IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

EILEEN MARIA LABADIE	:	CIVIL ACTION
	:	
v.	:	
	:	
NANCY A. BERRYHILL, Acting Commissioner of Social Security[1]	:	NO. 15-3493

REPORT AND RECOMMENDATION

ELIZABETH T. HEY, U.S.M.J. March 22, 2017

This action was brought pursuant to 42 U.S.C. § 405(g) to review the final decision of the Commissioner of Social Security ("Commissioner" or "Defendant"), denying the application for disability insurance benefits ("DIB") filed by Eileen Maria Labadie ("Plaintiff"). For the reasons that follow, I conclude that the decision of the Administrative Law Judge ("ALJ") is supported by substantial evidence. Therefore, I recommend that the decision of the Commissioner of Social Security be affirmed.

I. PROCEDURAL HISTORY

Plaintiff protectively applied for DIB on August 21, 2012, alleging an onset date of August 3, 2009. Tr. at 130, 175. The application was denied initially and Plaintiff requested an administrative hearing before an ALJ. Id. at 68, 73. The hearing took place on January 14, 2014. Id. at 33-53. The ALJ issued an unfavorable decision on February

[1]Nancy A. Berryhill became the Acting Commissioner of Social Security on January 23, 2017. Pursuant to Rule 25(d) of the Federal Rules of Civil Procedure, Ms. Berryhill should be substituted for the former Acting Commissioner, Carolyn Colvin, as the defendant in this action. No further action need be taken to continue this suit pursuant to section 205(g) of the Social Security Act. 42 U.S.C. § 405(g).

24, 2014. Id. at 19-29. On April 25, 2015, the Appeals Council denied Plaintiff's request for review. Id. at 1-3. Therefore, the ALJ's February 24, 2014 decision is the final decision of the Commissioner. 20 C.F.R. § 404.981.

Plaintiff filed her complaint in this action on June 22, 2015, and submitted a Brief and Statement of Issues in Support of Request for Review on February 8, 2016. Docs. 1 & 12. Defendant filed a response on March 11, 2016. Doc. 13. The Honorable Edward G. Smith referred the case to me to prepare a Report and Recommendation. Doc. 14.

II. LEGAL STANDARD

The court's role on judicial review is to determine whether the Commissioner's decision is supported by substantial evidence. 42 U.S.C. § 405(g); Schaudeck v. Comm'r of Soc. Sec., 181 F.3d 429, 431 (3d Cir. 1999). Therefore, the issue in this case is whether there is substantial evidence to support the Commissioner's conclusions that Plaintiff is not disabled and is capable of performing jobs that exist in significant numbers in the national economy. Substantial evidence is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion," and must be "more than a mere scintilla." Zirnsak v. Colvin, 777 F.2d 607, 610 (3d Cir. 2014) (quoting Rutherford v. Barnhart, 399 F.3d 546, 552 (3d Cir. 2005)). The court has plenary review of legal issues. Schaudeck, 181 F.3d at 431.

To prove disability, a claimant must demonstrate an "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment . . . which has lasted or can be expected to last for . . . not less than twelve

months." 42 U.S.C. § 423(d)(1). The Commissioner employs a five-step process, evaluating:

1. Whether the claimant is currently engaged in substantial gainful activity;

2. If not, whether the claimant has a "severe impairment" that significantly limits her physical or mental ability to perform basic work activities;

3. If so, whether, based on the medical evidence, the impairment meets or equals the criteria of an impairment listed in the "listing of impairments," 20 C.F.R. pt. 404, subpt. P, app. 1, which results in a presumption of disability;

4. If the impairment does not meet or equal the criteria for a listed impairment, whether, despite the severe impairment, the claimant has the residual functional capacity ("RFC") to perform her past work; and

5. If the claimant cannot perform her past work, then the final step is to determine whether there is other work in the national economy that the claimant can perform.

See Zirnsak, 777 F.3d at 610; see also 20 C.F.R. §§ 404.1520(a)(4), 416.920(a)(4). Plaintiff bears the burden of proof at steps one through four, while the burden shifts to the Commissioner at the fifth step to establish that the claimant is capable of performing other jobs in the local and national economies, in light of her age, education, work experience, and residual functional capacity. See Poulos v. Comm'r of Soc. Sec., 474 F.3d 88, 92 (3d Cir. 2007).

III. FACT RECORD AND THE ALJ'S DECISION

Plaintiff was born on January 27, 1961, and thus was 48 years old at the time of her alleged disability onset date (August 3, 2009), and 53 at the time of the ALJ's decision (February 24, 2014). Tr. at 130. Plaintiff is five feet, eleven inches tall. Id. at 148. She weighed approximately 231 pounds at the time of her application, and approximately 198 pounds at the time of the hearing as a result of trying to lose weight. Id. at 36-37, 148. She completed high school and attended a beauty academy for six months after high school. Id. at 37-38, 149. Plaintiff lives with her boyfriend and has a son in college. Id. at 37. She has a license and can drive. Id.

Plaintiff worked as a receptionist in a dental office, as a receptionist/child care worker at a group home, and as a clerk for the Internal Revenue Service ("IRS"). Tr. at 38, 150, 159-62. Plaintiff testified that she last worked in August of 2009, when she fell at work. Id. at 39. Plaintiff alleged disability due to cervical, thoracic, and lumbar injuries and pain, carpal tunnel syndrome ("CTS"), depression, anxiety and arthritis. Id. at 148.

