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

ANDREA GRABOWSKI, Plaintiff,	:	CIVIL ACTION
v.	:	
NANCY A. BERRYHILL, Acting Commissioner of Social Security, Defendant.	:	No. 17-1555

REPORT AND RECOMMENDATION

LINDA K. CARACAPPA
UNITED STATES CHIEF MAGISTRATE JUDGE

Plaintiff, Andrea Grabowski, brought this action under 42 U.S.C. § 405(g), seeking judicial review of the final decision of the Commissioner of Social Security ("Commissioner") denying plaintiff's claims for Supplemental Security Income ("SSI") under Title XVI of the Act. Presently before this court are plaintiff's request for review, the Commissioner's response, and plaintiff's reply. For the reasons set forth below, we recommend plaintiff's request for review be denied.

I. FACTUAL AND PROCEDURAL HISTORY

Plaintiff was born on December 31, 1981 and was thirty-one (31) years old on the date of the alleged disability onset date. (Tr. 25). Plaintiff has at least a high school education, but does not have any past relevant work experience. Id.

On August 14, 2013, plaintiff filed an application for SSI, alleging disability beginning August 16, 2005. (Tr. 13).[1] Plaintiff's claim was denied at the state level on December 10, 2013. Id. Plaintiff subsequently requested a hearing before an Administrative Law Judge ("ALJ"). Id.

1 The plaintiff filed prior Title II applications in 2005 and 2008, which were denied at the initial level. (Tr. 13).

On June 24, 2015, ALJ Paula Garrety held a hearing and heard testimony from an impartial vocational expert and the plaintiff, who was represented by counsel. (Tr. 13). At the hearing, the plaintiff amended the disability onset date to August 14, 2013. On July 29, 2015, the ALJ issued an opinion finding plaintiff not disabled under the Act from August 14, 2013. (Tr. 13-27). Plaintiff filed a request for review, which was denied by the Appeals Council on February 2, 2017, making the ALJ's decision the final decision of the Commissioner. (Tr. 1-5).

II. LEGAL STANDARDS

Upon judicial review, this court's role is to determine whether the ALJ's decision is supported by substantial evidence. 42 U.S.C. § 405(g); Pierce v. Underwood, 587 U.S. 552 (1988). "Substantial evidence is more than a mere scintilla but may be somewhat less than a preponderance of the evidence." Rutherford v. Barnhart, 399 F.3d 546, 552 (3d Cir. 2005). It is relevant evidence viewed objectively as adequate to support a decision. Richardson v. Perales, 402 U.S. 389, 401 (1971). In determining whether substantial evidence exists, the reviewing court may not weigh the evidence or substitute its own conclusion for that of the ALJ. Burns v. Barnhart, 312 F.3d 113, 118 (3d Cir. 2002). If the court determines the ALJ's factual findings are supported by substantial evidence, the court must accept the findings as conclusive. Richardson, 402 U.S. at 390; Plummer v. Apfel, 186 F.3d 422, 427 (3d Cir. 1999). It is the ALJ's responsibility to resolve conflicts in the evidence and to determine credibility and the relative weights to be given to the evidence. Richardson, 402 U.S. at 401. While the Third Circuit Court of Appeals has made it clear that the ALJ must analyze all relevant evidence in the record and provide an explanation for disregarding evidence, this requirement does not mandate that the ALJ "use particular language or adhere to a particular format in conducting his analysis." Jones v. Barnhart, 364 F.3d 501, 505 (3d Cir. 2004). Rather, it is meant "to ensure that there is

sufficient development of the record and explanation of findings to permit meaningful review." Id. Moreover, apart from the substantial evidence inquiry, a reviewing court must also ensure that the ALJ applied the proper legal standards. Coria v. Heckler, 750 F.2d 245 (3d Cir. 1984).

To establish a disability under the Act, a claimant must demonstrate there is some "medically determinable basis for an impairment that prevents him from engaging in any 'substantial gainful activity' for a statutory twelve-month period." Stunkard v. Sec'y of Health and Human Servs., 841 F.2d 57 (3d Cir. 1988) (quotation omitted); 42 U.S.C. § 423(d)(1) (1982). The claimant satisfies his burden by showing an inability to return to his past relevant work. Doak v. Heckler, 790 F.2d 26, 28 (3d Cir. 1986); Rossi v. Califano, 602 F.2d 55, 57 (3d Cir. 1979). Once this showing is made, the burden of proof shifts to the Commissioner to show the claimant, given his age, education, and work experience, has the ability to perform specific jobs that exist in the economy. 20 C.F.R. § 404.1520. See Rossi, 602 F.2d at 57.

As explained in the following agency regulation, each case is evaluated by the Commissioner according to a five-step process:

> (i) At the first step, we consider your work activity if any. If you are doing substantial gainful activity, we will find that you are not disabled.
>
> (ii) At the second step, we consider the medical severity of your impairment(s). If you do not have a severe medically determinable physical or mental impairment that meets the duration requirement in § 404.1509, or a combination of impairments that is severe and meets the duration requirement, we will find that you are not disabled.
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> (iii) At the third step, we also consider the medical severity of your impairment(s). If you have an impairment(s) that meets or equals one of our listings in appendix 1 of this subpart and meets the duration requirement, we will find that you are disabled.
>
> (iv) At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. If you can still do your past relevant work, we will find that you are not disabled.

> (v) At the fifth and last step, we consider our assessment of your residual functional capacity and your age, education and work experience to see if you can make an adjustment to other work. If you can make an adjustment to other work, we will find that you are not disabled. If you cannot make an adjustment to other work, we will find that you are disabled.

20 C.F.R. § 404.1520 (references to other regulations omitted).

III. ADMINISTRATIVE LAW JUDGE'S DECISION

Pursuant to the five-step sequential evaluation process, the ALJ determined plaintiff had not been under a "disability," as defined by the Act from August 14, 2013, through July 29, 2015, the date of the ALJ's decision. (Tr. 13-27).

