

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

BRENDA STEWART	:	CIVIL ACTION
Plaintiff,	:	
	:	
v.	:	NO. 11-1338
	:	
MICHAEL J. ASTRUE,	:	
Commissioner of the	:	
Social Security Administration,	:	
Defendant.	:	

**REPORT AND RECOMMENDATION**

DAVID R. STRAWBRIDGE  
UNITED STATES MAGISTRATE JUDGE

May 31, 2012

This action was brought pursuant to 42 U.S.C. § 405(g) seeking judicial review of the final decision of the Commissioner of the Social Security Administration (the “Commissioner” or “Defendant”), which denied the application of Brenda Stewart (“Stewart” or “Plaintiff”) for Supplemental Security Income (“SSI”) under Title XVI of the Social Security Act, 42 U.S.C. §§ 301 *et seq.* (the “Act”). Presently before the Court are Plaintiff’s Brief and Statement of Issues in Support of Request for Review (Doc. No. 11) (“Pl. Br.”), Defendant’s Response to Request for Review of Plaintiff (Doc. No. 12) (“Def. Br.”), Plaintiff’s Reply Brief (Doc. No. 13) (“Pl. Reply”), together with the record of the proceedings before the Administrative Law Judge (“ALJ”) and the Appeals Council (hereinafter “R.”).

Plaintiff asks the Court to vacate the Commissioner’s final decision and direct an award of benefits or, in the alternative, to remand the matter to the Commissioner pursuant to the fourth sentence of 42 U.S.C. § 405(g). The Commissioner opposes any award of benefits to Plaintiff and

any remand. For the reasons set out below, we recommend that the decision of the ALJ — that Stewart was not disabled because she could perform a range of light and sedentary work — be affirmed.

## **I. FACTUAL AND PROCEDURAL OVERVIEW**

Plaintiff protectively filed the application for SSI that gives rise to this litigation on September 5, 2007, alleging that she had been disabled since January 1, 2005. (R. 93-99.)<sup>1</sup> She had a history of short-duration jobs, including server and waitress, cashier, machine operator, and cleaner. (R. 31, 105, 122-23.) She was fifty (50) years old when she submitted her application and fifty-two (52) years old at the time of the decision under review. (R. 93, 109.)

Stewart complained to her primary care physician, Michael Krafchick, D.O., of bilateral leg and low back pain as early as February 2006. (R. 322.) Her back pain appeared to worsen after a slip-and-fall injury at a supermarket on June 16, 2007, for which she was pursuing litigation. (*See* R. 358 (orthopedic treatment note of 2/3/09 referring to “low back pain that began after a slip and fall” in June 2007); R. 360 (same, 1/13/09); R. 370 (orthopedic treatment note of 7/6/07 referring to “neck pain and crunching sensation and low back pain”).) Due to significant arthritis and tendinopathy, she underwent surgery on her left shoulder in November 2008, although she continued to have some pain post-surgery. (R. 25, 363, 378-80.) Her primary care physician prescribed all of her medications.

Stewart contended that her ability to work was limited by depression caused by the death of her son in 1986, chronic back and leg pain, and her inability to stand or sit. (R. 21-22, 31-32, 114.)

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<sup>1</sup> It appears that Stewart also filed an application for SSI in 2006, as the record contains a “Notice of Disapproved Claim” dated September 20, 2006, although not the actual application. (R. 58-62.) She did not appeal that decision.

In an undated disability report that appears to have been completed at the time of her SSI application, she elaborated: “I am in constant pain all the time, my legs ache and my feet as well. My whole spine is messed up, it kills me to stand, sit or even lay down. I am unable to get relief.” (R. 114.) She stated that it was her inability to stand due to pain in her back and legs, as well as her depression, that caused her to leave work with a commercial cleaner in 1995 and to also leave seasonal waitressing positions she held in 2001 and 2002. (R. 31-32.) She testified that her days are spent doing crossword puzzles and reading, and that she assists in the care of her elderly mother, including shopping for her and taking her to the doctor, approximately three days a week. (R. 29.)

On September 8, 2009, and after her claim was initially denied, Stewart was given a hearing. The ALJ took testimony from Plaintiff, who was represented by counsel, and a vocational expert (“VE”). (R.18-41.) In his decision dated October 29, 2009, the ALJ found that while Plaintiff had severe impairments, she retained the residual functional capacity (“RFC”) to perform a range of work at the light exertional level, including the jobs of inspector/examiner and sorter, and therefore was not disabled under the Act. (R. 12, 16-17.) The Appeals Council denied Plaintiff’s request for review, making the ALJ’s decision the final decision of the Commissioner. (R. 1-5.) Briefing is complete and the matter is ripe for review. *See* Doc. Nos. 11-13.

## **II. STANDARD OF REVIEW**

The Court has plenary review of legal issues arising from the ALJ’s conclusions but reviews the ALJ’s factual findings only to determine whether they are supported by substantial evidence. *Schaudeck v. Comm’r of Soc. Sec.*, 181 F.3d 429, 431 (3d Cir. 1999) (citing 42 U.S.C. § 405(g)); *Kryzstoforski v. Charter*, 55 F.3d 857, 858 (3d Cir. 1995). Substantial evidence “does not mean a large or considerable amount of evidence, but rather ‘such relevant evidence as a reasonable mind

might accept as adequate to support a conclusion.” *Pierce v. Underwood*, 487 U.S. 552, 564-65 (1988) (quoting *Consol. Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938)); *see also Dobrowolsky v. Califano*, 606 F.2d 403, 406 (3d Cir. 1979). It is more than a mere scintilla but may be less than a preponderance. *See Brown v. Bowen*, 845 F.2d 1211, 1213 (3d Cir. 1988). If the conclusion of the ALJ is supported by substantial evidence, the Court may not set aside the Commissioner’s decision even if it would have decided the factual inquiry differently. *Hartranft v. Apfel*, 181 F.3d 358, 360 (3d Cir. 1999); *see* 42 U.S.C. § 405(g).

### **III. THE DECISION UNDER REVIEW**

The issue before the ALJ at the time of his October 29, 2009 decision was whether Stewart had been disabled within the meaning of the Act at any time since her September 5, 2007 SSI application date. In undertaking this assessment, he embarked upon the familiar five-step sequential evaluation process set forth in 20 C.F.R. § 416.920(a). At Step One, he found that Stewart had not engaged in substantial gainful activity at any time relevant to his decision. (R. 11, Finding No. 1.) At Step Two, he found that Stewart met the criteria of having a severe medically-determinable impairment, e.g., one that causes functional limitations and has more than a *de minimus* effect on the her ability to perform basic work activities.<sup>2</sup> (R. 11, Finding No. 2.) At Step Three, the ALJ concluded that Plaintiff did not have an impairment or combination of impairments that satisfy the criteria of the listed impairments in 20 C.F.R. Part 404, Subpart P, Appendix 1 and therefore could not establish her entitlement to benefits on that basis, requiring that the evaluation process continue. (R. 12, Finding No. 3.) Plaintiff does not challenge any of these three findings.

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<sup>2</sup> The ALJ identified degenerative disc disease of the thoracic spine and lumbar spine and “status post (s/p) [sic] left shoulder subacromial decompression excision distal clavicle” as severe impairments from which Stewart suffered. (R. 11, Finding No. 2.)

The ALJ then proceeded to assess Stewart’s residual functional capacity (“RFC”), which is defined as “the most [a claimant] can still do despite [her] limitations,” 20 C.F.R. § 416.945(a)(1), describing it as follows:

Claimant has the residual functional capacity to perform a limited range of work at the light exertional level, as defined in 20 CFR 416.967(b), i.e., she can lift/carry 20 pounds occasionally and 10 pounds frequently; sit/stand/walk about 6 hours in an 8-hour workday; but can only occasionally climb, balance, stoop, kneel, crouch, and crawl.

(R. 12, Finding No. 4 (bold in original).) At Step Five,<sup>3</sup> the ALJ considered whether Stewart could make an adjustment to work based on her RFC, age, education, and work experience in conjunction with the Medical-Vocational Guidelines. *See* 20 C.F.R. § 416.920(g). Considering the limitations outlined by the ALJ and consistent with his ultimate RFC finding, the VE identified jobs existing in the local and national economy that Stewart could perform, including the positions of inspector/examiner and sorter. Accordingly, the ALJ concluded at Step Five that she was not disabled. (R. 16-17, Finding Nos. 9-10.)

#### **IV. DISCUSSION**

Plaintiff identifies six alleged errors that she believes require the ALJ’s decision be vacated: (1) the ALJ treated the findings of a state agency adjudicator as evidence (Pl. Br. at 2-4); (2) he refused to allow her to respond to the VE’s testimony (Pl. Br. at 4-6); (3) he failed to obtain the file created in connection with her previous SSI application (Pl. Br. at 6-10); (4) he provided an unacceptable explanation for his rejection of two specific sources of medical evidence and of

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<sup>3</sup> The ALJ did not make a Step Four finding concerning her ability to perform her past work because he determined that she had no past relevant work as defined in 20 CFR § 416.965, as her past work “did not rise to the level of SGA [substantial gainful activity].” (R. 16 & Finding No. 5.)

