UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

DAVID RUDY,	:
	:CIVIL ACTION NO. 3:16-CV-1687
Plaintiff,	:
	:(JUDGE CONABOY)
v.	:
	:
NANCY A. BERRYHILL,[1]	:
Acting Commissioner of	:
Social Security,	:
	:
Defendant.	:
	:

MEMORANDUM

Pending before the Court is Plaintiff's appeal from the Commissioner's denial of Disability Insurance Benefits ("DIB") under Title II of the Social Security Act ("Act") and Social Security Income ("SSI") under Title XIV of the Act. (Doc. 1.) Plaintiff filed applications for benefits on October 22, 2012, alleging a disability onset date of January 15, 2011. (R. 613.) After Plaintiff appealed the initial denial of the claims, a hearing was held on June 23, 2014, and Administrative Law Judge ("ALJ") Sharon Zanotto issued her Decision on August 6, 2014,

[1] Nancy A. Berryhill is now the Acting Commissioner of Social Security. Pursuant to Rule 25(d) of the Federal Rules of Civil Procedure which addresses the substitution of parties when a public officer is replaced, Nancy A. Berryhill should be substituted for Acting Commissioner Carolyn W. Colvin as the defendant in this suit. Fed. R. Civ. P. 25(d). No further action needs to be taken to continue this suit by reason of the last sentence of section 205(g) of the Social Security Act, 42 U.S.C. § 405(g), which states that "[a]ny action instituted in accordance with this subsection shall survive notwithstanding any change in the person occupying the office of Commissioner of Social Security or any vacancy in such office."

concluding that Plaintiff had not been under a disability at any time from July 12, 2013, the amended onset date, to the date of the decision. (R. 620.) Plaintiff requested review of the ALJ's decision which the Appeals Council denied on June 16, 2016. (R. 1-7, 522-25.) In doing so, the ALJ's decision became the decision of the Acting Commissioner. (R. 1.)

Plaintiff filed this action on August 12, 2016. (Doc. 1), asserting in his supporting brief that the Acting Commissioner's determination should be reversed or remanded for the following reasons: 1) the ALJ erred in failing to consider Plaintiff's chronic kidney disease, cervicalgia, hypertension, hyperlipidemia, and migraines as severe impairments; 2) the ALJ did not properly weigh opinion evidence; 3) the ALJ failed to construct a legally sufficient RFC; 4) the ALJ erred in finding Plaintiff was capable of performing past relevant work; and 5) the ALJ erred in failing to find Plaintiff met the provisions of the Medical Vocational Guidelines. (Doc. 13 at 9.) After careful review of the record and the parties' filings, the Court concludes this appeal is properly granted.

I. Background

Plaintiff was born on February 2, 1957, and was fifty-five years and eleven months old at the time of his onset. (R. 633; Doc. 13 at 2.) He has a high school education and past relevant

work as a fast food worker and cashier.[2] (*Id.*)

A. Medical Evidence

Prior to the alleged onset date of July 12, 2013, Plaintiff's medical history included a stroke in 2009 (R. 965), and a heart attack requiring stent placement in 2011 (R. 956). Plaintiff also had hypertension, and chronic kidney disease. (R. 965, 1043.) In April 2011 he reported to his primary care physician, James Sioma, M.D., that he was having back pain for which he had nephrology follow-up and a diagnosis of chronic kidney disease, stage 3. (R. 936, 1025-45.) In May of 2012, Plaintiff saw Dr. Sioma for continuing problems with lumbar muscle spasms which were diagnosed as lumbago. (R. 927-28.) In August of 2012 he reported headaches, dizziness, lightheadedness, and nausea with some vomiting, and a cervical spine x-ray showed mild cervical degenerative changes, preserved anterior cervical lordosis, and calcified plaque in the bilateral carotid bifurcations. (R. 863, 893.) From March 2012 through May 2013 Plaintiff often reported chest pain and shortness of breath to Dr. Sioma and other providers. (R. 921-22, 929, 1224, 1271, 1274-75.) In May 2013 Plaintiff had another heart attack and stent placement, after which he continued to report chest pain and EKGs remained abnormal. (R. 1201, 1205-07, 1266-67, 1403.) In June 2013, Plaintiff complained of back pain. (R. 1156.)

[2] Plaintiff had been incarcerated for ninety days beginning in Mary 2012 and was again incarcerated from June 5, 2013, to September 11, 2013. (R. 634.)

On July 12, 2013--the amended disability onset date--Plaintiff was admitted to York Hospital with complaints of lightheadedness, bilateral blurred vision, and headache. (R. 1369-72.) Brain imaging studies confirmed a diagnosis of vertebral basilar insufficiency, migraine headaches, transient ischemic attacks, basilar artery occlusion and vertebral artery occulsions. (R. 1371.) On the same date, Plaintiff had an EKG due to complaints of dizziness and vomiting which showed "nonsepcific ST&T changes" and ischemia could not be excluded. (R. 1208-09.) Nuerologist Fengium Jiang, M.D., prescribed Tramadol for headaches, discussed the option of intracerebral arterial intervention which Plaintiff declined, and recommended follow up with an outpatient neurologist. (R. 1393.) Plaintiff was discharged after four days with medications including Tylenol, aspirin, Plavix, isosorbide, metoprolol, simvastin, and Ultram. (R. 1371.)

