IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA

Trenna E. Powers, Plaintiff, vs. Nancy A. Berryhill,[1] Acting Commissioner of Social Security Administration, Defendant.	)	C/A No.: 1:16-3729-SVH ORDER

This appeal from a denial of social security benefits is before the court for a final order pursuant to 28 U.S.C. § 636(c), Local Civ. Rule 73.01(B) (D.S.C.), and the order of the Honorable David C. Norton, United States District Judge, dated March 6, 2017, referring this matter for disposition. [ECF No. 11]. The parties consented to the undersigned United States Magistrate Judge's disposition of this case, with any appeal directly to the Fourth Circuit Court of Appeals. [ECF No. 10].

Plaintiff files this appeal pursuant to 42 U.S.C. § 405(g) of the Social Security Act ("the Act") to obtain judicial review of the final decision of the Commissioner of Social Security ("Commissioner") denying the claim for Supplemental Security Income ("SSI"). The two issues before the court are whether the Commissioner's findings of fact are supported by substantial evidence and whether she applied the proper legal standards. For the reasons that follow, the court affirms the Commissioner's decision.

[1] Nancy A. Berryhill became the Acting Commissioner of Social Security on January 23, 2017. Pursuant to Fed. R. Civ. P. 25(d), Nancy A. Berryhill is substituted for Acting Commissioner Carolyn W. Colvin as the defendant in this lawsuit.

I. Relevant Background

A. Procedural History

On April 25, 2012, Plaintiff filed an application for SSI in which she alleged her disability began on January 1, 2011. Tr. at 170–75. Her application was denied initially and upon reconsideration. Tr. at 90–92 and 99–102. On May 1, 2015, Plaintiff had a hearing before Administrative Law Judge ("ALJ") Nicholas Walter. Tr. at 29–72 (Hr'g Tr.). The ALJ issued an unfavorable decision on June 23, 2015, finding that Plaintiff was not disabled within the meaning of the Act. Tr. at 6–28. Subsequently, the Appeals Council denied Plaintiff's request for review, making the ALJ's decision the final decision of the Commissioner for purposes of judicial review. Tr. at 1–4. Thereafter, Plaintiff brought this action seeking judicial review of the Commissioner's decision in a complaint filed on November 25, 2016. [ECF No. 1].

B. Plaintiff's Background and Medical History

1. Background

Plaintiff was 43 years old at the time of the hearing. Tr. at 22. She completed the tenth grade. Tr. at 38. She had no past relevant work ("PRW"). Tr. at 66. She alleges she has been unable to work since January 1, 2011. Tr. at 39.

2. Medical History

Plaintiff presented to the emergency room ("ER") at Stephens County Hospital on September 21, 2011, with a complaint of left-sided chest pain. Tr. at 302. She was diagnosed with a hiatal hernia and anxiety. Tr. at 305.

State agency consultant Glenda Scallorn, M.D. ("Dr. Scallorn"), reviewed the record and completed a psychiatric review technique form ("PRTF") on July 23, 2012. Tr. at 276–89. She found that Plaintiff had mild restriction of activities of daily living ("ADLs"), mild difficulties in maintaining social functioning, and mild difficulties in maintaining concentration, persistence, or pace and that her anxiety-related impairment was non-severe. Tr. at 286 and 288.

Plaintiff presented to Ashok K. Kancharla, M.D. ("Dr. Kancharla"), for a disability examination on July 25, 2012 Tr. at 290. She reported panic attacks and neuropathy and restlessness in her legs. *Id.* Range of motion testing was normal. Tr. at 293–96. Dr. Kancharla identified no abnormalities and indicated Plaintiff was able to ambulate without an assistive device and to get on and off the examination table without difficulty. Tr. at 291.

Plaintiff presented to Oconee Medical Center on August 15, 2012, with left arm pain and numbness. Tr. at 340. The attending physician diagnosed cervical radiculopathy. Tr. at 341.

On October 29, 2012, Plaintiff presented to the ER at Stephens County Hospital with right-sided chest pain. Tr. at 319. The attending physician diagnosed atypical right chest wall pain and chronic cholecystitis. Tr. at 322.

Plaintiff presented to Oconee Medical Center on November 2, 2012. Tr. at 347. She complained of five-day history of intermittent chest pain, after having sustained a fall and bruised her arm. Tr. at 348. X-rays of Plaintiff's right wrist revealed mild degenerative joint disease of the first metacarpal-carpal joint. Tr. at 367. A chest x-ray

showed streaky densities of the left mid-lung field that likely represented subsegmental atelectasis or scarring. *Id.* Juan Cabanero, M.D. ("Dr. Cabanero"), diagnosed a non-ST-elevation myocardial infarction, hypertension, dyslipidemia, and tobacco abuse. Tr. at 371–72. He referred Plaintiff for a left heart catheterization based on an abnormal troponin level and T-wave inversion. Tr. at 349. The heart catheterization revealed unstable angina and severe native coronary artery disease consisting of 90% left anterior descending ("LAD") coronary artery stenosis. Tr. at 364. Plaintiff was transported to St. Francis Hospital, where she underwent percutaneous coronary intervention and stenting of the LAD artery. Tr. at 374. She was discharged on November 4, 2012, with instructions to follow a diet low in saturated fat, salt, and cholesterol; to do no heavy lifting, straining, stooping, or squatting for five days; to monitor her incision site for signs of bleeding and infection; and to follow up with Dr. Cabanero in two weeks. Tr. at 377.

Plaintiff presented to nurse practitioner Shannon Robinson, CNP ("Ms. Robinson"), on November 9, 2012, to establish treatment and to follow up from her surgery. Tr. at 393. She denied chest pain and shortness of breath. *Id.* Ms. Robinson indicated Plaintiff's hypertension was controlled on medication. *Id.* She continued Plaintiff on Viibryd for anxiety. *Id.*

Plaintiff followed up with Ms. Robinson on November 30, 2012. Tr. at 400. Ms. Robinson indicated Plaintiff was doing well and that she should continue her current medications. Tr. at 401.

On December 22, 2012, Plaintiff presented to the ER at Oconee Medical Center with chest pain. Tr. at 444. She reported feeling "swimmy headed and dizzy." Tr. at 447.

The attending physician indicated that Plaintiff's hypertension medication dosage was likely too high, and the cardiologist concluded that Plaintiff's chest pain was not cardiac-related. Tr. at 447–48.

Plaintiff reported she was doing well on January 7, 2013. Tr. at 398. Ms. Robinson noted some sinus-related abnormalities and diagnosed a sinus infection and dysuria. Tr. at 399.

On March 7, 2013, Plaintiff complained of heartburn, burning, and a pulling sensation in her chest that had persisted for several weeks. Tr. at 396. She reported left arm pain, numbness, and tingling during the night. *Id.* She stated she had not been taking Lipitor or Effient because she could not afford them. *Id.* Ms. Robinson authorized prescription refills. Tr. at 397.

