenberry's physical therapy to continue for four more weeks. (R. at 244.) On March 12, 2001, Quesenberry called Dr. Aikin and requested an order for more time off work, and Dr. Aikin extended his time off work until March 19, 2001. (R. at 242.)

In addition, on March 12, 2001, Quesenberry presented to Dr. Edgar N. Weaver Jr., M.D., a neurosurgeon. (R. at 142.) Dr. Weaver noted that Quesenberry had undergone a simple decompressive procedure at the L5-6 level of the spine, and that he had spondylolysis at that level. (R. at 142.) On examination by Dr. Weaver, Quesenberry had some tenderness at the lumbosacral junction and some diminution of right angle jerk. (R. at 142.) Dr. Weaver recommended that Quesenberry return to work the next day, and if Quesenberry was unable to work, Dr. Weaver recommended that he undergo a formal functional capacity evaluation. (R. at 142.) Dr. Weaver opined that Quesenberry was not a surgical candidate. (R. at 142.)

On March 20, 2001, Quesenberry presented to Dr. Aikin, complaining of back pain that disturbed his sleep and caused him to feel fatigued and frustrated. (R. at 222.) Quesenberry noted that he did not feel he could perform his job adequately, and he did not feel like he could attend physical therapy. (R. at 222.) Dr. Aikin diagnosed a low back strain with persistent pain and depression that was secondary to his back pain. (R. at 222-23.) Dr. Aikin started Quesenberry on amitriptyline for sleep, ordered him off work until March 26, 2001, and directed Quesenberry to return to physical therapy. (R. at 223.)

On March 26, 2001, Dr. Aikin diagnosed Quesenberry with acute viral gastroenteritis, possible alcohol-induced gastritis and low back strain. (R. at 220.) Dr. Aikin increased Quesenberry's amitriptyline dosage and ordered him off work until April 3, 2001. (R. at 217-20.) Quesenberry returned to Dr. Aikin's office the next day, March 27, 2001, and was given an injection of Nubain and Phenergan for his continued stomach problems. (R. at 215-16.) An imaging report dated

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March 28, 2001, of an abdominal x-ray revealed that Quesenberry's intestinal gas pattern, soft tissues and bones appeared normal. (R. at 213.)

Quesenberry presented to Dr. Aikin for a back pain follow-up on April 2, 2001. (R. at 211-12.) Quesenberry reported that he was sleeping better because of the amitriptyline, had no new back-related symptoms and was eating normally, with no nausea, vomiting or other stomach problems. (R. at 211-12.) Dr. Aikin diagnosed Quesenberry with a lumbar strain, underlying chronic degenerative disc disease and degenerative joint disease, but he noted that Quesenberry had "certainly reached a level of improvement that would allow a trial of work." (R. at 212.) Quesenberry returned to work on April 3, 2001, but called Dr. Aikin's office on April 10, 2001, to inform Dr. Aikin that he could work only two and one-half days during the week of April 3 and would like a functional capacity evaluation to be performed. (R. at 209-10.) On April 10, 2001, Dr. Aikin wrote a letter to Quesenberry's then-current employer, noting that Quesenberry was disabled from his present occupation and that he had advised Quesenberry to remain off work and to continue treatment for his back. (R. at 207.) Dr. Aikin anticipated that Quesenberry's condition would result in a permanent disability for moderate to heavy work. (R. at 207.)

\*9 On May 22, 2001, Dr. Aikin reported that Quesenberry's back pain was moderate and radiated down to his legs. (R. at 197.) Dr. Aikin noted that Quesenberry continued to guard movement of his back, but that he ambulated normally. (R. at 197.) Quesenberry also complained of emotional distress due to concern over his health problems and financial matters. (R. at 197.) Dr. Aikin diagnosed depressive disorder with anxiety and chronic low back pain. (R. at 198.) Dr. Aikin prescribed Paxil for depression, and he recommended that Quesenberry see Dr. Wilson for a rehabilitation evaluation. (R. at 198.) On June 20, 2001, Dr. Aikin sent Dr. Wilson a letter asking him to suggest a new avenue of treatment for Quesenberry's pain. (R. at 194.) Dr. Aikin noted that Dr. Weaver did not feel that Quesenberry had a surgical problem, and that Quesenberry had failed to respond adequately to

medication and physical therapy. (R. at 194.) Dr. Aikin also wrote that Quesenberry appeared to be genuinely motivated to get back to some type of employment. (R. at 194.)

Quesenberry visited the ER on July 16, 2001, complaining of lower back pain. (R. at 144, 189.) A physical examination by the ER physician revealed pain and tightness primarily in the sacroiliac joints bilaterally and down through his paraspinous muscles bilaterally. (R. at 144, 189.) The ER physician gave Quesenberry an injection of Toradol, instructed him to use ice packs and prescribed Voltaren. (R. at 144, 189.)

On July 18, 2001, Quesenberry sought treatment at CFOM to follow up on his back pain. (R. at 187.) Quesenberry informed Dr. Aikin that he would like to stop taking Percocet, and that he did feel that Paxil was helping to level out his moods. (R. at 187.) Dr. Aikin diagnosed Quesenberry with low back pain and directed Quesenberry to resume taking Paxil and to take one-half of a Percocet along with Ultram and Celebrex for pain. (R. at 187.)

After being referred by Dr. Aikin, Quesenberry presented to Dr. Richard L. Wilson Jr., M.D., on August 1, 2001, complaining of low back pain and bilateral knee pain. (R. at 151.) On physical examination, Dr. Wilson found that Quesenberry had full range of motion of the lumbar spine, no real pain on direct palpation, normal strength, normal sensation, normal reflexes, no ligamentous laxities or other reproducible pains in the knee and some scattered mild arthritic changes. (R. at 151.) Dr. Wilson noted that x-rays of the lumbar spine and knees were essentially unremarkable. (R. at 151.) Dr. Wilson started Quesenberry on Voltaren, Neurontin and Ultram in an attempt to keep Quesenberry off opiates. (R. at 151.)

Quesenberry presented to Dr. Wilson for follow-ups on his back pain on August 29, September 5 and September 12, 2001. (R. at 148-50.) On August 2, Quesenberry informed Dr. Wilson that he was not tolerating Voltaren, but that Ultram helped with his knee pain. (R. at 150.) After reviewing a pain medication agreement with Quesenberry, Dr.

