

detailed instructions; carry out detailed instructions; maintain attention and concentration for extended periods; complete a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods; and respond appropriately to changes in the work setting (R. 246-47). Dr. Comer noted that Plaintiff's "functional capacity limitations do not exceed moderate" and she had "the mental/emotional capacity foe (sic) routine repetitive activity in a low stress/demand work environment that [could] accommodate her physical limitations" (R. 248).

On July 13, 2007, Plaintiff returned to Health Access for a follow-up on her laboratory results. It was noted Plaintiff's height was five-feet, four and one-half inches (5'4 ½") and her weight was one-hundred and fifty-three (153) pounds. The doctor noted Plaintiff's TSH was "high" in February, 2007, and she had been medicating with Lipitor. Plaintiff stated she thought she was "holding fluid" and her feet, hands and face were swelling. Plaintiff reported she was not urinating "much" and was medicating with 25mg HCTZ. Plaintiff reported she experienced anxiety and sleep "problems," lethargy, dryness of mouth, and fear of "passing out" (R. 381).

On September 6, 2007, a list of Plaintiff's medication was made at Health Access. It included Lipitor, HCTZ, Fluoxctine, Mobic, Premarin, Advair, Mirtazapine, Prevacid, Proventil, and Imitrex (R. 384).

On October 5, 2007, Plaintiff presented to Health Access for follow up on lab test results. Plaintiff stated she felt as if "something [was] stuck in throat." Plaintiff stated she felt "clammy sweets (sic) & [elevated] BP and glucose." It was noted that Plaintiff's fasting glucose level was 106. Plaintiff's height was listed at five feet, four and one-half inches (5'4 ½") and her weight was listed at two-hundred, seven (207) pounds (R. 385).

On October 22, 2007, the physician at Health Access noted Plaintiff had an obese abdomen (R. 383). It was noted that Plaintiff “[r]emain[ed] obese 207 (increased from) 198.” Plaintiff reported she was in constant pain and she felt pain in her upper, left abdomen. Plaintiff stated she felt bloated that Mylanta and Prevacid did not reduce her symptoms. Plaintiff stated she had dysphagia with all foods and “some” nausea (R. 385). A barium swallow and lab work for pancreatitis were ordered (R. 383).

On October 30, 2007, Plaintiff had a chest x-ray taken for dysphagia. It was normal (R. 387, 388). She had an upper gastrointestinal x-ray made for her complaints of dysphagia. The “findings [were] suspicious for at least one gastric ulcer.” It showed “diffuse gastric wall thickening from gastritis and/or limited distention” (R. 389). It also showed mild gastroesophageal reflux and “mildly prominent cricopharyngeus¹” (R. 390). An ultrasound of Plaintiff’s stomach was completed to evaluate for her complaints of abdominal and epigastric pain. It showed gallstones, a normal spleen, normal kidneys, and an unremarkable abdominal aorta. Plaintiff’s liver was normal except for “mild increased echogenicity . . . compatible with mild fatty infiltration.” The impression was for cholelithiasis² (R. 391). Plaintiff’s chemistry profile showed normal results except for low chloride, high AST, high ALT and high A1C. The expected range for A1C was 4.1 - 5.7; Plaintiff’s was 5.9 (R. 393).

On November 2, 2007, Plaintiff presented to Health Access with complaints of “sever (sic) stomach pain.” Her height was listed at five feet, four and one-half inches (5’4 ½”) and her weight

¹Cricopharyngeal: pertaining to the cricoid cartilage and the pharynx. *Dorland’s Illustrated Medical Dictionary*, 31st Ed., 2007, at 438.

²Cholelithiasis: the presence or formation of gallstones; they may be either in the gallbladder . . . or in the common bile duct *Dorland’s Illustrated Medical Dictionary*, 31st Ed., 2007, at 355.

was listed at two-hundred and eleven (211) pounds (R. 383).

A physician at Health Access made the following note: “DM II [Plaintiff] had glucose tolerance – which was normal.” Plaintiff’s TSH needed rechecked (R. 384)³.

Administrative Hearing

Plaintiff testified she completed school through the seventh grade and did not obtain her GED (R. 24). Plaintiff stated her eight-year old granddaughter lived with her (R. 26). Plaintiff stated her granddaughter did not “require too much” care, but she made “sure she’s in the tub and she’s doing what she’s got to do to be clean and fed” (R. 31). Plaintiff testified she had not smoked for two weeks (R. 26, 32) She did not drink alcohol. Plaintiff stated she did not have insurance (R.26).

Plaintiff testified she operated a boarding care home and had one person residing with her. Plaintiff cooked “very little” for and gave medicine to the person residing with her (R. 27-28).