At step one, the ALJ found that plaintiff had not engaged in substantial gainful activity since August 14, 2013, the alleged onset date. (Tr. 15). At step two, the ALJ found that plaintiff had the following severe impairment: anxiety and depression. Id. In making this determination, the ALJ relied on plaintiff's medical records, including records relating to treatment pre-dating the current application. The court has reviewed the medical records and finds that the ALJ's summary of the medical records is in depth and inclusive of all pertinent records. The ALJ's summary is as follows:

> Remote medical records show that the [plaintiff] was hospitalized in 2005 with obsessive-compulsive disorder ("OCD") and panic attacks. (Exhibit 1F). She improved significantly with medication and was discharged after a single day. (Exhibits 1F, p. 7). An initial evaluation at the Penn Foundation in 2005 showed that the [plaintiff] had been briefly hospitalized at Grand View Hospital in February 2005 for severe anxiety and depression. After the initial evaluation, she was diagnosed with major depressive disorder, single episode, recurrent, moderate, panic disorder without agoraphobia, and rule out possible OCD. (Exhibit 7F, p. 30). Her GAF was assessed at 55 to 60, which indicated symptoms bordering between moderate and mild.
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> Primary care records in 2007 and 2008 showed that the [plaintiff[was receiving mental health treatment at the Penn Foundation for anxiety and depression. (Exhibit 2F). Penn Foundation records between 2005 and 2008 are minimal and indicated that the [plaintiff] reported poor sleep and inconsistent compliance. (Exhibit 3F).

Ronald Karpf, Ph.D., a Social Security psychological consultant, evaluated the [plaintiff] on August 26, 2008 in conjunction with an earlier application. (Exhibit 4F). The [plaintiff] told Dr. Karpf that she had been depressed since middle school and having anxiety attacks since 2001. She also claimed OCD and bipolar disorder. The [plaintiff] denied that she had ever used street drugs or alcohol and stated that she had no medical problems other than seasonal allergies. She denied any problems with learning and stated that she had worked for 3 years in a doctor's office. The mental status examination showed lethargy, good hygiene, good eye contact, and she was fully cooperative. She had no involuntary movements, but Dr. Karpf did note problems with posture. Her mood was good with medications and she denied suicidal ideations. Her affect was constricted and her anxiety shifted during the interview. She had no delusions or hallucinations. She reported that she did little cleaning in the home and that she did not shop or cook. She denied any problem getting along with others and told Dr. Karpf that she completed tasks and could work within a schedule. Dr. Karpf diagnosed bipolar I disorder, most recent episode depressed, severe, without psychotic features and in partial remission, OCD in full remission, and panic disorder without agoraphobia. He opined that [plaintiff] had marked limitation in her ability to carry out detailed instructions and extreme limitations in her ability to respond appropriately to usual work pressures. (Exhibit 4F). He assessed moderate limitations in her ability to respond to changes in a routine work setting and to understand and remember detailed instructions, but no more than slight limitations in any other area. No weight is given to this opinion because it predates the current application.

Between 2008 and May 2013, primary care treatment notes show primarily routine treatment and no acute medical conditions. (Exhibits 6F, 10F). The records reflect that she was seeing a therapist and psychiatrist for depression and anxiety and taking medications including Abilify, Cymbalta, and Ativan.

A single page evaluation report by Susan Carpenter, LSW, ME.D. dated April 1, 2013 indicated that the [plaintiff] was diagnosed with bipolar disorder NOS (not otherwise specified), panic disorder without agoraphobia, and OCD and that she was assessed a GAF of 55, which indicated only moderate symptoms. (Exhibit 5F). Her mental status showed some anxiety but no paranoia, delusions, or hallucinations. The [plaintiff] had fair impulse control, judgment, and insight and Dr. Carpenter noted low self-esteem and co-dependency issues. Medical management notes on June 12, 2013 show that the [plaintiff] reported a depressed mood and she was encouraged to watch her diet and exercise. (Exhibit 7F, p. 14). Her medications were increased and therapy progress notes in early and mid-2013 showed that the [plaintiff] frequently reported feeling tired and sad, but there is no indication of suicidal ideation, psychosis, or other severe symptoms. (Exhibit 7F). Most of the notes related to her filing for disability benefits rather than specific symptoms or limitations. In June 2013, therapy notes indicate that the [plaintiff] missed several appointments. On July 1, 2013, the [plaintiff] reported that she had her 5-year-old niece overnight and enjoyed baking with her. (Exhibit 7F, p. 12). In July 2013, the [plaintiff] enjoyed a family barbeque on the 4th of July and a trip

to Ocean City with her family. August 4, 2013 notes show that the [plaintiff] took care of her cousin's home while the cousin was away and was able to care for and put together activities for the cousin's children. (Exhibit 7F, p. 9). The [plaintiff] reported that while caring for the children she felt [she] had a sense of purpose.

The instant application was filed on August 14, 2013. Penn Foundation notes dated August 1, 2013 show that the [plaintiff] had met with her recovery coach who was assisting her in applying for Social Security disability benefits. (Exhibit 11F). At the same time she reported that she was looking for online art classes and that she had been doing artwork and baking with relatives. The notes show that she was pleasant, but reported episodes of crying. Medication management notes dated August 21, 2013 reflect that she was tired and had mood swings since starting Wellbutrin, but her affect was brighter and she felt more effective. By September 8, 2013, therapy notes show that the [plaintiff[was still working on disability with her recovery coach and that she was happy the previous night. She was described as positive and smiling more. She reportedly felt better since her medications were reduced. On September 23, 2013, the [plaintiff]reported increased anxiety and she stated that she was motivated to redecorate her room, but was anxious about going into public and feared that people were looking at her. (Exhibit 11F, p. 79). She reported she had panic attacks when family members were delaying dinner and she feared her mother would not get to work on time. However, she also reported that she had a childcare job with her cousin 2 days a week. Notes dated October 7, 2013 show that she was upset about her upcoming Social Security consultative examination. She also discussed joining a co-dependency group, but told her therapist that she was unable to do so because she had a commitment to transport a special needs person and that would interfere. Therapy notes on October 14, 2013 and October 28, 2013 showed that the [plaintiff] seemed more stable and was using coping skills. She described her week as "pretty good." (Exhibit 11F, p. 76). The therapist stated that the [plaintiff] sketched throughout the session and this appeared to decrease her anxiety.