Stewart's own testimony (Pl. Br. at 11-20); (5) he improperly assessed Stewart's RFC (Pl. Br. at 20-24); and (6) he improperly relied upon VE testimony (Pl. Br. at 24-26). We disagree and conclude that the decision is not flawed by legal error and is supported by substantial evidence.

**A. The ALJ's treatment of the state agency adjudicator's findings**

Stewart first contends that the ALJ erred by allegedly resting his RFC assessment upon the finding of the state agency adjudicator below, in violation of the Commissioner's policy.<sup>4</sup> As we set forth below, we do not find sufficient indicia in the record that the ALJ interpreted the state agency adjudicator's decision as one to which he owed any deference nor those findings as medical opinion evidence to support his RFC assessment.

As part of the initial determination process, Valerie McCartt, an employee of the Pennsylvania Bureau of Disability Determination (the "state agency"), was designated to make the initial determination as to disability. In the capacity of adjudicator, and following upon her review of the claimant's statements and the file after development of the medical record, she completed a Physical Residual Functional Capacity Assessment form (the "PRFC form"), which was marked as Exhibit 10F for the hearing. (R. 199-205.)<sup>5</sup> She also signed off on the Disability Determination and Transmittal form that triggered a denial notice to Plaintiff. (R. 42.) In the PRFC form, McCartt

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<sup>4</sup> Plaintiff characterizes this as one of three "alleged evidentiary or administrative errors," as distinct from the final three claims characterized as "alleged legal errors." (*Compare* Pl. Br. at 2 *with id.* at 11.) She describes the particular error here as "treating the findings of a state agency adjudicator as evidence." (Pl. Br. at 2.)

<sup>5</sup> This form is designed for an adjudicator to set forth his or her conclusions as to the claimant's limitations, based upon a review of all evidence in the file; to discuss the claimant's symptoms and the extent to which they produce physical limitations; and to identify and reconcile any significant disparities between the adjudicator's conclusions and any treating or examining source statement on file regarding the claimant's physical capacities. *See* R. 199-205.

assessed Stewart as having the capacity to lift and carry 10 lbs frequently and 20 lbs. occasionally; stand and walk for 6 hours in an 8-hour workday; sit for 6 hours in an 8-hour workday, and only occasionally engage in various postural activities. (R. 199-205.) Based on her RFC assessment, and given the opinion of a reviewing psychologist that Stewart’s depression was not a severe impairment, she determined that Stewart was not disabled, as she could perform work at the light exertional level. (R. 43-47.) *See also* R. 154 (state agency “Development Summary Worksheet” reflecting McCartt’s supervision of claim and referral for psychologist’s opinion).

During the hearing, the ALJ utilized McCartt’s Physical RFC form in his questioning of the VE:

Let’s assume we have a person of the same[] age, education, and experience as Ms. Stewart. Let’s assume that this hypothetical person is limited to light work. I’m looking at Exhibit 10F, [counsel]. She can occasionally climb, balance, stoop, kneel, crouch and crawl and those are the only limitations?

(R. 35.)<sup>6</sup> The ALJ also referred to this exhibit in his subsequent written decision, including the following paragraph in the portion of his decision explaining the basis for his RFC finding and among several paragraphs describing the medical evidence:

On January 23, 2008, a DDS disability adjudicator opined that

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<sup>6</sup> At the outset of the hearing, when the ALJ asked whether there was any objection to admitting into evidence all of the exhibits in the case file, Plaintiff’s counsel objected:

ATTY: I object to 10F. 10F is a statement [-] it’s a BDDRFC [Bureau of Disability Determination Residual Functional Capacity] form prepared by an adjudicator[.] [I]t’s not the opinion evidence from a consultant.

ALJ: Well, it is admissible Mr. Savoy. It’s the issue of [weight] that we give to it. So, I will not exclude that Exhibit.

(R. 20.)

claimant was able to perform a limited range of work at the light exertional level, as defined in 20 CFR 416.967(b), i.e., she can lift/carry 20 pounds occasionally and 10 pounds frequently and can sit/stand/walk about 6 hours in an 8-hour workday; but can only occasionally climb, balance, stoop, kneel, crouch, and crawl (Exhibit 10F).

(R. 14.) After explaining why he did not credit Stewart's complaints of disabling limitations, he continued:

I find that the assessment of the DDS disability examiner *reasonably represents the findings of the consultative examiner, as well as the objective findings of the treating sources*. Treatment records and claimant's testimony with regard to her daily activities support this assessment. Her prior work record, which is spotty (Exhibits 6D, 7D, 3E), is insufficient to support an inference of disability from the fact that she is not working at this time. Thus, I only partially credit claimant's allegations of significant work-related limitations.

In reaching my conclusion I have also considered the opinions and findings of the State agency consultants that claimant is able to perform light exertional activities (Exhibit 10F) and that her emotional disorder resulted in mild functional limitations (Exhibit 11F).<sup>7</sup> Although non-examining physicians or practitioners render the opinions of State agency medical or psychological consultants, they are the opinions of expert[s] in the evaluation of medical issues in disability claims under the Social Security Act and are entitled to some probative weight (20 CFR 416.927 and SSRs 96-5p and 96-6p). As noted above, I find that the State agency adjudicator's assessment *is consistent with the overall objective evidence* and suggestions of disabling severity are not supported by the record.

(R. 15-16 (emphasis added).)

Plaintiff argues that the ALJ "explicitly relied on the [Physical RFC form] as substantive evidence of non-disability" in issuing his decision when, pursuant to agency policy, the findings

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<sup>7</sup> Exhibit 10F is the Physical RFC form completed by McCartt on January 23, 2008. Exhibit 11F is a Psychiatric Review Technique Form of that same date submitted by Elizabeth Hoffman, Ph.D., a state agency psychological consultant. (R. 206-18.)

of a single decisionmaker (“SDM”) are not to be treated as “opinion evidence” and any purported opinion she may have offered is “not evidence at all.” (Pl. Br. at 3, 4.) The Commissioner does not contest that McCartt’s role in Stewart’s claim at the initial determination stage with state agency was as an adjudicator and that her statement was not medical opinion evidence. (Def. Br. at 7.)<sup>8</sup> The Commissioner contends, however, that the record does not support the proposition that ALJ treated the Physical RFC form as medical opinion evidence upon which to rely and asserts that “the ALJ’s agreement with the state agency’s denial was based upon a de novo review of the entire record[.]” (Def. Br. at 7.)

There is no question that McCartt’s Physical RFC assessment, while useful in laying out the basis for the initial determination in January 2008 that Stewart was not disabled, does not reflect *medical* opinion evidence because McCartt is nowhere identified as an acceptable medical source (e.g., M.D. or D.O. for purposes of a physical assessment). In that the initial adjudication as Stewart’s claim is not entitled to any deference by the ALJ, who is to apply a *de novo* standard of review, the Commissioner has endeavored to clarify that the Physical RFC assessment form, Form SSA-4734-BK, when completed by a state agency adjudicator rather than a “medical consultant” is not to be treated as opinion evidence to be considered when formulating the RFC at the hearing level. *See* SSA Program Operations Manual System (“POMS”) § DI 24510.050. *See also* Mem. from Chief ALJ Cristaudo to Regional Chief ALJs, 5/21/10, *appended to* Pl. Br.

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<sup>8</sup> Although the Commissioner does not refer to McCartt as a “single decisionmaker,” we understand her to fill that role in light of how she is identified in the record. *See Yorkus v. Astrue*, No. Civ. A. 10-2197, 2011 WL 7400189, \*4 n.6 (E.D. Pa. Feb. 28, 2011), *approved and adopted* Mar. 24, 2011 (noting explanation by Commissioner that code “LEX” followed by number on the Physical RFC form indicates that signer is an SDM); R. 203, 205 (signature of McCartt followed by code “LEX 219”). *Cf.* R. 203 (McCartt’s signature in box labeled “adjudicator’s signature” and no notation in box for “medical consultant’s code”).

as Ex. A (noting that form should be considered an adjudicatory document only and not be accorded any evidentiary weight when deciding case at hearing level).

It cannot be denied that both certain wording in the ALJ's decision and a statement he made at the hearing give rise to legitimate concerns that the ALJ misperceived the value of the Physical RFC form. For example, in his response at the hearing to counsel's request that Exhibit 10F be excluded from evidence, the ALJ explained that it was admissible and that "[i]t's the question of [the weight] that we give to it," (R. 20), suggesting that he saw some evidentiary value in the assessment. In his written decision, he also referred to Exhibit 10F in the same breath as Exhibit 11F, which, as a form completed by the state agency reviewing psychologist, Elizabeth Hoffman, Ph.D., was a medical opinion. (R. 15.) *See also* R. 14 (in describing evidence found in "F" section of claims file, noting what was "opined" by "a DDS disability adjudicator" on January 23, 2008 as found in Exhibit 10F). What follows from the boilerplate language regarding the evidentiary value of state agency *medical and psychological consultants* who render opinions without having examined the claimant, however, was a more specific reference to McCart's role: "As noted above, I find that the *State agency adjudicator's* assessment is consistent with the overall objective evidence and suggestions of disabling severity are not supported by the record." (R. 15-16 (emphasis added).) In addition, unlike his descriptions of treating or examining physician assessments as to Stewart's "disability" status or limitations, the ALJ's description of the state agency adjudicator's opinion did not set forth any "weight" that he assigned to it. (R. 14.) *Cf.* R. 13 (noting that Dr. Krafchick's opinion on DPW forms regarding Stewart's "disability" status were "not controlling"); *id.* at 14 (reporting conclusion that he did "not accord any weight to" the functional capacity assessment form completed by Dr. Zoranski following consultative

examination); *id.* at 14 (reporting conclusion that he did “not accord much weight to” the assessment of Dr. Krafchick in his November 2007 “to whom it may concern” letter).