A. Medical Evidence

1. Back Pain

Plaintiff fell at work in 2009, injuring her lower back and right knee. Tr. at 38-39, 199.[2] On August 10, 2009, after reviewing the MRI of Plaintiff's thoracic spine, Stephen

[2]There are varying dates for Plaintiff's fall in the record. The Workers' Compensation paperwork indicates Plaintiff was injured on July 14, 2009. Tr. at 127. Treatment notes from the Rothman Institute indicate the injury occurred on July 16, 2009. Id. at 202. Plaintiff's physical therapist indicated the fall occurred on October 14,

Jaffe, M.D., diagnosed "[b]one contusions of the T7 and to a lesser extent T8 vertebrae with no actual deformity and no related soft tissue abnormalities." Id. at 405-06.[3] After reviewing the MRI report of Plaintiff's thoracic spine, Ari C. Greis, D.O., whom Plaintiff saw at the Rothman Institute ("Rothman") on August 20, 2009, diagnosed a "bone contusion of T7 greater than T8 with secondary thoracic paraspinal muscle hypertonicity."[4] Id. at 200. Dr. Greis prescribed a home TENS unit,[5] and Mobic[6] for her pain. Id. On September 21, 2009, Plaintiff followed up with William Anderson, M.D., at Rothman, who believed Plaintiff's continuing thoracic spine pain was due to the bone contusion at T7 and T8. Id. at 197. He also noted that Plaintiff's fall probably

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2009. Id. at 308. Plaintiff testified at the hearing that she fell at work in August 2009. Id. at 39.

[3]An x-ray of the thoracic spine performed a week earlier was negative. Tr. at 415.

[4]Hypertonicity refers to "excessive tone of the skeletal muscles, so that they have increased resistance to passive stretching and reflexes are often exaggerated." Dorland's Illustrated Medical Dictionary, 32nd ed. (2012) ("DIMD") at 897.

[5]TENS refers to "transcutaneous electrical nerve stimulation." DIMD at 1882. TENS units are used "to treat localized or regional pain, [using] electrodes [to] deliver electrical impulses to nearby nerve pathways – which can help control or relieve some types of pain." See http://www.mayoclinic.org/tens/expert-answers/faq-20058378 (last visited Mar. 9, 2017).

[6]Mobic is a nonsteroidal anti-inflammatory drug used to treat pain or inflammation caused by rheumatoid arthritis and osteoarthritis. See https://www.drugs.com/mobic.html (last visited Mar. 9, 2017).

exacerbated her chronic low back pain. Id. at 197.[7] The following week, Dr. Anderson prescribed a Medrol Dosepak, Celebrex, and omeprazole.[8] Id. at 193.

Plaintiff began physical therapy for her lower back and right knee on August 24, 2009. Tr. at 256, 258. At that time, the range of motion and strength of her lower back were non-functional. Id. at 259. She completed physical therapy in November 2009, with notations that her lifting was restricted to 10 - 20 pounds, and she experienced pain after sitting 30 minutes or standing 10 - 15 minutes. Id. at 287. Plaintiff had a flare up in back pain in the spring of 2011, and returned to physical therapy. Id. at 308. In a June 9, 2011 update to William Bonner, M.D., Plaintiff's sports and physical medicine physician, physical therapist Andrea Price noted that Plaintiff was "independent in her personal care activities and [activities of daily living], but does have difficulties with any type of heavy lifting and feels her sleep has been reduced by at least 50% because of her low back pain.

[7]Plaintiff had a history of lower back pain dating to at least early 2008, for which she received left sacroiliac joint injection in December 2008. Tr. at 205-08, 213-16. She was discharged from treatment in February 2009, having reached maximum medical improvement. Id. at 208.

[8]Medrol Dosepak (generic methylprednisolone) is a steroid that prevents the release of substances in the body that cause inflammation. It is used to treat many different inflammatory conditions such as arthritis, lupus, psoriasis, ulcerative colitis, allergic disorders, gland (endocrine) disorders, and conditions that affect the skin, eyes, lungs, stomach, nervous system, or blood cells. See https://www.drugs.com/mtm/medrol-dosepak.html (last visited Mar. 9, 2017). Celebrex is a nonsteroidal anti-inflammatory drug used to treat pain and inflammation caused by many conditions such as arthritis, ankylosing spondylitis, and menstrual pain. See https://www.drugs.com/search.php?searchterm=Celebrex (last visited Mar. 9, 2017). Omeprazole is used to treat symptoms of gastroesophageal reflux disease ("GERD"). See https://www.drugs.com/omeprazole.html (last visited Mar. 9, 2017).

[Plaintiff's] back pain prevents her from sitting greater than one hour, standing is only tolerated for 30 minutes and walking is only tolerated for less than a half a mile." Id.

Dr. Bonner began treating Plaintiff on November 18, 2009. Tr. at 459-60. Generally, Dr. Bonner supported Plaintiff's physical therapy regimen. Id. at 457. During his treatment of Plaintiff, he prescribed Percocet[9] for Plaintiff's pain. Id. at 482, 483, 485, 486. On March 5, 2010, Dr. Bonner conducted EMG studies and determined that Plaintiff had "an acute L5 radiculopathy of mild to moderate severity."[10] Id. at 455. Dr. Bonner also noted Plaintiff's consistent complaints of low back pain and mild radicular symptoms. Id. at 438, 450, 451 (EMG of lumbosacral spine shows evidence of acute radicular process at L5), 460. In May 2010, Dr. Bonner recommended continuing with the physical rehab for the lumbar spine. Id. at 450. An MRI of the lumbar spine performed in the summer of 2011 showed a disc bulge with facet hypertrophy at L5-S1.[11] Id. at 438.