A consultative examination was scheduled for November 1, 2013 and the [plaintiff] failed to appear. (Exhibit 8F). The examination was rescheduled for December 7, 2013 with Joseph Wieliczko, Psy.D. (Exhibit 9F). The [plaintiff] told Dr. Wieliczko that she attended art school but did not graduate because she could not keep up with the classes because of depression. She stated that she received "special services" but did not attend special education classes. When asked why she was not working, she could not identify any reason other than to state that she just could not keep up. She was vague about why she left her last job and simply stated that she could not do the job. She denied any medical conditions. She denied any use of drugs or alcohol. She reported that she was hospitalized six years earlier because "her mom didn't know what to do with [her]" but she was vague as to actual symptoms. She was currently in treatment at the Penn Foundation where she received therapy and medication management for the past10 years. She felt that treatment was helpful and that her symptoms were improving. The [plaintiff]] listed current symptoms including crying, feeling

physically slow, feelings of guilt, weight gain, low energy, indecisiveness, and feelings of hopelessness. She stated that she had feelings of not wanting to live on a weekly basis, but denied any suicide attempts. She also reported manic episodes during which she had excess energy and was talkative and did chores relentlessly and panic attacks during which she had shortness of breath, dizziness, and felt like she was "going crazy." (Exhibit 9F, p. 2). She claimed that the panic attacks occurred once or twice a week and lasted for about 30 minutes and that they were caused by stressful situation[s] such as having to leave the house.

The mental status examination showed that the [plaintiff] was cooperative, but had low energy and appeared depressed and distant. She had adequate social skills and grooming. Her gait and posture were normal. Her speech and thought process were unremarkable. There was no evidence of hallucinations or delusions. Her affect was flat and she reported a sad mood. Memory, concentration, and attention were intact. She was able to spell "world" forward and backwards and she had average abstract reasoning ability. She reported that she was independent in personal care and she cooked, shopped, cleaned, traveled, made appointments, read, did laundry, used the computer, and socialized. Dr. Wieliczko diagnosed bipolar disorder NOS, panic disorder without agoraphobia, and rule out bipolar I disorder.

Therapy notes from the Penn Foundation dated November 11, 2013 indicated that the [plaintiff] was organizing a birthday brunch for her mother and caring for a 4-year-old relative "full time." (Exhibit 11F, p. 74). However, she also reported that she was tired after a week of babysitting and that she felt she might be better suited for a part-time job. Notes in late November 2013 show that the [plaintiff's] mother accompanied her to the session and stated that the [plaintiff] was having suicidal ideations twice a week. (Exhibit 11F, p. 73). The [plaintiff] agreed that she had been more depressed and was crying often during the past two weeks. However, [by] early December, the [plaintiff] again reported that she was feeling better. By December 2013, therapy notes show that the [plaintiff] was experiencing racing thoughts, fear, and worries, and that these emotions "erupted" 4 to 5 days before her initial evaluation for disability. (Exhibit 11F, p. 72). She stated that she cried and shook throughout the session and felt that her anxiety was triggered by having to recall all of the losses she experienced in the last 10 years. However, she also reported that her symptoms were relieved by baking cookies with her grandmother and tutoring her cousin. She specifically stated that the structure of doing childcare and planning activities was stabilizing for her. (Exhibit 11F, p. 72). On December 23, 2013, the [plaintiff] reported enjoying spending a pre-holiday weekend with two female peers. In January 2014, she reported that she enjoyed the holidays and that during times of commotion she was anxious, but able to calm herself with self-talk and breathing exercises. She also talked with her therapist about appealing her disability denial. On January 15, 2014, medication management notes reflect that the [plaintiff] returned after five months and was with her mother who reported that the [plaintiff] had been "okay" but wanted to apply for disability again. (Exhibit 11F, p. 68). The psychiatric

examination was unremarkable other than constricted affect and her psychiatrist continued her medications unchanged.

The [plaintiff] and her mother had family therapy on January 20, 2014 at which time the [plaintiff] talked about attending a recovery group and possibly doing volunteer work. (Exhibit 11F, p. 67). The [plaintiff] and her mother were counseled about hoarding and urged to de-clutter their home. By February 2014, the therapist noted that the [plaintiff] was taking positive actions including showering, grocery shopping with her mother, and working with her attorney to complete SSI paperwork. The [plaintiff] felt more calm, but reported that she still felt anxious and isolated. She continued to complain of anxiety in public but also discussed the positive qualities she demonstrated as a caregiver for children. On February 24, the [plaintiff] reported having thoughts of killing herself. (Exhibit 11F, p. 63); however, by March 1, 2014 she was feeling better and was actually in a grocery store when the therapist called to check on her. Several appointments in March 2014 were rescheduled due to bad weather. In April 2014, the [plaintiff] attended her first therapy session in six weeks. She reported hosting two young relatives for a sleep over but continued to report anxiety at going to her group. The conversations continued to focus on her disability application and her mother assisting her with paper work. However, she also discussed planning a party for children and meeting people for dinner. A medication management note dated April 9, 2014 showed that the [plaintiff] presented with her mother and reported ongoing anxiety and depression. (Exhibit 11F, p. 57). She stated that she usually did not feel well in the morning, which suggests that she felt better as the day progressed. Her dosage of Cymbalta was increased but no other changes were made to her medication or treatment. File notes through the [remainder] of April show that the [plaintiff] was a no show for several sessions and claimed that she forgot them.

May 2, 2014 therapy notes [show] that the [plaintiff] has not been consistent with appointments and that she reported the winter was hard on her. (Exhibit 11F, p. 55). Notes from a family therapy session on June 16, 2014 show that the [plaintiff] had been crying and depressed over the past week and had not attended her group. She continued to discuss her disability appeal and is quoted as saying she felt [bad] because she "sees other[s] who 'really need it' and believes her need is her fault [for] 'not trying hard enough.'" (Exhibit 11F, p. 53). She also stated that she had agreed with her recovery coach that they would end services at this time. On June 23, 2014, the [plaintiff] reported that her mother had depression and was trying to establish care for herself. In late June she told her therapist that she was sleepy during the day and wondered if she could remain awake through the session. However, she also stated that she stayed awake until 2:00am.