We find it sufficiently clear from the record that the ALJ knew that the Physical RFC assessment found at Exhibit 10F was completed by an adjudicator rather than a medical consultant. *Cf. Siverio v. Commissioner of Social Security*, No. 11-12450, 2012 WL 573588, \*2 (11th Cir. Feb. 23, 2012) (*per curiam*) (finding “ALJ mistakenly treated [SDM’s] opinion [on the claimant’s RFC] as the ‘expert opinion’ of a ‘DDS physician,’ ‘State Agency physician,’ and ‘DDS medical consultant’”); *Yorkus*, 2011 WL 7400189 at \*4 (observing that ALJ’s decision explicitly stated that “[a]s for opinion evidence, great weight is given to the State agency’s residual functional capacity assessment”). The ALJ’s use this assessment in his questioning of the VE did not suggest that he was relying upon or placing any evidentiary weight on the assessment. Rather, he used the document as a short-hand reference for the RFC of a hypothetical individual — an RFC with which he ultimately agreed because it was “consistent with” the objective evidence. (R. 15-16.) Moreover, even if there were a concern that the ALJ labored under the mistaken belief that the Physical RFC form at Exhibit 10F had been authored by a physician, the error would be harmless in light of the remaining record evidence providing substantial evidence for the finding that Stewart was capable of performing work at the light exertional level. *See, e.g.* R. 170-71 (Medical Source Statement completed by Dr. Krafchick on 7/26/06 opining that Stewart had “no limitation” with respect to standing and walking or sitting and that she could lift and carry 10 lbs. frequently)<sup>9</sup>;

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<sup>9</sup> This document appears to have been created in relation to Stewart’s earlier SSI claim. She did not initiate the claim giving rise to the current request for review until September 2007. As part of that later claim, however, she continued to assert that her disability began in 2005. Around the time that Dr. Krafchick issued his July 2006 RFC assessment, Stewart had been complaining of left arm pain and leg pain. (R. 314.) He administered an injection in her shoulder on July 7, 2006 and

R. 130-37 (Function Report – Adult form completed by Stewart 10/20/07 describing daily activities); R. 193 (consultative examiner’s diagnosis, following review of x-rays of 6/17/07, of only “minimal osteoarthritis in the thoracic and lumbar spines”); R. 179 (radiologist’s impression on 6/17/07, following slip-and-fall, of “unremarkable cervical spine”); R. 29 (hearing testimony regarding activities of daily living). We conclude that Plaintiff has not met her burden to show that the ALJ’s decision was the product of legal error based upon her first assertion.

**B. The ALJ’s refusal to allow Plaintiff to respond to the VE testimony**

Stewart next contends that the ALJ erred in relying on VE testimony in the Step Five analysis because he did not “respect” Plaintiff’s “right to respond to vocational testimony” when he closed the record and denied her request for leave to “possibl[y]” submit a post-hearing memorandum commenting on the vocational testimony. (Pl. Br. at 5.) She argues that she was prejudiced by the ALJ’s closing of the record at the conclusion of the hearing because it deprived her of an opportunity to show that the number of local positions for the particular job identified by the VE by DOT number was “absurd” and that this testimony undermined his overall credibility. (Pl. Br. at 6.) We disagree that the ALJ committed reversible error.

Plaintiff bases her argument on a footnote found in Social Security Ruling 96-9p. This ruling concerns the impact of an RFC assessment for less than a full range of sedentary work on the Step Five analysis.<sup>10</sup> In a footnote to a discussion of the use of vocational resources to address the extent of erosion of the unskilled sedentary occupational base for a claimant limited to a

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referred her for an x-ray of the left shoulder. (R. 314, 344.)

<sup>10</sup> This does not describe Stewart’s RFC as found by the ALJ here, as he found her capable of work at the light exertional level.

restricted range of sedentary work, the ruling explains:

At the hearings and appeals levels, vocational experts (VEs) are vocational professionals who provide impartial expert opinion during the hearings and appeals process either by testifying or by providing written responses to interrogatories. A VE may be used before, during, or after a hearing. Whenever a VE is used, the individual has the right to review and respond to the VE evidence prior to the issuance of a decision. The VE's opinion is not binding on an adjudicator, but must be weighed along with all other evidence.

SSR 96-9p, n.8. Plaintiff contends that she could not exercise her “right” to “respond to the VE evidence prior to the issuance of a decision” when the ALJ closed the record at the conclusion of her hearing and without permitting counsel to “review the vocational testimony” — which he heard but could not have known of in advance — and “possibly comment on it.” (Pl. Br. at 5.) She cites no authority for the proposition that the “right . . . to respond to the VE evidence prior to the issuance of a decision” requires the ALJ to keep the record open following the conclusion of a hearing at which the claimant is represented by counsel who exercised his right to cross-examine the VE extensively.

Our review of the transcript of the administrative hearing shows that, after concluding his cross-examination of the VE, including asking him for the DOT numbers for the jobs he identified, counsel asked if the record could be kept open for 10 days to allow him to “submit a memo,” as counsel wanted “to review the vocational expert [sic] for the case and see if [he] had any comments on the vocational expert testimony.” (R. 40.) The ALJ denied counsel's request, noting that the hearing had been “normal, traditional,” and that counsel had been given the opportunity to — and did — cross-examine the expert and make a closing argument. (R. 40-41.) The only additional “response” that Plaintiff suggests counsel would have made to the VE testimony was

to challenge as “absurd” the notion that there were 3,300 jobs “in the region” (R. 38) for the “sorter” position identified by the VE, as the DOT reference he provided related to sorter positions in the tobacco industry. *See* R. 39 (providing reference number for DOT position entitled “BINDER SELECTOR (tobacco),” or alternately “binder sorter”). The fact that a characteristic position was one that Plaintiff apparently does not believe is sufficiently present “in the Philadelphia region” is something that counsel could have raised at the hearing. Plaintiff offers no proffer of the further specific response that he would have made that would be expected to have impacted upon the ALJ’s decision. Moreover, to the extent that Plaintiff believes this position is not sufficiently represented in the region or that the VE misstated the number of jobs regionally, we noted that the Commissioner need not demonstrate that work exists in significant numbers in the region in order to sustain his burden at Step Five. Rather, the relevant setting is the “national economy,” as to which the Regulations specifically provide:

We consider that work exists in the national economy when it exists in significant numbers either in the region where you live or in several other regions of the country. It does not matter whether—

- (1) Work exists in the immediate area in which you live;
- (2) A specific job vacancy exists for you; or
- (3) You would be hired if you applied for work.

20 C.F.R. § 416.866(a). This Court has also observed that, in addition to the language of this regulation, “under the controlling language of the statute, the court must look to the jobs that exist in the *national* economy that could accommodate [the plaintiff’s] physical limitations and that the legislative history of the Act makes it clear that “Congress did not intend the calculation of employment capabilities to be limited to the claimant’s immediate area.” *Torres v. Shalala*, Civ. No. 94-5492, 1995 WL 321902, at \*5 (E.D. Pa. May 23, 1995) (Giles, J.) (emphasis in original).

We decline to vacate the administration decision where the ALJ did not abuse his discretion in closing the record when he did. Plaintiff had an adequate opportunity to respond to the VE's testimony as to representative occupations at the hearing. Moreover, the VE testified to — and the ALJ relied upon — an additional representative occupation that Plaintiff could also perform besides the “sorter” position. *See* R. 17 (ALJ decision noting VE testimony that individual with Plaintiff's RFC could perform “occupations such as inspector/examiner (100,000+ jobs nationally/2,100 jobs regionally) and sorter (100,000+ jobs nationally/3,300 jobs regionally)”).

