

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

YVONNE JACKSON,	:	CIVIL ACTION
	:	
Plaintiff,	:	NO. 05-6232
	:	
v.	:	
	:	
JO ANNE BARNHART,	:	
Commissioner of Social Security,	:	
	:	
Defendant.	:	

MEMORANDUM

Giles, J.

March 12, 2007

Yvonne Jackson (“Plaintiff”) seeks judicial review, pursuant to 42 U.S.C. §§ 405(g) and 1383(c), of the final decision of the Commissioner of the Social Security Administration (“Commissioner”) denying her claim for Supplemental Security Income (“SSI”) under Title XVI of the Social Security Act (“Act”). Plaintiff has filed a Motion for Summary Judgment, arguing that Defendant’s decision is not supported by substantial evidence and is contrary to law. Plaintiff seeks an order that vacates the final decision of the Commissioner and remands the case for *de novo* adjudication. For the reasons set forth below, Plaintiff’s Motion for Summary Judgment is GRANTED, and the matter is REMANDED to the Commissioner for further proceedings consistent with this Memorandum and Order.

I. PROCEDURAL HISTORY

Plaintiff filed an application for SSI benefits on March 22, 2004 (protectively filed February 9, 2004).¹ (R. 14.) She alleged disability as of June 1, 2003 due to hypertension, asthma, diabetes and arthritis. (R. 14.) Plaintiff's claim was initially denied on July 6, 2004. (R. 27.) Plaintiff submitted a timely request for a hearing before an Administrative Law Judge ("ALJ") on July 26, 2004. (R. 31.) Plaintiff, represented by F. Randall Selagy, Esquire, appeared and testified at an administrative hearing before ALJ Volkman on January 31, 2005. In addition, Plaintiff's son, Howard C. Jackson, and Vocational Expert ("VE") Bruce Martin testified. (R. 204-243.)

On August 25, 2005, the ALJ issued her decision concluding that Plaintiff retained the residual functional capacity to perform light work in a clean environment and was, therefore, not disabled within the meaning of the Act. (R. 11-22.) Plaintiff submitted a request for a review of the hearing decision on September 28, 2005. (R. 10.) The Appeals Council declined Plaintiff's request on November 10, 2005, rendering the ALJ's decision the final decision of the Commissioner. (R. 6-7.)

II. FACTUAL HISTORY

A. Plaintiff's Testimony

Plaintiff was born on December 31, 1960 and completed the eleventh grade. (R. 209.) She last worked in 2002. (R. 11.) Her previous work experience included housekeeping and food services work. (R. 210.) She currently lives with her two sons, ages sixteen and nineteen, as well as a sixteen year old child of whom she is the legal guardian. (R. 227.) Her home is two stories, and

¹ Citations to the administrative record will be indicated by "R." followed by the page number.

her bedroom is on the second floor. (R. 212.) Plaintiff spends most of her time in her bedroom and bathroom, and does not go up and down the stairs because it is difficult. (R. 212, 214.) Plaintiff does not walk around often because it causes pain and she feels unstable. (R. 213.) She experiences discomfort when sitting in a chair, and spends most of the day in a recliner armchair. (R. 214-15.) Plaintiff cannot stand in one place for a period of time, and when standing, she is unable to bend forward at the waist due to pain in her back and sides. (R. 214.) She is in “a lot of pain” in her lower back, hips and knees. (R. 212-13.) In addition, she suffers from headaches once or twice a week. (R. 213.)

She has difficulty moving her arms up and down due to stiffness and has pain in her joints, especially her hands. (R. 215.) She has arthritis in her hands, complains of swelling in the morning, and has difficulty holding a pen to write. (R. 216.)

Plaintiff treats asthma with an inhaler (also known as a “puffer”) and a nebulizer. (R. 217.) She uses the nebulizer four times a day at the following times: 7:00 a.m., 2:00 p.m., 9:00 p.m. and 1:00 a.m. (R. 217.) She uses it more frequently if she is having a particularly difficult time breathing, due to, for example, a cold. (R. 218.) The nebulizer helps Plaintiff control her asthma, but she went to the hospital emergency room due to an asthma attack on January 4, 2005 shortly before the administrative hearing. (R. 218.)