Plaintiff testified her height was five feet, seven inches (5’7”) and her weight was two-hundred, ten pounds. Plaintiff stated she had gained fifty-five pounds in one year’s time. Plaintiff testified she could not work due to arthritis pain and diverticulitis (R. 27). Plaintiff stated she used the bathroom frequently, had to lie down periodically, and could not bend (R. 28). Plaintiff stated she went to the bathroom eight-to-ten times during the day and three or four times during the night (R. 38). The ALJ asked Plaintiff who “treat[ed] [her] depression?” Plaintiff stated her doctor gave her Prozac and she had not seen a psychologist as she could not afford one (R. 33).

Plaintiff testified she had surgery on her back in 1994, had not received physical therapy for treatment of her pain, had not visited an emergency department for her back, and had not received

³It is unclear if the notations regarding Plaintiff’s glucose tolerance and TSH were made on November 2, 2007. They appear on the page following the November 2, 2007 entry; however they are noted prior to the September 6, 2007, entry (R. 383, 384).

treatment from a pain clinic for her back (R. 31-32). Plaintiff stated she had no side effects from any of the medication she took except that Remeron, which she referred to as a “sleeping pill,” made her “a little drowsy, but it don’t (sic) always work” (R. 32). Plaintiff testified she was hospitalized the week prior to the administrative hearing for gall bladder surgery (R. 38). Plaintiff described her pain as radiating from her arms, down her back and into her legs (R. 33). Plaintiff testified that in the late 1990’s she had surgery for carpal tunnel, which did not “seem to help” (33-34). Plaintiff stated she did not “have [] full grip” capabilities with her hands. Plaintiff listed her pain as eight on a scale of one-to-ten. Plaintiff stated her pain was “ten plus. . . . [m]ost of the time. . . . Every day.” Plaintiff said there was “nothing that [she] [could] do to make [the pain] worse or make it better” (R. 34). Plaintiff testified she medicated asthma with two drugs and that weather exacerbated her symptoms (R. 35). Plaintiff used her Albuterol inhaler as prescribed, four times daily (R. 35-36). Plaintiff testified she did not “see[] any changes with” Mobic, which she used to treat arthritis. Plaintiff stated she had a migraine headache weekly and it lasted “for about two days” (36).

Plaintiff testified she had a driver’s license, but she did not drive. Plaintiff stated she read “[s]ome things, if [she] [could] understand them” (R. 26). Plaintiff testified she retired at midnight, awoke at 2:00 a.m., awoke at 4:30 a.m., and rose at 5:30 a.m. to assist her granddaughter in dressing for school (30, 36). She lay back down until 11:00 a.m. or 12:00 p.m., rose and stood “for maybe five to 10 minutes,” cooked “soup or something in the microwave for Pat,” lay back down, rose at 3:30 p.m. when her granddaughter came home from school, and lay or sat on the couch or sat in a recliner. Plaintiff stated those who lived with her prepared their own dinners, her boyfriend did the grocery shopping, she could shower and wash her own hair, she did not clean the house, she did not sweep or vacuum, she participated in no activities outside her home, she visited her mother for ninety

minutes “probably about once a month,” and she did “a little walking” as exercise for her back. Plaintiff testified that someone carried the laundry to the laundry room for her and she put it in the machine; the other person transferred the laundry from the washer to the dryer and took it out of the dryer and folded it (R. 30-31). Plaintiff testified she would like to “go to church[,] . . . crochet, work in the yard and flower beds,” but she could not due to pain (R. 33). Plaintiff stated she could lift a gallon of milk (R. 35). Plaintiff testified she could sit for ten minutes before she needed to stand (R. 36-37). She could stand for ten minutes before needing to sit (R. 37).

The ALJ asked the VE the following question:

If you take a hypothetical person of the claimant’s age, educational background and work experience who can do a range of light work: with occasional posturals; no climbing of ropes, ladders, scaffolds, anything of that nature; needs to avoid extremes of temperature of heat and cold; needs to avoid hazards such as dangerous moving machinery and unprotected heights; also needs to avoid noxious fumes, odors and gasses; needs to avoid vibrations also, could that hypothetical person do the claimant’s prior relevant work? I’m sorry. I’m going to add a sit/stand option. Could that hypothetical person do the claimant’s prior relevant work? (R. 41).

The VE responded that the individual could not her past relevant work as a nursing assistant, but she could do the work of companion (R. 41).

The ALJ asked if there were other jobs such a hypothetical person could perform. The VE responded that such a person could do the work of a storage facility counter clerk (69 jobs in the local economy and 58,011 jobs in the national economy); office helper (127 jobs in the local economy and 162,282 jobs in the national economy); mail clerk (non-postal) (86 jobs in the local economy and 82,490 jobs in the national economy) (R. 41-42).