**C. The ALJ's Failure to Obtain the File Created in Connection with a Prior Claim**

Plaintiff next contends that the ALJ violated his responsibility to develop the record as to her alleged disability by not retrieving the file associated with a prior SSI application that she contends she made sometime prior to September 2006.<sup>11</sup> She notes that the file presumably would have included the consultative examination report of Jeffrey Bryer, Ed.D., which is identified in a notice she received as having been received by the state agency on “9/12/06.” (Pl. Br. at 6, 8.) She argues that the ALJ should have obtained this report, if he would not order a consultative examination himself, to comply with his duty to develop the record as to her mental impairment, in that her treatment for anxiety and depression came only from her family doctor and there was “no opinion evidence from any examining or treating mental health professional indicating how severe the impairment is or what limitations it does or does not impose.” (Pl. Br. at 9, 10.) She

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<sup>11</sup> At one point in her brief, Plaintiff contends that she made this application *on* September 20, 2006. This must be a mistake, as she also contends that this application was *denied* following receipt of a report on September 12, 2006, and the denial notice that she provides is dated September 20, 2006. A document contained in the record that appears to be a referral form from a disability advocate within the Pennsylvania Department of Public Welfare suggests that an earlier SSI application may have been filed on June 1, 2005. *See* R. 103.

complains that due to the undeveloped record, the ALJ relied upon the “worthless” and unsupported opinion of the state agency psychological consultant in finding that Stewart did not have a severe mental impairment. (Pl. Br. at 9-10.) She characterizes the ALJ’s failure “to obtain pertinent evidence already in the possession of the Social Security Administration,” which Plaintiff had specifically requested, as a violation of the ALJ’s duty to develop the record and a denial of Plaintiff’s “right to obtain relevant evidence.” (Pl. Br. at 10.)

An ALJ’s duty to develop the record is set forth in the regulation that addresses the subject of evidence: 20 C.F.R. § 416.912. The regulation makes clear at the outset that, in general, it is the claimant’s burden to prove that she is disabled, which “means that [the claimant] must furnish medical and other evidence that [the agency] can use to reach conclusions about [her] medical impairment(s).” 20 C.F.R. § 416.912(a). The agency takes on the responsibility before making a determination to “develop” the claimant’s “complete medical history” *for at least the 12 months preceding the month in which she files her application*, “unless there is a reason to believe that development of an earlier period is necessary” or unless she says that her disability began less than 12 months before she filed her application. *Id.* § 416.912(d). The term “complete medical history” is further defined to mean “the records of your medical source(s) covering at least the 12 months preceding the month in which you filed your application,” or in cases where the disability began less than 12 months prior to the application date, then in that month. *Id.* § 416.912(d)(2).

The record that Plaintiff contends the ALJ should have obtained does not meet this criteria. Given that the consultative examination report of Jeffrey Bryer, Ed.D. was apparently provided to the state agency on September 12, 2006, it arguably dates to 12 months prior to the September 5, 2007 SSI application giving rise to this ALJ decision. The regulation’s description about obtaining

records of “your medical source,” however, suggest that it was the records of the claimant’s *treating* sources, which would provide a history and possible trajectory, that were significant in the analysis. A one-time consultative examination report would not provide that perspective.

As is true of many of the questions regarding the scope of the record that the ALJ must develop, the ALJ is given discretion to determine if additional evidence or clarification of the record is necessary due to conflicts or ambiguities that leave the record “inadequate” for a determination as to whether the claimant is disabled. *See id.* § 416.913(e), (e)(1). The ALJ here acted within his discretion to find the record before him “adequate” for a determination of Stewart’s disability without reviewing the report of Dr. Bryer. That record arose from a one-time consultative examination that presumably related to Stewart’s alleged depression and/or anxiety — impairments for which she was prescribed medication by her family physician, Dr. Krafchick, whose treatment notes were already found in the file dating back to May 2005. *See, e.g.*, R. 219-356. *See also* R. 334-35 (treatment notes from August 1 and 2, 2005 noting depression and symptoms of anxiety and new prescription for Effexor, an antidepressant). The ALJ had a proper basis to determine that the record before him — with treating physician records covering the period from May 2005 to May 2008, as well as treating physician functional capacity (R. 170-71) and employability assessment forms (R. 182-87) — was adequate to determine that Stewart was not disabled.

Contrary to Plaintiff’s suggestion, the report of Dr. Bryer would not have been the only piece of evidence presumably documenting that she has depression.<sup>12</sup> To be sure, the ALJ did not

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<sup>12</sup> It *would* have been the only opinion evidence from any examining mental health professional, as Stewart does not treat with a psychiatrist, psychologist, or psychotherapist for her depression or anxiety. The actual contents of the report, however, are unknown. Dr. Bryer’s report

question that she suffered from an impairment related to depression, and the state agency reviewing psychologist — upon whose opinion the ALJ relied at Step Two (*see* R. 11) — opined on January 23, 2008 that Stewart suffered from “Depressive Disorder, NOS.” (R. 209.) The relevant question was whether her depression had more than a de minimus affect on her ability to perform basic work activities. What impressed the ALJ about Stewart’s depression was that, although Dr. Krafchick referenced it in employability forms that he completed on Plaintiff’s behalf to enable her to continue to receive welfare benefits, “his notes rarely mention depression or anxiety, and they do not discuss his observations about severity.” (R. 11.) Moreover, although Dr. Krafchick did not hesitate to refer Stewart to various other specialists to manage her pain and treat her orthopedic impairments (R. 14), the ALJ noted that Dr. Krafchick did not find her psychological condition “severe enough to warrant referral to a mental health professional.” (R. 15.) *See also* R. 11 (observation in ALJ decision that opinion of state agency reviewing psychologist “is consistent with the lack of treatment by a mental health professional”). The notion that Stewart’s depression resulted in functional limitations impacting her ability to work was also belied by what the ALJ noted were Stewart’s “broad range of activities of daily living.” (R. 11.) *See also, e.g.*, R. 130-37 (Function Report completed by Stewart suggesting no limitations caused by depression or anxiety). Again, the opinion of a consultative examiner that pre-dated the administrative hearing by some three years and pre-dated the month at which disability needed to be established

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was one of seven sources of medical evidence (including a “response” of Dr. Krafchick received on August 3, 2006) upon which the state agency based its decision to deny her earlier claim. The Notice of Disapproved Claim states that the Agency recognized that Stewart claimed that she was unable to work because of “depression and chronic pain Syndrome [sic] in legs and feet and possible breast cancer.” (R. 58.) The Notice continued: “You do have some depression, but you are able to follow direction [sic] and perform routine tasks. Based on your description of the job you performed as a waitress for 1 year we have concluded that you have the ability to perform this type of work.” (*Id.*)

by some 12 months, was not improperly found by the ALJ to be unnecessary to his decision in light of the record before him concerning the effects of (or lack thereof) her mild mental impairment.<sup>13</sup>

**D. The ALJ’s rejection of favorable evidence**

Plaintiff’s fourth argument is concerned with the ALJ’s rejection of evidence that was favorable to her without having provided what she considers “good reasons” for the rejection. (Pl. Br. at 11.) She focuses upon opinion evidence offered by her treating physician and by a consultative examiner, as well as to her testimony at the hearing concerning her work-related limitations. We first address the question of the ALJ’s reconciliation of the opinions from medical sources and then address the propriety and sufficiency of the explanation for the ALJ’s credibility determination as to Stewart’s own testimony.

**1. The rejection of opinions from medical sources**

Plaintiff identifies two medical sources of opinion evidence that she contends were rejected without the sufficient explanation required by *Reefer v. Barnhart*, 326 F.3d 376, 381-82 (3d Cir. 2003) and *Cotter v. Harris*, 642 F.2d 700, 706-07 (3d Cir. 1981): opinions in three documents

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<sup>13</sup> Plaintiff’s citation to the Hearings, Appeals and Litigation Law Manual (“HALLEX”) does not change our view of the ALJ’s conduct here. The HALLEX provides that, upon receipt of the claimant’s request for a hearing, the hearing office staff “should consider whether the evidence in any prior [case file(s)] is material to the current claim” and that “[i]f it appears that the evidence in the prior [case file] is not material to the current claim, the [hearing office] staff should recommend to the ALJ that no action be taken to obtain the prior [case file].” HALLEX § I-2-1-10(C). The manual goes on to provide a list of five “examples of situations when an ALJ may not need the prior claim file,” *id.* § I-2-1-10(D), none of which are applicable to Stewart’s case. It did not, however, purport to describe the entire universe of situations in which an ALJ “may not need the prior claim file,” nor to obligate him to seek to obtain the file in all other cases. Plaintiff’s references to case law addressing the ALJ’s “well-established duty to develop the record” (Pl. Br. at 8-9) provide no support for the specific contention here that the ALJ erred in denying Stewart’s disability claim without reviewing the case file from the earlier application that she abandoned after the initial denial. This alleged error does not require that the administrative decision be vacated.

from Michael A. Krafchick, D.O. her primary care physician since May 27, 2005, and the RFC assessment of Bernard S. Zoranski, D.O., who performed a consultative examination of Stewart on November 30, 2007 at the request of the state agency during the initial determination phase of her application.

**a. Dr. Krafchick**

Stewart points to three opinions expressed by Dr. Krafchick that she contends the ALJ improperly rejected: two contained in forms that he completed for the Pennsylvania Department of Public Welfare (“DPW”), which impacted upon Stewart’s continued receipt of welfare benefits and Medicaid, and one letter addressed “To Whom it May Concern.”