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[9]Percocet contains a combination of oxycodone, an opioid pain medication, and acetaminophen, a less potent pain reliever that increases the effects of oxycodone. It is used to relieve moderate to severe pain. See https://www.drugs.com/search.php?searchterm=percocet (last visited Mar. 9, 2017).

[10]Radiculopathy is disease of the nerve roots, such as from inflammation or impingement by a tumor or bony spur. Lumbar radiculopathy refers to disease of the lumbar nerve roots, such as from disk herniation or compression with lower back pain and often paresthesias. DIMD at 1571.

[11]A disc bulge can be distinguished from a disc herniation as follows:

> A bulging disc extends outside the space it should normally occupy. The bulge typically affects a large portion of the disc, so it may look a little like a hamburger that's too big for its bun. The part of the disc that's bulging is typically the tough outer layer of

Plaintiff began treatment for her back pain with John J. Mahoney, D.O., at Clinical Pain Management Associates on November 4, 2011. Tr. at 254-55. After reviewing an MRI, Dr. Mahoney noted mild narrowing at the L4-L5 level and mild degenerative changes particularly at the facet joints at L4-L5 and L5-S1. Id. at 255. He planned a trial of bilateral intra-articular lumbar facet injections, which he then performed on November 28, 2011.[12] Id. at 253, 255. On January 6, 2012, Plaintiff followed up with Dr. Mahoney, who noted "a radicular component to her pain related to foraminal stenosis and lumbar spondylosis."[13] Id. at 252. The doctor noted diffuse tenderness across the

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> cartilage. Usually bulging is considered part of the normal aging process of the disc and is common to see on MRIs of people in almost every age group.
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> A herniated disc, on the other hand, results when a crack in the tough outer layer of cartilage allows some of the softer inner cartilage to protrude out of the disc. Herniated discs are also called ruptured discs or slipped discs.

See http://www.mayoclinic.com/health/bulging-disk/AN00272 (last visited Mar. 9, 2017). "Facet [h]ypertrophy is the term used to describe a degeneration and enlargement of the facet joints. The facet joints, which are a pair of small joints at each level along the back of the spine, are designed to provide support, stability, and flexibility to the spine." See http://www.spine-health.com/glossary/hypertrophic-facet-disease (last visited Mar. 9, 2017).

[12] [F]acet joint injection involves involves injecting a small amount of local anesthetic (numbing agent) and/or steroid medication, which can anesthetize the facet joints and block the pain. The pain relief from a facet joint injection is intended to help a patient better tolerate a physical therapy routine to rehabilitate his or her injury or back condition.

See http://www.spine-health.com/treatment/injections/cervical-thoracic-and-lumbar-facet-joint-injections (last visited Mar. 9, 2017).

[13] "Foraminal stenosis is the narrowing of the cervical disc space caused by enlargement of a joint in the spinal canal." See http://www.spine-

lumbosacral junction and pain with back extension and side lateral bending. Id. The doctor suggested a lumbar epidural and facet rhizotomy for her lower back.[14] Id. At her January 27, 2012 visit, Dr. Mahoney noted that Plaintiff had been involved in a car accident on November 25, 2011, and since that time had been having pain in the cervical region on the left side that radiated into the left upper back. Id. at 250-51.

Dr. Mahoney performed a lumbar epidural steroid injection on February 13, 2012. Tr. at 248. A month later, Dr. Mahoney reported on her progress. "She was having some shooting pain radiating down into the buttock and proximal lower extremity that has been helped with the epidural injection and the facet injections helped her low back pain." Id. at 247. On March 23, 2012, Dr. Mahoney diagnosed "cervical spondylosis and cervical facet syndrome with resultant cervicogenic-type headaches," for which he performed intra-articular facet injections bilaterally at C4-C5, C5-C6, and C6-C7. Id. at 245, 246. To address Plaintiff's lumbar related pain, on April 16 and April 30, 2012, Dr. Mahoney

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health.com/glossary/foraminal-stenosis (last visited Mar. 9, 2017). Lumbar spondylosis is degenerative joint disease affecting the lumbar vertebra and intervertebral disks, causing pain and stiffness, sometimes with sciatic radiation due to nerve root pressure by associated protruding disks or osteophytes. DIMD at 1754.

[14]Epidural injection describes the procedure by which "a steroid is injected directly around the dura, the sac around the nerve roots that contains cerebrospinal fluid." This decreases inflammation caused by common conditions such as spinal stenosis, disc herniation, or degenerative disc disease. See http://www.spine-health.com/treatment/injections/epidural-steroid-injections (last visited Mar. 9, 2017). Facet rhizotomy is used "to provide lasting low back pain relief by disabling the sensory nerve that goes to the facet joint. In this injection procedure, a needle with a probe is inserted just outside the joint. The probe is then heated with radiowaves and applied to the sensory nerve to the joint in order to disable the nerve." See http://www.spine-health.com/treatment/injections/facet-rhizotomy-and-sacroiliac-joint-block-injections (last visited Mar. 9, 2017).

performed radiofrequency facet rhizotomy on the left side at the L3, L4, L5, and sacral levels of the spine. Id. at 243, 244. At a July 2012 physical therapy session, Ms. Price noted that the rhizotomy decreased Plaintiff's pain complaints in the short term, but the results did not have a lasting effect. Id. at 329.