The ALJ asked the VE if there were jobs the hypothetical person could do at the sedentary level. The VE responded that such a person could do the work of document preparer (67 jobs in the local economy and 62,756 jobs in the national economy); table worker (13 jobs in the local economy

and 14,749 in the national economy); and surveillance system monitor (13 jobs in the local economy and 13,474 jobs in the national economy) (R. 42).

The ALJ asked the following: “If a person were to be off task due to a lack of concentration, persistence or pace, how much time off task would generally be tolerated by entry level employers?”

The VE stated two days a month of absenteeism would be tolerated (R. 42).

III. Administrative Law Judge Decision

Utilizing the five-step sequential evaluation process prescribed in the Commissioner’s regulations at 20 C.F.R. §§ 404.1520 and 416.920, ALJ Cannon made the following findings:

1. The claimant meets the insured status requirements of the Social Security Act through December 31, 2011 (Exhibit 3D) (R. 11).
2. The claimant has not engaged in substantial gainful activity since November 1, 2004, the alleged onset date (20 CFR 404.1520(b), and 404.1571 *et seq.*, 416.920(b) and 416.971 *et seq.*) (R. 11).
3. The claimant has the following severe impairments: Organic mental disorder, back pain syndrome, GERD and asthma (20 CFR 404.1520(c) and 416.920(c)) (R. 11).
4. The claimant does not have an impairment or combination of impairments that meets or medically equals one of the listed impairments in 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 404.1520(d), 404.1525, and 404.1526, 416.920(d), 416.925 and 416.926) (R. 12).
5. After careful consideration of the entire record, the undersigned finds that the claimant has the residual functional capacity to perform a range of light work as defined in 20 CFR 404.1567(b) and 416.967(b) except she is limited to occasional postural movements with no climbing of ropes, ladders and/or scaffolds, requires a sit/stand option, must avoid extremes of temperatures as well as hazardous machinery, moving machinery, vibrations, and unprotected heights as well as fumes, odors, and gases (R. 14).
6. The claimant is unable to perform any past relevant work (20 CFR 404.1565 and 416.965) (R. 16).
7. The claimant was born on December 23, 1963 and was 41 years old, which

is defined as younger individual age 18-44, on the alleged disability onset date (20 CFR 404.1563 and 416.963) (R. 16).

8. The claimant has a limited (7th grade) education and is able to communicate in English (20 CFR 404.1564 and 416.964) (R. 16).
9. Transferability of job skills is not material to the determination of disability because using the Medical-Vocational Rules as a framework supports a finding that the claimant is “not disabled,” whether or not the claimant has transferable job skills (See SSR 82-41 and 20 CFR Part 404, Subpart P, Appendix 2) (R. 16).
10. Considering the claimant’s age, education, work experience, and residual functional capacity, there are jobs that exist in significant number in the national economy that the claimant can perform (20 CFR 404.1560(c), and 404.1566, 416.960(c), and 416.966)(R. 16).
11. The claimant has not been under a disability, as defined in the Social Security Act, from November 1, 2004 through the date of this decision(20 CFR 404.1520(g) and 416.920(g)) (R. 17).

IV. Discussion

A. Scope of Review

In reviewing an administrative finding of no disability, the scope of review is limited to determining whether “the findings of the Secretary are supported by substantial evidence and whether the correct law was applied.” *Hays v. Sullivan*, 907 F.2d 1453, 1456 (4th Cir. 1990). Substantial evidence is “such relevant evidence as a reasonable mind might accept to support a conclusion.” *Richardson v. Perales*, 402 U.S. 389, 401 (1971) (quoting *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938)). Elaborating on this definition, the Fourth Circuit has stated 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 jury verdict were the case before a jury, then there is ‘substantial evidence.’” *Shively v. Heckler*, 739 F.2d 987, 989 (4th Cir. 1984) (quoting *Laws v. Celebrezze*, 368 F.2d 640, 642 (4th Cir. 1968)). In reviewing the

Commissioner’s decision, the 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.” *Coffman v. Bowen*, 829 F.2d 514, 517 (4th Cir. 1987).

B. Contentions of the Parties

The Plaintiff contends:

1. The Administrative Law Judge’s decision is not supported by substantial evidence because she failed to consider all [Plaintiff’s] impairments (Plaintiff’s brief at p. 7).
2. The Administrative Law Judge’s findings concerning [Plaintiff’s] residual functional capacity is not supported by substantial evidence because she did not include any mental limitations although the Administrative Law Judge found that [Plaintiff] suffered from organic mental disorder, a severe impairment (Plaintiff’s brief at p. 10).