The DPW form that Dr. Krafchick periodically was asked to complete gives the medical provider the opportunity to check off that the patient is “permanently disabled,” where the doctor finds “a physical or mental condition which **permanently** precludes any gainful employment” and where “*the patient is a candidate for Social Security Disability or SSI*”; “temporarily disabled – 12 months or more,” where “the patient remains disabled due to a temporary condition or as a result of an injury or an acute condition and the disability **temporarily** precludes any gainful employment,” such that “*the patient may be a candidate for Social Security Disability or SSI benefits*”; “temporarily disabled – less than 12 months,” reflecting a similar definition as “temporarily disabled – 12 months or more” but without the reference to eligibility for Social Security Disability or SSI; or “employable.” (R. 183, 185, 187 (bold in original; italic emphasis added).) In the form Dr. Krafchick completed for Stewart on May 27, 2005, he provided only a diagnosis for bilateral bunions and opined that Stewart was “temporarily disabled – less than 12

months” from May 27, 2005 to a date yet to be determined. (R. 187.)<sup>14</sup> In the form he completed the following year, he provided a primary diagnosis of major depressive disorder and secondary diagnosis of chronic pain syndrome and again opined that Stewart was “temporarily disabled – less than 12 months” for a six-month period beginning on May 18, 2006. (R. 185.) The following year, while identifying chronic pain syndrome as the “primary” diagnosis and major depression disorder as the “secondary” diagnosis, he selected the characterization of Stewart’s employability as “temporarily disabled — 12 months or more,” and identified the beginning date of the temporary disability as June 1, 2007 and the expected duration of the temporary disability until June 1, 2008. (R. 183.)

With respect to the opinions offered by Dr. Krafchick in 2007 and 2008, the ALJ commented that:

In Pennsylvania, such forms must periodically be completed by a recipient’s attending physician in order for the recipient to continue to remain eligible for public assistance cash benefits and medical coverage, and for the attending physician to be reimbursed for the cost of services rendered. However, such opinions on “disability” for purposes of the Department of Public Assistance are not controlling within the meaning and scope of Social Security Rule 96-2p.[<sup>15</sup>] Opinions as to disability are reserved to the Commissioner (Social Security Ruling 96-5p).

R. 13. Plaintiff argues that the ALJ “reject[ed] the opinions outright.” (Pl. Br. at 13.) The only *medical opinions* reflected in the DPW forms, however, are the diagnoses and Dr. Krafchick’s implicit conclusion that the listed conditions impact upon Stewart’s ability to engage in gainful

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<sup>14</sup> The progress note dated May 27, 2005 identifies Stewart as a new patient. (R. 335.)

<sup>15</sup> This ruling sets forth the Commissioner’s policy interpretation concerning when medical opinions offered by treating sources are to be given “controlling weight.”

employment.” (R. 183, 185, 187.) The opinions that she was “temporarily disabled” are not *medical opinions* under the Regulations. To be sure, a treating physician’s opinion that a patient is “disabled” is *excluded* from the definition of a “medical opinion”:

(d) *Medical source opinion on issues reserved to the Commissioner.* **Opinions on some issues**, such as the examples that follow, **are not medical opinions**, as described in paragraph (a)(2) of this section,<sup>[16]</sup> but are, instead, opinions on issues reserved to the Commissioner because they are administrative findings that are dispositive of a case; i.e., that would direct the determination or decision of disability.

(1) *Opinions that you are disabled.* We are responsible for making the determination or decision about whether you meet the statutory definition of disability. In so doing, we review all of the medical findings and other evidence that support a medical source’s statement that you are disabled. A statement by a medical source that you are “disabled” or “unable to work” does not mean that we will determine that you are disabled.

(2) *Other opinions on issues reserved to the Commissioner.* We use medical sources, including your treating source, to provide evidence, including opinions, on the nature and severity of your impairment(s). Although we consider opinions from medical sources on issues such as whether your impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments in appendix 1 to subpart P of part 404 of this chapter, your residual functional capacity (see §§ 416.945 and 416.946), or the application of vocational factors, the final responsibility for deciding these issues is reserved to the Commissioner.

(3) We will not give any special significance to the source of an opinion on issues reserved to the Commissioner described in paragraphs (d)(1) and (d)(2) of this section.

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<sup>16</sup> That section provides in relevant part that:

Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of your impairment(s), including your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions.

20 C.F.R. § 416.927(d) (2012)<sup>17</sup> (bold emphasis added). Accordingly, while the ALJ was to consider Dr. Krafchick’s opinion that Stewart was “temporarily disabled” as he would any other opinion evidence, this opinion was not controlling nor subject to “rejection” by the ALJ only upon a showing of contrary evidence because it was not a “medical opinion.” The ALJ’s explanation that these opinions were not controlling upon him was adequate.

The third opinion offered by Dr. Krafchick was found in a letter contained within the records from Stewart’s chart:<sup>18</sup>

November 26, 2007

BRENDA STEWART  
PO BOX 272  
KENNETT SQUARE, PA 19348

To Whom it May Concern,

This letter is to be used to help understand the need for disability for Ms. Stewart. Brenda has been my patient for approximately 4 years. Thru [sic] this time we have tried to deal with her chronic pain issues in a variety of ways. Her chronic pain has developed in her neck, shoulders and low back. She also experiences continued fatigue and severe anxiety related to a lot of family issues. For all of her symptoms, I have sent to [sic] her to multiple specialists, provided many different medications to manage her symptoms, and followed her closely with office visits. All of her issues put together prohibit her from working in any capacity. It is of [sic] my medical opinion that she needs disability for at least 12 months to help manage her symptoms and improve her quality of life.

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<sup>17</sup> In previous editions of the Regulations, this section was subsection (e).

<sup>18</sup> The contemporaneous treatment notes do not provide any insight as to what prompted the letter to be written or to whom it was intended to be distributed, although there is a notation that Stewart called Dr. Krafchick on September 27, 2007 “re: letter.” (R. 282-83.) Stewart initiated this SSI application on or about September 5, 2007 and retained counsel on September 21, 2007. *See* R. 50 (Appointment of Representative form dated 9/21/07).

Should you have any further questions feel free to call me.

Sincerely,

[/s/]

Mike Krafchick DO, MBA

(R. 268.) After describing the contents of this letter, the ALJ explained in his decision that he did “not accord much weight to this assessment” because it was “not supported by the medical evidence of record,” noting that “Dr. Krafchick’s records do not document frequent visits, and [Plaintiff’s] treatment during the period at issue in this case (i.e., since the date of filing in September 2007) has been limited at best.” (R. 14.) He characterized the letter as “simply an attempt to help [Plaintiff] acquire disability benefits.” (R. 14.) He also noted that while Dr. Krafchick labeled her as disabled due to a combination of impairments including anxiety, “[Dr. Krafchick] has not felt her psychological condition to be severe enough to warrant referral to a mental health professional,” and for this reason the ALJ would not credit his opinion. (R. 15.) The ALJ also noted that Dr. Krafchick was “not the treating source for her multiple orthopedic complaints, and none of those doctors has offered an opinion as to her level of functionality.” (R. 15.) He found that “the objective findings of the treating sources” and the findings of the consultative examiner were more “reasonably represent[ed]” in the assessment of the state agency adjudicator made below. (R. 15.).

Plaintiff also complains that Dr. Krafchick’s “lack of disinterest” was not a good reason for rejecting his medical opinion and that the ALJ’s assertion that treatment since September 2007 had been limited was “flatly inconsistent with the record[,] which documents extensive treatment during that period, including surgery.” (Pl. Br. at 15.) Plaintiff’s citations to the record, however, show little medical evidence of record leading up to the date of Dr. Krafchick’s November 26, 2007 letter. In the first portion of the record to which she cites, R. 269-88, Stewart called in to Dr. Krafchick to

obtain a prescription for back pain (R. 282, 9/20/07), called for an increased dose of hydrocodone (R. 279,<sup>19</sup> 10/15/07), called in to obtain a prescription for elbow pain (R. 276-77, 11/15/07), and was seen for a urinary tract infection and sent for labwork regarding her reported fatigue (R. 274-75, 11/20/07). Plaintiff's citations to another portion of the record for the proposition that she received extensive treatment since September 2007, R. 357-69, concerns her treatment with orthopedists that post-dates Dr. Krafchick's opinion letter. The most recent orthopedic treatment note before his letter concerned a diagnosis of cervical and low back strain on July 6, 2007 from a slip-and-fall on June 17, 2007.<sup>20</sup> (R. 370.) Stewart was not seen again by the orthopedists until February 8, 2008, when she complained of left shoulder pain and received a steroid injection. (R. 368-69.) In light of the medical evidence of record at the time Dr. Krafchick made his assessment, the ALJ was well within his right to accord it little weight. *See* R. 14 ("I do not accord much weight to this assessment as it is not supported by the medical evidence of record.")<sup>21</sup> We find no reversible error in the ALJ's explanation for his rejection of Dr. Krafchick's opinion.

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<sup>19</sup> Plaintiff requested that her dose be increased from 500mg to 750mg. Dr. Krafchick prescribed 650mg tablets to be taken as needed for severe pain. (R. 279.)

<sup>20</sup> Plaintiff apparently brought a personal injury lawsuit against the supermarket where she fell. She testified at the hearing that her doctors were aware of that litigation. (R. 30.) *See also* R. 358 (orthopedic treatment note of 2/3/09 describing pending litigation and Stewart's claim that low back pain began after that fall).