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Wilson started Quesenberry on methadone and noted that Quesenberry did have the functional capacities to perform the majority of job duties, particularly if they were in the sedentary or light work categories. (R. at 150.) On September 5, 2001, Dr. Wilson increased Quesenberry's dosage of Methadone and noted that Quesenberry was observed ambulating normally. (R. at 149.) Dr. Weaver continued Quesenberry's medication regime on September 12, 2001, and scheduled him for monthly visits after noting that Quesenberry's complaints of pain were subjective and Quesenberry appeared to be active and doing well. (R. at 148.)

\*10 Quesenberry presented to Dr. Aikin on October 23, 2001, for a follow-up to a hospital visit on October 14, 2001. (R. at 183.) Dr. Aikin's records indicate that Quesenberry fell off of a ladder on October 11, 2001, and went to the ER three days later after continued shortness of breath and discomfort. (R. at 183.) Quesenberry was admitted to the hospital and was under a hospital physician's care for two days. (R. at 183.) Quesenberry noted that he was no longer under Dr. Wilson's care, however, because Dr. Wilson was unable to help with his symptoms. (R. at 184.) Dr. Aikin noted that Quesenberry's lungs were clear and that his chest wall was somewhat tender on the right side. (R. at 184.) Quesenberry was advised to quit smoking and to continue symptomatic treatment for his back and rib pain. (R. at 184.)

Quesenberry presented to Dr. Aikin on December 17, 2001, for an evaluation of a twisted left knee after he slipped in his kitchen and struck the anterior aspect of his left knee. (R. at 239.) Dr. Aikin noted an abrasion across the prepatellar aspect of the left knee, guarded movement, excellent strength and stability in the joint, diffuse tenderness and slight swelling. (R. at 239.) An x-ray of Quesenberry's left knee did not reveal any evident bony abnormality. (R. at 239.) Dr. Aikin diagnosed a contusion and probable mild strain of the left knee, and he ordered Quesenberry to use crutches and ice several times a day, followed by heat for several days. (R. at 240.)

On January 9, 2002, Quesenberry presented to Dr. Thomas C. Mogen, M.D., of CFOM, complaining

of pain as a result of falling on ice. (R. at 235-36.) Quesenberry reported having abrasions and pain around his shoulder and right lateral ribs as a result of the fall. (R. at 235.) Dr. Mogen's physical exam revealed no other significant abnormalities except tenderness over his right lateral rib area accompanied by abrasions on his right side. (R. at 236.) Dr. Mogen diagnosed minor chest pain and a contusion to Quesenberry's chest wall, prescribed Lodine and Tylenol # 3 and instructed Quesenberry to rest and apply heat to the pain. (R. at 236.)

On January 18, 2002, Quesenberry complained of cough and sinus congestion accompanied by right lateral upper chest and lateral and upper right back pain. (R. at 232-33.) Dr. Mogen's physical exam revealed tenderness in Quesenberry's right lateral ribs, which extended to Quesenberry's back and right shoulder blade region. (R. at 233.) Dr. Mogen diagnosed minor chest pain and prescribed Percocet and Skelaxin for relief. (R. at 233.) Dr. Mogen also scheduled physical therapy for Quesenberry, ordered rib x-rays and directed him to start a walking program. (R. at 233.)

Quesenberry had a left knee x-ray at Carilion Health Systems on January 22, 2002. (R. at 231.) The imaging report revealed no evidence of fracture or dislocation; however, there was a small focus of sclerosis involving the posterior cortex of the distal femoral diaphysis/metaphysis. (R. at 231.) On January 29, 2002, Quesenberry called CFOM requesting medication for depression and was prescribed Paxil by Dr. Aikin. (R. at 230.) On November 16, 2002, Quesenberry had right rib x-rays taken at Carilion New River Valley Medical Center. (R. at 146.) The x-rays revealed no rib abnormalities and widening of the upper mediastinum. (R. at 146.) Radiologist, Dr. Donna L. Aubrey, M.D., recommended a CT scan for further evaluation. (R. at 146.)

\*11 Quesenberry was seen at the ER for abdominal pain on May 13, 2003. (R. at 175.) The ER physician determined that Quesenberry "probably [had] a small ventral hernia." (R. at 175.) The ER physician ordered a CT scan and prescribed Vicodin for pain. (R. at 175.) CFOM's records show that Quesenberry underwent a CT scan of his pelvis and

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abdomen on May 14, 2003, which revealed several small right middle lobe nodules and a small left lower lobe nodule, all completely characterized. (R. at 293.) A tiny right anteriorpericardiophrenic lymph node was noted along with minimal bilateral pleural thickening. (R. at 293.) The CT scan also revealed no definite evidence of acute intra-abdominal or pelvic inflammatory process, no free fluid, no free air, no abscess, no stones or hydronephrosis and no evidence of obstruction. (R. at 293.)

On May 15, 2003, Quesenberry's hernia was reduced, and a ventral herniorrhaphy was performed. (R. at 165-67.) Quesenberry tolerated the procedure well and left the operating room in satisfactory condition. (R. at 167.) Quesenberry presented to Dr. Robert M. Bowers, M.D., of CFOM, for a follow-up regarding his ventral hernia repair on May 20, 2003, and May 28, 2003. (R. at 160, 164.) On May 20, Dr. Bowers noted that Quesenberry was having some discomfort, but was doing well overall. (R. at 164.) On May 28, Dr. Bowers indicated that Quesenberry was feeling well with no complaints. (R. at 160.) At both visits, Dr. Bowers instructed Quesenberry not to do any heavy lifting. (R. at 160, 164.)

Quesenberry presented to Dr. Ae-Sik Kim, M.D., on May 29, June 26 and July 24, 2003, for referral visits regarding his back pain.<sup>FN6</sup>(R. at 153-54, 159.) Dr. Kim reported that Quesenberry had pain in the middle of his back, extending into his right hip and down the back of his leg. (R. at 159.) Quesenberry indicated that the pain had become worse over the previous three weeks and that pain pills helped a little. (R. at 159.) Quesenberry also indicated increased hernia pain. (R. at 159.) On June 26, 2003, Dr. Kim noted that Quesenberry continued to have lower back pain and that he was experiencing anxiety and depression. (R. at 154.) On July 24, 2003, Dr. Kim noted that Quesenberry had "stabbing and aching" back pain that affected his hips and legs. (R. at 153.)

FN6. Dr. Kim's records are mostly illegible.