The Commissioner contends:

1. The ALJ properly considered Plaintiff’s impairments (Defendant’s brief at p. 8).
2. The ALJ accounted for all of the functional limitations resulting from Plaintiff’s mental impairment and properly concluded that Plaintiff could perform work in the national economy (Defendant’s brief at p. 11).

C. Evidence not Considered

Plaintiff argues that the ALJ “made no effort to develop the record concerning the symptoms, limitations and treatment of” obesity, depression, and diabetes mellitus (Plaintiff’s brief at p. 7). Plaintiff further contends the ALJ “did not mention the treatment records from UHC Family Medicine Center or Health Access in her decision at all” (Plaintiff’s brief at p. 8)⁴. Defendant asserts

⁴In her Reply Brief, Plaintiff asserts that Exhibit 14F is the medical record from University Health Center’s Family Medicine Center (Plaintiff’s reply brief at p. 3). The index for

that, “[b]ecause the ALJ accounted for all of Plaintiff’s credibly established physical limitations when assessing her RFC, including any limitations related to obesity, diabetes and depression, the ALJ’s decision is supported by substantial evidence . . .” (Defendant’s brief at p. 11).

20 C.F.R. §404.1527(d) mandates, in part, the following: “. . . *How we weigh medical evidence.* Regardless of its source, we will evaluate every medical opinion we receive. . . .”

In her decision, the ALJ considered, reviewed, and evaluated evidence provided by Dr. Medina and Doctor’s Quick Care relative to Plaintiff’s complaints of abdominal pain (R. 202-09, 210-33). The ALJ also reviewed the October, 2007, upper gastrointestinal test results from United Hospital Center (R. 389-90). The ALJ reviewed the March, 2006, x-rays made at United Hospital Center of Plaintiff’s spine (R.314-16). The ALJ considered Dr. Garner’s June, 2006, consultative examination (R. 238-45). The ALJ weighed the evidence of the state-agency physicians and psychologists (R. 246-49, 250-63, 264-71, 286-93). The ALJ evaluated the opinions of Ms. Yost, a psychologist (R. 234-37).

The ALJ also considered the record of evidence relative to Plaintiff’s depression from United Hospital’s Family Practice. On November 28, 2006, Plaintiff presented to Family Practice of United Hospital Center and stated she had been diagnosed with depression, which she treated with Prozac. Plaintiff also reported she medicated her insomnia with Remeron (R. 294).⁵ On December 12, 2006,

this case identifies Exhibit 14F as “Outpatient Medical Records, dated 11/28/2006 to 12/12/2006, from United Hospital Family Practice.” Several of the records contained in Exhibit 14F are titled “United Hospital Center Family Medicine” and “United Hospital Center – Family Practice Residency” (R. 294-301)

⁵Plaintiff, in her brief, contends that her depression was treated with Prozac and Remeron; however, the record is clear that she took Remeron exclusively for the treatment of insomnia (Plaintiff’s brief at p. 7) (R. 294, 298, 378). Plaintiff testified, at the administrative hearing, that she took Remeron as a “sleeping pill” (R. 32).

Dr. Courtney, of the Family Practice of United Hospital Center, prescribed Prozac for depression (R. 298). At the administrative hearing, the ALJ asked Plaintiff who “treat[ed] [her] depression?” Plaintiff stated her doctor gave her Prozac and she had not seen a psychologist as she could not afford one (R. 33). In her decision, the ALJ correctly noted that “[c]laimant reported that she takes Prozac prescribed by her primary care physician as she cannot afford mental health specialist. (A review of the record fails to show Prozac as one of claimant’s prescribed medications prior to November 28, 2006 (Exhibit 14F))” (R. 15). The ALJ noted that Plaintiff had “not required any psychiatric hospitalizations and ha[d] received no treatment from a mental health specialist” (R. 13). Additionally, Plaintiff reported to Ms. Yost, during her consultative examination, that she had no feelings of hopelessness. She stated that, “[o]nce in a great while,” when she was ““fed up,”” she felt ““what’s the use.”” She did not state she was depressed (R. 234).

Contrary to Plaintiff’s assertion that the ALJ did not consider the evidence from United Hospital Center relative to Plaintiff’s depression, the record shows that the ALJ did consider those records. The ALJ noted that Plaintiff had not been treated for depression by a specialist prior to her November 1, 2006; Plaintiff expressed no limitations relative to her depression; and Plaintiff received the medication two years after her onset date from her family physician (R. 13, 15, 234). Additionally, neither the records of Ms. Yost nor the state-agency psychologists, which were considered and evaluated by the ALJ, contain a diagnosis or limitations caused by depression (R. 234-37, 246-63). Finally, based on her review of the record, the ALJ asked Plaintiff about her depression at the administrative hearing (R. 33). The ALJ’s decision as to Plaintiff’s depression is supported by substantial evidence.