<sup>21</sup> Plaintiff makes much of the ALJ's remark that Dr. Krafchick's letter "is simply an attempt to help claimant acquire disability benefits." (R. 14.) Given his finding — expressed in the previous sentence of his discussion — that Dr. Krafchick's "assessment [was] not supported by the medical evidence of record," it is not necessary for us to speculate about Dr. Krafchick's motive in authoring this letter.

**b. Dr. Zoranski**

Stewart also contends that the ALJ improperly rejected medical opinion evidence from Bernard S. Zoranski, D.O., who performed a consultative examination on November 30, 2007 at the request of the state agency during the initial determination phase of her application. (R. 190-93.)

As the ALJ recounted in his decision, Dr. Zoranski observed in his narrative report that Stewart's reflexes were decreased but that there was no atrophy; station and gait were normal; she could get up and off of the examination table without any difficulties, her grip strength was normal and her endurance appeared normal. (R. 14.) Dr. Zoranski reviewed imaging studies and diagnosed "minimal osteoarthritis in the thoracic and lumbar spines." (*Id.*)<sup>22</sup> He also completed a chart showing that Stewart had full range of motion in all areas. (R. 197-98.) Notwithstanding what the ALJ characterized as "the minimal objective findings" (R. 14), Dr. Zoranski also completed an assessment form indicating significant limitations: carrying and lifting no more than 2-3 lbs.; standing and walking limited to an hour due to back pain; sitting limited to 20 minutes; pushing and pulling limited in both arms; and a restriction to only occasional postural activities like bending and stooping. (R. 195-96.) Where asked on the form to indicate "supportive medical findings" for the limitations assessed, he responded only with "back pain," adding a comment as to the 20-minute sitting limitation that Stewart "must lay down & rest." (R. 195.)

The ALJ explained in his decision that he would "not accord any weight to this assessment as it is totally inconsistent with the essentially normal findings on physical examination. It is clear

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<sup>22</sup> Dr. Zoranski noted that the MRI of the left shoulder showed tendinopathy (tendon injury) and mild joint osteoarthritis. He noted that the June 17, 2007 cervical spine x-ray was "completely normal," a thoracic spine x-ray showed "minimal degenerative changes," and a lumbar spine x-ray showed "minimal osteoarthritis." (R. 193.)

that Dr. Zoranski was basing [his] opinion on claimant’s subjective, supported assessment of her own abilities.” (R. 14.) Plaintiff contends that the ALJ’s determination that Dr. Zoranski’s RFC assessment on the form was inconsistent with the findings in his report “constitutes substitution of the ALJ’s lay judgment for that of a physician on a medical matter.” (Pl. Br. at 16.) We disagree. The ALJ is tasked with assessing the supportability of medical opinions offered, as well determining the consistency of that opinion with the other evidence of record. *See generally* 20 C.F.R. § 416.927. We do not view the ALJ’s reconciliation of this evidence to represent an improper substitution of his judgment for that of Dr. Zoranski. Nor do we find that “radiological evidence of musculoskeletal abnormalities in the left shoulder, upper back and lower back” referred to by Plaintiff (*see* Pl. Br. at 16 (citing R. 193)) to have justified Dr. Zoranski’s RFC assessment due to “back pain,” inasmuch as he himself characterized the radiological evidence of the cervical area as “normal” and of the thoracic and lumbar areas as showing only “minimal” degeneration. (R. 193.) While Plaintiff characterizes the ALJ’s assumption that Dr. Zoranski based his opinion on Stewart’s self-reported abilities as “unacceptable” and “unwarranted speculation,” (Pl. Br. at 16), we find the ALJ’s conclusions here to be supported by substantial evidence given the disconnect between Dr. Zoranski’s narrative report with minimal findings and his documentation of no limitations in Stewart’s range of motion, and coupled with her contention that she is severely limited. We conclude that the ALJ cited appropriate reasons for rejecting the RFC assessment offered by Dr. Zoranski.<sup>23</sup>

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<sup>23</sup> As the ALJ was not rejecting a treating physician’s opinion, and inasmuch as the RFC assessment of Dr. Zoranski was not supported by the record, Plaintiff’s citation to *Morales v. Apfel*, 225 F.3d 319 (3d Cir. 2000) is inapposite. *See* Pl. Br. at 17.

## **2. The adequacy of the explanation of the ALJ's credibility determination**

Plaintiff next contends that the ALJ provided an inadequate explanation for his rejection of certain “non-medical evidence”: her own testimony at the September 8, 2009 hearing. She also contends that the ALJ had an inadequate basis for rejecting her testimony as a matter of law if it was only due to a lack of supporting objective medical evidence. (Pl. Br. at 18-19.) Plaintiff cites to the following paragraphs from the ALJ's decision:

While the record supports some of claimant's complaints, there are no findings to support the extent of her disabling allegations. There is no evidence that she is unable to perform at least some work activities. Claimant has multiple arthritic complaints. However, there is limited evidence supporting her complaints. She does not have a herniated disc or stenosis. On a consultative examination, her physical examination was essentially normal. In November 2007, her primary care physician said she was disabled due to a combination of impairments, one of which was anxiety, which he described as severe. Yet, he has not felt her psychological condition to be severe enough to warrant referral to a mental health professional, and I do not credit his statement. He is not the treating source for her multiple orthopedic complaints, and none of those doctors has offered an opinion as to her level of functionality.

I find that the assessment of the DDS disability examiner [Valerie McCartt] reasonably represents the findings of the consultative examiner [Dr. Zoranski], as well as the objective findings of the treating sources. Treatment records and claimant's testimony with regard to her daily activities support this assessment. Her prior work record, which is spotty (Exhibits 6D, 7D, 3E), is insufficient to support an inference of disability from the fact that she is not working at this time. Thus, I only partially credit claimant's allegations of significant work-related limitations.

(Pl. Br. at 18 (quoting R. 15).)

Plaintiff offers little by way of argument here apart from her insistence that the ALJ improperly substituted his opinion for that of Dr. Zoranski and that there was “ample medical

evidence that Plaintiff has serious musculoskeletal pathology” substantiating her complaints of pain. (Pl. Br. at 18-19.)<sup>24</sup> While she contends that Social Security Ruling 96-7p prohibits an ALJ from disregarding allegations concerning the intensity and persistence of pain only because they are not substantiated by objective medical evidence, the ALJ provided other bases. He noted that she had an essentially normal physical exam within a short time after applying for SSI based upon her back pain, that she has no disc herniations or stenosis that would account for the degree of pain alleged, and that her “spotty” past work history could not be used to support an inference that her failure to work was due to disability. *See, e.g., Dobrowolsky v. Califano*, 606 F.2d 403, 409 (3d Cir.1979) (holding claimant’s work ethic valid consideration for an ALJ in assessing credibility); *Powell v. Barnhart*, 437 F. Supp.2d 340, 343 (E.D. Pa. 2006) (noting that ALJ considered plaintiff’s “spotty

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<sup>24</sup> Plaintiff testified about her pain as follows:

Q [ALJ] Well, what’s wrong with you that you’re not working?

A [Plaintiff] I have a bad back, bad spine, it affects my legs and I’m just in constant pain all the time and take [sic] a little bit of depression too.

Q Your back is [sic] in your lower back?

A Low - - my neck and my lower back and my legs. My whole back really.

\* \* \*

Q Where is the worst pain?

A My whole back.

Q From your shoulders down - -

A From my neck down - -

Q - - to your lower - -

A - - all the way to my toes really.

Q How bad is the pain?

A On a scale of one to ten? Well, today it’s like 9 ½ because it’s going to rain and it could go down to like five.

Q And most days where is it?

A Maybe four. I can’t do a lot of things that I used to do because if I overexert myself it just makes it worse.

(R. 22-23.)

work history before the alleged date of disability” when assessing the plaintiff’s credibility regarding his subjective complaints of pain). Therefore, the ALJ here adequately considered Plaintiff’s subjective complaints of pain in conjunction with the other evidence in the case when he made a determination that such claims were not fully credible.

In addition, after finding that an underlying condition could produce the symptoms alleged, the ALJ was required by 20 C.F.R. § 416.929 to determine the extent to which the claimant’s symptoms actually limit her capacity for work. *See* 20 C.F.R. § 416.929(c)(1). The ALJ is directed to consider all of the evidence of the record, including but not limited to, objective medical evidence, findings from medical sources, the claimant’s regular activities, the claimant’s work history, the intensity of the symptoms, factors which induce the symptoms, the effects of medication, treatment history, any other measures used to reduce symptoms, and any other factors concerning functional limitations and restrictions. *Id.* § 416.929(c)(3). The ALJ noted here that Stewart’s testimony regarding her daily activities — reading, doing crossword puzzles, checking in on her elderly mother three times a week, including shopping for her and taking her to the doctor (R. 29) — was consistent with someone who could lift and carry 20 lbs. occasionally and 10 lbs. frequently; sit for 6 hours and stand or walk for 6 hours of an 8-hour workday; and be required to climb, balance, stoop, kneel, crouch, and crawl no more than occasionally. Her ability to read and do crossword puzzles also suggested that her anxiety or depression was not interfering with her ability to concentrate and complete tasks. Her poor work history even prior to her alleged disability onset date belies the notion that she would be engaged in some sort of substantial gainful activity if she were not compromised by pain. We see no reason for the ALJ’s credibility assessment to require a remand.