On May 3, 2013, state agency medical consultant Charles Jones, M.D. ("Dr. Jones"), evaluated the evidence and determined Plaintiff had the physical residual functional capacity ("RFC") to occasionally lift and/or carry 20 pounds; frequently lift and/or carry 10 pounds; stand and/or walk for a total of about six hours in an eight-hour workday; sit for a total of about six hours in an eight-hour workday; frequently reach and handle; and must avoid concentrated exposure to humidity and hazards. Tr. at 82–84.

On June 3, 2013, Plaintiff reported occasional chest pressure. Tr. at 482. She indicated it occurred at night and was relieved by rest and Flexeril. *Id.* Ms. Robinson recommended Plaintiff use Nitroglycerin when she experienced symptoms. *Id.* She replaced Lipitor with Pravastatin because Plaintiff was unable to afford Lipitor. *Id.* She

noted that Plaintiff was oriented to time, place, person, and situation and demonstrated the appropriate mood and affect. *Id.*

Plaintiff presented to Justin Huthwaite, Psy. D. ("Dr. Huthwaite"), for a psychological consultative examination on June 28, 2013. Tr. at 405–10. She reported that she had been enrolled in special education classes from kindergarten through fifth grade, but had subsequently transferred to a private school that had no special education department. Tr. at 406. She indicated she had done well with reading, but had struggled with math, science, and social studies. *Id.* She stated she had repeated the first grade and had typically earned Cs and Ds. *Id.* She indicated she had worked for a week at Arby's, but had quit because she could not learn how to operate the cash register. *Id.* She stated she had worked for a year at a nursing home, but had been fired after her patient fell. *Id.* Plaintiff denied a history of psychiatric treatment. Tr. at 407. She indicated that Citalopram had effectively treated her symptoms. *Id.* She reported occasional bouts of depression and indicated she felt hopeless and cried at times. *Id.* She endorsed decreased sleep, variable appetite, and low energy. Tr. at 408. She reported symptoms of anxiety that were triggered by being in crowded places and riding in vehicles, but denied having experienced anxiety symptoms while in her home. *Id.* Dr. Huthwaite described Plaintiff as having normal speech; showing no signs of delusions or hallucinations; demonstrating a mildly anxious mood and affect; and having adequate insight and judgment. *Id.* He indicated Plaintiff had some problems recalling objects after a delay. *Id.* He assessed depressive disorder, not otherwise specified ("NOS") and anxiety disorder, NOS. Tr. at 409. He indicated a provisional diagnosis of borderline intellectual functioning. *Id.* He

stated "[g]iven her reported learning difficulties in school as well as on the job, it is recommended that she undergo cognitive testing." *Id.*

On July 8, 2013, Plaintiff requested that Pravastatin and Flexeril be refilled. Tr. at 479. Ms. Robinson observed Plaintiff to have left shoulder tenderness. Tr. at 479. She noted Plaintiff was oriented to time, place, person, and situation and demonstrated the appropriate mood and affect. Tr. at 480. She refilled Plaintiff's prescriptions for Lisinopril and Pravastatin and prescribed Tramadol for left arm pain. *Id.*

Plaintiff presented to Oconee Medical Center on July 16, 2013, with abdominal pain that radiated into her right jaw and was associated with dizziness, nausea, and pain with inspiration. Tr. at 419. She was diagnosed with acute cholecystitis. Tr. at 423. She indicated a desire to proceed with laparoscopic cholecystectomy. Tr. at 428. However, after reviewing her medication list and discovering that she was on Effient and aspirin for coronary artery disease, Michael Paluzzi, M.D., indicated it would be best to defer surgery. *Id.*

On July 30, 2013, state agency consultant Fran Shahar, Ph. D. ("Dr. Shahar"), reviewed the record and completed a PRTF. Tr. at 80–81. She considered Listings 12.02 for organic mental disorders, 12.04 for affective disorders, and 12.06 for anxiety-related disorders and determined that Plaintiff had mild restriction of ADLs, mild difficulties in maintaining social functioning, and moderate difficulties in maintaining concentration, persistence, or pace. *Id.*

On September 3, 2013, Ms. Robinson noted that Plaintiff presented with anxious/fearful thoughts, depressed mood, and diminished interest or pleasure, but denied

fatigue and suicidal thoughts. Tr. at 476. She noted that Plaintiff's anxiety was triggered by conflict or stress. *Id.* She observed that Plaintiff was oriented to time, place, person, and situation and demonstrated the appropriate mood and affect. Tr. at 477.

Plaintiff reported that her impairments were controlled on October 7, 2013. Tr. at 473. She denied fatigue and suicidal thoughts and indicated her functioning was not difficult. *Id.* She was oriented to time, place, person, and situation and demonstrated an appropriate mood and affect. Tr. at 474.

On April 1, 2014, Plaintiff presented with concerns over elevated blood pressure. Tr. at 470. She indicated that her depressive symptoms were controlled and that she was functioning without difficulty. *Id.* She endorsed anxious and fearful thoughts, but denied fatigue. *Id.* She indicated she was responding well to Citalopram. *Id.* Ms. Robinson observed that Plaintiff was oriented to time, place, person, and situation and demonstrated appropriate mood and affect. Tr. at 471. She increased Plaintiff's dosage of Lisinopril to 40 mg. Tr. at 472.

On July 17, 2014, Plaintiff reported worsening hypertension. Tr. at 490. Ms. Robinson noted no abnormalities on examination and described Plaintiff as being oriented to time, place, person, and situation and demonstrating the appropriate mood and affect. Tr. at 491.

On July 23, 2014, Karen Frank, D.O. ("Dr. Frank"), and Ms. Robinson completed a clinical assessment of pain form. Tr. at 488. In response to a question regarding the significance of Plaintiff's pain, they circled "[p]ain is present to such an extent as to be distracting to adequate performance of daily activities or work." *Id.* In response to a

question regarding the extent to which physical activity would increase Plaintiff's experience of pain, they selected "[g]reatly increased pain is likely to occur, and to such a degree as to cause distraction from the task or even total abandonment of the task." *Id.* In response to a question about the effects of prescribed medications, they indicated "[s]ignificant side effects can be expected to limit the effectiveness of work duties or the performance of such daily tasks such as driving an automobile, etc." *Id.* They also completed a medical opinion form regarding Plaintiff's ability to perform work-related physical tasks. Tr. at 489. They noted Plaintiff's maximum ability to sit during an eight-hour workday would be about two hours. *Id.* They indicated her maximum ability to stand/walk during an eight hour workday would be about two hours. *Id.* They stated Plaintiff needed the opportunity to shift at will from sitting to standing/walking. *Id.* They noted that Plaintiff would sometimes need to elevate her feet at unpredictable intervals during a work shift. *Id.* They denied that Plaintiff would need to lie down to relieve pain during a normal workday and indicated she did not require a cane to ambulate. *Id.* They estimated Plaintiff would be absent from work an average of three days per month. *Id.*

On May 14, 2015, Plaintiff's attorney received a letter from Dr. Frank. Tr. at 496. Dr. Frank indicated that Plaintiff's continued tobacco use following the placement of a cardiac stent in November 2012 had likely led to blockage of the stent. *Id.* She stated she felt that Plaintiff had decreased exercise endurance and increased shortness of breath and was in need of immediate cardiac attention. *Id.* She stated Plaintiff had been unable to obtain the care she needed because of her lack of health coverage and inability to work. *Id.*

C. The Administrative Proceedings

1. The Administrative Hearing

a. Plaintiff's Testimony

At the hearing on May 1, 2015, Plaintiff testified that she had dropped out of school in the eleventh grade because she had to earn income to support her mother. Tr. at 38. She indicated she was able to read and write, but later noted that she could not read, write, or perform mathematical calculations well. Tr. at 38 and 57. She stated she had stopped working around 1990 to care for her diabetic parents. Tr. at 39.