Following his hospitalization, Plaintiff continued to have problems with headaches and dizziness for which he sought treatment on multiple occasions in August 2013. (R. 1131.) On August 29, 2013, he reported sharp pain at the base of his neck and blurry vision. (R. 1162.)

Office notes from visits to Dr. Sioma's office in September and November 2013 show that Plaintiff's cardiovascular examinations were normal, he had a normal gait, and his diagnoses included hypertension and hypercholesterolemia. (R. 1260-61, 1264.)

On November 13, 2013, Plaintiff was admitted to York Hospital for headache which had lasted for six days. (R. 1362.) Plaintiff also complained of blurry vision, lightheadedness, neck pain, and balance issues. (*Id.*) Brain imaging studies showed extensive vascular calcification, and severe stenosis (versus occulsion) of the basilar artery and distal bilateral vertebral arteries. (R. 1352-53.) Plaintiff was diagnosed with a basilar migraine. (R. 1365.) Treating provider, Robert Reif, M.D., recommended that Plaintiff continue Plavix for stroke prevention and that he see an outpatient nuerologist for treatment of migraines. (*Id.*)

A November 14, 2013, bubble echocardiogram showed moderate left ventricular hypertrophy, bilateral enlargement, and sclerotic aortic vavle. (R. 1211-12, 1358.)

Later in November 2013, Plaintiff returned for nephrology follow up. (R. 1222-23.) Shelly Levenstein, CRNP, indicated Plaintiff's kidney disease was stable with controlled blood pressure, and his hypertension and hyperlipidemia also remained controlled with medication. (R. 1223.)

On December 16, 2013, Plaintiff saw Ellen Deibert, M.D., at WellSpan Neurology. (R. 1283-89.) Plaintiff reported two headaches per week that were only severe "at times." (R. 1284.) Plaintiff had normal muscle strength, tone, and bulk, normal reflexes, and a normal gait, but diminished cranial nerve VII and tender neck muscles. (R. 1283, 1286.) Dr. Deibert noted severe

intracranial disease and severe neck muscle spasms for which she prescribed gabapentin and recommended physical therapy. (R. 1283-84.) December 19, 2013, x-rays showed degenerative changes at C6-C7 and vascular calcifications. (R. 1280.)

Later in December, Plaintiff saw Dr. Sioma. (R. 1256-58.) Plaintiff denied chest pain, shortness of breath, and muscle pain or weakness, but he complained of cervical muscle spasms. (R. 1256.) He had normal ambulation. (R. 1257.) Dr. Sioma diagnosed migraine headaches and prescribed Imitrex, Tylenol, and aspirin. (*Id.*) Plaintiff continued to take gabapentin, hydralazine, hydrochlorothiazide, potassium, and simvastin. (*Id.*)

At his February 2014 visit to WellSpan Neurology, Dr. Deibert noted headaches as well as low back and leg pain since November 2013. (R. 1277.) Plaintiff reported that his headaches and dizziness had improved with physical therapy--he only had headaches once or twice a week, he rated the severity as three out of ten, and he said he rarely took Tylenol for them. (*Id.*) Dr. Deibert found sciatic notch tenderness, muscle spasms in the low back, slightly reduced reflexes, a stiff "hunched" gait, normal stance, negative straight leg raising, normal muscle strength, tone, and bulk, and normal sensation. (R. 1280.) An x-ray showed degenerative changes in the cervical spine. (*Id.*) Dr. Deibert diagnosed cervicalgia, sciatica, and lumbago. (R. 1277.) She increased the Gabapentin dosage and advised Plaintiff to avoid

Imitrex due to his history of stroke and high blood pressure and advised Plaintiff to try to just use Tylenol for the headaches. (R. 1278.)

Plaintiff continued to complain of low back pain at his March 2014 visit to Dr. Sioma. (R. 1248-55.)

On April 30, 2014, Plaintiff was hospitalized overnight at York Hospital. (R. 1316.) He complained of tingling in his arms, weakness, confusion, headache, and difficulty ambulating. (R. 1334.) Imaging studies showed mild to moderate calcific atherosclerotic plaque in bilateral carotid bulbs and proximal ICA's with posterior cruciate shadowing. (R. 1328.) An echocardiogram showed concentric left ventricular hypertrophy with underlying regional wall motion abnormalities consistent with coronary artery disease. (R. 1329-30.) Neurologist Robert Reif, M.D., diagnosed cephalgia, ruled out cardiac and ischemic events, and assessed that carpal tunnel syndrome caused the numbness. (R. 1316, 1334-36.) Dr. Reif recommended EMG/nerve conduction testing, a wrist splint at night, and continuation of physical therapy for neck pain. (R. 1336.) He also recommended "aggressive control of his hypertension and hyperlipidemia" and follow up with Dr. Deibert. (*Id.*)

At a May 13, 2014, nephrology visit, Plaintiff reported right flank pain and decreased urine output. (R. 1450-51.) She noted that Plaintiff was using a cane for ambulation. (R. 1451.) She

indicated that Plaintiff's kidney disease remained stable and secondarry to hypertensive nephrosclerosis. (R. 1452.)