The ALJ also inquired of Plaintiff about her height and weight during the administrative

hearing; however, that inquiry was not based on the ALJ's review of the record. The evidence in this case included doctor's notes from Health Access containing a diagnosis of obesity and a possible diagnosis of diabetes mellitus. The ALJ did not consider, evaluate or weigh those records.

Plaintiff was treated at Health Access from January 22, 2007, through November 2, 2007. On October 5, 2007, the doctor at Health Access noted Plaintiff's fasting glucose level was 106 (R. 385). On November 2, 2007, the physician at Health Access noted the following: "DM II [Plaintiff] had glucose tolerance – which was normal" (R. 384). Additionally, the physician at Health Access noted, on October 22, 2007, that Plaintiff "[r]emain[ed] obese 207 (increase from) 198" (R. 385). The ALJ did not consider this evidence.

The ALJ is required to determine, based on a review of the record, Plaintiff's medical impairments; in order to do that, the ALJ must evaluate all evidence. The ALJ, in this case, did not.

20 CFR section 404.1512 (a) provides:

In general, you have to prove to us that you are blind or disabled. Therefore, you must bring to our attention everything that shows that you are blind or disabled. This means that you must furnish medical and other evidence that we can use to reach conclusions about your medical impairment(s) and, if material to the determination of whether you are blind or disabled, its effect on your ability to work on a sustained basis. We will consider only impairment(s) that you say you have or about which we receive evidence

As noted by Defendant in his brief, the treatment notes from Health Access as to diabetes are "unclear" (Defendant's brief at p. 18). Reference is made to diabetes and then the notation that Plaintiff's glucose tolerance test was normal is made; however, there are the results of Plaintiff's September 6, 2007, A1C test, which was 5.9 (expected range for A1C was 4.1 - 5.7) and a May 4, 2007, lactose tolerance study, which showed Plaintiff's fasting glucose tolerance was 116, glucose tolerance at one-half hour was 168, glucose tolerance at one hour was 173, and glucose tolerance at

two hours was 112 (R. 393, 348). The ALJ reviewed both of these records (R. 12, 15). Nonetheless, the ALJ, as Plaintiff asserts, “did not mention the treatment record from . . . Health Access in her decision at all” (Plaintiff’s brief at p. 8); the ALJ also failed to mention diabetes in her decision. The ALJ did not make a determination as to whether Plaintiff had actually been diagnosed with diabetes; she did not evaluate Plaintiff’s possible diagnosis of diabetes in light of the lactose tolerance study and AC1 test Plaintiff underwent; she did not analyze the opinion of the doctor who treated Plaintiff at Health Access for possible diabetes; she did not make a determination as to whether Plaintiff was limited by diabetes. “The courts . . . face a difficult task in applying the substantial evidence test when the Secretary has not considered all relevant evidence. Unless the Secretary has analyzed all evidence and has sufficiently explained the weight he has given to obviously probative exhibits, to say that his decision is supported by substantial evidence approaches an abdication of the court’s ‘duty to scrutinize the record as a whole to determine whether the conclusions reached are rational.’” *Gordon v. Schweiker*, 725 F.2d 231, 236 (4th Cir. 1984) (quoting *Arnold v. Secretary*, 567 F.2d 258, 259 (4th Cir. 1977)). The ALJ’s decision is, therefore, not supported by substantial evidence.

During the administrative hearing, the following question/answer exchange occurred between the ALJ and Plaintiff:

ALJ: How tall are you?

Pla: 5’7”

Q: How much do you weigh?

A: 210.

Q: Has your weight gone up or down –

A: Up.

Q: – in the last couple of years?

A: Up.

Q: How much have you gained?

A: Oh my. I used to weigh 145 and I've went (sic) up to 219.
So that's a pretty good bit (R. 24-25).

As noted by Plaintiff, the medical records contained differing entries as to Plaintiff's height (R. 202, 210-31, 234, 240, 381, 383, 385). By asking Plaintiff her height, the ALJ verified what the record of evidence did not – that Plaintiff's true height was five feet, seven inches (5'7"). The ALJ, however, failed to evaluate the record as to Plaintiff's weight. As noted above, in October, 2007, a physician at Health Access noted that Plaintiff "[r]emain[ed] obese 207 (increase from) 198" (R. 385). The ALJ did not consider this evidence.

SSR 02-1p provides the following:

How Is Obesity Identified as a Medically Determinable Impairment?