Plaintiff is currently on medication for diabetes, which she testified is not under control. (R. 219.) She complained of dry mouth. (R. 219.) When her blood sugar is high, she has blurry vision, sees spots, and suffers confusion and forgetfulness. (R. 219-20.) Plaintiff obtained new glasses shortly before her administrative hearing, but reported that her vision was still blurry. (R. 220.)

Plaintiff also suffers from a rapid heartbeat. (R. 221.) She has dizzy spells at least twice a

week. (R. 221.) She complained of difficulty sleeping. (R. 221.) Her doctor has prescribed sleeping pills, but she testified that they only worked for the first couple of nights. (R. 222.)

Plaintiff described the following side effects from her current medications: daytime drowsiness, shaky hands, frequent use of the bathroom and hair loss. (R. 222.)

In addition, Plaintiff feels depressed. (R. 222.) She sought mental health treatment at Horizon House once in 2004. (R. 223-24.)

Plaintiff does not cook and her children take care of the housework. Plaintiff's niece assists her with getting dressed and washing her hair. (R. 224.) Plaintiff usually wears a nightgown all day. (R. 224.)

When asked what she does during the day, Plaintiff responded that she will "sit and worry." (R. 215.) She is unable to read because of difficulty focusing. (R. 215.) She listens to gospel music. (R. 215.) She does not participate in activities outside of the home, with the exception of occasional doctor visits. (R. 225.) Her brother takes her to these doctor visits. (R. 225.) Plaintiff does not visit friends or family, go out to dinner, go to the movies or participate in other social activities and she no longer attends religious services. (R. 225.)

Plaintiff's physician is Dr. Azad Kahn, M.D. at A.K. Medical Associates. (R. 229.) She has seen him once or twice a month since 2002. (R. 229.) Plaintiff stated that she cannot exercise as recommended by Dr. Kahn because she is in too much pain. (R. 229.)

B. Testimony of Plaintiff's Son

The ALJ also heard testimony from Plaintiff's son, Howard Jackson, who is nineteen years old. (R. 31.) Mr. Jackson's responsibilities at home include mopping the floor, cooking dinner and

going to the store. (R. 231-32.) Plaintiff does not assist him with those activities and stays upstairs in her bedroom. (R. 232.) He takes food to his mother and sometimes feeds her. (R. 232.) Mr. Jackson has to remind his mother of her breathing treatments, to take her medications and to attend her doctor's appointments. (R. 233.) He sets up his mother's nebulizer machine, which she uses four times a day. (R. 233.) He and his brother take turns helping their mother get washed and dressed. (R. 233.)

Plaintiff's niece also provides assistance with dressing and bathing. (R. 233-34.)

Mr. Jackson described Plaintiff's typical daily activities as watching television, reading the newspaper and staying in bed. (R. 235.) She is awake "on and off." (R. 235.) She only comes down the stairs once a week, and does so slowly, relying on assistance. (R. 235.)

While Mr. Jackson stated that it has been a long time since he has seen Plaintiff write anything out or sign checks, he said that she writes checks to pay the bills. (R. 235-36.) Plaintiff tells Mr. Jackson what is needed from the grocery store and he is responsible for writing it down and doing the shopping. (R. 236.) Plaintiff will go out to doctor appointments, as well as to get clothing and other things for herself. (R. 235.)