A record included a summary from the Penn Foundation in July 2014 showed that the [plaintiff] was most recently treated on January 28, 2014 and had diagnoses of bipolar disorder NOS and panic disorder, without agoraphobia (Exhibit 10F, p. 6) and that she was being medicated with Wellbutrin, Cymbalta, and Abilify and receiving medication management and individual therapy. Medication

management notes on July 2, 2014 show that the [plaintiff[was complaining that she was sedated by her medications. (Exhibit 11F, p. 50). The psychiatrist described the [plaintiff] as obese, pleasant, and cooperative and also noted that she was depressed and had a constricted affects. Dr. Pobreso decreased the dosage of Cymbalta and continued Wellbutrin, Abilify, and Ativan and also referred the [plaintiff] to her primary care provider to discuss nutrition and exercise to lose weight. Therapy sessions in July show that she had a panic attack after arguing with family about politics at a 4th of July gathering and that she took three children to a festival. She was upset that her mother backed out of plans to go to a movie. By late July, she was again missing appointments. Medication management notes dated July 23, 2014 showed that the [plaintiff] was weaning [off] Cymbalta and was more alert. Her mood was described as "bright" and "smiling." (Exhibit 11F, p. 46). Therapy records in August show that the [plaintiff] was helping her grandmother with canning and that she was behind on craft projects she was doing for a Facebook craft group and that she was trading crafts with people online but having concerns about dealing with deadlines. (Exhibit 11F, p. 44). She was looking forward to a family trip to Lancaster. August 13, 2014 medication notes reflect that she was off Cymbalta and was having withdrawal symptoms. (Exhibit 11F, p. 43). She was starting on Brintellix.

Therapy notes in August show she was upset because her 16-year-old cat died and her family had a burial and shared memories of the cat. (Exhibit 11F, p. 42). She again discussed doing projects for an online craft club. She was also pleased that her mother and her friend were clearing clutter from the house and that she felt guilty that she did not help, but also stated that she simpl[y] did not want to help. She reported that she was better able to read since her medication change and that she was an "avid reader." (Exhibit 11F, p. 42). Session notes in September showed that the [plaintiff] was enjoying art and putting her abilities into meaningful projects. (Exhibit 11F, p. 40). She was helping to preserve fresh vegetables with family and enjoyed the process. She also talked about using her creativity to design Halloween costumes for her nieces. She reported having anxiety attacks every other day, but no panic attacks. On September 10, 2014, she told the psychiatrist she felt more awake and was keeping busy but still had anxiety attacks. However, notes on September 30, 2014 show that she was shopping with her mother and engaging in family pumpkin painting at a local fair, but felt overwhelmed by having to give instructions to people. Her cousin complemented her on what a good job she did. Therapy notes in October show that she was cooperative and showed a sense of humor. She seemed to be positive about starting a group session and reported that she went to a funeral with her mother. Notably, on October 20, 2014 she told her therapist that she had completed a project for her online craft group and that it took longer than she expected because her family members kept asking her to do errands for them. She also showed her therapist pictures of the costumes she made for her niece for which the niece won a prize. She was looking forward to making Christmas presents for her family and talking about getting another cat as a Christmas present. Progress notes in November show that the [plaintiff] admitted that she did not care about activities of daily living. (Exhibit 11F, p. 32). She stated that

she "deserved" her anxiety and depression. However, she also talked about her interests in crafts, being with children and the elderly, and baking.

Progress notes on November 27, 2014 show that the [plaintiff] met a peer at a local restaurant although she had some anxiety. (Exhibit 11F, p. 29). She also reported that she spent time with her grandmother, she cared for her nieces, and she transported relatives during the holiday. She was enthusiastic about bringing the turkey for the first time. In early December, she reported that Thanksgiving was positive and she was pleased with having prepared the turkey. She also expressed that family members were depending on her more and that gave her a reason to get up in the morning. By December 9, 2014 she stated that she had been doing her own wash on a weekly basis and being more active; however, she missed appointments in December due to illness. Notes on January 6, 2015 show that the [plaintiff] attended family gatherings over the holidays; she made 12 homemade handcrafted gifts for relatives; and she was looking forward to attending a theatrical performance. However, on January 12, 2015 she told her therapist that she was having crying spells and felt as if she was lazy and should be working and that she was guilty because her mother had to work so much. In February 2015, the [plaintiff] reported that she was more depressed in the winter due to less sunlight and less structure. She cancelled appointment but reported that she was planning to attend an event to sign up for volunteer work and was looking forward to helping others. Notes on February 10, 2015 show that she would be starting volunteer work that week at a food pantry and was looking forward to it. A medication management note on February 25, 2015 shows that the [plaintiff] reported less anxiety but she still did not feel "good." (Exhibit 11F, p. 19). On March 10, 2015, the [plaintiff] told her therapist that she felt positive about her first volunteer session at the food pantry. (Exhibit 11F, p. 17). Note[s] on March 17, 2015 show that the [plaintiff] was pleased that she was able to make deadlines for her craft swap commitment. She talked about joining her mother for yoga classes and taking a walk in the park.

On March 15, 2015, the [plaintiff] told her therapist that her mother drove her to the session because she was too upset to drive after [a] recent episode in which her nieces were discovered "playing doctor" and it brought back memories of a similar episode when she was 7 and was questioned by Children and Youth Services. By March 28, 2015 the [plaintiff] was feeling "much better" and she planned to get a new cat. She also discussed having some anxiety about an upcoming trip to North Carolina for a family event and Easter dinner with family. April 8, 2015 medication management notes showed that the [plaintiff] was doing volunteer work at a food pantry. She denied suicidal ideations [for] over a year. The notes show that she was slovenly dressed, but adequately groomed. Her affect was blunted but there was no evidence of psychosis. Notes on April 21, 2015 show that the [plaintiff] went to a family event in North Carolina and that her mother was irritable and mean on the way, but the [plaintiff] was able to cope. On April 28, 2015, the [plaintiff] reported that she had applied for a job at the library and for 2 other jobs because her mother had reduced work hours. (Exhibit 11F, p. 7). The therapist noted that the [plaintiff[appeared more positive and seemed

> anxious about getting a job. Medication management notes on May 19, 2015 indicated that the [plaintiff] was feeling "woozy" and "unnatural" during the adjustment to her new medications and that she was anxious about her upcoming SSDI hearing. On June 8, 2015 she claimed that she was still adjusting to her new medications and that she was grieving because her grandmother passed away. (Exhibit 11F, p. 4).
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> As for the opinion evidence, there is no opinion evidence from a treating source. Dr. Wieliczko, the consultative examiner, opined that the [plaintiff] had marked limitations in her ability to carryout [sic] complex instructions; to make judgments on complex work-related decisions; to interact appropriately with co-workers; and to respond appropriately to usual work situations and changes in a routine work setting. (Exhibit 9F). She had only mild limitations in her ability to understand, remember, and carryout [sic] short, simple instructions and moderate limitation in her ability to make judgments on simple work-related decisions; to understand and remember complex instructions; and to interact appropriately with the public or co-workers. The undersigned rejects Dr. Wieliczko's assessment because it is not supported by the evaluation report and the [plaintiff's] reported level of daily activities. It is also inconsistent with the contemporaneous treatment records.