On May 19, 2014, Dr. Diebert prescribed a cane for Plaintiff to use due to pain and weakness in his legs. (R. 1460.)

B. Opinion Evidence

1. State Agency Physician

In January 2013, Candelaria Legaspi, M.D., conducted a review of Plaintiff's records. (R. 677-78.) She opined that Plaintiff could perform light work involving lifting and carrying twenty pounds occasionally and ten pounds frequently, and standing or walking six hours in an eight-hour day. (*Id.*)

2. Treating Physician

Dr. Sioma, who treated Plaintiff regularly for several years, completed a "Physical Residual Functional Capacity Questionnaire"(R. 1060-64), and "Cardiac Residual Functional Capacity Questionnaire" (R. 1055-59) on February 14, 2013. He opined that Plaintiff could stand for fifteen minutes at a time before needing to sit down; he could stand/walk for less than two hours in an eight-hour day and could sit for six hours; he could lift and carry ten pounds occasionally and less than ten pounds frequently; he could rarely twist and climb stairs and never stoop, bend, crouch, squat, or climb ladders. (R. 1057-58, 1061-63.) Dr. Sioma also indicated that Plaintiff should avoid all exposure to extreme temperatures, high humidity, and wetness; he should avoid

even moderate exposure to cigarette smoke, solvents/cleaners, fumes, odors, gases, and dust; he needed to alternate positions; he would require unscheduled breaks every forty-five to sixty minutes; and he estimated that Plaintiff was likely to be absent from work as a result of his impairments about four days per month and related the symptoms back to January 2011 when Plaintiff had his first heart attack. (R. 1057-59, 1062-63.) He indicated that Plaintiff did not require a cane for ambulation. (R. 1062.)

3. <u>Physical Therapist</u>

Plaintiff's physical therapist, Rick J. Topper, completed a function questionnaire in May 2014. (R. 1455-59.) He had been treating Plaintiff since January 2014 and noted diagnoses of low back pain, sciatica, cervicalgia, and TIA. (R. 1455.) Mr. Topper identified symptoms of neck pain, back pain, weakness, and difficulty walking. (*Id.*) He stated that Plaintiff was not a malingerer. (R. 1456.) He indicated that Plaintiff could sit, stand, or walk for less than two hours each in an eight-hour day; he could rarely twist, stoop, bend, crouch, or squat; he was incapable of even low stress jobs; he would miss work more than four days per month; he had significant limitations in grasping, handling, and fingering. (R. 1455-59.) He did not complete certain sections of the questionnaire, indicating they were "not applicable." (R. 1457.) The "not applicable" portion primarily sought information about limitations which would occur in an "8-

hour working day" and other job-related questions and followed Mr. Topper's assessment that Plaintiff was incapable of even low stress jobs. (*Id.*)

C. Hearing Testimony

Plaintiff testified that the conditions which prevented him from working before July 2013 were breathing problems related to his heart, thereafter the stroke on July 12, 2013, caused a lot of issues with walking, and back pain resulting from sciatica beginning in November 2013. (R. 638, 640-41.) Plaintiff also testified that he began having problems with migraine headaches in July of 2013. (R. 643-44.) He said his migraines had increased in frequency the two months before the hearing and pain related to his chronic kidney disease had also gotten worse. (R. 645, 649-51.)

Upon examination of the VE, ALJ Zanotto noted that, with no transferable skills, Plaintiff "would grid" at either the light or sedentary level. (R. 667.) She then stated "[s]o the only place, that I need to ask any questions about, would be, potentially, if I were to find that he was able to perform his past work." (*Id.*)

ALJ Zanotto then asked the VE to consider that Plaintiff was limited to performing the full range of light, . . . but was limited to occasional crouching, occasional stooping; rarely crawling; . . . needed to avoided concentrated exposure to dusts, fumes, odors, gases, chemicals, . . . concentrated exposure to hot and cold temperature extremes, and wetness, and humidity." (R.