C. Medical Assessments

1. Plaintiff's Treating Physician

The medical records submitted indicate that Dr. Azad Khan, Plaintiff's treating physician, treated Plaintiff five times between August 7, 2003 and April 23, 2004. (R. 96-100.) At each appointment, the doctor notes that Plaintiff came into the office for follow-up and that she had run out of medication. For four of the five appointments, Plaintiff specifically denied having any

complaints, and on August 7, 2003, no complaints are listed. (R. 100.) At each visit, Plaintiff was “not in acute distress,” her lungs were clear to auscultation and her heart had regular rate and rhythm. (R. 96-100.) On each occasion, Plaintiff’s knees were mildly tender to palpation, and she experienced mild tenderness over the lumbosacral area of her back. (R. 96-100.) During these examinations, Dr. Khan diagnosed diabetes mellitus, hypertension, hypertensive heart disease, arthritis of the knees, arthritis of the back and hypercholesterolemia. (R. 96-100.) At each appointment, Dr. Khan noted that Plaintiff should continue to take the same medication, that he had told her the importance of diet and exercise and that he advised her on the side effects of all medications. (R. 96-100.) Plaintiff’s weight at these visits ranged from 225 to 238 pounds. (R. 96-100.)

A laboratory test report dated April 27, 2004 indicates that Plaintiff’s glucose was 423 mg/dl, which is outside of the reference range of 65-99mg/dl listed. (R. 103-106.) Plaintiff’s sodium and carbon dioxide levels were low and her alkaline phosphatase level was high. (R. 103-106.) Finally, a urinalysis test showed that Plaintiff’s glucose level was out of range at 3+. (R. 106.) The record contains no treatment notes from Dr. Kahn or another physician following this laboratory work.

2. Medical Evidence Regarding Plaintiff’s Vision

On October 28, 2002, prior to the alleged onset of her disability, Plaintiff visited the Wills Eye Ophthalmology Clinic. (R. 124.) She complained of having difficulty reading for a month and indicated that she had been diagnosed with diabetes one year prior. (R. 124.) The record notes that Plaintiff suffers from mild nonproliferative diabetic retinopathy (NPDR), for which the doctor recommended diet, exercise and medication for tight glucose control. (R. 125.) Plaintiff received

a new prescription for reading glasses. (R. 125.)

Plaintiff also received a new eyeglass prescription from the Philadelphia Vision Center on August 1, 2003 and January 18, 2005. (R. 123.)

3. Mercy Hospital Emergency Room Records

On September 8, 2004, Plaintiff went to the emergency department of Mercy Hospital. (R. 137-152.) Plaintiff's chief complaint was lower back pain with an onset of two days prior. She described her back pain as shooting and similar to prior back pain. (R. 142.) Plaintiff reported that she suffers from chronic back pain, which she manages at home with Motrin 800 mg. (R. 138.) Plaintiff presented with limited range of motion in her back related to pain and thoracic tenderness. (R. 143.) Plaintiff's airway/respirations were patent and unlabored, her respiration spontaneous, and her breath sounds present and clear. (R. 137, 139.) Plaintiff had a CT scan of her head, which revealed cavum septum pellucidum² with cavum vergae,³ representing "an anatomic variation." (R. 147.) Her brain was "otherwise within normal limits." (R. 147.) Plaintiff received a prescription for Percocet and left against medical advice. (R. 138, 144.)

Plaintiff was seen again at Mercy Hospital on April 20, 2004, complaining of right shoulder

²Otherwise known as the "cavity of septum pellucidum." Stedman's Online Medical Dictionary (27th ed. 2004), <http://www.stedmans.com>. A "thin plate of brain tissue, containing nerve cells and numerous nerve fibers, that is stretched like a flat, vertical sheet between the column and body of fornix below, and the corpus callosum above and anteriorly; ... in less than 10% of humans there is a blind, slitlike, fluid-filled space between the two transparent septa, the cavity of septum pellucidum." Id.

³Otherwise known as the "verga ventricle." Id. An "inconsistent, horizontal, slitlike space between the posterior one-third of the corpus callosum and the underlying commissura fornicis ... resulting from failure of these two commissural plates to fuse completely during fetal development." Id.

pain and back pain with an onset of two days prior. (R. 153.) She was discharged with prescriptions for Percocet, Valium and Motrin. (R. 162.) The discharge instructions for after-care include “No heavy lifting.” (R. 168.)