(Tr. 18-24).

Continuing with the five-step sequential evaluation, at step three, the ALJ found that the plaintiff did not have an impairment or combination of impairments that met or medically equaled one of the listed impairments in 20 C.F.R., Part 404, Subpart P, Appendix 1. (Tr. 15). At step four, the ALJ found the plaintiff had the residual functional capacity to perform the full range of work at all exertional levels, but with the following non-exertional limitations: plaintiff was limited to no detailed or complex instructions; to no assembly lines or production quotas; to no more than occasional interaction with the public or co-workers; and to routine, repetitive tasks. (Tr. 17). In making this finding, the ALJ considered all symptoms and the extent to which these symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence. Id. Further, the ALJ considered opinion evidence. Id.

The ALJ determined that while plaintiff's medically determinable impairments could reasonably be expected to produce the alleged symptoms, the plaintiff's statements did not

demonstrate work preclusive limitations. (Tr. 18). Further, to the extent plaintiff described purported work preclusive limitations, the ALJ did not accept those limitations.

Finally, at step five, the ALJ found plaintiff had no relevant work experience but that based on plaintiff's age, education, work experience, and residual functional capacity, there are jobs that exist in significant numbers in the national economy that the plaintiff can perform. (Tr. 25-26). Thus, the ALJ determined that plaintiff had not been under a "disability," as defined in the Act from August 14, 2013, through the date of the decision. (Tr. 26).

IV. PLAINTIFF'S CONTENTIONS

Plaintiff argues that: (i) the ALJ selectively cited the evidence of record in order to support her decision, in violation of the Act; (ii) the ALJ's decision to reject the decision of Dr. Wieliczko, the consultative examiner, was not supported by substantial evidence; (iii) the ALJ's decision to reject the plaintiff's testimony was not supported by substantial evidence and that the ALJ failed to make a credibility finding with regard to statements made by plaintiff's witnesses; and, (iv) the ALJ failed to include all of plaintiff's credibly established limitations when presenting a hypothetical to the vocational expert and that the vocational expert's testimony supported a finding of disability.

V. DISCUSSION

The Commissioner's findings must be affirmed if they are supported by substantial evidence. 42 U.S.C. § 405(g); Richardson, 402 U.S. at 401. The role of this court is to determine whether there is substantial evidence to support the Commissioner's decision. See Williams v. Sullivan, 970 F.2d 1178, 1182 (3d Cir. 1992). After review of the records, we recommend plaintiff's request for review be denied.

A. Claim One: Whether the ALJ Selectively Cited the Evidence of Record to Support Her Decision

Plaintiff argues that the ALJ selectively reviewed plaintiff's treatment records. Pl. Brief at 5. Further, the plaintiff argues that the "ALJ's pattern was to cite only some aspects of the treatment records to the exclusion of other aspects of those records, and to emphasize those aspects of the records which portrayed [plaintiff] as capable of various activities, at least at times." Pl. Brief at 8. The plaintiff goes so far as to accuse the ALJ of "cherry-picking" the record to support her decision. Id.

In response, the Commission argues that the ALJ individually discussed every one of plaintiff's therapy sessions during the relevant period and fierily summarized plaintiff's mental health treatment history, noting "plaintiff's intermittent complaints of episodes of crying, increased anxiety, racing thoughts, and depression, among other symptoms, but…that the symptoms were sporadic and generally contradicted by the mental health exams and reports of extensive daily living activities…" Resp. Brief at 3-5.

The ALJ is required to weigh all relevant and probative evidence. Adorno v. Shalala, 40 F.3d 43, 48 (3d Cir. 1994). The Third Circuit has explained that the ALJ must provide an "expression" of evidence that supports his conclusion as well as "some indication" of the evidence that he rejected in reaching that conclusion in order to enable the reviewing court to assess whether "significant probative evidence was not credited or simply ignored." Cotter v. Harris, 642 F.2d 700, 705 (3d Cir. 1981). The ALJ is not required to cite all evidence, only *pertinent* or *probative* evidence, and moreover, the ALJ may implicitly reject irrelevant evidence without explanation. Johnson v. Comm'r of Soc. Sec., 529 F.3d 198, 203-04 (3d Cir. 2008) (emphasis in original). The Third Circuit has clarified that "[a] written evaluation of every piece of evidence is not required, as long as the ALJ articulates at some minimum level her analysis of a particular line of evidence. Moreover, the ALJ's mere failure to cite specific evidence does not

establish that the ALJ failed to consider it." Phillips v. Barnhart, 91 Fed. App'x 775, 780 n. 7 (3d Cir. 2004). Although the ALJ is not required to reference every relevant treatment note in his opinion, the ALJ must evaluate the records consistent with his responsibilities under the regulations. Fargnoli v. Halter, 247 F.3d 34, 41 (3d Cir. 2001) (finding there to be such a great disparity between the 115 pages of relevant treatment notes in the record compared to the ALJ's sparse four-paragraph synopsis that the court was not able to review the ALJ's decision because the court could not determine whether probative evidence had not been credited or simply ignored).

After a review of the record, the court finds that the ALJ provided an extensive, thorough and detailed discussion of plaintiff's treatment records, which we have reproduced above. The ALJ's summary accurately reflected plaintiff's overall condition and ability. Although the ALJ may have failed to include every single one of plaintiff's complaints or the therapist's notations, the summary accurately depicts the entirety of plaintiff's treatment sessions and reflects her overall struggle with her mental health. The ALJ did not omit plaintiff's problems but rather was careful to include the majority of plaintiff's complaints, issues and symptoms. This court does not find that the ALJ omitted pertinent information giving rise to error, or that the ALJ's discussion amounts to "cherry picking" of the record, as the plaintiff alleges. As such, it is recommended that the plaintiff's request for review be denied as to this issue.