When establishing the existence of obesity, we will generally rely on the judgment of a physician who has examined the claimant and reported his or her appearance and build, as well as weight and height. Thus, in the absence of evidence to the contrary in the case record, we will accept a diagnosis of obesity given by a treating source or by a consultative examiner. However, if there is evidence that indicates that the diagnosis is questionable and the evidence is inadequate to determine whether or not the individual is disabled, we will contact the source for clarification, using the guidelines in 20 CFR 404.1512(e) and 416.912(e).

The ALJ did not comply with this regulation. She knew Plaintiff weighted two-hundred and ten (210) pounds at the time of the administrative hearing; however, she did not know there had been a notation in the medical records from Health Access as to Plaintiff's being obese because she did not review that evidence. The ALJ did not make a determination as to whether Plaintiff had actually been diagnosed with obesity; she did not analyze the opinion of the doctor who made a finding of

obesity as to Plaintiff; she did not make a determination as to whether Plaintiff was limited by obesity.

SSR 02-1p provides the following additional guidance:

How Do We Consider Obesity in the Sequential Evaluation Process?

We will consider obesity in determining whether:

The individual has a medically determinable impairment.

The individual's impairment(s) is severe.

The individual's impairment(s) meets or equals the requirements of a listed impairment in the listings. . . .

The individual's impairment(s) prevents him or her from doing past relevant work and other work that exists in significant numbers in the national economy. However, these steps apply only in title II and adult title XVI cases.

SSR 02-1p further provides:

How Does Obesity Affect Physical and Mental Health?

Obesity is a risk factor that increases an individual's chances of developing impairments in most body systems. It commonly leads to, and often complicates, chronic diseases of the cardiovascular, respiratory, and musculoskeletal body systems. Obesity increases the risk of developing impairments such as type II (so-called adult onset) diabetes mellitus-even in children; gall bladder disease; hypertension; heart disease; peripheral vascular disease; dyslipidemia (abnormal levels of fatty substances in the blood); stroke; osteoarthritis; and sleep apnea. It is associated with endometrial, breast, prostate, and colon cancers, and other physical impairments. Obesity may also cause or contribute to mental impairments such as depression. The effects of obesity may be subtle, such as the loss of mental clarity and slowed reactions that may result from obesity-related sleep apnea.

The fact that obesity is a risk factor for other impairments does not mean that individuals with obesity necessarily have any of these impairments. It means that they are at greater than average risk for developing the other impairments.

As noted above, Plaintiff had asthma, and the ALJ found it to be a severe impairment (R. 11, 35, 238-39, 293). Plaintiff was diagnosed with and consistently treated for hypertension (R. 216-17, 228-29, 238-39). Plaintiff was treated for depression (R. 15, 294, 298). Plaintiff had been diagnosed with cholelithiasis (R. 391). Plaintiff testified at the administrative hearing that she had

had gall bladder surgery (R. 38). Plaintiff may have been diagnosed with diabetes mellitus (R. 384). The ALJ did not comply with the policies contained in SSR 02-1p relative to Plaintiff's obesity. In failing to review the medical evidence provided by Health Access relative to Plaintiff's weight, the ALJ did not "consider all relevant evidence" in order to make a determination as to whether Plaintiff was obese and, if she was obese, if that obesity limited her. *Gordon, supra*. The ALJ's decision is, therefore, not supported by substantial evidence.

Because the ALJ failed to evaluate the evidence of record provided by Health Access, which contained evidence as to obesity and diabetes, the undersigned finds the ALJ's decision is not supported by substantial evidence.

D. Severe Impairment

Plaintiff contends the ALJ's finding as to Plaintiff's RFC was not supported by substantial evidence because the ALJ did not include any limitations for Plaintiff's organic mental disorder, an impairment that the ALJ found to be severe (Plaintiff's brief at p. 10). Defendant contends the ALJ found that Plaintiff "had a severe mental impairment and then accounted for all of the functional limitations resulting from her severe mental impairment that were supported by the record in determining that Plaintiff could perform routine, repetitive work jobs" (Defendant's brief at p. 11).

The ALJ found Plaintiff's organic mental disorder (borderline intelligence functioning), back pain syndrome, GERD and asthma were severe impairments (R. 11). To be severe, an impairment must significantly limit the claimant's physical or mental ability to do basic work activities. 20 C.F.R. §§ 404.1520(c), 416.920(c). "Basic work activities" are defined as "the abilities and aptitudes necessary to do most jobs," and include: (1) physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling; (2) capacities for seeing, hearing,

and speaking; (3) understanding, carrying out, and remembering simple instructions; (4) use of judgment; (5) responding appropriately to supervision, coworkers and usual work situations; and (6) dealing with changes in a routine work setting. 20 C.F.R. §§ 404.1521(b), 416.921(b).