More recent notes from Dr. Mahoney show that Plaintiff underwent facet injections to the cervical discs on January 14, 2013, radiofrequency facet rhizotomy in the cervical spine on April 22, 2013 (left) and May 6, 2013 (right), facet injections to the lumbar area on June 3, 2013, and radiofrequency rhizotomy to the lumbar area on September 23, 2013 (left) and October 7, 2013 (right). Tr. at 488-89, 490, 491, 498, 499, 500. Dr. Bonner's July 3, 2013 note indicates that Plaintiff had continued low back pain, but that her "neck pain is much improved since the injections have been performed." Id. at 474.

An MRI of Plaintiff's cervical spine performed on December 15, 2013, showed a variety of disc space narrowing, disc bulges and disc protrusions causing central canal stenosis and minimal bilateral neural foraminal narrowing. Tr. at 501-02. The most notable area was at C5-C6, where the MRI showed a "tiny disc-osteophyte complex and mild diffuse disc bulge as well as uncovertebral and facet hypertrophy, causing moderate to severe canal stenosis with mild flattening of the cervical spinal cord as well as moderate bilateral neural foraminal narrowing." Id. at 501. On the same day, an MRI of Plaintiff's lumbar spine showed "a posterior annular tear" and "a tiny central protrusion"

at both L1-L2 and at L5-S1, and "mild diffuse bulging of the disc" and "bilateral moderate to severe facet osteoarthritis," at L4-L5. Id. at 503-04.

Plaintiff saw Louis Pearlstein, D.O., of Neurologic and Headache Associates on October 25, 2013, complaining of muscle spasms in her back downward. Tr. at 512. In December 2013, after reviewing the MRI results, Dr. Pearlstein concluded that Plaintiff "has multiple levels of disk pathology with cervical and lumbar disease." Id. at 510. He recommended Plaintiff see Srinivas Prasad, M.D., from Jefferson to see if she is a surgical candidate. Id. Dr. Prassad saw Plaintiff on January 9, 2014, to evaluate her neck and back pain radiating to her shoulders, left buttock, and posterior thigh. Id. at 519-20. He saw no basis for surgical intervention based on his review of the imaging studies, but ordered additional testing.

> Although the buttock and posterior thigh pain do seem radicular in nature, she has negative straight leg raise[15] and her imaging of the lumbar spine really looks quite normal. I do not see any structural pathology specifically compressing the S1 or even L5 nerve roots. Additionally, she has well preserved disc height and hydration. In the cervical spine, she does have degenerative disease at C5-C6 and C6-C7, which may contribute to some of her arm symptoms, although the bulk of her symptoms are really trapezius and shoulder. She does have some positive shoulder findings and I think a shoulder evaluation may be reasonable. I would like to see her back with a CT scan and flexion-extension x-rays of both

[15]The straight leg raise test is done to determine whether a patient with low back pain has an underlying herniated disc. The patient, either lying or sitting with the knee straight, has his or her leg lifted. The test is positive if pain is produced between 30 and 70 degrees. Johnson v. Colvin, Civ. No. 09-2228, 2014 WL 7408699, at *5 n.17 (M.D. Pa. Dec. 30, 2014) (quoting Niccola V. Hawkinson, DNP, RN, Testing for Herniated Discs: Straight Leg Raise, SpineUniverse, http://www.spineuniverse.com /experts/testing-herniated-discs-straight-leg-raise (accessed December 5, 2014) (revisited June 2, 2016)).

> her neck and her lumbar spine. Additionally, I would like her to get a shoulder evaluation to exclude other contributions to her symptom complex.

Id. at 520.

2. Knee Pain

As noted, Plaintiff's fall in 2009 also affected her right knee. On August 10, 2009, after reviewing an MRI of Plaintiff's right knee, Stephen Jaffe, M.D., diagnosed "a tear of the anterior lateral meniscus and probably the posterior medial meniscus." Tr. at 403. He also found a small joint effusion and a small Baker cyst.[16] Id. On September 28, 2009, Plaintiff saw Christopher Dodson, M.D., at Rothman, for persistent right knee pain. Id. at 194-95. Dr. Dodson concluded that Plaintiff had a symptomatic meniscal tear and recommended she continue with physical therapy before considering arthroscopic surgery. Id. at 195. Although the surgical notes are not contained in the record, treatment notes indicate that Plaintiff underwent surgery on the torn meniscus in the right knee in the spring of 2010. Id. at 450, 451.[17]

Plaintiff began physical therapy for her right knee on August 24, 2009. Tr. at 256. At that time, her range of motion and the strength of her knee were within functional limits, as opposed to within normal limits. Id. at 257. On May 17, 2010, Dr. Bonner noted that Plaintiff was status-post surgical correction in her right knee and found that the

[16]A Baker cyst is a swelling behind the knee, caused by escape of synovial fluid which becomes enclosed in a membranous sac. DIMD at 458.

[17]In November 2012, Plaintiff reported to Dr. Farooq, whose consultative examination will be discussed below, that she had the right meniscus repair in 2010, and expected to have the left meniscus repaired shortly. Tr. at 462-63.

right knee pain continued to improve.[18] Id. at 450. The following month, Dr. Bonner noted that the right knee pain "has almost resolved." Id. at 449.

As for Plaintiff's left knee, an MRI done on September 5, 2012, showed "[m]edial and lateral meniscal tears," "[m]ild secondary osteoarthritis in the lateral compartment," and "[m]ild joint effusion and [a] small Baker's cyst." Tr. at 366-67, 505.