Dr. Michael J. Hartman, M.D., a state agency

physician, completed a physical residual functional capacity assessment on September 2, 2003. (R. at 294-99.) Dr. Hartman found that Quesenberry was able to occasionally lift and/or carry items weighing up to 50 pounds, frequently lift and/or carry items weighing up to 25 pounds, stand and/or walk for a total of six hours in a typical eight-hour workday, sit for a total of six hours in a typical eight-hour workday and push and/or pull an unlimited amount of time during a typical eight-hour workday. (R. at 295.) Dr. Hartman imposed no postural, manipulative, visual, communicative or environmental limitations. (R. at 296-97.) Dr. Hartman found Quesenberry's statements regarding his symptoms to be partially credible. (R. at 300.) Dr. F. Joseph Duckwall, M.D., another state agency physician, reviewed Dr. Hartman's report and affirmed his findings on November 26, 2003. (R. at 299.)

\*12 Joseph Leizer, Ph.D., a state agency psychologist, completed a Psychiatric Review Technique form, ("PRTF"), on September 2, 2003. (R. at 301-13.) Leizer's assessment revealed a nonsevere impairment, namely depression. (R. at 301, 304.) Leizer reported that Quesenberry had no limitation on his ability to maintain social functioning, no difficulty in maintaining concentration, persistence and pace and no repeated episodes of decompensation. (R. at 311.) Leizer reported that there was insufficient evidence to determine whether Quesenberry had any restrictions on his activities of daily living. (R. at 311.) Leizer noted that Quesenberry's mental impairments were not severe, and his allegations were not considered credible. (R. at 313.) R.J. Milan Jr., Ph.D., another state agency psychologist, reviewed Leizer's report and affirmed his findings on November 25, 2003. (R. at 301.)

On May 4, 2004, Quesenberry was admitted as a walk-in patient to Carilion Saint Albans Behavioral Health Unit, ("Saint Albans"), for treatment of opiate abuse and depression. (R. at 344-54.) Quesenberry was treated by Dr. Hal G. Gillespie, M.D., and was diagnosed with recurrent and severe, recurrent major depression and opiate dependence and abuse. (R. at 345.) Quesenberry's medication was slowly reduced throughout eight days of

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treatment, and multiple medications were provided for his depression and anxiety related to his withdrawal symptoms. (R. at 344-54.) At discharge, Dr. Gillespie noted that Quesenberry denied suicidal ideation, continued to complain of nonmanageable severe back pain and continued to have significant depression and anxiety. (R. at 345.) Quesenberry was released with instructions on how to control his use of pain medicine, and he was prescribed enough Percocet to last him until his next appointment with Dr. Kim. (R. at 345.)

Quesenberry presented to Dr. Aikin on June 2, 2004, complaining of continued symptoms from a previous bout with pneumonia. (R. at 377.) Dr. Aikin informed Quesenberry that many of his symptoms could be the result of Percocet withdrawal and instructed him to contact the psychiatry service at Saint Albans if necessary. (R. at 378.) Dr. Aikin did not feel it was appropriate to prescribe Quesenberry any more narcotic medication, including cough medicine, and instead, prescribed Tessalon Perles for Quesenberry's cough. (R. at 377.)

Dr. Chris Newell, M.D., completed a medical consultant report for Quesenberry on March 17, 2005. (R. at 315.) Dr. Newell determined that Quesenberry could stand or walk at least two hours in a typical eight-hour workday, sit about six hours in a typical eight-hour workday, lift and/or carry items weighing up to 10 pounds frequently and items weighing up to 20 pounds occasionally, bend, stoop and crawl occasionally and reach, handle, feel, grasp and finger frequently. (R. at 318-19.) Dr. Newell imposed no visual or communicative limitations. (R. at 319.)

Upon referral of legal counsel, Quesenberry presented to Teresa E. Jarrell, M.A., a licensed psychologist, on October 6, 2005. (R. at 325-42.) Jarrell completed a psychological evaluation on October 6, 2005, and a mental assessment on October 22, 2005. (R. at 325-42.) Jarrell found that Quesenberry had mild limitations on his ability to remember locations and work-like procedures, to understand, remember, and carry out short, simple instructions, to sustain an ordinary routine without special supervision and to make simple

work-related decisions. (R. at 325.) Jarrell also found that Quesenberry had a moderate limitation on his ability to work with or near others without being distracted by them. (R. at 325.) Jarrell also found that Quesenberry had marked limitations on his ability to understand, remember and carry out detailed or complex instructions, to maintain attention and concentration for extended periods, to perform activities within a schedule, maintain regular attendance and be punctual, to complete a normal workday or workweek, to perform at a consistent pace, to interact appropriately with the public, supervisors and co-workers and to respond appropriately to work pressures and changes in a normal or routine work setting. (R. at 325-26.) In addition, Jarrell noted that Quesenberry's abilities to apply mathematical skills, to spell and to express thoughts were significantly below average, while his alertness to attention and detail was hindered by pain. (R. at 326.) Jarrell determined that Quesenberry's mental impairments would cause him to be absent from work about three times a month. (R. at 327.) Jarrell assessed Quesenberry's Global Assessment of Functioning, ("GAF"), score to be 50.<sup>FN7</sup>(R. at 341.) Jarrell concluded that Quesenberry did not appear capable of sustained, competitive, gainful employment and that his prognosis was poor. (R. at 341-42.)

FN7. The GAF scale ranges from zero to 100 and "[c]onsider[s] psychological, social and occupational functioning on a hypothetical continuum of mental health-illness."DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS FOURTH EDITION, ("DSM-IV"), 32 (American Psychiatric Association 1994.) A GAF score of 41-50 indicates "serious symptoms ... OR any serious impairment in social, occupational or school functioning."DSM-IV at 32.

\*13 Quesenberry presented to Dr. Reed R. Lambert, M.D., of CFOM, on March 2, 2006, complaining of chronic back pain and weakness. (R. at 393-94.) Dr. Lambert noted that Quesenberry had right radicular problems, 3/5 extensor weakness and that he could not stand on his toes due to his right foot weakness.

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(R. at 393.) Dr. Lambert prescribed Ultram and Naprosyn for Quesenberry's back pain and recommended an MRI. (R. at 394.)

Quesenberry was admitted to MRH on March 12, 2006. (R. at 355-56.) While at MRH, Quesenberry was treated for abdominal pain due to acute pancreatitis. (R. at 356.) Quesenberry was discharged on March 16, 2006. (R. at 356.) He also was admitted to MRH on April 13, 2006, for pancreatitis and dyslipidemia and was discharged on April 18, 2006. (R. at 360-61.) After an ER visit on May 2, 2006, for abdominal pain and vomiting, Quesenberry was admitted to MRH a third time on May 3, 2006, for pancreatitis and irritable bowel syndrome. (R. at 357-58, 366-67.) He was discharged on May 8, 2006. (R. at 358.) Quesenberry also was seen at MRH's ER on May 20, 2006, for dental pain. (R. at 373-76.)