Plaintiff testified she was unable to work because she had experienced a heart attack, had pain and swelling in her legs, and always felt tired. Tr. at 40. She indicated she needed to elevate her legs for five or ten minutes two to three times per day to reduce the swelling. Tr. at 42 and 51. She endorsed pain in her left arm that had caused difficulty with lifting and carrying items and reaching overhead. Tr. at 42 and 48. She indicated the swelling in her legs and fatigue had begun after her heart attack, but noted that her fatigue was worsened by her current medication regimen. Tr. at 42 and 43.

Plaintiff testified that she felt nervous when she was around a lot of people. Tr. at 44. She recalled incidents in which she had left Walmart and a restaurant because she felt overwhelmed by the number of people around her. Tr. at 45. She endorsed some memory problems. Tr. at 62–63. She stated she was able to follow a recipe, but would have to reread it. Tr. at 63. She indicated her mental health problems were being treated by her primary care physician. Tr. at 47. She stated her doctor had recommended she see a counselor, but she had been unable to afford to do so. *Id.*

Plaintiff estimated that she could sit, stand, and walk for five to ten minutes each before she would begin to feel pain in her legs and back. Tr. at 49–50. She denied having dropped things from her left hand, but indicated her left arm would become weak after 10 minutes of use. Tr. at 61. She indicated she spent approximately half of a typical day lying down or in a reclined position. Tr. at 62.

Plaintiff testified that she lived with her boyfriend and her 23-year-old son. Tr. at 35. She stated her son was receiving disability benefits because he was diagnosed with autism and attention deficit hyperactivity disorder ("ADHD"). Tr. at 35–36. She indicated she was her son's primary caregiver and that she typically prepared his meals, washed his clothes, and administered his medications. Tr. at 36 and 40. She testified that she engaged in daily housework that included washing dishes, doing laundry, sweeping, and making the beds. Tr. at 51. She indicated she cooked breakfast for her boyfriend, her son, and herself each morning. Tr. at 53. She noted that she would perform a chore for 10 minutes, would rest and elevate her feet for 10 minutes, and would return to the chore for another 10 minutes. Tr. at 55 and 60. She stated she had never obtained a driver's license because she had problems with her "nerves." Tr. at 36. She indicated she attended church and occasionally dined in restaurants. Tr. at 37. She stated she watched television and played games on her phone during the day. Tr. at 54–55. She indicated she fed and cared for her dog. Tr. at 55.

b. Vocational Expert Testimony

Vocational Expert ("VE") Benson Hecker, Ph. D., reviewed the record and testified at the hearing. Tr. at 65–69. The ALJ described a hypothetical individual of

Plaintiff's vocational profile who could perform work at the light exertional level with frequent reaching and handling with the left upper extremity; no concentrated exposure to humidity; and no hazards. Tr. at 66. He further stated the individual would be limited to simple, routine tasks; that her time off-task could be accommodated by normal breaks; and that she would be subjected to few changes in the work setting. *Id.* The VE testified that the hypothetical individual could perform jobs as a packer, *Dictionary of Occupational Titles* ("*DOT*") number 753.687-038, with 660,000 positions nationally; a marker/pricer, *DOT* number 209.587-034, with 1,800,000 positions nationally; and an assembler, *DOT* number 706.684-022, with 218,000 positions nationally. *Id.*

For a second hypothetical question, the ALJ asked the VE to consider an individual of Plaintiff's vocational profile who would be limited to work at the sedentary exertional level and would be further limited by the other restrictions included in the first question. Tr. at 67. The VE testified that the hypothetical individual could perform work as a sorter, *DOT* number 521.687-086, with 410,000 positions nationally; an assembler, *DOT* number 739.684-094, with 229,000 positions nationally; and a finisher, *DOT* number 731.687-014, with 200,000 positions nationally. *Id.*

For a third hypothetical question, the ALJ asked the VE to consider an individual of Plaintiff's vocational profile who would be limited as described in the second question, but who would be expected to be absent from work three times per month. *Id.* The VE testified that no jobs would be available and that current research suggested that unskilled jobs would typically allow for only five to six absences per year. *Id.*

For a fourth hypothetical question, the ALJ asked the VE to consider the restrictions in the second hypothetical question, but to further assume that the individual would have to elevate her feet for half of the time that she was seated. Tr. at 67–68. The VE testified that the individual would be unable to perform any work. Tr. at 68.

Plaintiff's attorney asked the VE to consider an individual of Plaintiff's vocational profile who would be limited as described in the second hypothetical question, but who would require cueing to learn and recall simple information; would have variable ability to attend to information; and would work at a reduced pace. Tr. at 68–69. The VE indicated that the individual would be unable to work. *Id.*

2. The ALJ's Findings

In his decision dated June 23, 2015, the ALJ made the following findings of fact and conclusions of law:

1. The claimant has not engaged in substantial gainful activity since April 25, 2012, the application date (20 CFR 416.971 *et seq.*).
2. The claimant has the following severe impairments: Ischemic heart disease; obesity; anxiety; and affective disorder (20 CFR 416.920(c)).
3. 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 416.920(d), 416.925 and 416.926).
4. 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 416.967(b) except she can frequently reach and handle with her left upper extremity. The claimant must also avoid hazards and concentrated exposure to humidity. In addition, the claimant is limited to simple, routine tasks. Any "off task" periods would be accommodated by regular breaks. Finally, the claimant can tolerate few changes in the routine work setting.
5. The claimant has no past relevant work (20 CFR 416.965).
6. The claimant was born on August 9, 1971 and was 40 years old, which is defined as a younger individual age 18–49, on the date the application was filed (20 CFR 416.963).

7. The claimant has a limited education and is able to communicate in English (20 CFR 416.964).
8. Transferability of job skills is not an issue because the claimant does not have past relevant work (20 CFR 416.968).
9. Considering the claimant's age, education, work experience, and residual functional capacity, there are jobs that exist in significant numbers in the national economy that the claimant can perform (20 CFR 416.969, and 416.969(a)).
10. The claimant has not been under a disability, as defined in the Social Security Act, since April 25, 2012, the date the application was filed (20 CFR 416.920(g)).