667.) The VE testifed that the hypothetical individual would be able to perform past relevant work as a cashier and fast food worker. (R. 668.) He further testified that the fast food worker position non-exertionals include stooping on an occasional basis; reaching and handling are constant; fingering is frequent; and there are no environmental factors. (*Id.*) For the cashier position, the VE testified that reaching, handling, and fingering are all on a frequent basis and there are no environmental factors. (*Id.*)

Plaintiff's attorney asked the VE if the hypothetical individual were limited to standing and walking less than two hours and sitting at least six hours whether he would be able to perform past work. (R. 669.) The VE responded that he would not. (*Id.*)

D. ALJ Decision

In her October 3, 2014, Decision, ALJ Cutter made the following Findings of Fact and Conclusions of Law:

> 1. The claimant meets the insured status requirements of the Social Security Act through December 31, 2015.
>
> 2. The claimant has not engaged in substantial gainful activity since July 12, 2013, the alleged onset date (20 CFR 404.1571 et seq., and 416.971 et seq.).
>
> 3. The claimant has the following severe impairments: coronary artery disease post myocardial infarction, sciatica, lumbago, transient ischemic attack, and chronic brain artery occlusion (20 CFR 404.1520(c) and 416.920(c)).

4. The claimant does not have an impairment or combination of impairments that meets or medically equals the severity of one of the listed impairments in 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 404.1520(d), 404.1525, 404.1526, 416.920(d), 416.925 and 416.926).

5. After careful consideration of the entire record, the undersigned finds that the claimant has the residual functional capacity to perform light work as defined in 20 CFR 404.1567(b) and 416.967(b) except he is limited to occasional crouching and stooping/bending, rare crawling and needs to avoid concentrated exposure to dust, fumes, odors, gases, chemicals, extreme cold and heat and wetness and humidity.

6. The claimant is capable of performing past relevant work as a cashier and fast food worker. This work does not require the performance of work-related activities precluded by the claimant's residual functional capacity (20 CFR 404.1565 and 416.965).

7. The claimant has not been under a disability, as defined in the Social Security Act, from July 12, 2013, through the date of this decision (20 CFR 404.1520(f) and 416.920(f)).

(R. 615-20.) Other relevant portions of the ALJ's Decision will be referenced in the Discussion section of this Memorandum.

II. Disability Determination Process

The Commissioner is required to use a five-step analysis to determine whether a claimant is disabled.[3] It is necessary for the

[3] "Disability" is defined as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to

Commissioner to ascertain: 1) whether the applicant is engaged in a substantial activity; 2) whether the applicant is severely impaired; 3) whether the impairment matches or is equal to the requirements of one of the listed impairments, whereby he qualifies for benefits without further inquiry; 4) whether the claimant can perform his past work; 5) whether the claimant's impairment together with his age, education, and past work experiences preclude him from doing any other sort of work. 20 C.F.R. §§ 404.1520(b)-(g), 416.920(b)-(g); *see Sullivan v. Zebley*, 493 U.S. 521, 110 S. Ct. 885, 888-89 (1990).

If the impairments do not meet or equal a listed impairment, the ALJ makes a finding about the claimant's residual functional capacity based on all the relevant medical evidence and other evidence in the case record. 20 C.F.R. § 404.1520(e); 416.920(e). The residual functional capacity assessment is then used at the

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result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months . . . ." 42 U.S.C. § 423(d)(1)(A). The Act further provides that an individual is disabled

> only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work.

42 U.S.C. § 423(d)(2)(A).

fourth and fifth steps of the evaluation process. *Id.*

The disability determination involves shifting burdens of proof. The initial burden rests with the claimant to demonstrate that he or she is unable to engage in his or her past relevant work. If the claimant satisfies this burden, then the Commissioner must show that jobs exist in the national economy that a person with the claimant's abilities, age, education, and work experience can perform. *Mason v. Shalala*, 993 F.2d 1058, 1064 (3d Cir. 1993).

As set out above, the instant decision was decided at step four of the sequential evaluation process when the ALJ found that Plaintiff could perform his past relevant work. (R. 619-20.)

III. Standard of Review

This Court's review of the Commissioner's final decision is limited to determining whether there is substantial evidence to support the Commissioner's decision. 42 U.S.C. § 405(g); *Hartranft v. Apfel*, 181 F.3d 358, 360 (3d Cir. 1999). Substantial evidence means "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971); *see also Cotter v. Harris*, 642 F.2d 700, 704 (3d Cir. 1981). The Third Circuit Court of Appeals further explained this standard in *Kent v. Schweiker*, 710 F.2d 110 (3d Cir. 1983).

> This oft-cited language is not . . . a talismanic or self-executing formula for adjudication; rather, our decisions make clear that determination of the existence *vel*

> *non* of substantial evidence is *not* merely a quantitative exercise. A single piece of evidence will not satisfy the substantiality test if the Secretary ignores, or fails to resolve, a conflict created by countervailing evidence. Nor is evidence substantial if it is overwhelmed by other evidence--particularly certain types of evidence (e.g., that offered by treating physicians)--or if it really constitutes not evidence but mere conclusion. *See* [*Cotter*, 642 F.2d] at 706 ("'Substantial evidence' can only be considered as supporting evidence in relationship to all the other evidence in the record.") (footnote omitted). The search for substantial evidence is thus a qualitative exercise without which our review of social security disability cases ceases to be merely deferential and becomes instead a sham.

Kent, 710 F.2d at 114.