**E. The adequacy of the ALJ’s explanation as to the evidence upon which he relied in making his RFC finding**

Plaintiff next contends that, in addition to the alleged errors in the ALJ’s rejection of evidence favorable to Stewart, he also erred in providing an inadequate explanation for the evidence supporting his RFC finding. (Pl. Br. at 20-21.) We disagree.

The ALJ crafted an RFC finding — for light work, with limited postural activities — that he intended to reflect the findings contained in the narrative report of the consultative examiner, Dr. Zoranski. That examination revealed that:

Her sensation was normal. Her motor power was +4/+4. Her reflexes are +3/+4. There is no atrophy noted in any place. Both upper and lower extremities appeared to be very symmetric. Straight-leg raising was to +90 degrees, both seated and supine. Her station and gait were completely normal. Her mental status was completely normal as well.

\* \* \*

The patient was able to get up and off the table without any problems. Her grip strength was normal. Her endurance appeared to be normal.

(R. 192-93.) He also noted that he reviewed an MRI of the left shoulder showing tendinopathy and mild joint osteoarthritis and a cervical spine x-ray from June 2007 “which is unremarkable and completely normal,” although a thoracic spine showed minimal degenerative changes and a lumbar spine x-ray showed minimal osteoarthritis.” (R. 193.) She had a full range of motion in all areas.

(R. 197-98.) The ALJ also intended for his RFC finding to reflect Stewart’s credible activities of daily living. (R. 15.) As he recited in his decision, those activities consisted of reading and doing puzzles and, three times a week, checking on her elderly mother, shopping for her, and taking her to the doctor. (R. 13. *See also* R. 29 (hearing testimony).) Plaintiff complains in her brief that “[t]ransient, sporadic activities can never show that an individual can perform such employment in

the competitive workplace.” (Pl. Br. at 24.) She overlooks the fact, however, that nothing in the record suggests that she cannot perform activities such as these on a regular basis. The record does not suggest that she would be unable to tolerate regular work at the light exertional level. Her reports as to her daily activities suggest a rather normal existence, with her going out a few times a day and shopping for whatever was needed, *See, e.g.*, R. 129-39 (Function Report and Supp. Function Questionnaires concerning fatigue and pain, completed in Oct. 2007). In addition, she reported that her medications helped her pain. (R. 138.)

The ALJ’s discussion in support of his RFC finding describes Stewart’s daily activities and the findings of the diagnostic studies that her doctors have ordered for her, along with their diagnoses. He explained how he concluded that “the record supports some of claimant’s complaints,” but that “there are no findings to support the extent of her disabling allegations,” particularly where the radiological findings show no herniated disc or stenosis. (R. 15.) We find no deficiency in the explanation by the ALJ for his RFC finding that would require his decision be vacated.

**F. The ALJ’s reliance on VE testimony**

Plaintiff’s final contention is that the ALJ’s reliance upon the VE testimony was improper because he did not ascertain from the VE whether his testimony was consistent with the Dictionary of Occupational Titles (the “DOT”) and because his hypothetical question to the VE did not reflect the ALJ’s earlier findings that Stewart had mild limitations with respect to engaging in daily activities, social functioning, and concentration, persistence or pace due to a mental impairment. (Pl. Br. at 25-26.)

## 1. The duty to ascertain the consistency of the VE's testimony with the DOT

Plaintiff argues that the ALJ was required by Social Security Ruling 00-4p to inquire on the record whether the VE's testimony was consistent with the DOT. She further contends that the ALJ must obtain an explanation for any inconsistency between the testimony and the DOT and then decide whether the explanation is "convincing." (Pl. Br. at 25-26.)

The ruling upon which Stewart relies provides in pertinent part that:

Occupational evidence provided by a [VE] generally should be consistent with the occupational information supplied by the DOT. When there is an apparent unresolved conflict between [VE] evidence and the DOT, the adjudicator must elicit a reasonable explanation for the conflict before relying on the [VE] evidence to support a determination or decision about whether the claimant is disabled. At the hearings level, as part of the adjudicator's duty to fully develop the record, *the adjudicator will inquire, on the record, as to whether or not there is such consistency.*

Neither the DOT nor the [VE] evidence automatically "trumps" when there is a conflict. The adjudicator must resolve the conflict by determining if the explanation given by the [VE] is reasonable and provides a basis for relying on the [VE] testimony rather than on the DOT information.

\* \* \*

### **The Responsibility To Ask About Conflicts**

When a [VE] provides evidence about the requirements of a job or occupation, the adjudicator has an affirmative responsibility to ask about any possible conflict between that [VE] evidence and information provided in the DOT. In these situations, the adjudicator will:

Ask the [VE] if the evidence he or she has provided conflicts with information provided in the DOT; and

If the [VE's] evidence appears to conflict with the DOT, the adjudicator will obtain a reasonable explanation for the apparent conflict.

SSR 00-4p, 2000 WL 1898704, \*2, \*4 (emphasis added).

A review of the hearing transcript confirms that the ALJ failed to ask the VE about the consistency of his testimony concerning representative jobs at the light exertional level that Stewart could perform with the DOT descriptions of the requirements of those positions. Plaintiff stops there, not even attempting to make any proffer that there *is* “an apparent unresolved conflict between [the VE] evidence and the DOT” that should have prompted the ALJ to inquire further before relying upon the VE’s testimony. We are unaware of any authority binding upon this Court that would require a remand based upon the ALJ’s failure to make this inquiry. Rather, the more persuasive authorities assess whether this error can be excused as harmless due to a lack of a conflict between the VE’s testimony and the DOT. For example, in *Rutherford v. Barnhart*, 399 F.3d 546 (3d Cir. 2005), the court rejected the contention that remand was required where the ALJ relied upon VE testimony without having inquired about inconsistencies or explained why he relied upon the DOT, as the court found no inconsistencies were actually present as to each of the jobs identified by VE. *Id.* at 557-58. *See also Simpson v. Astrue*, Civ. A. No. 10-2874, 2011 WL 1883124, \*8 (E.D. Pa. May 17, 2011) (Baylson, J.) (finding no reversible error where plaintiff pointed to no evidence in record that she could not perform jobs suggested by VE, which were only representative examples, and that any perceived inconsistency between VE testimony and DOT was “simply not egregious enough . . . to bring into question the ALJ’s reliance on the expert testimony as a whole”); *Diehl v. Barnhart*, 357 F. Supp.2d 804 (E.D. Pa. 2005) (Robreno, J.) (finding no reversible error despite ALJ’s failure to inquire of VE about possible conflict where record showed VE was questioned extensively and demonstrated knowledge of DOT); *Terry v. Astrue*, 580 F.3d 471, 478 (7th Cir. 2009) (recognizing ALJ’s failure to inquire of VE about conflict with DOT but finding error harmless where no actual conflict and where ALJ’s obligation to reconcile the opinions was triggered

only where the conflict between DOT and VE testimony was “apparent” and “obvious enough that the ALJ should have picked up on it without any assistance”); *Renfrow v. Astrue*, 496 F.3d 918, 921 (8th Cir. 2007) (finding failure to inquire about any conflict between VE’s testimony and DOT was harmless error because there was no conflict).

The ALJ’s failure to have inquired of the VE as to any conflict between his testimony and the DOT will not give rise to a remand absent some demonstration by Plaintiff that there was a conflict between those two sources that the ALJ would have to address before he could rely upon the VE’s testimony. Stewart has not done so here. We thus find that she has failed to demonstrate that she is entitled to any relief from the Commissioner’s final decision in this regard.

**2. The lack of any restrictions in the hypothetical reflecting mental limitations**

Finally, Plaintiff contends that the ALJ’s hypothetical to the VE was deficient — and therefore the VE’s response to it should not have formed the basis for the ALJ’s decision finding Stewart “not disabled” at Step Five — because it (and the RFC finding upon which it was based) did not include three “mild” limitations that the ALJ earlier found. She contends that, notwithstanding the fact that the ALJ did not find her to have a “severe” mental impairment at Step Two, the ALJ was required to consider all impairments — severe and non-severe — in the subsequent steps of the sequential evaluation. (Pl. Br. at 26, citing 20 C.F.R. § 416.923<sup>25</sup> and *Bailey v. Sullivan*, 885 F.2d

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<sup>25</sup> This regulation provides:

In determining whether your physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under the law, we will consider the combined effect of all of your impairments without regard to whether any such impairment, if considered separately, would be of sufficient severity. If we do find a medically severe combination of impairments, the combined impact of the impairments will be

52, 59-61 (3d Cir. 1989).)