Tr. at 11–23.

II. Discussion

Plaintiff alleges the Commissioner erred for the following reasons:

1) the ALJ did not properly consider the medical opinions of record in determining which mental limitations to include in the RFC assessment;

2) the ALJ did not adequately develop the record; and

3) the ALJ failed to present a proper hypothetical question to the VE and erred in relying on the VE's testimony to meet the Commissioner's burden at step five.

The Commissioner counters that substantial evidence supports the ALJ's findings and that the ALJ committed no legal error in his decision.

A. Legal Framework

1. The Commissioner's Determination-of-Disability Process

The Act provides that disability benefits shall be available to those persons insured for benefits, who are not of retirement age, who properly apply, and who are under a "disability." 42 U.S.C. § 423(a). Section 423(d)(1)(A) defines disability as:

> the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be

> expected to result in death or which has lasted or can be expected to last for at least 12 consecutive months.

42 U.S.C. § 423(d)(1)(A).

To facilitate a uniform and efficient processing of disability claims, regulations promulgated under the Act have reduced the statutory definition of disability to a series of five sequential questions. *See, e.g., Heckler v. Campbell*, 461 U.S. 458, 460 (1983) (discussing considerations and noting "need for efficiency" in considering disability claims). An examiner must consider the following: (1) whether the claimant is engaged in substantial gainful activity; (2) whether she has a severe impairment; (3) whether that impairment meets or equals an impairment included in the Listings;[2] (4) whether such impairment prevents claimant from performing PRW;[3] and (5) whether the impairment prevents her from doing substantial gainful employment. *See* 20 C.F.R. § 416.920. These considerations are sometimes referred to as the "five steps" of the Commissioner's disability analysis. If a decision regarding disability may be made at any step, no further

[2] The Commissioner's regulations include an extensive list of impairments ("the Listings" or "Listed impairments") the Agency considers disabling without the need to assess whether there are any jobs a claimant could do. The Agency considers the Listed impairments, found at 20 C.F.R. part 404, subpart P, Appendix 1, severe enough to prevent all gainful activity. 20 C.F.R. § 416.925. If the medical evidence shows a claimant meets or equals all criteria of any of the Listed impairments for at least one year, she will be found disabled without further assessment. 20 C.F.R. § 416.920(a)(4)(iii). To meet or equal one of these Listings, the claimant must establish that her impairments match several specific criteria or are "at least equal in severity and duration to [those] criteria." 20 C.F.R. § 416.926; *Sullivan v. Zebley*, 493 U.S. 521, 530 (1990); *see Bowen v. Yuckert*, 482 U.S. 137, 146 (1987) (noting the burden is on claimant to establish his impairment is disabling at Step 3).

[3] In the event the examiner does not find a claimant disabled at the third step and does not have sufficient information about the claimant's past relevant work to make a finding at the fourth step, he may proceed to the fifth step of the sequential evaluation process pursuant to 20 C.F.R. § 416.920(h).

inquiry is necessary. 20 C.F.R. § 416.920(a)(4) (providing that if Commissioner can find claimant disabled or not disabled at a step, Commissioner makes determination and does not go on to the next step).

A claimant is not disabled within the meaning of the Act if she can return to PRW as it is customarily performed in the economy or as the claimant actually performed the work. *See* 20 C.F.R. Subpart P, § 416.920(a), (b); Social Security Ruling ("SSR") 82-62 (1982). The claimant bears the burden of establishing her inability to work within the meaning of the Act. 42 U.S.C. § 423(d)(5).

Once an individual has made a prima facie showing of disability by establishing the inability to return to PRW, the burden shifts to the Commissioner to come forward with evidence that claimant can perform alternative work and that such work exists in the regional economy. To satisfy that burden, the Commissioner may obtain testimony from a VE demonstrating the existence of jobs available in the national economy that claimant can perform despite the existence of impairments that prevent the return to PRW. *Walls v. Barnhart*, 296 F.3d 287, 290 (4th Cir. 2002). If the Commissioner satisfies that burden, the claimant must then establish that she is unable to perform other work. *Hall v. Harris*, 658 F.2d 260, 264–65 (4th Cir. 1981); *see generally Bowen v. Yuckert*, 482 U.S. 137, 146 n.5 (1987) (regarding burdens of proof).

2. The Court's Standard of Review

The Act permits a claimant to obtain judicial review of "any final decision of the Commissioner [] made after a hearing to which he was a party." 42 U.S.C. § 405(g). The scope of that federal court review is narrowly-tailored to determine whether the findings

of the Commissioner are supported by substantial evidence and whether the Commissioner applied the proper legal standard in evaluating the claimant's case. *See Richardson v. Perales*, 402 U.S. 389, 390 (1971); *Walls*, 296 F.3d at 290 (*citing Hays v. Sullivan*, 907 F.2d 1453, 1456 (4th Cir. 1990)).

The court's function is not to "try these cases de novo or resolve mere conflicts in the evidence." *Vitek v. Finch*, 438 F.2d 1157, 1157–58 (4th Cir. 1971); *see Pyles v. Bowen*, 849 F.2d 846, 848 (4th Cir. 1988) (*citing Smith v. Schweiker*, 795 F.2d 343, 345 (4th Cir. 1986)). Rather, the court must uphold the Commissioner's decision if it is supported by substantial evidence. "Substantial evidence" is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson*, 402 U.S. at 390, 401; *Johnson v. Barnhart*, 434 F.3d 650, 653 (4th Cir. 2005). Thus, the court must carefully scrutinize the entire record to assure there is a sound foundation for the Commissioner's findings and that her conclusion is rational. *See Vitek*, 438 F.2d at 1157–58; *see also Thomas v. Celebrezze*, 331 F.2d 541, 543 (4th Cir. 1964). If there is substantial evidence to support the decision of the Commissioner, that decision must be affirmed "even should the court disagree with such decision." *Blalock v. Richardson*, 483 F.2d 773, 775 (4th Cir. 1972).

B. Analysis

1. Evaluation of Medical Opinions in Assessing RFC

Plaintiff argues the RFC assessment was unsupported by substantial evidence to the extent that the ALJ failed to properly account for the mental limitations that Drs. Huthwaite and Shahar identified. [ECF No. 14 at 10–15]. The Commissioner argues that

the ALJ provided valid reasons for accepting and rejecting parts of Drs. Huthwaite's and Shahar's opinions and accounted for the accepted limitations in the RFC assessment. [ECF No. 18 at 8].

A claimant's RFC represents the most she can still do despite her limitations. 20 C.F.R. § 416.945(a). It must be based on all the relevant evidence in the case record and should account for all of the claimant's medically-determinable impairments. *Id.*

In determining a claimant's RFC, an ALJ must carefully consider medical source opinions of record. *SSR* 96-5p; *see also* 20 C.F.R. § 416.927(b). He should evaluate and weigh those opinions based on the factors in 20 C.F.R. § 416.927(c), which include (1) the examining relationship between the claimant and the medical provider; (2) the treatment relationship between the claimant and the medical provider, including the length of the treatment relationship and frequency of treatment and the nature and extent of the treatment relationship; (3) the supportability of the medical provider's opinion in his or her own treatment records; (4) the consistency of the medical opinion with other evidence in the record; and (5) the specialization of the medical provider offering the opinion. *Johnson*, 434 F.3d at 654.