Plaintiff was also seen in the emergency department of Mercy Hospital on January 4, 2005. (R. 128.) The records from this visit consist only of boilerplate discharge instructions concerning asthma and prescriptions for prednisone and an albuterol oral inhaler. (R. 128-131.)

4. Consultative Examination

William C. Hunter, M.D. examined Plaintiff on May 31, 2004, at the request of the Pennsylvania Bureau of Disability Determination. (R. 107-110.) Plaintiff told Dr. Hunter that she used a nebulizer to treat her asthma and prevent emergency room visits. She reported pain in her left shoulder, as well as thoracic and lumbar spinal pain. Plaintiff’s medications at the time of the consultative examination included blood pressure pills, Combivent MDI, Albuterol MDI, Ibuprofen 800 mg t.i.d., Glucophage, Actos and Lipitor. (R. 108.)

Dr. Hunter based his functional assessment on Plaintiff’s self-report. (R. 108.) Her children assist with household chores including shopping, cooking and cleaning. (R. 108.) Plaintiff is able to independently attend to her own activities of daily living including feeding and grooming. (R. 108.) She has a two-block and a one-flight exercise tolerance, can sit comfortably for up to an hour and can stand comfortably for up to 20 to 30 minutes. (R. 108.)

At the time of the examination, Plaintiff weighed 244 pounds. (R. 109.) Her lungs were clear to auscultation bilaterally. (R. 109.) Dr. Hunter recommended adding an inhaled steroid to Plaintiff’s asthma regimen, as well as tighter hypertension management. (R. 109.) For her diabetes,

he recommended several laboratory tests and a podiatry follow-up. (R. 109.) With respect to the thoracic and lumbar spinal pain, Dr. Hunter suggested analgesia and physical therapy. (R. 109.) He noted that weight loss and hydrotherapy would decrease discomfort and improve Plaintiff's diabetes and hypertension. (R. 109.)

Lumbar x-rays performed on June 1, 2004 showed minimal levoscoliosis and probable narrowing of the L5/S1 disc space. (R. 111.)

5. Other Medical Evidence

An Opensided MRI L Spine examination on September 20, 2004 revealed L4-L5 bilateral facet osteoarthritis and ligament flavum infolding causing minimal anterolisthesis of L4-L5, mild bilateral neural foramina and lateral recess narrowing. (R. 126.) The MRI report described L5-S1 as "Normal" and noted left hip osteoarthritis. (R. 127.)

6. Evidence Submitted to the Appeals Council

The record includes evidence submitted to the Appeals Council after the ALJ issued her decision. (R. 201-203.) Such evidence cannot be used to determine whether substantial evidence supports the ALJ's decision. Matthews v. Apfel, 239 F.3d 589 (3d Cir. 2001). If this court, however, determines that the evidence submitted to the Appeals Council is new and material and that there was good cause for not having submitted it to the ALJ, it may serve as the basis for a remand of this matter, pursuant to the sixth sentence of 42 U.S.C. § 405(g). Id. at 593.

Plaintiff was treated for menorrhagia on July 27, 2005, at Methodist Hospital, and was prescribed Motrin and Percocet. (R. 203.) A CT scan of Plaintiff's chest on August 12, 2005 revealed "stable solitary 3 x 4 mm pleural based nodule." (R. 201.) The radiology report further

notes the presence of “degenerative changes involving the spine.” (R. 201.) Finally, Plaintiff was treated at the Penn Center for Primary Care on September 19, 2005, the records from which list her current medications as including “Albuterol Sulfate 0.083 % in Nebu.” (R. 202.) Her diagnoses included “depressive disorder NEC.” (R. 202.)

D. Vocational Testimony

Bruce Martin, vocational expert (VE), also testified at the administrative hearing. He characterized Plaintiff’s past work as follows: housekeeper/cleaner as light and unskilled; hospital food service worker as medium and unskilled; food assembler for a contract service as light and low semiskilled. (R. 237-38.) The VE testified that Plaintiff does not have any transferable skills from her past work. (R. 238.)