3. Carpal Tunnel Syndrome

Plaintiff has a history of CTS.[19] Tr. at 39-40, 202. According to Plaintiff, she had carpal tunnel release surgery in 1992, 1997, and 2010. Tr. at 40.[20] Dr. Bonner conducted EMG studies in October 2010, which indicated bilateral CTS and ulnar neuropathy at the left elbow. Id. at 442. She had right carpal tunnel release surgery on February 17, 2011. Id. at 236. Plaintiff is right-handed. Id. at 290. She began physical therapy for the right hand and wrist on March 9, 2011. Id. At that time, her grip strength was reduced compared to her left. Id. When Dr. Bonner again saw Plaintiff in August 2011, he noted that Plaintiff had no complaints of right wrist or hand pain and found she had good range of motion of the wrist joint, the sensation in the hand was intact and she had no paresthesias in the hand. Id. at 438. Shortly thereafter, however, Plaintiff was again

[18]Dr. Bonner repeatedly refers to Plaintiff seeing Dr. Mannherz for treatment of her knee pain. Tr. at 447-51. There are no treatment notes from Dr. Mannherz in the record.

[19]CTS is "an entrapment neuropathy characterized by pain and burning or tingling paresthesias in the fingers and hand, sometimes extending to the elbow. Symptoms result from compression of the median nerve of the carpal tunnel." DIMD at 1824.

[20]Although both Plaintiff and Dr. Farooq state that the last surgery was in 2010, see tr. at 40, 462, the operative report bears a surgery date of February 17, 2011. Id. at 236.

complaining of pain in her right hand. Id. at 428, 354. An EMG performed on December 8, 2011, revealed mild right carpal tunnel syndrome. Id. at 428. On July 3, 2013, Dr. Bonner noted "right TFC [triangular fibrocartilage] pain with decreased range of motion, occasional weakness and tingling in her hand, ulnar neuropathy at the elbow," and "elbow pain with tingling and paresthesias to the 4th and 5th digits of the left hand." Id. at 474.

4. General Treatment and RFC Assessments

From March 2007, predating Plaintiff's alleged disability onset, though September 2012, Plaintiff's primary care physician was Sigrid Larson, M.D. Tr. at 348-65, 379-81. Dr. Larson's notes indicate treatment for various routine conditions, but also evidence complaints regarding neck and back pain and symptoms related to Plaintiff's hands coinciding with her complaints made to her treating specialists. See id. at 364 (10/13/08 – order for x-ray of lumbar spine after work-related fall), 365 (4/7/10 – complaint of clicking in her right wrist and pain to elbow), 379 (5/20/10 – complaints of wrist pain),

380 (9/28/09 – meniscal tear and low back pain). Dr. Larson prescribed Soma, Simvastatin, Atorvastatin, and omeprazole,[21] as well as Valium.[22] Id. at 359, 362.

Umar Farooq, M.D., conducted a consultative examination on November 9, 2012. Tr. at 461-72. During his examination, Dr. Farooq found Plaintiff's neck movements were slightly limited in rotation and her forward flexion was limited, and she had a positive left straight leg raise and positive Phalen and Tinel tests in the right hand.[23] Id. at 464. Dr. Farooq diagnosed Plaintiff with "[c]hronic neck pain due to cervical spine disk disease," "[c]hronic lower back pain secondary to lumbar disk disease, status post

[21]Soma is a combination of aspirin, a pain reliever and fever reducer, and carisoprodol, a muscle relaxant. Soma is used short-term to treat painful muscular conditions. See https://www.drugs.com/mtm/soma-compound.html (last visited Mar. 9, 2017). Simvastatin and Atorvastatin are statins which reduces levels of bad cholesterol and triglycerides in the blood while increasing good cholesterol. See https://www.drugs.com/search.php?searchterm=simvastatin&a=1 (last visited Mar. 9, 2017); https://www.drugs.com/search.php?searchterm=atorvastatin&a=1 (last visited Mar. 9, 2017).

[22]Valium is a benzodiazepine used to treat anxiety disorders, alcohol withdrawal symptoms, or muscle spasms. See https://www.drugs.com/search.php?searchterm=valium (last visited Mar. 9, 2017). Dr. Larson prescribed Valium at various times. The treatment note from September 28, 2009, indicates that Plaintiff was complaining of stress and asked to "restart antidepressant." Tr. at 380. The more recent treatment notes indicate Dr. Larson refilling the Valium prescription without mention of any mental health diagnosis. See id. at 348-49 (3/10/11), 351-353 (8/8/11), 354-56 (1/13/12), 357-59 (5/3/12), 360-62 (9/10/12). There are no mental health treatment notes in the record.

[23]The Phalen test and Tinel sign or used in diagnosing CTS. The Phalen test indicates that the size of the carpal tunnel is reduced by holding the affected hand with the wrist fully flexed or extended for 30 to 60 seconds, or by placing a blood pressure cuff on the involved arm and inflating to a point between diastolic and systolic pressure; appearance of numbness or paresthesias indicates CTS. DIMD at 1896. Tinel sign is a tingling sensation in the distal end of a limb when percussion is made over the site of a divided nerve. It indicates a partial lesion or the beginning regeneration of the nerve. DIMD at 1716.

facet rhizotomy in April 2012," "[b]ilateral knee meniscus tear, status post repair of the right knee meniscus tear," "[CTS]," and "anxiety and depression disorder." Id. at 464-65.

Based on his evaluation, Dr. Farooq found Plaintiff could occasionally lift and carry 10 pounds, stand and walk for less than an hour in an 8-hour workday, had no limitation in sitting, was limited in the use of hand and foot controls, could occasionally kneel, balance and climb, but could never bend, stoop, or crouch. Id. at 467-68.