The RFC assessment must include a narrative discussion describing how all the relevant evidence in the case record supports each conclusion and must cite "specific medical facts (e.g., laboratory findings) and non-medical evidence (e.g., daily activities, observations)." SSR 96-8p. The ALJ must explain how any material inconsistencies or ambiguities in the record were resolved. *Id.* This court is generally prohibited from disturbing the ALJ's weighing of the medical opinion evidence "absent some indication

that the ALJ has dredged up 'specious inconsistencies,' *Scivally v. Sullivan*, 966 F.2d 1070, 1077 (7th Cir. 1992), or has not given good reason for the weight afforded a particular opinion." *Craft v. Apfel*, 164 F.3d 624 (Table), 1998 WL 702296, at *2 (4th Cir. 1998) (per curiam). Nevertheless, "remand may be appropriate . . . where an ALJ fails to assess a claimant's capacity to perform relevant functions, despite contradictory evidence in the record, or where other inadequacies in the ALJ's analysis frustrate meaningful review." *Mascio v. Colvin*, 780 F.3d 632, 636 (4th Cir. 2015), citing *Cichocki v. Astrue*, 729 F.3d 172, 177 (2d Cir. 2013).

a. Dr. Huthwaite's Opinion

Dr. Huthwaite concluded that Plaintiff was capable of understanding and carrying out simple instructions, but was likely to struggle with carrying out complex instructions. Tr. at 409. He indicated Plaintiff had variable ability to attend to information, but would be able to learn and recall simple information with cueing. *Id.* He further noted the following:

> If employed, she appears likely to work at a reduced pace, is at risk for not persisting with tasks she struggles to understand, and would require at least intermittent supervision. She is at moderate risk for experiencing difficulty adapting to work-related stress given her psychiatric difficulties. Ms. Powers would likely require assistance with managing disability funds, if awarded.

Id.

Plaintiff argues that the ALJ gave invalid reasons for discounting some of the limitations that Dr. Huthwaite indicated and failed to address others. *Id.* at 10–14. She specifically maintains that the ALJ failed to adopt or to explain his rejection of Dr. Huthwaite's opinions that she would have difficulty with stress, would require additional

supervision, and would have variable ability to attend to information. *Id.* at 12. She contends that it was insufficient for the ALJ to discount some of the restrictions Dr. Huthwaite assessed without providing an explanation. [ECF No. 19 at 1].

The Commissioner maintains that the ALJ explained that he considered all of the limitations Dr. Huthwaite assessed and implicitly rejected those limitations that would preclude simple work. [ECF No. 18 at 8–9]. She contends the ALJ found that the cueing and pace limitations were unsupported by Dr. Huthwaite's examination findings; were inconsistent with the longitudinal record; were inconsistent with Plaintiff's conservative treatment history; and were unsupported by her ADLs. *Id.* at 9–10.

The ALJ noted that Dr. Huthwaite had opined that Plaintiff was "capable of understanding and carrying out simple instructions," but was "likely to struggle with complex instructions." Tr. at 19. He indicated Dr. Huthwaite had stated Plaintiff had variable ability to attend to information, but appeared "able to learn and recall simple information with cueing" and "able to communicate adequately with others." *Id.* He further stated Dr. Huthwaite had found that "the claimant appears likely to work at a reduced pace, is at risk of not persisting with tasks she struggles to understand, and would require at least intermittent supervision." *Id.* He noted that Dr. Huthwaite had provided a provisional diagnosis of borderline intellectual functioning and had found Plaintiff to be "at moderate risk for experiencing difficulty adapting to work-related stress" and to "likely require assistance with managing disability funds." *Id.*

The ALJ stated the following with respect to Dr. Huthwaite's opinion:

> To the extent Dr. Huthwaite found that the claimant is capable of performing simple work, his opinion is consistent with the evidence of

> record—including his own mental status examination, and the unremarkable observations by the claimant's primary care physician. This finding is also consistent with the claimant's conservative mental treatment, which appears to have been effective. Indeed, the claimant informed the consultative examiner that her mental health medication was effective. However, to the extent Dr. Huthwaite concluded that the claimant would need cueing and would work at a reduced pace even with respect to simple tasks, his opinion is inconsistent with the above evidence. To this extent, it is also inconsistent with the claimant's activities of daily living, such as performing simple household chores, being able to sustain concentration for movies and puzzle games, caring for her son, and going shopping. Therefore, the undersigned gives partial weight to Dr. Huthwaite's opinion.

Tr. at 19–20.

Contrary to Plaintiff's assertion, the ALJ explicitly noted Dr. Huthwaite's opinion that she would have difficulty with stress, would require additional supervision, and would have variable ability to attend to information. *See* Tr. at 19 (acknowledging these components of Dr. Huthwaite's opinion). Although the ALJ did not explicitly state that he rejected these particular restrictions, he specified that he was crediting that portion of Dr. Huthwaite's opinion that was consistent with a finding that Plaintiff could perform "simple work" because it was supported by Dr. Huthwaite's examination findings and the other evidence of record. *See* Tr. at 19–20. As Plaintiff acknowledged in her brief (ECF No. 14 at 12), the VE testified that these additional restrictions would not allow an individual to engage in work activity. *See* Tr. at 68–69. The ALJ specifically stated that he was rejecting Dr. Huthwaite's opinion that Plaintiff could need cueing and would work at a reduced pace even with respect to simple tasks, but did not specifically state that he was rejecting Dr. Huthwaite's opinion that Plaintiff would have difficulty with stress, would require additional supervision, and would have variable ability to attend to information. Nevertheless, it is clear from his decision that he was rejecting these

restrictions as inconsistent with the evidence that showed Plaintiff to be capable of performing "simple work." *See* Tr. at 19–20.