This guidance makes clear it is necessary for the Secretary to analyze all evidence. If she has not done so and has not sufficiently explained the weight given to all probative exhibits, "to say that [the] 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." *Dobrowolsky v. Califano*, 606 F.2d 403, 406 (3d Cir. 1979). In *Cotter*, the Circuit Court clarified that the ALJ must not only state the evidence considered which supports the result but also indicate what evidence was rejected: "Since it is apparent that the ALJ cannot reject evidence for no reason or the wrong reason, an explanation from the ALJ of the reason why probative evidence has been rejected is required so that a reviewing court can determine whether the reasons for rejection were improper."

Cotter, 642 F.2d at 706-07. However, the ALJ need not undertake an exhaustive discussion of all the evidence. *See*, *e.g.*, *Knepp v. Apfel*, 204 F.3d 78, 83 (3d Cir. 2000). "There is no requirement that the ALJ discuss in its opinion every tidbit of evidence included in the record." *Hur v. Barnhart*, 94 F. App'x 130, 133 (3d Cir. 2004). "[W]here [a reviewing court] can determine that there is substantial evidence supporting the Commissioner's decision, . . . the *Cotter* doctrine is not implicated." *Hernandez v. Comm'f of Soc. Sec.*, 89 Fed. Appx. 771, 774 (3d Cir. 2004) (not precedential).

A reviewing court may not set aside the Commissioner's final decision if it is supported by substantial evidence, even if the court would have reached different factual conclusions. *Hartranft*, 181 F.3d at 360 (*citing Monsour Medical Center v. Heckler*, 806 F.2d 1185, 1190-91 (3d Cir. 1986); 42 U.S.C. § 405(g) ("[t]he findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive . . ."). "However, even if the Secretary's factual findings are supported by substantial evidence, [a court] may review whether the Secretary, in making his findings, applied the correct legal standards to the facts presented." *Friedberg v. Schweiker*, 721 F.2d 445, 447 (3d Cir. 1983) (internal quotation omitted). Where the ALJ's decision is explained in sufficient detail to allow meaningful judicial review and the decision is supported by substantial evidence, a

claimed error may be deemed harmless. *Albury v. Comm'r of Soc. Sec.*, 116 F. App'x 328, 330 (3d Cir. 2004) (not precedential) (citing *Burnett v. Commissioner*, 220 F.3d 112 (3d Cir. 2000) ("[O]ur primary concern has always been the ability to conduct meaningful judicial review."); *see also Rutherford v. Barnhart*, 399 F.3d 546, 553 (3d Cir. 2005) (a remand is not required where it would not affect the outcome of the case.). An ALJ's decision can only be reviewed by a court based on the evidence that was before the ALJ at the time he or she made his or her decision. *Matthews v. Apfel*, 239 F.3d 589, 593 (3d Cir. 2001).

IV. Discussion

Plaintiff asserts that the Acting Commissioner's decision should be reversed or remanded for the following reasons: 1) the ALJ erred in failing to consider Plaintiff's chronic kidney disease, cervicalgia, hypertension, hyperlipidemia, and migraines as severe impairments; 2) the ALJ did not properly weigh opinion evidence; 3) the ALJ failed to construct a legally sufficient RFC; 4) the ALJ erred in finding Plaintiff was capable of performing past relevant work; and 5) the ALJ erred in failing to find Plaintiff met the provisions of the Medical Vocational Guidelines. (Doc. 13 at 9.)

A. Step Two Determination

Plaintiff alleges the ALJ erred at step two in concluding that his chronic kidney disease, hypertension, cervicalgia,

hyperlipidemia, and migraines were not severe impairments. (Doc. 13 at 10.) Defendant responds that the ALJ's step two findings were reasonable because these impairments did not interfere with his basic work activities, and the claimed error would be harmless because the ALJ did not decide the case at step two. (Doc. 18 at 15.) The Court concludes remand is required on this issue.

If the sequential evaluation process continues beyond step two, a finding of "non-severe" regarding a specific impairment at step two may be deemed harmless if the functional limitations associated with the impairment are accounted for in the RFC. *Salles v. Commissioner of Social Security*, 229 F. App'x 140, 145 n.2 (3d Cir. 2007) (not precedential) (citing *Rutherford v. Barnhart*, 399 F.3d 546, 553 (3d Cir. 2005)). In other words, because the outcome of a case depends on the demonstration of functional limitations, where an ALJ identifies at least one severe impairment and ultimately properly characterizes a claimant's symptoms and functional limitations, the failure to identify a condition as severe is deemed harmless error. *Garcia v. Commissioner of Social Security*, 587 F. App'x 367, 370 (9th Cir. 2014) (citing *Lewis v. Astrue*, 498 F.3d 909, 911 (9th Cir. 2007)); *Burnside v. Colvin*, Civ. A. No. 3:13-CV-2554, 2015 WL 268791, at *13 (M.D. Pa. Jan. 21, 2015); *Lambert v. Astrue*, Civ. A. No. 08-657, 2009 WL 425603, at *13 (W.D. Pa. Feb. 19, 2009).