B. Hearing Testimony and Other Evidence

Plaintiff explained at the administrative hearing that she suffered two falls at the group home where she worked. Tr. at 40. The first occurred in 2008 and she hit her hand and it swelled but she did not go to the hospital. Plaintiff believes this fall aggravated her CTS resulting in numbness in her hand an eventual surgery in 2010. Id. Plaintiff fell again in August of 2009, injuring her lower back and her right knee, for which she had a workers' compensation claim. Id. at 39.[24] As a result of that fall, Plaintiff required surgery on her right knee. Id. However, Plaintiff later explained that she was again having problems with the knee at the time of the hearing. Id. at 45.

Plaintiff testified that she can only stand for about 45 minutes to an hour before she has pain and pressure in her low back and sometimes down her left side into her leg. Tr. at 41, 48. She can walk for about 30 minutes. When she walks for longer periods, her feet start to go numb. Id. at 41-42. She also has trouble sitting for long periods of time and gets stiff and suffers from muscle spasms. Id. at 42, 47. Plaintiff estimated that

[24]Plaintiff reported to physical therapist Price that she injured her right wrist in the 2009 fall. Tr. at 290.

she can sit for a couple of hours. Id. at 42. She can lift a gallon of milk with her left hand, but not with her (dominant) right hand. Id. She has trouble with household chores due to her lower back and neck pain. Id. at 43.

Although Plaintiff has a driver's license, she testified that she only drives locally and normally brings someone with her – for example to the supermarket. Tr. at 47. The doctor has warned her that as long as she kept using a keyboard, she would aggravate the CTS. Id. at 49.

A vocational expert ("VE") also testified at the administrative hearing. Tr. at 50-51. The VE characterized Plaintiff's prior work as a receptionist, secretary and IRS clerk as sedentary.[25] Id. at 51. The VE testified that someone who could perform the full range of sedentary work could perform Plaintiff's past relevant work. Id. The ALJ asked the VE to consider additional limitations: standing and walking for only an hour, no more than occasional pushing and pulling of controls, occasional postural activities, but no bending or crouching. Id. at 51-52. The VE stated that the limitation to only one or two hours standing and walking would preclude sedentary work other than surveillance system monitor. Id. at 52.

[25]Jobs are classified by their physical exertional requirements. "Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met." 20 C.F.R. § 404.1567(a).

C. ALJ'S Opinion

In the decision dated February 24, 2014, the ALJ found as follows:

1. At step one, the ALJ found that Plaintiff had not engaged in substantial gainful activity since August 3, 2009, her alleged onset date. Tr. at 21.

2. At step two, the ALJ found that Plaintiff has the following severe impairments: cervical and lumbar degenerative disc disease, degenerative joint disease, status post medial and lateral meniscal tears of the left knee, and obesity. Id.

3. At step three, the ALJ found that Plaintiff does not have an impairment or combination of impairments that meet or medically equal the severity of one of the listed impairments in 20 C.F.R. Part 404, Subpart P, Appendix 1. Id. at 22.

4. The ALJ determined that Plaintiff retains the RFC to perform the full range of sedentary work. Id. at 23.

5. At step four, the ALJ found that Plaintiff is capable of performing her past relevant work as a secretary, receptionist, and clerical worker. Id. at 28.

Therefore, the ALJ concluded that Plaintiff was not disabled. Id. at 29.

In her request for review, Plaintiff argues that the ALJ's decision is not supported by substantial evidence because the ALJ (1) erred by giving significant deference to the opinion of the Workers' Compensation judge, (2) failed to consider Plaintiff's impairments in combination and failed to consider the nonexertional limitations resulting from Plaintiff's medications, and (3) failed to include all of Plaintiff's medically supported limitations in the question to the VE. Doc. 12. Defendant argues that the ALJ properly considered all the evidence including the Workers' Compensation decision and the ALJ's decision is supported by substantial evidence. Doc. 13.

IV. DISCUSSION

A. Consideration of Workers' Compensation Decision

Plaintiff argues that the ALJ gave improper deference to the Workers' Compensation judge, and in particular to that judge's determination of Plaintiff's credibility. Doc. 12 at 9-12. Defendant responds that substantial evidence supports the ALJ's credibility determination and that the ALJ gave appropriate deference to the Workers' Compensation judge. Doc. 13 at 7-11.

The heart of this issue goes to the ALJ's credibility analysis. Once an underlying physical impairment has been shown that can cause the claimant's symptoms, the ALJ must next evaluate the intensity and persistence of the claimant's symptoms to determine to what extent those symptoms limit her capacity for work. 20 C.F.R. § 404.1529(c) "There is no requirement that the ALJ defer to [the claimant's] testimony as to [her] ability to work, as long as the ALJ makes clear that she gave [claimant's] subjective views of [her] limitations 'serious consideration,' Mason v. Shalala, 994 F.2d 1058, 1067 (3d Cir. 1993), and made specific findings of fact as to [her] credibility." Rowan v. Barnhart, 67 F. App'x 725, 729 (3d Cir. 2003) (citing Burns v. Barnhart, 312 F.3d 113, 129 (3d Cir. 2002)). An ALJ can reject a claimant's subjective testimony if she does not find it credible, but must indicate in her decision which evidence she has rejected and which she is relying on as the basis for her finding. See Schaudeck, 181 F.3d at 433; see also SSR 96-7p, "Policy Interpretation Ruling Titles II and XVI: Evaluation of Symptoms in Disability Claims: Assessing the Credibility of an Individual's Statements,

1996 WL 374186 (July 2, 1996) ("The reasons for the credibility finding must be grounded in the evidence and articulated in the determination or decision.").[26]

Here, the ALJ relied on the medical evidence, Plaintiff's activities of daily living, and the evidence adduced during the Workers' Compensation proceedings to find that "claimant's statements concerning the intensity, persistence and limiting effects of these symptoms are not entirely credible." Tr. at 24. With respect to the medical evidence, the ALJ conducted a thorough review of Plaintiff's treatment history, and noted that "[w]ithin treating source records there are inconsistencies with respect to [Plaintiff's] characterization of her pain and symptoms, which does not serve to enhance her overall credibility." Id. at 27. The ALJ relied on Dr. Prasad's assessment in rejecting Plaintiff's claims of disabling pain and limitations.