## II. Analysis

The Commissioner uses a five-step process in evaluating DIB claims. *See* 20 C.F.R. § 404.1520 (2007); *see also Heckler v. Campbell*, 471 U.S. 458, 460-62 (1983); *Hall v. Harris*, 658 F.2d 260, 264-65 (4th Cir.1981). This process requires the Commissioner to consider, in order, 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. *See* 20 C.F.R. § 404.1520 (2007). If the Commissioner finds conclusively that a claimant is or is not disabled at any point in the process, review does not proceed to the next step. *See* 20 C.F.R. § 404.1520(a) (2007).

Under this analysis, a claimant has the initial burden of showing that he is unable to return to his past relevant work because of his impairments. If the claimant is able to establish a prima facie case of disability, the burden shifts to the Commissioner. To satisfy the burden, the Commissioner must then establish that the claimant maintains the residual functional capacity, considering the claimant's age, education, work experience and impairments, to perform alternative jobs that exist in the national

economy. *See* 42 U.S.C.A. §§ 423(d)(2)(A) (West 2003 & Supp.2007); *McLain v. Schweiker*, 715 F.2d 866, 868-69 (4th Cir.1983); *Hall*, 658 F.2d at 264-65; *Wilson v. Califano*, 617 F.2d 1050, 1053 (4th Cir.1980).

By decision dated August 18, 2006, the ALJ denied Quesenberry's claim. (R. at 14-29.) The ALJ found that Quesenberry had medically determinable severe impairments, but that Quesenberry's impairments, considered either singly or in combination, did not meet or equal the criteria of any impairments listed at or medically equal to one listed at 20 C.F.R. Part 404, Subpart P, Appendix 1. (R. at 28.) In addition, the ALJ determined that since the alleged onset of disability, and through the date of his decision, Quesenberry retained the residual functional capacity to perform light work with a sit/stand option and occasional abilities to reach, including overhead reaching, to climb, to balance, to kneel, to crouch, to crawl, to stoop and to bend. (R. at 28.) Thus, the ALJ determined that Quesenberry was unable to perform any of his past relevant work. (R. at 28.) Based on Quesenberry's age, education, past work experience and residual functional capacity and the testimony of a vocational expert, the ALJ determined there were a significant number of unskilled jobs in the national and regional economies that Quesenberry could perform, including jobs as a parking lot attendant, a nonpostal mail sorter and an office helper. (R. at 27-28.) Thus, the ALJ found that Quesenberry was not disabled at any time through at least the date of the ALJ's decision. (R. at 28-29.) *See* 20 C.F.R. § 404.1520(g) (2007).

\*14 Quesenberry argues that the ALJ's decision was not supported by substantial evidence. (Brief In Support Of Motion For Judgment On The Pleadings, ("Plaintiff's Brief"), at 2-9.) In particular, Quesenberry first argues that the ALJ erred by not allowing him to be represented by counsel at his first hearing. (Plaintiff's Brief at 4-5.) Second, Quesenberry argues that the ALJ failed to identify his severe impairment(s). (Plaintiff's Brief at 5.) Third, Quesenberry argues that the ALJ disregarded expert evidence concerning his mental limitations and, instead, relied on his own personal opinion regarding those limitations, excluding certain

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mental limitations from his hypothetical question to the vocational expert. (Plaintiff's Brief at 6-8.) Fourth, Quesenberry argues that the ALJ erred by failing to consider Dr. Newell's opinion that Quesenberry would need to be absent from work two or more days a month. (Plaintiff's Brief at 8.) Fifth, Quesenberry argues that the ALJ's determination of Quesenberry his residual functional capacity is not supported by the record and is based solely on his own opinion. (Plaintiff's Brief at 8-9.)

The court's function in this case is limited to determining whether substantial evidence exists in the record to support the ALJ's findings. This court must not weigh the evidence, as this court lacks the authority to substitute its judgment for that of the Commissioner, if his decision is supported by substantial evidence. *See Hays*, 907 F.2d at 1456. In determining whether substantial evidence supports the Commissioner's decision, the court also must consider whether the ALJ analyzed all of the relevant evidence and whether the ALJ sufficiently explained his findings and his rationale in crediting evidence. *See Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 439-40 (4th Cir.1997).

Quesenberry's first argument is that the ALJ erred by not allowing him to be represented by counsel at his first hearing.<sup>FN8</sup> (Plaintiff's Brief at 4-5.) I disagree. While, it is well-settled that claimants in disability cases are entitled to a full and fair hearing of their claims, and the failure to have such a hearing may constitute good cause sufficient to remand to the Commissioner under 42 U.S.C. § 405(g), the "lack of representation by counsel is not by itself an indication that a hearing was not full and fair...." *Sims v. Harris*, 631 F.2d 26, 27-28 (4th Cir.1980). The absence of counsel at Quesenberry's first hearing did not create clear prejudice or unfairness to Quesenberry and thus, remand is not proper on this basis. *See Dombrowsky v. Califano*, 606 F.2d 403 (3rd Cir.1979); *Cross v. Finch*, 427 F.2d 406 (5th Cir.1970).

FN8. Exhibit A to Plaintiff's Brief is a form completed by Quesenberry, noting that he did not wish to proceed without an

attorney or non-attorney representative.

Quesenberry offers no evidence that his record was not fully developed. To the contrary, the ALJ provided Quesenberry with the opportunity to obtain a representative, supplement the record and obtain a supplemental hearing. Quesenberry did, in fact, obtain a representative, supplement the record and attend a supplemental hearing. There is no evidence to suggest that the ALJ did not adequately develop the record after two hearings, two examinations of two different vocational experts and the ability of Quesenberry's counsel to examine both Quesenberry and the vocational expert upon which the ALJ relied. (R. at 27.) Moreover, Quesenberry has failed to offer any harmful or incorrect evidence from the first administrative hearing that was unable to be clarified at the second hearing. For these reasons, I find that the ALJ did not err in this regard.

\*15 Quesenberry's second argument is that the ALJ failed to identify his severe impairment(s). (Plaintiff's Brief at 5.) Particularly, in his brief, Quesenberry asks, "[h]ow can a reviewing court possibly determine whether an impairment(s) was properly evaluated if one does not know what the impairment is or the Listing to which it was compared?" (Plaintiff's Brief at 6.) Quesenberry's brief, however, fails to suggest any listed impairment that the ALJ should have considered. Further, Quesenberry fails to cite any case law, statute, regulation or significant reason indicating why the ALJ should mechanically state that each physical symptom discussed was compared to any possible applicable listing. Quesenberry's argument is analogous to the following argument made in *Russell v. Chater*, No. 94-2371, 1995 WL 417576, \*3-4 (4th Cir. July 7, 1995):

[Russell's counsel] maintains that the ALJ should have undertaken a detailed comparison of Russell's symptoms with each of the listed impairments set forth in the applicable regulations. Absent such an examination, Russell contends, judicial review is impossible.