Defendant argues that medical evidence does not support

functional limitations related to the impairments found non-severe, the ALJ fully accounted for them in his RFC to the extent his impairments resulted in functional limitations, and Plaintiff does not identify any specific functional limitations stemming from the non-severe impairments that were not accounted for in the RFC. (Doc. 18 at 17-19.)

Although Plaintiff's position on this issue is not fully articulated, he points to medical evidence which he asserts shows that the conditions are significant enough to affect his ability to perform basic work activities. (Doc. 13 at 10-12; Doc. 20 at 1-3.) The record shows that, within a six-month period, Plaintiff was twice hospitalized for headaches that lasted for an extended period and his presenting condition was serious enough to warrant admission. (R. 1328-30, 1334, 1336, 1352-53, 1362.) Plaintiff testified that headaches affected his ability to work, stating "I get these massive headaches sometimes" and they had been getting worse in the four or five months preceding the June 2014 hearing. (R. 643.) He said they often start in his neck and spread to his face, causing a stiff neck, trouble turning his neck, trouble keeping his eyes open and pressure in the back of his neck and head. (R. 647.) He also said when the headacaches get bad and turn into migraines he has trouble comprehending what people are saying to him. (R. 647-48.) To combat the more severe headaches he takes propranolol (which he must be careful about taking because of his heart medicine) and otherwise treats them with Tylenol. (R.

648-49.)

Plaintiff also said that kidney pain which had worsened over the two months preceding the hearing affected his ability to work. (R. 649.) He explained that the pain was on the lower right side of his back, it was made worse if he raised his hand above his head, if he reached for something, or if he twisted the wrong way. (R. 650.)

As noted in the ALJ's summary of applicable law, at step two "[a]n impairment or combination of impairments is 'not severe' when medical and other evidence establish only a slight abnormality or a combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work." (R. 614 (citing 20 C.F.R. §§ 404.1521, 416.921; SSRs 85-28, 96-3p, 96-4p).) Plaintiff's testimony about limitations related to some impairments found non-severe is "other evidence." (*Id.*) Medical evidence supports the underlying impairments. *See supra* pp. 4-8. Limitations causing hospitalization twice in six months and limitations regularly and/or frequently affecting a claimant's ability to concentrate, turn his head, reach, and/or twist could not be deemed to have only a "minimal effect" on his ability to work. The ALJ's cryptic summary of evidence related to the non-severe impairments is not a comprehensive longitudinal picture of the evidence supporting the impairments or evaluation of the testimonial evidence. For example, she cites progress notes from York County Prison showing that Plaintiff had stable blood pressure

from June through September 2013 but she does not talk about his November 2013 and April 2014 hospitalizations (R. 1328-30, 1334, 1336, 1352-53, 1362) or December 16, 2013, visit with neurologist Ellen Deibert, M.D., where, although Plaintiff reported that his headaches which occurred twice a week were only severe at times, she noted severe intracranial disease and severe neck muscle spasms for which she prescribed gabapentin and recommended physical therapy. (R. 1283-84.) Physical therapist Rick Topper began to see Plaintiff in January 2014 and in May 2014 reported that cervicalgia and neck pain were among the conditions and symptoms that contributed to the limitations he found.[4] (R. 1455.) December 19, 2013, x-rays showed degenerative changes at C6-C7 and vascular calcifications. (R. 1280.)

This summary shows that ALJ Zanotto did not review evidence relevant to the severity of conditions she found non-severe, evidence which supports greater severity than evidence reviewed and found compelling. Because the ALJ did not review probative evidence, the Court cannot say that her step two finding is based on substantial evidence. *Cotter*, 642 F.2d at 706-07. Thus, the Court must determine whether the ALJ's error was harmless.

Although the disability determination proceeded beyond step two, here the Court cannot conclude the error was harmless because

[4] Mr. Topper noted that related clinical findings and objective signs were available in "notes as requested," as were details about Plaintiff's treatment and response. (R. 1455.)

limitations related to some conditions found non-severe were not included in the RFC. As noted above, Plaintiff testified about functional difficulties related to his neck pain, kidney pain, and headache pain. ALJ Zanotto does not discuss functional limitations related to these conditions in her RFC analysis and the Court cannot glean from her discussion that she inferentially found these limitations not credible for specific reasons. (*See* R. 617-19.) Because the Court cannot conclude ALJ Zanotto's step two error is harmless, this matter must be remanded to the Acting Commissioner for further consideration.

B. Opinion Evidence

Plaintiff next asserts ALJ Zanotto failed to properly weigh opinion evidence. (Doc. 13 at 12-15.) Defendant maintains the ALJ reasonably discounted the treating physician's opinion because it was inconsistent and unsupported by the record during the relevant time period. (Doc. 18 at 19-26.) The Court concludes that further consideration of this issue is also warranted upon remand.