> While [Plaintiff] has sought treatment from an orthopedist, a pain management specialist, a physical therapist, and recently, a neurosurgeon, the objective medical findings do not weigh in favor of a finding of disability. As Dr. Prasad noted, [Plaintiff's] MRIs do not show significant pathology. Moreover, [Plaintiff] is neurologically intact, retains good range of motion of the lumbar and cervical spine and does not have any notable weakness. While she complains of lower extremity pain, she is able to ambulate normally without assistive devices and EMG findings have shown only incidental evidence of radiculopathies and no evidence of neuropathies.

[26]Although SSR 96-7p has been superseded by SSR 16-3p to eliminate reference to the word credibility, SSR 96-7p was the governing Ruling at the time of the ALJ's decision.

Id. at 27. The ALJ has accurately described Dr. Prasad's findings. Id. at 519-20. Dr. Prasad's is the most recent evaluation in the record, and his findings support the ALJ's decision.

Likewise, Plaintiff's statement of her activities is also consistent with an ability to perform sedentary work. As noted, sedentary work involves sitting with occasional walking and standing. Supra n.25. Plaintiff testified that she can stand for 45 minutes to an hour at a time, and described her weight loss regimen which included walking half an hour. Tr. at 41. When she pushed that to 40 minutes, she experienced numbness in her feet. Id. Likewise, Plaintiff said she could stand to do the dishes or make breakfast, but would then have to sit down. Id. She also said she could sit for "a couple of hours" at a time. Id. at 42. She puts laundry in the washer and helps to fold it when it is dry. Id. at 43. Thus, the ALJ properly considered this factor in assessing Plaintiff credibility.[27]

The ALJ also considered the credibility findings of the Workers' Compensation judge, finding them "persuasive and probative" and giving them "significant deference." Id. at 27.[28] Although a disability decision by another governmental agency is not binding

[27]The ALJ also relied on Plaintiff's statement of her activities in considering Dr. Farooq's RFC assessment. The ALJ gave significant but not great weight to this assessment, noting that Dr. Farooq relied on Plaintiff's subjective complaints "to the detriment of the objective medical findings." Tr. at 28. Specifically, Dr. Farooq's conclusion that Plaintiff could stand/walk for an hour or less a day is contradicted by Plaintiff's administrative hearing testimony, including the walking that she did to lose weight and the activities which she does around the house.

[28]In summary, the Workers' Compensation judge found that Plaintiff's testimony that she could perform only minimal activities of daily living was undermined by her Facebook pages which documented travels to the beach, bars, and concerts, and a vacation to Jamaica. Tr. at 27.

on the ALJ, 20 C.F.R. § 404.1504, the ALJ can consider the evidence underlying the other agency's decision in making his determination. See id. § 404.1513((d) (listing "other sources" of evidence). Plaintiff concedes that the ALJ acted "within her authority to take into consideration the findings of another government agency when making her determination on disability," but argues that those findings should not be binding or dispositive. Doc. 12 at 10. Plaintiff also argues that the ALJ failed to address Plaintiff's testimony at the administrative hearing or the more recent medical records. Id.

As previously discussed, the ALJ relied on Plaintiff's testimony from the administrative hearing in determining that her activities were inconsistent with an inability to perform sedentary work and the ALJ specifically relied on Dr. Prasad's assessment, which is the most recent piece of medical evidence in the record. The ALJ did not defer entirely to the Workers' Compensation judge's decision, but found it persuasive in light of "treating source records [that contain] inconsistencies with respect to [Plaintiff's] characterization of her pain and symptoms." Tr. at 27. Thus I conclude that the ALJ did not err in her consideration of the Workers' Compensation judge's decision.

Subsumed in Plaintiff's claim is an argument that the ALJ failed to properly consider the evidence presented by Plaintiff's boyfriend regarding her abilities. Doc. 12 at 10. Walter Wright, Plaintiff's boyfriend, completed a Function Report regarding Plaintiff's abilities on July 20, 2012. Tr. at 167-74. Mr. Wright indicated the Plaintiff is in pain all the time, could cook frozen dinners, could not do household chores, and

occasionally drove or rode in a car. Id. at 167-70. The ALJ noted that the assessment was not "particularly detailed or informative" and was "somewhat inconsistent with [Plaintiff's] own testimony whereby she acknowledged an ability to walk for 30-minutes at a time and also acknowledged social outings and activities." Id. at 28. The ALJ's decision in this regard is supported by substantial evidence.

B. Failure to Consider Cumulative Effect of Plaintiff's Conditions and Non-Exertional Impairments

Plaintiff also complains that the ALJ failed to consider her impairments in combination and failed to consider the side effects of her medications. Doc. 12 at 13-14. Defendant responds that the ALJ properly took the entire record into account in formulating Plaintiff's RFC. Doc. 13 at 15-16.