We disagree. In *Cook v. Heckler*, 783 F.2d 1168 (4th Cir.1986), we remanded for further explanation because the ALJ failed to explain his conclusion that the claimant's disabilities were not equivalent to

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any listed impairment. We explained: The ALJ should have identified the relevant listed impairments. He should then have compared each of the listed criteria to the evidence of Cook's symptoms. Without such an explanation, it is simply impossible to tell whether there was substantial evidence to support the determination. *Cook*, however, does not establish an inflexible rule requiring an exhaustive point-by-point discussion in all cases. Here, the need for a full explanation is questionable at best because Russell does not take issue with the *substance* of the ALJ's step-three analysis; notably absent from his briefs on appeal is any meaningful contention that the ALJ's step-three determination is unsupported by substantial evidence. Moreover, this case is factually distinguishable from *Cook*. There, a number of listed conditions were potentially applicable, but we could not sort through the possibilities because of the ALJ's cursory and internally inconsistent findings; here, the ALJ discussed the evidence in detail and amply explained the reasoning which supported his determination. There is thus no impediment to judicial review in the case before us. (citations omitted)

Likewise, in this case, Quesenberry's brief lacks any meaningful contention that the ALJ's step-three determination is unsupported by substantial evidence. Further, the ALJ's opinion does not contain cursory or internally consistent findings. The ALJ discussed the pertinent medical evidence in detail and amply explained the reasoning which supported his determination. See *Huntington v. Apfel*, 101 F.Supp.2d 384, 391 n. 7 (D.Md.2000); *Ketcher v. Apfel*, 68 F.Supp.2d 629, 646-47 (D.Md.1999). Thus, the record below is adequate and there is no impediment to judicial review of this case.

\*16 Quesenberry's third argument is that the ALJ impermissibly disregarded psychologist Teresa Jarrell's expert evidence concerning Quesenberry's mental limitations. (Plaintiff's Brief at 6-8.) As a result, Quesenberry argues that the ALJ failed to include all of Quesenberry's mental limitations in his hypothetical question to the vocational expert. Insofar as Quesenberry argues substantial evidence does not exist in the record to support the ALJ's

determination of his mental impairments, I disagree. As a result, the ALJ's hypothetical question is not required to include mental impairments that the ALJ rejects. It is clear in the ALJ's opinion that he rejected Jarrell's assessment because it conflicted with substantial evidence in the record. (R. at 20-24.) It is well-settled that the ALJ has a duty to weigh the evidence, including the medical evidence, in order to resolve any conflicts which might appear therein. See *Hays*, 907 F.2d at 1456; *Taylor v. Weinberger*, 528 F.2d 1153, 1156 (4th Cir.1975). Specifically, the ALJ must indicate explicitly that he has weighed all relevant evidence and must indicate the weight given to this evidence. See *Stawls v. Califano*, 596 F.2d 1209, 1213 (4th Cir.1979). While an ALJ may not reject medical evidence for no reason or for the wrong reason, see *King v. Califano*, 615 F.2d 1018, 1020 (4th Cir.1980), an ALJ may, under the regulations, assign no or little weight to a medical opinion, even one from a treating source, based on the factors set forth at 20 C.F.R. § 404.1527(d), if he sufficiently explains his rationale and if the record supports his findings.

Here, conflicting psychiatric and psychological evidence exists in the record. In this case, the evidence shows that Quesenberry's mental limitations, aside from sporadic bouts of depression, appear only in Teresa Jarrell's report, which was made after only one visit with Quesenberry. (R. at 20.) None of Quesenberry's treating physicians referred him to a mental health professional, and he sought treatment from Jarrell only after being referred by his attorney. (R. at 20.) As the ALJ notes:

The severe and debilitating symptoms which psychologist Jarrell concludes the claimant experiences do not appear in any of his other medical records during the prior four years; symptoms that one must assume would have raised the concern of his physicians and the need for immediate treatment. The claimant did not report these debilitating [signs]/symptoms to his physicians, only stating on one occasion that he had some recurrent depression and wanted to restart Paxil. Psychologist Jarrell did not see the claimant prior to October 2005, and has not seen or treated him since that time. The record does not document

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that any of his treating physicians believed his mental health warranted referral to a psychologist or psychiatrist.

(R. at 20-21.)

The ALJ also noted, "[a] longitudinal review of the medical records does not document any symptoms reflecting any significant functional restriction from the claimant's mental impairment(s)." (R. at 23.) Further, he stated, "other than the claimant's self reporting to psychologist Jarrell, his well documented medical record is absent any corroboration" for Jarrell's opinion. (R. at 23.) Accordingly, where substantial evidence exists to support the ALJ's determination, and the ALJ has set forth his findings, this court may not upset the ALJ's decision. Therefore, I reject Quesenberry's argument on this issue and find that substantial evidence supports the rejection of Jarrell's opinion.

\*17 Quesenberry's fourth argument is that the ALJ erred by failing to consider Dr. Newell's opinion that Quesenberry would need to be absent from work two or more days a month. (Plaintiff's Brief at 8.) As previously noted, an ALJ has a duty to weigh the evidence in order to resolve any conflicts which might appear therein. *See Hays*, 907 F.2d at 1456; *Taylor*, 528 F.2d at 1156. The ALJ, therefore, has a duty to indicate explicitly that he has weighed all relevant evidence, indicate the weight given to this evidence and sufficiently explain his rationale in crediting the evidence. *See Stawls*, 596 F.2d at 1213. As a result, the court's function in this case is limited to determining whether substantial evidence exists in the record to support the ALJ's findings. *See Hays*, 907 F.2d at 1456.

As the ALJ noted, the "record does not support the opinion that the claimant would be absent from work two or more days per month," and Quesenberry's "treatment history does not support a conclusion that he would be absent from work two or more days per month." (R. at 26.) Dr. Wilson opined that Quesenberry had "the functional capacities to perform the majority of job duties, particularly if they were in the sedentary or light duty category." (R. at 150.) Similarly, Dr. Aikin limited Quesenberry only from the performance of

moderate to heavy manual work. (R. at 207.) Further, both state agency physicians determined that Quesenberry had the ability to perform medium work. (R. at 300.)