Under applicable regulations and the law of the Third Circuit, a treating medical source's opinions are generally entitled to controlling weight, or at least substantial weight. *See*, *e.g.*, *Fargnoli v. Halter*, 247 F.3d 34, 43 (3d Cir. 2001) (citing 20 C.F.R. § 404.1527(c)(2); *Cotter v. Harris*, 642 F.2d 700, 704 (3d Cir. 1981)). Sometimes called the "treating physician rule," the principle is codified at 20 C.F.R. 404.1527(c)(2), and is widely

accepted in the Third Circuit. *Mason v. Shalala*, 994 F.2d 1058 (3d Cir. 1993); *see also Dorf v. Brown*, 794 F.2d 896 (3d Cir. 1986). The regulation addresses the weight to be given a treating source's opinion: "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 your case, we will give it controlling weight." 20 C.F.R. § 404.1527(c)(2).[5] "A cardinal principle

[5] 20 C.F.R. § 404.1527(c)(2) states in relevant part:

> 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 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 your 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 (c)(2)(i) and (c)(2)(ii) of this section, as well as the factors in paragraphs (c)(3) through (c)(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.

guiding disability eligibility determinations is that the ALJ accord treating physicians' reports great weight, especially when their opinions reflect expert judgment based on continuing observation of the patient's condition over a prolonged period of time." *Morales v. Apfel*, 225 F.3d 310, 317 (3d Cir. 2000) (citations omitted); see also *Brownawell v. Commissioner of Social Security*, 554 F.3d 352, 355 (3d Cir. 2008). In choosing to reject the treating physician's assessment, an ALJ may not make "speculative inferences from medical reports and may reject a treating physician's opinion outright only on the basis of contradictory medical evidence and not due to his or her own credibility judgments, speculation or lay opinion." *Morales*, 225 F.3d at 317 (citing *Plummer v. Apfel*, 186 F.3d 422, 429 (3d Cir. 1999); *Frankenfield v. Bowen*, 861 F.2d 405, 408 (3d Cir. 1988)).

The Court of Appeals for the Third Circuit addressed a plaintiff's argument that an ALJ failed to give controlling weight to the opinion of a treating physician in *Horst v. Commissioner of Social Security*, 551 F. App'x 41, 46 (3d Cir. 2014) (not precedential).

> "Under applicable regulations and the law of this Court, opinions of a claimant's treating physician are entitled to substantial and at times even controlling weight." *Fargnoli v. Massanari*, 247 F.3d 34, 43 (3d Cir. 2001). Controlling weight is given when a treating physician's opinion is "well supported by

> medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence." 20 C.F.R. § 404.1527(d)(2). "Although the ALJ may weigh the credibility of the evidence, he must give some indication of the evidence that he rejects and his reason(s) for discounting that evidence." *Fargnoli*, 247 F.3d at 43.

551 F. App'x at 46. *Horst* noted that neither the ALJ nor the court needed to rely on the treating physician's opinion that the plaintiff was completely disabled: "As an initial matter, 'the ALJ--not treating or examining physicians or State agency consultants--must make the ultimate disability and RFC determinations." 551 F. App'x at 46 n.7 (quoting *Chandler v. Comm'r of Social Sec.*, 667 F.3d 356, 361 (3d Cir. 2011); citing 20 C.F.R. § 404.1527(d)). Although it is true that an ALJ's credibility judgments alone cannot override a treating physician's medical opinion that is supported by the evidence, *Morales v. Apfel*, 225 F.3d 310, 310 (3d Cir. 2003), where an ALJ relies "upon more than personal observations and credibility determinations in discounting the treating physician's finding of disability," the ALJ does not run afoul of relevant law. *Drejka v. Commissioner of Social Security*, 61 F. App'x 778, 782 (3d Cir. 2003) (not precedential) (distinguishing *Morales v. Apfel*, 225 F.3d 310, 318 (3d Cir. 2000) (holding that an ALJ's credibility judgments alone cannot override a treating physician's medical opinion that is supported by the evidence)).

Here the ALJ reviewed Dr. Sioma's findings and stated that she

found "the restrictions overstated based on the longitudinal medical and examination findings as well as the claimant's activities of daily living." (R. 619.) ALJ Zanotto added that the "opinions were provided prior to the amended alleged disability onset date and are not consistent with treatment notes from Dr. Sioma showing very limited examination findings and improvement with rehabilitation (Exhibit 13F)." (*Id.*) For all of these reasons, the ALJ accorded limited weight to Dr. Sioma's opinions. (*Id.*)