As to limitations caused by Plaintiff's severe organic mental disorder impairment, the ALJ found the following: "With regard to concentration, persistence or pace, the claimant is afforded every benefit of the doubt and found to have moderate difficulties. Notably, Dr. Yost reported that claimant reviews her granddaughter's homework. Based on the Digit Span portion of the WAIS-III, claimant's concentration was noted as mildly deficient (Exhibit 7F)" (R. 13). The ALJ assigned ". . . significant weight . . . to the State agency medical examiners' assessment of claimant's mental status finding claimant capable of performing routine repetitive activity in a work environment that accommodates her physical limitations (Exhibit 9F, 10F)" (R. 16). This same state-agency medical examiner, Dr. Comer, also found that Plaintiff had moderate limitations in her ability to maintain concentration, persistence or pace (R. 260). These findings are supported by the record of evidence; however, these limitations are not contained in the ALJ's RFC.

The ALJ found Plaintiff had the following RFC:

After careful consideration of the entire record, the undersigned finds that the claimant has the residual functional capacity to perform a range of light work as defined in 20 CFR 404.1567(b) and 416.967(b) except she is limited to occasional postural movements with no climbing of ropes, ladders and/or scaffolds, requires a sit/stand option, must avoid extremes of temperatures as well as hazardous machinery, moving machinery, vibrations, and unprotected heights as well as fumes, odors, and gases (R. 14).

SSR 85-16: Residual Functional Capacity for Mental Impairments holds:

When a case involves an individual . . . who has a severe impairment(s), which does not meet or equal the criteria in the Listing of Impairments, the individual's RFC must be considered in conjunction with the individual's age, education, and work experience. While some individuals will have a significant restriction of the ability

to perform some work-related activities not all such activities will be precluded by the mental impairment. *However, all limits on work-related activities resulting from the mental impairment must be described in the mental RFC* (Emphasis added.)

The ALJ's RFC does not account for Plaintiff's organic mental disorder, a severe impairment. It does not provide for Plaintiff's moderate limitations in concentration, persistence and pace or need for low stress/demand work environment. The RFC does not even include a limitation for "routine repetitive activity," which the ALJ determined Plaintiff capable of performing (R. 16).

As defined in 20 C.F.R. §§ 404.1545 and 416.941, residual functional capacity is what the Plaintiff can still do despite his limitations. Plaintiff's RFC is an assessment based upon all of the relevant evidence. It may include descriptions of limitations that go beyond the symptoms, such as pain, that are important in the diagnosis and treatment of Plaintiff's medical condition. Observations by treating physicians and psychologists of Plaintiff's limitations may be used in formulating the RFC and these observations must be considered along with the medical records to assist the Commissioner in deciding to what extent the impairments prevent Plaintiff from performing particular work activities.

The ALJ relied on the findings of Ms. Yost and Dr. Comer in formulating Plaintiff's RFC. Ms. Yost completed a psychological evaluation of Plaintiff on May 23, 2006. Ms. Yost did find that Plaintiff's concentration was mildly deficient; Ms. Yost did note that Plaintiff assisted her granddaughter with her homework; however; Ms. Yost also noted that Plaintiff attended high school only until the seventh grade, was retained in the first grade, received special education classes throughout her schooling, and did not obtain her GED; she could not pass her CNA test; the granddaughter whom Plaintiff assisted with her homework was only six years old; and Plaintiff's full-scale IQ was 74. Plaintiff was diagnosed with borderline intellectual functioning (R. 234-37).

Dr. Comer completed a Mental Residual Functional Capacity Assessment and a Psychiatric Review Technique of Plaintiff on July 7, 2006 (R. 246-63). Dr. Comer's opinions, which the ALJ assigned "significant weight" because they were "well supported by the evidence of record," contained the findings that Plaintiff was moderately limited in her ability to carry out detailed instructions, maintain attention and concentration for extended periods, complete a normal workday and workweek without interruptions from psychologically based symptoms and perform at a consistent pace without an unreasonable number and length of rest periods (R. 247). Dr. Comer found Plaintiff was moderately limited in her ability to maintain concentration, persistence or pace (R. 260). Additionally, Dr. Comer found Plaintiff had "the mental/emotional capacity for [sic] routine repetitive activity in a *low stress/demand work environment* that can accommodate her physical limitations (R. 248). (Emphasis added.)⁶

Because the ALJ failed to include any limitations for Plaintiff's organic mental disorder, an impairment she found to be severe, in her RFC, her RFC is incomplete.