Thus, the ALJ did not err in limiting the weight he assigned to Dr. Newell's opinion because it conflicted with other evidence in the record. *See* 20 C.F.R. § 404.1527 (2007). The "ALJ holds the discretion to give less weight to the testimony of a treating physician in the face of persuasive contrary evidence." *Mastro v. Apfel*, 270 F.3d 171, 178 (4th Cir.2001) (citing *Hunter v. Sullivan*, 993 F.2d 31, 35 (4th Cir.1992) (per curiam)).<sup>FN9</sup> Substantial evidence exists in the record to support the ALJ's findings and Quesenberry's argument is without merit. *See Hays*, 907 F.2d at 1456.

FN9. *Hunter* was superseded by 20 C.F.R. § 404.1527(d)(2), which states in relevant part, as follows:

If we find that a treating source's opinion on the issue(s) of the nature and severity of your 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, we will give it controlling weight.

20 C.F.R. § 404.1527(d)(2) (2007).

Quesenberry's fifth argument is that the ALJ's determination of Quesenberry's residual functional capacity is not supported by the record and is based solely on opinion. (Plaintiff's Brief at 8-9.) Specifically, concerning the ALJ's determination of Quesenberry's residual functional capacity, Quesenberry states, "[by] identifying no source, one must form the obvious conclusion that it is [the ALJ's] personal opinion." (Plaintiff's Brief at 9.) Again, Quesenberry's argument is supported by no legal analysis and lacks merit. Contrary to Quesenberry's assertion, the ALJ has the final responsibility for assessing a claimant's residual functional capacity. *See* 20 C.F.R. § 404.1546(c) (2007). The undersigned finds that the ALJ analyzed all the relevant evidence and sufficiently explained his rationale in determining

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Quesenberry's residual functional capacity. As such, the ALJ's determination of Quesenberry's residual functional capacity is supported by substantial evidence in the record.

*IV. Conclusion*

\*18 For the foregoing reasons, I will grant the Commissioner's motion for summary judgment and deny Quesenberry's motion for judgment on the pleadings. The Commissioner's decision denying benefits will be affirmed.

An appropriate order will be entered.

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Wilcox v. Barnhart  
D.N.H.,2004.

NOT FOR PUBLICATION

United States District Court,D. New Hampshire.  
Christine WILCOX

v.

Jo Anne BARNHART, Commissioner, Social  
Security Administration  
No. Civ. 03-408-PB.

July 28, 2004.

Jeffry A. Schapira, Manchester, NH, for Plaintiff.  
David L. Broderick, US Attorney's Office, Concord,  
NH, for Defendant.

*MEMORANDUM AND ORDER*

BARBADORO, Chief J.

\*1 On January 30, 2002, Christine Wilcox filed an application with the Social Security Administration ("SSA") for disability insurance benefits ("DIB"). In her application for DIB, Wilcox alleged that she had been unable to work since December 20, 2000. The SSA denied her application and granted her request for a hearing by an Administrative Law Judge ("ALJ"). On January 22, 2003, ALJ Frederick Harap held a hearing and in an opinion dated April 23, 2003, denied Wilcox's request for DIB. Wilcox appealed, but the Office of Hearings and Appeals denied her request for review of the ALJ's decision. At that point, the decision of the ALJ became the final decision of the Commissioner of Social Security ("Commissioner").

Wilcox brings this action pursuant to 42 U.S.C. § 405(g) of the Social Security Act seeking review of the denial of her application for benefits. She argues that the ALJ failed to identify, inquire into, or resolve conflicts between the vocational expert's ("VE") testimony and the listing in the Dictionary of Occupational Titles ("DOT"), and that the ALJ

failed to properly consider the effect of her subjective complaints of pain on her ability to work. For the reasons set forth below, I conclude that the ALJ's decision is supported by substantial evidence. Therefore, I affirm the Commissioner's decision and deny Wilcox's motion to reverse.

*I. BACKGROUND<sup>FN1</sup>*

FN1. Unless otherwise noted, the background facts are taken from the Joint Statement of Material Facts (Doc. no. 10) submitted by the parties.

*A. Education and Work History*

Christine Wilcox was 44 years old when her application for DIB was denied by the ALJ in April 2003. She has an eighth grade education and has worked as a factory machine operator, cashier, dishwasher, and most recently as a factory operator and assembler.

*B. Medical History*

Wilcox performed hand assembly work and repetitive motion assembly at her last job. Over time she developed pain and numbness in her right hand along with tingling sensations in several of her right fingers. Wilcox sought assistance from her primary care physician, Dr. Amy Schneider, who prescribed anti-inflammatory medications and a number of different splints during their meeting on November 20, 2000.<sup>FN2</sup> After two more appointments, and worsening pain and numbness, Dr. Schneider gave Wilcox a no-work note on December 20, 2000. Physical therapy proved to be unsuccessful and on January 9, 2001, Schneider referred Wilcox to Dr. Jeffrey Clingman, an orthopedic surgeon. Dr. Clingman diagnosed Wilcox with right carpal tunnel syndrome and on

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January 29, 2001 performed right carpal tunnel release surgery on Wilcox. After surgery, Wilcox returned to physical therapy for a strengthening program but pain and numbness continued despite her good progress in grip and pinch strength.

FN2. Dr. Schneider initially prescribed Ultram Tabs (50 Mg.) (centrally acting analgesic, generically known as Tramadol HCL) and Amitriptyline HCL Tabs (25 Mg.) (antidepressant/sedative) originally. In subsequent visits, she prescribed Ibuprofen Tabs (800 Mg.) (nonsteroidal anti-inflammatory) and Relafen Tabs (750 Mg.) (nonsteroidal anti-inflammatory, generically known as nabumetone). *Dorland's Illustrated Medical Dictionary*, 1934, 63, 903, 1219 (30th ed.2003).

Dr. Clingman referred Wilcox to Dr. Christopher Martino, a neurologist, to undergo nerve conduction studies. Dr. Martino performed an EMG on May 11, 2001, and found that Wilcox had a mild compromise at the median nerve in her right hand and diminished sensory functions. After an MRI on May 21, 2001, Dr. Clingman concluded that Wilcox had an entrapped nerve and that her options were to have a revision carpal tunnel release or to do nothing. Wilcox decided against the re-release and consulted Dr. Gary Woods, a hand specialist, for a second opinion. Dr. Woods found the MRI to be consistent with continued nerve entrapment and offered to re-explore the area, but Wilcox declined.