I conclude that the ALJ properly considered Plaintiff's impairments in combination. As previously mentioned, the ALJ conducted a thorough review of the medical evidence in her decision. The ALJ specifically addressed obesity in conjunction with Plaintiff's other impairments. Tr. at 22.

With respect to CTS and Plaintiff's alleged mental impairments, the ALJ found that these conditions were not severe. After reviewing Plaintiff's history of CTS and treatments, the ALJ noted that Plaintiff completed physical therapy for her right hand in June of 2011, at which time she reported "minimal difficulties with her right hand" and the "restoration of mobility and strength." Id. at 21 (citing id. at 306). Despite EMG studies suggesting mild right CTS in December of 2011, the ALJ noted that Plaintiff did not have any ongoing treatment for CTS, nor does she wear any brace. Id. Plaintiff's

testimony supports this finding. Id. at 43. Likewise, the ALJ relied on Plaintiff's testimony regarding her activities to determine that CTS did not impose more than minimal limitations on her abilities. Id. at 21 (noting abilities to use a smart-phone, do laundry, and wash dishes). With respect to mental impairments, the ALJ noted that Plaintiff had not sought any mental health treatment. Id. at 22. As noted in my recitation of the medical evidence, Plaintiff's diagnosis of anxiety seems to stem from a September 28, 2009 treatment note from Dr. Larson which indicates that Plaintiff was complaining of stress, resulting in a prescription for Valium that has been subject to constant refill without any mental health diagnosis in the corresponding records.[29]

As for side effects of medication, at the administrative hearing, Plaintiff testified that the Soma she was taking may have been causing chest pain, so the prescription had been changed to Flexeril. Tr. at 45. When asked about any other side effects, she said that the first pain medication she had been prescribed made her sleepy, so that was changed to Percocet, which does make Plaintiff a little nauseous if she does not eat before taking it. Id. at 45. Because Plaintiff can alleviate this side effect by eating and there is no other evidence of side effects of Plaintiff's medication, there was no basis to include any other limitation in Plaintiff's RFC based on side effects of medications.

C. Flawed VE Testimony

Finally, Plaintiff contends that the ALJ's hypothetical question, asking if someone who could perform the full range of sedentary work could perform Plaintiff's past

[29]In her brief, Plaintiff states that Valium is a narcotic prescribed for pain rather than for anxiety. Doc. 12 at 14.

relevant work, failed to take into account her pain, fatigue, inability to sit for long periods of time, and perform fine motor skills with her dominant hand. Doc. 12 at 15. Defendant responds that substantial evidence supports the hypothetical posed to the VE. Doc. 13 at 17.

Testimony of a VE constitutes substantial evidence for purposes of judicial review where a hypothetical question considers all of a claimant's impairments which are supported by the medical record. Chrupcala v. Heckler, 829 F.2d 1269, 1276 (3d Cir. 1987). As previously explained, the ALJ properly considered Plaintiff's complaints of pain and other limitations. As for Plaintiff's ability to sit and stand, Plaintiff testified that she can stand and walk for 45 minutes to an hour at a time and can sit for "[a] couple of hours" before she has to get up and move." Tr. at 42. Plaintiff specifically argues that she has an inability to sit for long periods of time, withut pointing to a medical record or opinion supporting the limitation. Doc. 12 at 15. However, Dr. Farooq, who conducted a consultative examination in November of 2012, found that Plaintiff had no limitation in sitting. Id. at 467. Finally with respect to Plaintiff's fine motor skills, as previously discussed, when Plaintiff completed physical therapy for her hand in June of 2011, she reported "minimal difficulties with her right hand" and she felt "the mobility and strength have gradually returned." Id. at 306. Despite EMG studies suggesting mild right CTS in December of 2011, Plaintiff has not sought any treatment, nor does she wear any brace. Similarly, Plaintiff testified that she performs activities which require fine motor skills like using an iPhone to access social media and doing the dishes. Thus, the medical

record and Plaintiff's testimony do not provide support for any limitation in Plaintiff's fine motor skills.

V. CONCLUSION

On appeal to the federal court, the ALJ's findings of fact and inferences reasonably drawn from the evidence are conclusive if supported by substantial evidence. See Fargnoli v. Massanari, 247 F.3d 34, 38 (3d Cir. 2001) ("Where the ALJ's findings of fact are supported by substantial evidence, we are bound by those findings, even if we would have decided the factual inquiry differently."). The court is not permitted to reweigh the evidence. Burns v. Barnhart, 312 F.3d 113, 118 (3d Cir. 2002). Guided by this standard, I conclude that the ALJ's decision is supported by substantial evidence. The ALJ properly considered Plaintiff's credibility, relying on the medical evidence, including her more recent treatment, her activities, and the Workers' Compensation record. The record supported only minimal side effects of Plaintiff's medications that could be overcome by eating prior to taking it. The ALJ also considered Plaintiff's impairments in combination and included the medically supported limitations in questioning the VE.

Therefore, I make the following:

R E C O M M E N D A T I O N

AND NOW, this 22nd day of March, 2017, it is RESPECTFULLY RECOMMENDED that Commissioner's decision denying Plaintiff's application for DIB be AFFIRMED. The parties may file objections to this Report and Recommendation. See Local Civ. Rule 72.1. Failure to file timely objections may constitute a waiver of any appellate rights.

BY THE COURT:

/s/ELIZABETH T. HEY

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ELIZABETH T. HEY, M.J.