Although Plaintiff argues that the record does not support the ALJ's rejection of the restrictions in Dr. Huthwaite's opinion that were inconsistent with an ability to perform "simple work," the ALJ cited substantial evidence to sustain his weighing of the evidence, as he evaluated Dr. Huthwaite's opinion based on the relevant factors in 20 C.F.R. § 416.927(c). He considered that Dr. Huthwaite was an examining physician, but had no treating relationship with Plaintiff. *See* Tr. at 19 (noting that Plaintiff attended a psychological consultative examination with Dr. Huthwaite on June 28, 2013). He reflected on the supportability of Dr. Huthwaite's opinion in his own record. *See id.* (discussing findings on mental status examination, observations of "only mildly fluctuating attention" and "only mildly anxious mood," Plaintiff's ability to spell "world" forward on the first attempt and backward on the second attempt, her ability to count backward from 100 by fives, and her inability to remember words after a 15-minute delay with cues). He also considered the supportability factor in crediting Dr. Huthwaite's opinion that Plaintiff could perform "simple work" and in rejecting other elements of Dr. Huthwaite's opinion. *See* 19–20 (noting "unremarkable observations by the claimant's primary care physician," Plaintiff's history of "conservative mental treatment," her indications that her medication was effective, and her ADLs). The ALJ noted earlier in the decision that Plaintiff was able to engage in a variety of ADLs. *See* Tr. at 13 (observing that Plaintiff indicated abilities to prepare meals on a daily basis; engage in light housework; take care of her disabled son; administer her son's medications; engage

in personal care; shop in stores; manage her finances; live with and maintain an excellent relationship with her boyfriend and son; dine in restaurants once or twice a month; spend time with friends once or twice a week; visit the movie theater with her boyfriend; get along with authority figures and others; concentrate on two-hour movies; complete puzzle books; follow recipes; care for a dog; watch the news; and play games on her telephone).

In light of the foregoing, it appears the ALJ properly assessed Plaintiff's ability to perform relevant mental functions and gave good reasons for rejecting the portions of Dr. Huthwaite's opinion that were not supported by the record.

b. Dr. Shahar's Opinion

On July 30, 2013, Dr. Shahar indicated in a mental RFC assessment that Plaintiff was moderately limited in her abilities to understand and remember detailed instructions; to carry out detailed instructions; to maintain attention and concentration for extended periods; to complete a normal workday and workweek without interruptions from psychologically-based symptoms; to perform at a consistent pace without an unreasonable number and length of rest periods; and to respond appropriately to changes in work setting. Tr. at 84–86. Dr. Shahar specified that Plaintiff was likely to have difficulty recalling some complex directions, doing complex tasks, and sustaining concentration, attention, pace, and persistence for complex routines. Tr. at 85. She noted Plaintiff was at some risk of decompensating under ordinary work stress, but was not currently presenting with psychiatric symptoms that would preclude workplace

functioning. Tr. at 85–86. She stated Plaintiff could adapt to ordinary work transitions, but may have difficulty adapting to frequent or major workplace changes. Tr. at 86.

Plaintiff argues that the ALJ substituted his own opinion for Dr. Shahar's medical opinion and that substantial evidence does not support his rejection of the opinion. *Id.* at 14–15. The Commissioner notes that the ALJ accepted most of Dr. Shahar's opinion and articulated valid reasons to discounting his opinion that Plaintiff was generally at risk for decompensating under ordinary stress. [ECF No. 18 at 11–12].

The ALJ noted that Dr. Shahar had assessed Plaintiff to have mild restriction of ADLs, mild limitations in social functioning, and moderate limitations in concentration, persistence, or pace. Tr. at 20. He stated Dr. Shahar had indicated Plaintiff would "likely have difficulty recalling some complex instructions, but did "not have significant limitations in remembering locations and work-like procedures or understanding and remembering very short and simple instructions." *Id.* He indicated that Dr. Shahar had observed that Plaintiff was "likely to have difficulty performing complex tasks, and sustaining concentration, attention, pace and persistence for complex routines." *Id.* He stated Dr. Shahar had indicated Plaintiff was "at some risk for decompensating under ordinary work stress," but was "not currently presenting with symptoms that would preclude workplace functioning" and was not "significantly limited" in her "ability to carry out very short and simple instructions." *Id.* He noted that Dr. Shahar had found that Plaintiff could "adapt to ordinary work transitions, but may have difficulty adapting to frequent or major workplace changes." *Id.*

The ALJ accorded "great weight" to Dr. Shahar's opinion, noting that it was "generally consistent with the multiple unremarkable objective findings in the record, as well as the claimant's conservative mental treatment history" and with Plaintiff's "activities of daily living, which include playing puzzle games, performing multiple household chores and caring for her son." *Id.* However, he found that "to the extent Dr. Shahar found that the claimant is at risk of decompensation under ordinary stress," her opinion was "inconsistent with the evidence." Tr. at 20–21. He stated that Dr. Shahar had not addressed "the actual likelihood of decompensation" and "there was no indication in the record that Plaintiff had decompensated over the three-year period reflected in the evidence or that she had "received more than conservative medication treatment." Tr. at 21.

A review of the decision reveals that the ALJ weighed Dr. Shahar's opinion based on the relevant factors in 20 C.F.R. § 416.927(c). The ALJ noted that Dr. Shahar was a "State agency psychological consultant," as opposed to an examining or treating medical provider. *See* 20 C.F.R. § 416.927(c)(1), (2). Thus, the examining, treating, and supportability factors did not provide support for Dr. Shahar's opinion. However, the ALJ acknowledged that, as an agency psychological consultant, Dr. Shahar had "an understanding of our rules and regulations." *See* 20 C.F.R. § 416.927(c)(5); *see also* 20 C.F.R. § 416.927(e)(2) (providing that state agency consultants are "highly qualified physicians, psychologists, and other medical specialists who are also experts in Social Security disability evaluation").

The ALJ primarily relied on the consistency factor in crediting most of Dr. Shahar's opinion, but discounting her indication that Plaintiff was at risk for decompensation under normal work stress. *See* 20 C.F.R. § 416.927(c)(4). Contrary to Plaintiff's assertion, the ALJ did not substitute his own opinion for that of Dr. Shahar in reaching this conclusion, but instead relied on evidence from Plaintiff's treating physician and her ADLs. *See* Tr. at 18–19 (noting that Plaintiff endorsed symptoms of anxiety and depression in September 2013, but exhibited appropriate mood and affect and was oriented times four; indicating "mental status examinations were similarly unremarkable" in November 2012, January and October 2013, and April and July 2014; acknowledging that Plaintiff endorsed symptoms of depression and anxiety in April 2014, but that her symptoms were "apparently mild because she indicated that her depression-related symptoms were controlled, and that she did not have any difficulty functioning" and "reported a good response to medication") and Tr. at 20–21 (citing "multiple unremarkable objective findings in the record," Plaintiff's "conservative mental treatment history," ADLs that included "playing puzzle games, performing multiple household chores and caring for her son," and the absence of periods of decompensation over the three-year period since her application was filed). Much of the evidence the ALJ cited was not in the record when Dr. Shahar reviewed it in July 2013. Given Dr. Shahar's opinion that Plaintiff was not presenting with symptoms that would preclude her from working at the time he reviewed the record and subsequent records that showed no periods of decompensation, it was not unreasonable for the ALJ to discount the notion

that Plaintiff would be at some undefined risk of decompensating under ordinary work stress in assessing her RFC.

In light of the foregoing, substantial evidence supported the ALJ's decision to give great weight to Dr. Shahar's opinion, but to discount her indication that Plaintiff was at risk of decompensation under ordinary stress.