B. Claim Two: Whether Substantial Evidence Supports the ALJ's Assessment of Dr. Wieliczko's Opinion

Plaintiff argues that the ALJ's decision to reject the opinion of Dr. Wieliczko was not supported by substantial evidence. Pl. Brief at 11-13. Plaintiff also argues that had Dr. Wieliczko's opinion been credited, the ALJ would have found plaintiff to be disabled. Pl. Brief

at 12. The plaintiff argues that the ALJ's decision to reject Dr. Wieliczko's opinion was "predicated on the [ALJ's] demonstrated misinterpretation of the record by 'cherry-picking' the evidence." Id. Finally, the plaintiff argues that Dr. Wieliczko's opinion is "essentially corroborated" by an evaluation performed by Dr. Ronald Karpf, Ph.D. in 2008. Id.

In response, the Commissioner argues that the ALJ's decision to reject Dr. Wielickzo's opinion was justified due to the fact that the opinion was internally inconsistent and unsupported, as well as inconsistent with contemporaneous treatment records and plaintiff's own statements regarding her daily activity level. Resp. Brief 5-9.

The amount of weight accorded to medical opinions is well-established. Generally, the ALJ will give more weight to the opinion of a source who has examined the claimant than to a non-examining source. 20 C.F.R. § 416.927(c)(1). Although the ALJ may choose whom to credit when faced with a conflict, he "cannot reject evidence for no reason or for the wrong reason." Diaz v. Comm'r of Soc. Security, 577 F.3d 500, 505 (3d Cir. 2009). Although, in general, "the opinions of a doctor who has never examined a patient have less probative force as a general matter, than they would have had if the doctor had treated or examined him," Morales v. Apfel, 225 F.3d 310, 320 (3d Cir. 2000)(internal quotations omitted), where "the opinion of a treating physician conflicts with that of a non-treating, non-examining physician, the ALJ may choose whom to credit." Id. at 317, see also Dula v. Barnhardt, 129 Fed. Appx. 715, 718-19 (3d Cir. 2005). The ALJ, of course, " 'cannot reject evidence for no reason or for the wrong reason,' " Morales, 225 F.3d at 317 (quoting Plummer, 186 F.3d at 429), and can only give the opinion of a non-treating, non-examining physician weight insofar as it is supported by evidence in the case record, considering such factors as the supportability of the opinion in the evidence, the consistency of the opinion with the record as a

whole, including other medical opinions, and any explanation provided for the opinion. See SSR 96-6p, 1996 WL 374180 (S.S.A.), at *2 (July 2, 1996). In certain cases, it would not be unwarranted to give more weight to the non-examining professional's opinion. See Salerno v. Comm'r of Soc. Sec., 152 Fed. Appx. 208 (3d Cir. 2005) (affirming an ALJ's decision to credit the opinion of the non-examining state agency reviewing psychologist because his opinion was more supported by the record than the opinions of the treating physician and the consultative examiner).

Plaintiff saw Dr. Wieliczko for a consultative examination on December 6, 2013. (Tr. 341-346). Dr. Wieliczko diagnosed plaintiff with bipolar disorder NOS, panic disorder without agoraphobia and R/O bipolar disorder. (Tr. 343). Although plaintiff presented as depressed, distant and with low energy, Dr. Weiliczko noted that plaintiff was cooperative; her manner of relating and social skills were adequate; her eye contact was appropriate; speech was spontaneous and easy to understand; and, thought process was coherent, logical and goal directed. (Tr. 342). Plaintiff's affect appeared to be limited and consistent with her reported mood, but she was alert, oriented to time/place/person and her recent and remote memory skills were intact. Id. Plaintiff's attention and concentration were relatively intact and her fund of knowledge and abstract reasoning ability were adequate. (Tr. 342-343). Plaintiff reported that she was "independent with dressing, bathing and grooming; is able to shop, cook, clean, manage money/medications, travel, make appointments, reads, does laundry, uses the computer and socializes at times" and that a typical day includes being with her mother and running errands. (Tr. 343).

On a medical source statement, Dr. Wieliczko made the following determinations: plaintiff had marked limitations in her ability to carry out complex instructions; to make

judgments on complex work-related decisions; to interact appropriately with co-workers; and to respond appropriately to usual work situations and changes in a routine work setting. (Tr. 344-345). Plaintiff had mild limitations in her ability to understand, remember, and carry out short, simple instructions. Id. Finally, Dr. Wieliczko indicated plaintiff had moderate limitations in her ability to make judgments on simple work-related decisions; to understand and remember complex instructions, and to interact appropriately with the public or co-workers. Id.

The ALJ reviewed Dr. Wieliczko's report and "reject[ed] [the] assessment because it is not supported by the evaluation report and the [plaintiff's] reported level of daily activities. It is also inconsistent with the contemporaneous treatment records." (Tr. 24). We agree with the ALJ's assessment. Although Dr. Wieliczko indicated that plaintiff had marked limitations in her ability to interact with co-workers and moderate limitations in her ability to interact appropriately with the public or co-workers, the evaluation report described plaintiff's manner of relating and social skills as adequate. Moreover, despite Dr. Wieliczko's opinion that plaintiff was limited in her ability to interact, he indicated that plaintiff is capable of socializing, her eye contact was appropriate and her speech was spontaneous and easy to understand. In addition, Dr. Wieliczko noted that plaintiff's thought process was coherent, logical and goal directed. Despite the apparent contradictions between the limitations indicated in the medical source statement and the observations included in the evaluation report, Dr. Wieliczko declined to identify the factors that would support the limitations in the medical source statement. In light of the above, we find that the ALJ's observation that Dr. Wieliczko's medical source statement was not supported by the evaluation report to be justified.

The ALJ also noted that the medical source statement contradicted plaintiff's own reported level of activity as relayed to Dr. Wieliczko. Plaintiff reported to Dr. Wieliczko that she

was "independent with dressing, bathing and grooming; is able to shop, cook, clean, manage money/medications, travel, make appointments, reads, does laundry, uses the computer and socializes at times" and that a typical day includes being with her mother and running errands. (Tr. 343). Plaintiff's own reported activity level suggests that she is capable of being in public, interacting with others, and caring for herself. In addition, plaintiff denied "hav[ing] any problems getting along with family, friends, neighbors, or others" on her function report. (Tr. 166). As such, we agree with the ALJ that Dr. Wieliczko's medical source statement was not consistent with plaintiff's own statements about her activity level which were relayed in the evaluation report.