As noted regarding the ALJ's step two analysis in the preceding section of this Memorandum, the ALJ's RFC discussion focuses on evidence tending to discount Plaintiff's symptoms and limitations and she does not discuss evidence tending to support such limitations. ALJ Zanotto notes that Plaintiff had normal muscculoskeletal range of motion and strength in April 2013 and, in January 2014, he ambulated normally and denied muscle weakness and no exercise intolerance. (R. 618.) However, she does not mention other probative evidence. In addition to the many hospitalizations, records also show the following: Plaintiff reported cervical muscle spasm bilaterally in December 2013 (R. 1256); he reported exercise intolerance and being "very fatigued with walking short distances, pain in his legs which he thought was a hip issue . . . and back pain" to another provider on January 24, 2014 (R. 1252); Dr. Deibert's December 16, 2013, findings that Plaintiff's neck muscles were tight and tender and he "most likely

has muculoskeletal headaches with C2 neuralgia component" for which she prescribed gabapentin (R. 1283-84); Dr. Deibert's February 2014 notation that Plaintiff's exam still showed "spasms on [left] side of neck and in the back as well as pain in the sciatic notch" with a working diagnosis of cervicalgia and sciatica (R. 1277), and she reported an abnormal back examination with spasms in the bilateral lumbar paraspinous muscles (R. 1279) and a stiff, hunched gait (R. 1280); in March 2014 examination showed "right sciatic with left hip and left leg pains" (R. 1248); and May 2014 records showed "a slightly antalgic but narrow based gait" (R. 1301).

This type of review of evidence is problematic because it does not contain reasoning as to why probative evidence has been rejected which is required so that a reviewing court can determine whether the reasons for rejection were improper and the decision is based on substantial evidence. *Cotter*, 642 F.2d at 706-07. It also affects ALJ Zanotto's opinion analysis because one reason for rejecting the opinion was overstatement based on "the longitudinal medical and examination findings" (R. 619), the ALJ's review of which did not include probative evidence (R. 618). A further problem with the ALJ's analysis is her finding that the opinions were entitled to limited weight in part because they were provided prior to the alleged onset date. (R. 619.) While this rationale may be valid in isolation, here it becomes less so when the opinion of the State agency medical consultant, which was provided *before* Dr. Sioma's opinions, is given great weight. (*Id.*) For all of

these reasons, further consideration of the opinion evidence is required upon remand.[6]

C. Residual Functional Capacity Assessment

Plaintiff asserts the ALJ failed to address Plaintiff's use of a cane or make any findings regarding his ability to stand, walk, lift, and carry in her RFC assessment. (Doc. 13 at 15.) Defendant responds that the ALJ accounted for all of Plaintiff's credibly established limitations. (Doc. 18 at 26.) The Court's preceding discussion regarding probative evidence not considered by the ALJ and the determination that remand is required for further consideration indicate that remand is required for reconsideration of the RFC assessment. Specifically, the ALJ discusses Plaintiff's testimony about use of a cane and limitations related to standing,

[6] Plaintiff notes the ALJ gave no weight to his physical therapist's opinion. (Doc. 13 at 15.) Although 20 C.F.R. § 404.1513 addressing consideration of evidence was recently amended, *see* § 404.1513(a) (referring to 20 C.F.R. § 404.1527 for cases filed before March 27, 2017), at the time the ALJ considered the case the regulations provided that the opinion of a physical therapist was entitled to consideration as the opinion of a non-medical source, and SSR 06-03p indicates that such opinions may constitute substantial evidence where the opinions are well documented and supported by the medical evidence. 20 C.F.R. § 404.1527(f); SSR 06-03p, 2006 WL 2329939, at *6 (S.S.A. Aug. 9, 2006); *see also Acevedo v. Colvin*, 20 F. Supp. 3d 377, 389 (W.D. N.Y. 2014). As noted in *Jones v. Colvin*, Civ. A. No. 13-4831, 2014 WL 2862245 (E.D. Pa. June 24, 2014), physical therapists are "other sources" whose opinions the ALJ may use to determine the severity of a condition. *Id.* at *11 (citing *Hatton v. Comm'r of Soc. Sec. Admin.*, 131 F. App'x 877, 878 (3d Cir. 2005)). One reason given for discounting the opinion was that it was not supported by treatment notes. (R. 619.) Mr. Topper indicated that he would supply supporting notes as requested. (R. 1455.) Because remand is required for other reasons, expansion of the record regarding Mr. Topper's notes may be indicated.

walking, changing position, and lifting, but she does not reference any evidence of record that could be considered supportive of these limitations (R. 618-19), and, as discussed above, the record contains such evidence. Though Defendant expands upon the ALJ's RFC discussion, Defendant cannot now do what the ALJ should have done. *Fargnoli v. Massanari*, 247 F.3d 34, 42 (3d Cir. 2001); *Dobrowolsky*, 606 F.2d at 406-07.

D. Past Relevant Work and Medical Vocational Guidelines

Plaintiff also claims the ALJ erred in determining that Plaintiff was capable of performing past relevant work and erred in failing to find Plaintiff disabled pursuant to Medical Vocational Rule 202.04 given his age (past fifty-five), skills and education. (Doc. 13 at 16-17.) Because the Court's preceding conclusions call these findings into question, further discussion is not warranted.

V. Conclusion

For the reasons discussed above, Plaintiff's appeal is properly granted and this matter is remanded to the Acting Commissioner for further consideration. An appropriate Order is filed simultaneously with this action.

S/Richard P. Conaboy
RICHARD P. CONABOY
United States District Judge

DATED: April 5, 2017