\*2 On August 27, 2002, Wilcox met again with Dr. Clingman complaining of carpal tunnel syndrome on the left side. Dr. Clingman then referred Wilcox back to Dr. Martino for further nerve test studies. On October 16, 2001, Dr. Martino again performed an EMG test and found evidence of a left-side medium nerve compression at the wrist. Shortly after, on November 7, 2001, Wilcox met with Dr. Arnold Miller for an independent medical evaluation. Dr. Miller recommended that Wilcox be retrained for light-duty work that did not require repetitive motion with the right hand or wrist. Wilcox underwent left carpal tunnel release surgery on December 3, 2001. Wilcox was again referred to

occupational therapy following her surgery but despite improved progress with grip strength, she continued to have numbness in some of her fingers.

On April 1 and 2, 2002, Wilcox participated in a Work Capacity Evaluation that was supervised by occupational therapist Joyce Sylvester. After assessing all 20 physical demands listed in the DOT, Sylvester concluded that Wilcox was best suited for sedentary work. Overall, Sylvester found that Wilcox had no trouble sitting, standing, or walking, but that she should avoid tasks that demand dexterity. Finally, Sylvester found that Wilcox could perform tasks that involved brief periods of writing and lifting, and that she would benefit from a 3-4 week reconditioning program to build upper body strength and endurance prior to starting a job.

By June, Wilcox had finished her therapy and on June 19, 2002, she returned to see Dr. Miller for an independent medical evaluation. Dr. Miller concluded that Wilcox had a 9% impairment in both her upper right and left extremities (Tr. 235). He agreed with the recommendation of the occupational therapist regarding work, saying that Wilcox needed to be in a light duty job that would not require repetitive work with her hands.

### C. Wilcox's Testimony

At the January 22, 2003 hearing, Wilcox testified that the pain she experienced from both her left and right hands made it more difficult to do chores around the house such as vacuuming, washing dishes, dusting, doing laundry, cooking, dressing, and showering (Tr. 24-25). Wilcox also testified that since she was not employed, she would spend the rest of her day napping, watching television, receiving visitors, or driving to visit others (Tr. 27-28). When asked by her attorney if she had difficulty concentrating, she replied "yes," that her persistent pain made it difficult for her to concentrate, having been "so cooped up." (Tr. 29.) Wilcox also responded "yes" when her attorney asked her if she had trouble sleeping at night as a result of her pain (Tr. 29). Wilcox claimed that she would have trouble sleeping as much as three times

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per month and, as a result, some housework would take three to four times longer to do, while other housework would remain unfinished.

Wilcox further testified that she took naps between 3-5 days per week for an average of three hours (Tr. 33). Lastly, Wilcox testified that she believed she was incapable of holding any job because of her constant pain. She also testified that the pain medication she took dulled the pain but did not make it go away <sup>FN3</sup> (Tr. 31, 35).

FN3. At the time of the administrative hearing, Wilcox was taking 800 Mg. tablets of Ibuprofen and 30 Mg. tablets of Tylenol with Codeine (Tr. 31).

#### D. Testimony of VE

\*3 Howard Steinberg testified as a VE. The ALJ inquired of Steinberg if a woman of Wilcox's age, education, and work experience, who had a functional capacity for sedentary work, but had limited use of both upper extremities reaching in all directions, handling, gross manipulation, fingering, fine manipulation, and feeling, who needed to avoid working around machinery and vibrating equipment, working at heights, and frequent prolonged upper extremity grasping and lifting, could perform any of her past relevant jobs (Tr. 38-39). Steinberg responded that a person such as Wilcox would not be able to perform any of her past jobs, but could work as a surveillance system monitor, of which 87,000 jobs existed in the national economy and 280 could be found within the state (Tr. 39). When Wilcox's attorney questioned Steinberg, he asked whether someone who took naps 3-5 hours per day, 10 to 15 times per month could perform the job of surveillance system monitor. *Id.* To this question, Steinberg responded that with the further limitation proposed by Wilcox's attorney, one could not hold the job of surveillance system monitor and that there existed no unskilled jobs in the national economy that fit all of the functional limitations posited (Tr. 42). Steinberg also testified that if someone lacked the ability to concentrate in addition to the other limiting factors specified by the ALJ, the job of

surveillance system monitor would be "close to impossible." (Tr. 43.)

#### E. The ALJ's Decision

The ALJ followed the five-step sequential evaluation process established by the SSA in rendering his decision of April 23, 2003. First, the ALJ found that Wilcox had not performed substantial gainful work since December 20, 2000, the date of the alleged onset of her disability (Tr. 14). At step two, the ALJ determined that Wilcox's impairment was severe within the meaning of the regulations. But, at step three, since Wilcox's impairment was "not severe enough to meet or medically equal one of the impairments listed in Appendix 1, Subpart P, Regulations No. 4," the ALJ was required to continue the inquiry.*Id.* At the fourth step of the sequential evaluation process, the ALJ determined, based on Steinberg's testimony, that Wilcox could not return to any prior employment because her functional work capacity was no longer light duty work, but sedentary (Tr. 16). Finally, at step five, the ALJ determined that other jobs exist in significant numbers in the national economy that could accommodate Wilcox's residual functional capacity ("RFC") and her specific vocational limitations.

As evidence of Wilcox's ability to work, the ALJ cited the medical examinations of Dr. Miller and the occupational therapist, Joyce Sylvester. Dr. Miller's most recent exam suggested that Wilcox had no swelling or discoloration in either the right wrist or the left wrist (Tr. 15). He also determined that Wilcox was able to dorsiflex about 75 degrees and palmer flex 70 degrees. *Id.* Although Wilcox had some decreased sensation to a pinprick on some of her right fingers, there was no pain or atrophy. *Id.* Dr. Miller concluded that Wilcox could expect to have long-term problems and chronic pain in both wrists, but that she could perform light duty work that did not involve repetitive activities. *Id.*

\*4 Sylvester's examination determined that Wilcox had the ability to lift and carry 12 pounds with her left arm and 9 pounds with her right. Although Sylvester also found pain to be a chronic problem

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for Wilcox, she stated that Wilcox still maintained an RFC and that Wilcox could learn to manage her pain through the use of rest, avoidance, and pacing. *Id.*

The ALJ determined that despite Wilcox's complaints of chronic pain, her allegation that she could not perform any work was not persuasive. *Id.* He found that Wilcox retained the following RFC:

[A]n ability to lift and carry less than ten pounds on a regular and occasional basis. Further, the claimant can sit, stand and walk without limitation. Ms. Wilcox can push and pull up to twenty pounds on an occasional basis. She should never crawl and she should avoid heights, ropes and scaffolding. The claimant's ability to reach, handle and finger are limited as well to an occasional basis only. Finally, Ms. Wilcox should avoid vibrating machinery and equipment and repetitive actions.