Based on the ALJ's incomplete RFC, she asked the VE the following hypothetical question:

If you take a hypothetical person of the claimant's age, educational background and work experience who can do a range of light work: with occasional posturals; no climbing of ropes, ladders, scaffolds, anything of that nature; needs to avoid extremes of temperature of heat and cold; needs to avoid hazards such as dangerous moving machinery and unprotected heights; also needs to avoid noxious fumes, odors and gasses; needs to avoid vibrations also, could that hypothetical person do the claimant's prior relevant work? I'm sorry. I'm going to add a sit/stand option.

⁶It must be noted here that the ALJ did not accurately recite the findings of Dr. Comer in her decision. In her decision, as noted above, the ALJ assigned "significant weight . . . to the State agency medical examiners' assessment of claimant's mental status finding claimant capable of performing routine repetitive activity in a work environment that accommodates her physical limitations (Exhibit 9F, 10F)" (R. 16). There was no mention of Dr. Comer's finding that Plaintiff had only "the mental/emotional capacity for [sic] routine repetitive activity in a *low stress/demand work environment*" (R. 248).

Could that hypothetical person do the claimant's prior relevant work? (R. 41).

As noted by Plaintiff, the ALJ failed to include limitations in her hypothetical question to the VE that accommodates Plaintiff's severe organic mental disorder, namely moderate limitations for concentration, persistence and pace and a work environment that provides "routine repetitive activity in a low stress/demand" setting (R. 14-17, 248). The Fourth Circuit has held, in *Walker v. Bowen*, 889 F.2d 47 (1989), that "[f]or vocational expert's opinion to be relevant or helpful in disability benefits proceeding, it must be based on consideration of all other evidence in the record and must be in response to proper hypothetical questions which fairly set out all of claimant's impairments."

As to moderate limitations in a Plaintiff's ability to maintain concentration, persistence, or pace, the Fourth Circuit has not squarely addressed the issue of what language must be included in a hypothetical question; however, other circuits have. The Eighth Circuit, in *Brachtel v. Apfel*, 132 F.3d 417 (1997), held that a hypothetical question that included the ability "to do only simple routine repetitive work, which does not require close attention to detail [and] no[] work at more than a regular pace" was sufficient for a claimant who "often" exhibited limitations of concentration, persistence, or pace. The Eighth Circuit also held, in *Howard v. Massanair*, 255 F.3d 577 (2001), that a hypothetical, "upon which . . . (the ALJ) relied to deny social security claimant disability and supplemental security income benefits, which assumed that claimant was able to do simple, routine, repetitive work, adequately captured claimant's deficiencies in concentration, persistence, or pace, and thus, was substantial evidence to support award or denial of social security disability benefits." In the instant case, the ALJ found Plaintiff was capable of performing routine, repetitive activity, but made no such inclusion for that work in her hypothetical question to the VE. Additionally, the ALJ's hypothetical question did not include any limitation for low stress/demand work environment (R.

14-17, 41). The Fourth Circuit has held that “[h]ypothetical questions asked of vocational expert in disability case were not proper where they did not ensure that the expert knew what claimant’s abilities and limitations were.” *Walker, supra*. The VE could not consider Plaintiff’s limitation in maintaining concentration, persistence, or pace and her need for a routine, repetitive activity in a low stress/demand work environment in formulating a response to the ALJ’s hypothetical question because the hypothetical questions was inadequate. The undersigned finds, therefore, that substantial evidence does not support the ALJ’s RFC or hypothetical question.

VI. RECOMMENDATION

For the reasons herein stated, I find substantial evidence does not support the Commissioner’s decision denying the Plaintiff’s applications for DIB and for SSI. I accordingly recommend Defendant’s Motion for Summary Judgment be **DENIED**, and the Plaintiff’s Motion for Summary Judgment be **GRANTED** and this action be **REMANDED** to the Commissioner for further action in accordance with this recommendation for disposition.

Any party may, within fourteen (14) days after being served with a copy of this Report and Recommendation, file with the Clerk of the Court written objections identifying the portions of the Report and Recommendation to which objection is made, and the basis for such objection. A copy of such objections should also be submitted to the Honorable Irene M. Keeley, United States District Judge. Failure to timely file objections to the Report and Recommendation set forth above will result in waiver of the right to appeal from a judgment of this Court based upon such Report and Recommendation. 28 U.S.C. § 636(b)(1); *United States v. Schronce*, 727 F.2d 91 (4th Cir. 1984), cert. denied, 467 U.S. 1208 (1984); *Wright v. Collins*, 766 F.2d 841 (4th Cir. 1985); *Thomas v. Arn*, 474 U.S. 140 (1985).

The Clerk of the Court is directed to mail an authenticated copy of this Report and Recommendation to counsel of record.

Respectfully submitted this 25 day of April , 2011.



JOHN S. KAULL
UNITED STATES MAGISTRATE JUDGE

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