Plaintiff further argues that the ALJ erred in rejecting Dr. Wieliczko's opinion because that opinion was "essentially corroborated" by an earlier evaluation by Dr. Ronald Karpf, Ph.D. In the 2008 evaluation, Dr. Karpf diagnosed bipolar I disorder, most recent episode depressed, severe, without psychotic features and in partial remission, OCD in full remission, and panic disorder without agoraphobia. He opined that [plaintiff] had marked limitations in her ability to carry out detailed instructions and extreme limitations in her ability to respond appropriately to usual work pressures. (Exhibit 4F).

"An ALJ may not reject pertinent or probative evidence without explanation." Johnson v. Comm. of Soc. Sec., 529 F.3d 198, 204 (3d Cir. 2008). Therefore, "ALJ's failure to explain his implicit rejection of [] evidence or even to acknowledge its presence [is] error." Cotter v. Harris, 642 F.2d 700, 707 (3d Cir. 1981). In this case, the ALJ rejected Dr. Karpf's opinion because the report "predates the current application." (Tr. 19). We believe this is a sufficient reason for the ALJ to ascribe no weight to Dr. Karpf's opinion.

Finally, plaintiff argues that if the ALJ had credited Dr. Wieliczko's opinion, disability would have been established. We disagree with plaintiff's assertion. Plaintiff's attorney asked the vocational expert whether Dr. Wieliczko's opinion would prevent plaintiff from performing the identified jobs which included laundry worker, warehouse worker, and cleaner:

> BY THE ATTORNEY:
>
> Q: Dr. [Wieliczko] indicated that interacting appropriately with the public would be a moderate limitation; interacting appropriately with supervisors would be moderate; interacting appropriately with coworkers would be marked; respond[ing] appropriately to usual work settings, situations, and changes in a routine work setting would be marked. The definition of marked is there's serious limitation in this area, there's substantial loss in the ability to effectively function.
>
> Mrs. Harter, if the judge credited those responses on page 5 of 9F as I've read them to you, would the hypothetical individual be able to do any of the jobs you previously enumerated?
>
> A: Well, you're looking at marked in terms of working with coworkers, is that correct?
>
> Q: Yes.
>
> A: And workplace—and workplace changes?
>
> Q: Work situations—
>
> A: Those are the only two marked?
>
> Q: Respond appropriately to usual work situations and to changes in routine work setting, yes.
>
> A: Okay. Workplace. This is—this is one of those situations where the way I would look at it is that you would put somebody in a very routine situation and not—with very little interaction with—with—or no interaction just about with anybody else. I would eliminate—I would eliminate the job as warehouse worker. Laundry workers pretty much do the same thing everyday [sic] and they don't have any interaction. It's loud in there that discourages interaction so I think that's still an appropriate job and there certainly aren't high rigid standards for production over there. And the office cleaner is pretty much alone time. It's not paced and the jobs don't change. So, yes, I think the occupational base is going to

> be reduced, but I still think there'd be substantial number of jobs even with those two restrictions if those are the only two.

(Tr. 59-60). As the vocational expert testified, even with the limitations recommended by Dr. Wieliczko, there were still jobs that plaintiff would be capable of performing. As such, we disagree with plaintiff's argument that if credited, Dr. Wieliczko's opinion would have established disability.

C. Claim Three: Whether Substantial Evidence Supports the ALJ's Credibility Assessment

Plaintiff argues that the ALJ erroneously determined that the plaintiff's testimony and plaintiff's mother's statement were not credible, in violation of the regulations and controlling authority. Pl. Brief 13-19. Plaintiff argues that "the ALJ's own recounting of Ms. Grabowski's functioning as depicted in her treatment records was inaccurate, and thus the ALJ's claim that her (i.e. plaintiff's own) testimony (which mirror the treatment records) was not accurate rings hollow." Pl. Brief at 16. Further, plaintiff argues that the ALJ's rejection of plaintiff's mother's statement is also erroneous because the ALJ failed to provide specific reason for doing so. Pl. Brief at 17-18. In response, the Commissioner argues that the "ALJ's credibility assessment was well-reasoned, consistent with the record, and in accordance with the Agency's two-step credibility determination process. Reply Brief at 9-11. For the reasons that follow, we find the ALJ's credibility determination was supported by substantial evidence, and we recommend that this claim be denied.

An ALJ is empowered to evaluate a claimant's credibility. Van Horn v. Schweiker, 717 F.2d 871, 873 (3d Cir. 1983). Even if an ALJ concludes a medical impairment exists, which could reasonably cause the symptoms alleged, he must evaluate the intensity and persistence of the symptoms, and the extent to which they affect a claimant's ability to work. 20

CFR § 404.1529(b)-(c). In doing so, an ALJ may consider the internal consistency of a claimant's own statements, the medical evidence, a claimant's medical treatment history, and findings by state agency or other program physicians. See 20 C.F.R. § 1529. Deference must be given to an ALJ's determination on issues of credibility so long as the ALJ discusses the issue and the ALJ's finding is supported by substantial evidence. See Alvarez v. Sec'y of Health and Human Servs., 549 F. Supp. 897, 899-900 (E.D. Pa. 1982). Therefore, this court will review the ALJ's analysis and the relevant medical records in dispute, but will not re-weigh the evidence or substitute the court's own opinion for that of the ALJ. See Burns, 312 F.3d at 118.

At the hearing, the plaintiff testified that she had applied for a job at the local library and worked at a food pantry on one occasion. (Tr. 37-38). Plaintiff also testified that she is capable of driving to her appointments and on family road trips. (Tr. 38-39). She babysits her niece multiple times per week, during which they watch movies, read books and do arts and crafts. (Tr. 43). Although plaintiff testified that she no longer has the desire to sketch like she used to, she was able to complete crafts on time for Christmas the year prior. (Tr, 44). Plaintiff had difficulty adhering to deadlines in the past but acknowledged that she is "getting better." (Tr. 44, 48-49). Plaintiff is able to go to the grocery store and has good days and bad days. (Tr. 52).