*Id.* Accordingly, the ALJ concluded that Wilcox retained the capacity for work that exists in substantial numbers in the national economy and that she did not qualify for a "disability" as defined by the Social Security Act.

## II. STANDARD OF REVIEW

Under the Social Security Act, the factual findings of the ALJ are conclusive if supported by "substantial evidence." 42 U.S.C. § 405(g); *see also Ortiz v. Sec'y of Health & Human Servs.*, 955 F.2d 765, 769 (1st Cir.1991). I must uphold the ALJ's findings "if a reasonable mind, reviewing the evidence in the record as a whole, could accept it as adequate to support [the ALJ's] conclusion." *Rodriguez v. Sec'y of Health & Human Servs.*, 647 F.2d 218, 222 (1st Cir.1981). The ALJ's decision is therefore supported by substantial evidence if, given all the evidence, it is reasonable. It is also the function of the ALJ, and not the courts, to determine issues of credibility, to draw inferences from the record evidence, and to resolve conflicts in the evidence. *Ortiz*, 955 F.2d at 769.

The ALJ's findings of fact are not conclusive, however, "when derived by ignoring evidence, misapplying the law, or judging matters entrusted to

experts." *Nguyen v. Chater*, 172 F.3d 31, 35 (1st Cir.1999). If the Commissioner, through the ALJ, has misapplied the law or failed to provide a fair hearing, deference to the Commissioner's decision is not appropriate, and remand for further development of the record may be necessary. *See Seavey v. Barnhart*, 276 F.3d 1, 11 (1st Cir.2001). I apply these standards to the arguments Wilcox raises in her appeal.

## III. ANALYSIS

Wilcox argues that the ALJ's ruling failed to identify, inquire into, or resolve differences between the VE's testimony and the definition in the DOT. Wilcox also argues the ALJ failed to properly consider her subjective complaints of pain which further restricted her RFC. For the reasons set forth below I reject Wilcox's claims and affirm the decision of the ALJ.

### I. Duty to Inquire about Potential Variance

\*5 Wilcox does not dispute the ALJ's objective determination of her RFC, but rather points to a potential variance in the job description of a surveillance system monitor as described by the VE from the description of the job provided by the DOT. Wilcox contends that the ALJ erred by not inquiring of the VE whether the job description he provided was consistent with that in the DOT. The SSA has issued a policy interpretation ruling, which requires the adjudicator to ask about any possible conflict between the VE's evidence and information provided in the DOT. S.S.R. 00-4p, 2000 WL 1898704 at \*4. The mere failure to ask such a question, however, cannot require remand on its own. *Hogson v. Barnhart*, No. 03-185-B-W, 2004 WL 1529264, at \*2 (D.Me. June 24, 2004). "Such an exercise would be an empty one if the VE's testimony were in fact consistent with the DOT." *Id.* I find this logic persuasive. The ALJ in this case asked what the source of the VE's testimony was concerning the job description of surveillance system monitor, and the VE cited the DOT. Thus, the ALJ would have no cause to believe a discrepancy existed where the VE identified the

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source of his information as the DOT.

Moreover, I do not agree with Wilcox's assertion that there are discrepancies between the VE's testimony and the DOT. First, Wilcox asserts that the DOT identifies surveillance system monitor as a "government service" job, which conflicts with the VE's testimony describing a private sector job. A more close examination, however, reveals that the DOT's industry designation shows "in what industries the occupation was studied but does not mean that it may not be found in others." *Dictionary of Occupational Titles*, XXI (4th ed., rev. Vol. I 1991). "Therefore, industry designations are to be regarded as indicative of industrial location, but not necessarily restrictive." *Id.*

Wilcox points to a second "difference" between the VE's testimony and the DOT. The VE did not specifically describe the additional functions of adjusting monitor controls and pushing a hold button to maintain surveillance where an incident is developing, which are identified in the DOT job description. These items, however, are not material. The VE testified that a person with an RFC of sedentary and unskilled could perform the job of surveillance system monitor with "limited use of hands." (Tr. 40.) This description conforms to Wilcox's RFC as identified by Dr. Miller and Wilcox's occupational therapist. Where the ALJ found Wilcox to have the ability to reach, handle, and finger somewhere between a limited and occasional basis, the job of surveillance system monitor matches the ALJ's determination of Wilcox's ability level. I am not persuaded either that the VE neglected minor aspects of the job description or that the alleged inconsistencies are material to the analysis.

## II. Credibility of Wilcox's Complaints of Pain

I am also not persuaded by Wilcox's second argument that the ALJ failed to consider the effect of her subjective complaints of pain on her ability to effectuate the job of surveillance system monitor. In determining the credibility of a person's statements, an adjudicator must consider the entire record, which includes the objective medical evidence, the

individual's subjective statements about symptoms, information provided by medical specialists, and any other relevant evidence in the record. S.S.R. 96-7p, 1996 WL 374186 at \*1, *see also Avery v. Sec'y of Health & Human Servs.* 797 F.2d 19 (1st Cir.1986). So long as a credibility determination is supported by the evidence, the ALJ's determination is entitled to deference since he observed the claimant, evaluated the claimant's demeanor, and considered how her testimony corresponded with the rest of the evidence. *Frustaglia v. Sec'y of Health & Human Servs.*, 829 F.2d 192, 195 (1st Cir.1987) (per curiam).

\*6 The ALJ did in fact consider Wilcox's testimony concerning her physical limitations and pain allegations. But despite her claims of inability to perform any work because of her pain, the ALJ found that Wilcox retained a sedentary work capacity. The ALJ concluded, based on substantial evidence in the record, including the medical opinions of Dr. Miller and the occupational therapist, that Wilcox's claim of pain was not so severe as to preclude all work.

Dr. Miller's examination from June 2002 found that Wilcox is "expected to have long term problems with both wrists and with chronic pain," but that she "is able to perform light duty work that does not involve repetitive activities." (Tr. 15.) Moreover, Wilcox's physical therapist, Joyce Sylvester, found that "pain was an overall factor in the claimant's ability to perform activities," but that she "retains a RFC." *Id.* As such, I find that the ALJ adequately considered the various factors concerning Wilcox's condition and reached a determination of her RFC that is supportable in the record.

## IV. CONCLUSION

Since I have determined that the ALJ's denial of Wilcox's benefits was supported by substantial evidence, I affirm the Commissioner's decision. Accordingly, Wilcox's Motion to Reverse (Doc. no. 8) is denied, and Defendant's Motion for an Order Affirming the Decision of the Commissioner (Doc. no. 9) is granted. The clerk shall enter judgment accordingly.

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SO ORDERED.

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