The findings upon which Plaintiff relies were offered by the ALJ in the context of his explanation for his Step Two finding regarding the impairments alleged by Plaintiff that could be considered “severe” to comply with the requirements of 20 C.F.R. § 416.920a.<sup>26</sup> The ALJ recognized that Stewart alleged an anxiety disorder and depression as elements of her disability and that Dr. Krafchick cited mental impairments on forms used by Stewart to attempt to obtain various benefits. The ALJ also noted, however, that Dr. Krafchick “has not felt her condition to be severe enough to warrant a referral to a mental health professional,” and that “his notes rarely mention depression or anxiety, and they do not discuss his observations about severity.” (R. 11.) He also noted that Stewart “engages in a broad range of activities of daily living (including some care for her mother); there is no evidence of impaired social functioning; she is able to concentrate and attend

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considered throughout the disability determination process. If we do not find that you have a medically severe combination of impairments, we will determine that you are not disabled (see §§ 416.920 and 416.924).

20 C.F.R. § 416.923 (2012).

<sup>26</sup> This regulation provides a specific procedure for the evaluation of mental impairments when assessing whether the claimant has a medically determinable mental impairment, whether the impairment is severe, and whether the claimant satisfies the Listings. *See* 20 C.F.R. §§ 416.920a(b)(1), (d), (d)(1)-(2). The procedure, known as the psychiatric review technique (“PRT”), involves a rating of the degree of functional limitation in four broad areas: activities of daily living; social functioning; concentration, persistence, or pace; and episodes of decompensation. *See* 20 C.F.R. § 416.920a(c)(3). The rating scale for the first three functional categories is a five-point scale: “none,” “mild,” “moderate,” “marked,” and “extreme.” The rating scale for the fourth category is “none,” “one or two,” “three,” or “four or more.” The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. A rating of “none” or “mild” in the first three functional areas and “none” in the fourth area will generally result in a finding that the impairment is not severe for purposes of the Step Two determination, “unless the evidence otherwise indicates that there is more than a minimal limitation in [the claimant’s] ability to do basic work activities[.]” 20 C.F.R. § 416.920a(c)(4), (d)(1).

to asks long enough to read, do word puzzles, and drive a car [sic],” and that Stewart had never been hospitalized for any mental illness. (R. 11.) Relying upon the identical findings of Elizabeth Hoffman, Ph.D., the state agency reviewing psychologist, at Exhibit 11F of the record (R. 206-18), he found that Stewart “has no more than mild impairments in Activities of Daily Living, Social Functioning, or Concentration, Persistence or Pace[.]” (R. 11).<sup>27</sup>

It is well established in this circuit that a “hypothetical question posed to a vocational expert must reflect *all* of a claimant’s impairments” that are supported by the record and that “‘great specificity’ is required when an ALJ incorporates a claimant’s mental or physical limitations into a hypothetical.” *Ramirez v. Barnhart*, 372 F.3d 546, 554-55 (3d Cir. 2004) (quoting *Chrupcala v. Heckler*, 829 F.2d 1269, 1276 (3d Cir. 1987), and *Burns v. Barnhart*, 312 F.3d 113, 122 (3d Cir. 2002)). Our Court of Appeals addressed this issue most comprehensively in *Ramirez v. Barnhart*, 372 F.3d 546 (3d Cir. 2004). In that case, the ALJ had attached to her decision, pursuant to the version of 20 C.F.R. § 416.920a then in effect, a Psychiatric Review Technique Form in which she checked off that the claimant “often” experienced “deficiencies of concentration, persistence, or pace resulting in a failure to complete tasks in a timely manner (in work settings or elsewhere).” *Ramirez*, 372 F.3d at 549.<sup>28</sup> When the ALJ posed her hypothetical question to the VE at the hearing, however,

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<sup>27</sup> Completing his PRT analysis, the ALJ also stated his finding that Stewart had demonstrated no episodes of decompensation. (R.11.)

<sup>28</sup> The applicable regulation no longer requires an ALJ to complete this separate form but rather to incorporate his or her findings in this regard into the written decision. In addition, the nomenclature has been modified from a scale of “never,” “seldom,” “often,” “frequent” and “constant” to “none,” “mild,” “moderate,” “marked” and “severe.” The designation that the claimant “often” experiences deficiencies is considered to correspond to the current designation that she has “moderate” limitations in a particular regard. *See, e.g., Colon v. Barnhart*, 424 F. Supp.2d 805, 811 (E.D. Pa. 2006) (describing change in terminology of 5-point rating system and comparison of ratings).

the non-exertional and non-environmental restrictions that she included were that the job had to “provide for occasional breaks, for the individual use of an inhaler or pump. The work should involve simple one to two step tasks. The work should not require the individual during the course of performing the work to travel outside of the workplace. And . . . the work setting should provide reasonable opportunity for the individual to make and receive personal phone calls.” *Id.*<sup>29</sup> The Third Circuit was “not satisfied that these limitations take into account the ALJ’s own observation (both in her opinion and in the PRT [form]) that Ramirez *often* suffered from deficiencies in concentration, persistence, or pace,” concluding that the limitations to simple tasks, the restriction on travel, and the phone privileges “[did] not adequately convey all of Ramirez’s limitations,” particularly deficiencies in pace. *Id.* at 554. The court recognized that there could have been “a valid explanation for this omission from the ALJ’s hypothetical. For example, the ALJ may have concluded that the deficiency in pace was so minimal or negligible that, even though Ramirez ‘often’ suffered from this deficiency, it would not limit her ability to perform simple tasks under a production quota.” *Id.* at 555. Because the record “would seem to suggest otherwise,” however, the court was not willing to make that assumption at the expense of the claimant. *Id.*

In light of *Ramirez*, which Plaintiff invokes in her brief (Pl. Br. at 26), the question presented by this aspect of Stewart’s appeal is whether, for purposes of the hypothetical, the ALJ was required to convey to the VE those criteria from the PRT form in which he found Stewart to have “no more than mild impairments.” (R. 11.) We are aware of the many cases in this district in which Plaintiffs

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<sup>29</sup> The record reflected that the claimant in *Ramirez* suffered from an anxiety-related disorder that was in large part attributable to her need to feel that she was reasonably protective of her children. A medical expert at her hearing testified that her ability to maintain a full-time job depended primarily on “the proximity to where her children would be.” *Ramirez*, 372 F.3d at 555.

have been granted a remand where the hypothetical to the VE failed to address, either at all or with the requisite specificity, limitations in one of the functional areas (e.g., as to either concentration, persistence or pace; social functioning; or activities of daily living) where the ALJ had, as part of the PRT assessment, specifically found that the claimant either “often” had deficiencies or had “moderate” limitations or restrictions. *See, e.g., Keiderling v. Astrue*, No. 07-2237, 2008 WL 2120154, \*7 (E.D. Pa. May 20, 2008) (Buckwalter, J.) (cataloguing cases). Plaintiff has not, however, identified precedents for remand where the ALJ’s PRT findings only reflected “mild” deficiencies, nor are we aware of any such cases decided by our Court of Appeals.<sup>30</sup>

We are prepared to accept that the ALJ’s failure to include in his RFC assessment or hypothetical question to the VE a specific reference to “mild limitations” in the three functional areas reflected his determination that those limitations or deficiencies were each “so minimal or negligible” that they would not significantly limit her ability to perform the work and did not warrant further questioning of the VE. *See Ramirez*, 372 F.3d at 555. Moreover, to the extent that the Third Circuit in *Ramirez* looked to the record for confirmation of the ALJ’s perceived conclusion about the minimal effects of the claimant’s mental impairments, we believe that the record here does not

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<sup>30</sup> We are also cognizant of the fact that the Third Circuit in *Ramirez* left open the possibility that there could be “a valid explanation” for the omission from a hypothetical of what was in that case a PRT finding of greater limitation than in this case:

For example, the ALJ may have concluded that the deficiency in pace was so minimal or negligible that, even though *Ramirez* “often” suffered from this deficiency, it would not limit her ability to perform simple tasks under a production quota. The record, however, would seem to suggest otherwise.

*Ramirez*, 372 F.3d at 555.

suggest that the ALJ ignored evidence of significant vocational limitations concerning Stewart's abilities with regard to any of these areas. *Cf. Ramirez*, 372 F.3d at 555 (concluding that the record "would seem to suggest otherwise," e.g., that the deficiency that Ramirez "often" suffered from *would* impact her ability to meet production quota). The ALJ provided a lengthy paragraph of support for the proposition that neither Plaintiff's reported activities of daily living nor the treatment notes of Dr. Krafchick nor his treatment plan of Plaintiff support the proposition that she has any limitations due to anxiety or depression.

While the claimant is entitled to have included in the RFC assessment and hypotheticals all of the limitations that are caused by her medically-determinable impairments, there must be support for those limitations in the record. We do not believe that the ALJ here erred where his RFC assessment and hypothetical to the VE did not include work restrictions based upon what were only "mild" limitations in three aspects of functioning.

### **RECOMMENDATION**

AND NOW, this 31st day of May, 2012, upon consideration of the brief in support of review filed by Plaintiff, Defendant's response thereto, and Plaintiff's reply (Doc. Nos. 11-13), as well as the administrative record, for the reasons set forth above, it is respectfully **RECOMMENDED** that the decision of the Commissioner be **AFFIRMED**.

BY THE COURT:

/s/ David R. Strawbridge  
DAVID R. STRAWBRIDGE  
UNITED STATES MAGISTRATE JUDGE