Plaintiff also testified that when she gets "overwhelmed," she gets lightheaded and experiences tightness in her chest with difficulty breathing. (Tr. 41). This has caused plaintiff to cancel appointments at time, especially if she is running late. (Tr. 41). When plaintiff experiences anxiety, she testified that her thoughts get "jumbled" and she has a "hard time knowing when to leave and what to do." (Tr. 42). In addition, plaintiff "freezes up" about "once a week" but she could not be sure of the frequency. (Tr. 47). She admitted that she "avoids" certain tasks, including appointments, chores and socializing. (Tr. 45, 50, 51). Plaintiff's coping

mechanisms include removing herself from the situation and practicing her breathing. (Tr. 47). In addition, plaintiff feels that her medication is helping and keeping her "balanced." (Tr. 53). At the time of her testimony, plaintiff was experiencing racing thoughts daily but her panic attacks decreased to once a week. (Tr. 52-53). Plaintiff also testified that she would like to have a job in 6 to 12 months. (Tr. 54).

The ALJ found plaintiff's testimony to be generally credible, noting, in relevant part:

> After careful consideration of the evidence, the undersigned finds that the [plaintiff's] medically determinable impairments could reasonably be expected to cause the alleged symptoms; however, the [plaintiff's] statements and testimony (much of which is accepted as generally credible) does not demonstrate work preclusive limitations. To the extent [plaintiff] has described limitations purported to be work preclusive, those limitations have not been accepted as an accurate recounting of [plaintiff's] functioning to the extent and for the reasons explained in this decision. This applies as well to the written statement submitted by [plaintiff's] mother in support of this application.

(Tr. 18).

The plaintiff objects to the ALJ's finding and argues that the ALJ's failed to include specific reasons for the credibility determination as required by SSR 96-7p. However, in addition to the incredibly detailed summary of medical records, the ALJ provided a thorough explanation justifying the decision:

> In sum, the above residual functional capacity assessment is supported by the longitudinal evidence of record. The treatment records show that the [plaintiff's] problems focused primarily on her relationship with her mother who purportedly also had mental problems and with whom the [plaintiff] had many joint sessions. The contemporaneous treatment notes show that the [plaintiff] was generally able to perform activities of daily living. The records show that she took several trips and went to community and family events. She babysat for her nieces and planned their parties and events and designed and made award winning Halloween costumes for them. She drove with her nieces in the car and took them to the park. The records also show that she provided transportation and ran errands for family members. She worked in a pumpkin painting exhibit at a fair, volunteered at a food bank, and applied for jobs. She also participated in an online craft group and exchange, which required her to complete original projects, plan, and schedule

> work as well as meet deadlines, and she was able to do so. She did volunteer work and has applied for jobs at the library and elsewhere. The [plaintiff's] mother attended several sessions and even though she described troubling symptoms exhibited by the [plaintiff] those symptoms are not so extreme as to preclude all work. Generally, the treatment records show that her OCD was controlled with medication and that she was capable of activities of daily living including cooking, cleaning, shopping with her mother, and doing laundry. She was active on Facebook and in a craft exchange group. She went to theatrical performances, movies, and lunch. She babysat for nieces as young as 3 and took her to the park and prepared activities for her. She testified that she baked from scratch with her niece and her grandmother. She planned a party for her nieces and made a special cake for her nieces doll's birthday. The [plaintiff] testified that she has occasions where she would "freeze up" but she said this only happened about once a week. The most recent treating source assessment showed no suicidal ideations for more than one year. She used to become anxious and call her mother when her mother was at work, but recent notes show that she did not make those calls when her mother's work situation changed and she was no longer able to take calls from [plaintiff], which shows that [plaintiff] can control the behavior, and is not so dependent so as to be unable to function without calling her mother. Overall, the [plaintiff's] impairments warrant restrictions to no detailed or complex instructions; to no assembly lines or productions quotas; to no more than occasional interaction with the public or co-workers; and to routine, repetitive tasks, but these restrictions are not work preclusive.

(Tr. 25).

The ALJ is not required to use any specific format or language in his analysis, as long as he sufficiently develops the record to permit meaningful judicial review. Jones v. Barnhart, 364 F.3d 501, 505 (3d Cir.2004). We find that the ALJ's development of the record in this case is more than sufficient. As such, we recommend that this claim be denied.

D. Claim Four: Whether Substantial Evidence Supports the ALJ's Finding at Step Five

Plaintiff argues that the ALJ failed to include all of plaintiff's functional limitations when posing a hypothetical to the vocational expert. Pl. Brief at 20-21. Specifically, plaintiff argues that the ALJ's hypothetical did not include limitations assessed by Dr. Wieliczko and Dr. Karpf and that as a result, the vocational expert's testimony did not provide an adequate basis for the Commissioner's finding that the plaintiff was capable of working. Pl. Brief at 20-21.

The Third Circuit has provided criteria for evaluating an ALJ's reliance on vocational expert testimony at step five of the ALJ's analysis. While the ALJ is not required to include every impairment alleged by the claimant in the hypothetical submitted to the vocational expert, "the ALJ must accurately convey to the vocational expert all of a claimant's *credibly established limitations*." Rutherford v. Barnhart, 399 F.3d 546, 554 (3d Cir. 2005) (other citations omitted) (emphasis in original). When a hypothetical question does not include limitations that are medically supported and "otherwise uncontroverted in the record," the ALJ is precluded from relying on the expert's response. Id.; see also Strouse v. Astrue, 2010 U.S. Dist. LEXIS 27600, at *19. Moreover, specificity is required when an ALJ incorporates a claimant's mental or physical limitations into a hypothetical. See Burns, 312 F.3d at 122.

We agree with the Commissioner that plaintiff's argument depends on the success of her first two claims—that the ALJ selectively cited the record and that the ALJ erroneously rejected Dr. Wieliczko's opinion. As discussed previously, the ALJ thoroughly and completely cited to the treatment records in the opinion. Further, the ALJ sufficiently supported the decision to reject Dr. Wieliczko's opinion. The ALJ was not required to ask the vocational expert about restrictions recommended by source that was not considered credible. The ALJ's hypothetical posed the credibly established limitations that were supported by the record. As such, we recommend that this claim be denied.

Therefore, we make the following:

RECOMMENDATION

AND NOW, this 31st day of January, 2018, it is RESPECTFULLY RECOMMENDED that Plaintiff's Motion for Summary Judgment be DISMISSED and Plaintiff's Request for Review be DENIED.

BY THE COURT:

_/S/ LINDA K. CARACAPPA __
LINDA K. CARACAPPA
UNITED STATES MAGISTRATE JUDGE