2. Development of the Record

Plaintiff argues the ALJ erred in failing to obtain cognitive testing and intelligence quotient ("IQ") scores. [ECF No. 14 at 15–16]. She maintains that a need for IQ testing was indicated by her poor performance during the consultative examination with Dr. Huthwaite and her history of limited education, special education instruction, poor grades, poor academic performance, and difficulty sustaining work. *Id.* at 16. She contends that IQ testing was necessary to determine if disability was established under the Listings and to provide more information as to how her intellectual functioning affected her RFC. *Id.* at 16–17.

The Commissioner argues that the ALJ was not obligated to order Plaintiff's IQ be tested. [ECF No. 18 at 12]. She maintains that the record did not allege intellectual disability; that neither Plaintiff nor her counsel requested IQ testing; and that Dr. Huthwaite's suggestion for further testing was based solely on Plaintiff's subjective statements. *Id.* at 12.

It is the claimant's burden to produce evidence of disability. *See Hall v. Harris*, 658 F.2d 260, 264–65 (4th Cir. 1981); 42 U.S.C. § 423(d)(5)(A) ("An individual shall not be considered to be under a disability unless he furnishes such medical and other

evidence of the existence thereof as the Secretary may require"). However, "the ALJ has a duty to explore all relevant facts and inquire into the issues necessary for adequate development of the record, and cannot rely on the evidence submitted by the claimant when that evidence is inadequate." *Cook v. Heckler*, 783 F.2d 1168, 1173 (4th Cir. 1986), citing *Walker v. Harris*, 642 F.2d 712, 714 (4th Cir. 1981); *Marsh v. Harris*, 632 F.2d 296, 300 (4th Cir. 1980). If the evidence in the case record is insufficient[4] or inconsistent,[5] the ALJ may need to take additional actions. *Id.*

"Where the ALJ fails in his duty to fully inquire into the issues necessary for adequate development of the record, and such failure is prejudicial to the claimant, the case should be remanded." *Marsh*, 632 F.2d at 300, citing *Cutler v. Weinberger*, 516 F.2d 1282 (2nd Cir. 1975); *Hess v. Secretary of Health, Education and Welfare*, 497 F.2d 837 (3rd Cir. 1974); *Hicks v. Mathews*, 424 F. Supp. 8 (D. Md. 1976). However, "[w]hile the ALJ must make a reasonable inquiry into a claim of disability, he has no duty to 'to go to inordinate lengths to develop a claimant's case.'" *Craft v. Apfel*, 164 F.3d 624, 1998 WL 702296, at *2 (4th Cir. 1998) (per curiam) (unpublished table decision), citing *Thomas v. Califano*, 556 F.2d 616, 618 (1st Cir. 1977).

[4] An ALJ should consider the evidence to be insufficient if it does not contain all the information necessary to make a decision. 20 C.F.R. § 416.920b (effective March 26, 2012 to March 26, 2017).

[5] An ALJ should consider the evidence to be inconsistent when it conflicts with other evidence, contains an internal conflict, is ambiguous, or does not appear to be based on medically-acceptable clinical or laboratory diagnostic techniques. 20 C.F.R. § 416.920b (effective March 26, 2012 to March 26, 2017). If the ALJ determines that the evidence is inconsistent, he should weigh the relevant evidence to determine if the record contains sufficient evidence to decide the issue of disability. 20 C.F.R. § 416.920b(b) (effective March 26, 2012 to March 26, 2017).

As an initial matter, the court notes that Plaintiff did not allege in her application for benefits or hearing testimony that she had a cognitive disability. *See* Tr. at 40 (testifying that she was unable to work as a result of a heart attack, swelling in her legs, fatigue, and "nerves"), Tr. at 195 (listing "panic attacks" and "neuropathy/restless leg (not diagnosed)" as the physical or mental conditions that limited her ability to work), and Tr. at 220 (indicating a history of heart attack and problems with shortness of breath, restless legs, arm pain, and panic attacks). Plaintiff's representative also declined to allege a cognitive impairment or to request that she be referred for cognitive testing. *See* Tr. at 264–65 (neglecting to include borderline intellectual functioning or cognitive disorder among Plaintiff's severe impairments and failing to request consideration under Listing 12.05 in a pre-hearing memorandum). *Cf. Mink v. Apfel*, 215 F.3d 1320, 2000 WL 665664, at *1 (4th Cir. 2000) (unpublished table decision) (holding that an ALJ did not fail to properly develop the medical record where the plaintiff "was represented at the hearing by counsel, who could have easily submitted the disputed documents").

Nevertheless, the ALJ had at least constructive notice that cognitive testing might be needed based on Plaintiff's reported history of academic deficits and Dr. Huthwaite's provisional diagnosis of borderline intellectual functioning and suggestion that she be referred for cognitive testing. Despite this evidence, the ALJ was not required to further develop the record if he had sufficient evidence before him to make a decision. *See* 20 C.F.R. § 416.920b(c) (providing that a consultative examination at the agency's expense is one of the options available to an ALJ if he determines the evidence of record is insufficient to allow him to reach a conclusion about whether the claimant is disabled).

Plaintiff argues that an assessment of her IQ was necessary to determine whether she met Listing 12.05. [ECF No. 14 at 16–17]. An ALJ "must fully analyze whether a claimant's impairment meets or equals a 'Listing' where there is factual support that a listing could be met." *Huntington v. Apfel*, 101 F. Supp. 2d 384, 390 (D. Md. 2000), citing *Cook v. Heckler*, 783 F.2d 1168, 1172 (4th Cir. 1986) (remanded, in part, because of ALJ's failure to specifically identify relevant Listing and compare each of the Listed criteria to the evidence of the claimant's symptoms).

To establish disability under the version of Listing 12.05 that was applicable at the time of the ALJ's decision, an individual was required to show significantly subaverage general intellectual functioning with deficits in adaptive functioning that initially manifested before age 22 and meet the severity requirements in either paragraph A, B, C, or D. 20 C.F.R., Pt. 404, Subpt. P, App'x. 1, § 12.05 (effective June 12, 2015 to July 19, 2015).[6] "Deficits in adaptive functioning can include limitations in areas such as communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety." *Jackson v. Astrue*, 467 F. App'x 214, 218 (4th Cir. 2012), citing *Atkins v. Virginia*, 536 U.S. 304, 309 n.3 (2002). The Supreme Court has held that intellectual disability is characterized by "significant limitations" in at least two of the areas of adaptive functioning in conjunction with significantly subaverage general intellectual functioning.

[6] A change to Listing 12.05 provides different criteria to establish disability under the Listing. 20 C.F.R., Pt. 404, Subpt. P, App'x. 1, § 12.05 (effective March 27, 2017).

Atkins, 536 U.S. at 309 n.3. "An essential element to meeting all but paragraph 'A'[7] of Listing 12.05 is a 'valid' IQ score." *English v. Astrue*, No. 3:08-2887-MBS-JRM, 2010 WL 1258025, at *5 (D.S.C. Feb. 23, 2010). Paragraph B requires "[a] valid verbal, performance, or full scale IQ of 59 or less and paragraphs C and D require "[a] valid verbal, performance, of full scale IQ of 60 through 70" and additional limitations. 20 C.F.R., Pt. 404, Subpt. P, App'x. 1, § 12.05(B), (C), and (D) (effective June 12, 2015 to July 19, 2015).

Although Plaintiff points to the academic history she reported to Dr. Huthwaite (Tr. at 406) and his provisional assessment of borderline intellectual functioning (Tr. at 409), the record contains no evidence to suggest she had significantly subaverage general intellectual functioning, as required for a finding of disability under Listing 12.05. By definition, Dr. Huthwaite's provisional diagnosis of borderline intellectual functioning suggested that Plaintiff's IQ score was above 70 and would not trigger analysis under Listing 12.05. *See Diagnostic & Statistical Manual of Mental Disorders,* Fourth Edition, Text Revision, Washington, DC, American Psychiatric Association, 2000 ("*DSM-IV-TR*") (defining mild mental retardation by an IQ score of 50–55 to approximately 70 and borderline intellectual functioning by slightly higher IQ scores in the 71–84 range). Plaintiff is essentially requesting that the court order the ALJ to refer her for cognitive testing because it might show her IQ was in a lower range than that suggested by Dr. Huthwaite. In the absence of any indication in the record that testing would yield an IQ

[7] Paragraph A requires "dependence upon others for personal needs (e.g., toileting, eating, dressing or bathing) and inability to follow directions, such that the use of standardized measures of intellectual functioning is precluded. 20 C.F.R., Pt. 404, Subpt. P, App'x. 1, § 12.05(A) (effective June 12, 2015 to July 19, 2015).

score below the borderline range, it appears that Plaintiff is requesting that the court order the ALJ to go to inordinate lengths to develop the record. *See Craft*, 1998 WL 702296, at *2.

In addition, the record does not support a finding that Plaintiff had deficits in adaptive functioning. While the ALJ did not address Plaintiff's adaptive functioning in the context of an analysis under Listing 12.05, he cited substantial evidence that showed Plaintiff to have no significant limitations in adaptive functioning. *See* Tr. at 13 (observing that Plaintiff prepared meals on a daily basis, did light housework, cared for and administered medications to her disabled son, managed her personal care, shopped in stores, was able to go out alone, indicated an ability to manage her finances independently, ate in restaurants, spent time with family and friends once or twice a week, visited the movie theater, reported getting along well with others, completed puzzle books, followed recipes, and cared for a dog). *Cf. Weedon v. Colvin*, No. 0:11-2971-DCN-PJG, 2013 WL 1315206, at *4 (D.S.C. Mar. 28, 2013) ("Despite Weedon's educational records, which reflect her enrollment in special education classes due to learning disabilities, the balance of the record provides substantial evidence to support the ALJ's conclusion that Weedon does not exhibit deficits in adaptive functioning. As the ALJ discussed in her opinion, Weedon lives independently while serving as the main caretaker for her three children, is able to manage her own finances, and has a significant work history, including semi-skilled work as a certified nursing assistant."). In light of the foregoing, it does not appear that obtaining Plaintiff's IQ scores would have directed a different finding under Listing 12.05.

Plaintiff also maintains that cognitive testing was necessary "to determine the extent of [her] limitations" that resulted from a potential diagnosis of borderline intellectual functioning. [ECF No. 14 at 17]. Plaintiff's claim that cognitive testing may show her to have additional limitations is merely speculative, and she cannot show that she was prejudiced by the ALJ's decision not to refer her for cognitive testing. The ALJ found that Plaintiff's credibly-established mental impairments limited her to simple, routine tasks that required her to tolerate few changes in the routine work setting, but that her time off task could be accommodated by regular breaks. Tr. at 14. In assessing these components of Plaintiff's RFC, the ALJ analyzed the evidence of record, including Dr. Huthwaite's psychological consultative examination report and the treatment notes from Plaintiff's physician. *See* Tr. at 13 and 19–20. He provided a thorough explanation for the mental limitations he assessed and valid reasons for finding Plaintiff was not further limited. *See id.* In light of the foregoing, substantial evidence supports the ALJ's conclusion that the record was sufficient to allow him to make a decision without obtaining an additional consultative examination.

3. Improper VE Hypothetical and Step Five Determination

Plaintiff argues that the ALJ erred in relying on the jobs the VE identified to meet the Commissioner's burden at step five because his hypothetical question to the VE did not properly account for all of her impairments. [ECF No. 14 at 17]. The Commissioner maintains the ALJ was only required to question the VE regarding Plaintiff's credibly-established limitations. [ECF No. 18 at 14–15]. She contends the ALJ reasonably relied

on the VE's testimony that Plaintiff could perform a significant number of jobs in the national economy. *Id.* at 15.

To support a finding that a claimant is "not disabled," the ALJ must either find that the claimant's RFC allows her to perform her PRW or that she can make an adjustment to other work. *See* 20 C.F.R. § 416.920(a)(4)(iv), (v). To produce specific vocational evidence showing that the national economy provides employment opportunities, it is often necessary for the ALJ to solicit the services of a VE. *See Walker*, 889 F.2d at 50; *see also Aistrop*, 36 F. App'x at 147 (providing that where a claimant has both exertional and nonexertional impairments that prevent performance of a full range of work at a given exertional level, "the Commissioner must prove through expert vocational testimony that jobs exist in the national economy which the claimant can perform"). The VE's opinion, "must be based upon a consideration of all other evidence in the record . . . and it must be in response to proper hypothetical questions which fairly set out all of [a] claimant's impairments." *Johnson*, 434 F.3d at 659 (quoting *Walker*, 889 F.2d at 50); *see also English v. Shalala*, 10 F.3d 1080, 1085 (4th Cir. 1993). A VE's testimony cannot constitute substantial evidence in support of the Commissioner's decision if the VE identified jobs in response to a hypothetical question that did not include all of the claimant's restrictions. *See id.*

The ALJ's RFC assessment mirrored the first hypothetical question he presented to the VE during the hearing. *Compare* Tr. at 14, *with* Tr. at 66. In response to the hypothetical question, the VE identified the jobs of packer, marker/pricer, and assembler.

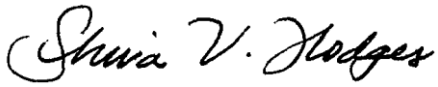
Tr. at 66. The ALJ relied on the VE's testimony and cited these jobs to satisfy the Commissioner's burden at step five. *See* Tr. at 22–23.

In light of the court's prior findings and because Plaintiff presents no additional challenges to the assessed RFC, the court finds the ALJ properly relied on the VE's testimony to meet the Commissioner's burden to produce specific job information at step five.

III. Conclusion

The court's function is not to substitute its own judgment for that of the Commissioner, but to determine whether her decision is supported as a matter of fact and law. Based on the foregoing, the undersigned affirms the Commissioner's decision.

IT IS SO ORDERED.



July 20, 2017
Columbia, South Carolina

Shiva V. Hodges
United States Magistrate Judge