The ALJ posed several hypothetical scenarios to the VE. In the first hypothetical, she described an individual who is 44 years old, has an eleventh grade education and Plaintiff’s past work experience. (R. 238.) She specified that the individual could do light work, “provided it was done with asthma precautions, that is no dust, fumes, heat or chemical.” (R. 238.) The VE gave his opinion that in that scenario, an individual with those limitations would not be able to return to her past work, because each of the work areas would give exposure to dust, fumes, or chemicals. (R. 238.)

The ALJ posed a second hypothetical to the VE, describing the same individual of 44 years of age, an eleventh grade education, Plaintiff’s past work experience and a residual functional capacity (RFC) for sedentary work with “the standard asthma precautions.” (R. 238.) The VE responded that there would be jobs that such an individual could do, in the job categories of

assembler, inspector and packager. (R. 239.)

The ALJ included the following restrictions in her final hypothetical scenario: the limitations posed in the first hypothetical, an assumption that she found Plaintiff's testimony to be credible and a restriction that the individual would be unable to leave the house in any regular and consistent manner. The VE testified that an individual with those limitations would not be able to work. (R. 239.)

In response to questioning by Plaintiff's attorney, the VE admitted that assembler, inspector and packaging jobs require manual dexterity. (R. 239.) The VE explained that an assembler position would require frequent use of the hands, packing line work would require occasional manual dexterity,⁴ and an inspection worker would require less than occasional bimanual capacity/bimanual work. (R. 240.)

The VE used the following asthma restrictions in responding to the ALJ's hypothetical scenarios: avoidance of concentrated extremes of heat or cold, extremes of particles in the air, fumes such as hydrocarbons and other irritants such as airborne gases including ammonia or heavy detergents. (R. 240.) **An "asthma restriction" would prohibit concentrated exposure to such irritants.** (R. 240.) While the VE admitted that dust and pollens are also considered irritants, and that they are "certainly in any work environment", he testified that concentrated exposure to dust and pollen is required to be vocationally relevant. (R. 241.)

The VE testified that the most generous allocation of personal absence and sickness days allotted by an employer is typically ten to twelve days a year. (R. 241.) Most employers do not offer an employee any sick leave until after six months of absence-free work. Typically, an employer will

⁴Defined by the VE as "up to one-third of the time." (R. 240.)

offer an employee a meal break and a scheduled fifteen minute break in the later part of the shift. The VE testified that a typical employer at this level would not allow an employee two breaks per day, of approximately twenty minutes each, to set up a nebulizer machine, use it, and then break it down and put it away. (R. 242.)

III. DISCUSSION

A. Standard of Review

The role of this court upon judicial review is to determine whether substantial evidence in the administrative record supports the Commissioner's final decision. See Stunkard v. Sec'y of Health & Human Serv., 841 F.2d 57, 59 (3d Cir. 1988). The United States Supreme Court has defined substantial evidence as "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Richardson v. Perales, 402 U.S. 389, 401 (1971) (citations omitted). It is more than a mere scintilla of evidence but may be less than a preponderance. See Stunkard, 841 F.2d at 59. This court's review is not *de novo*, and the evidence of record will not be weighed a second time. See Monsour Med. Ctr. v. Heckler, 806 F.2d 1185, 1190-91 (3d Cir. 1986).

B. Burden of Proof in Disability Proceedings

In order to be found "disabled" under the Act, a plaintiff must carry the initial burden of demonstrating that she is unable to engage in "any substantial gainful activity by reason of any medically determinable physical or mental impairment . . . which has lasted or can be expected to last for a continuous period of not less than twelve months." 20 C.F.R. § 416.905(a).

The Social Security Administration (SSA) has promulgated regulations establishing a five-step sequential evaluation for determining whether a claimant is disabled. Plummer v. Apfel, 186

F.3d 422, 428 (3d Cir. 1999). At step one, the Commissioner must determine whether a claimant is engaged in “substantial gainful activity.” 20 C.F.R. § 416.920(b); Plummer, 186 F.3d at 428. If a claimant is, then she is not disabled. Id. At step two, the Commissioner must determine whether claimant suffers from a “severe” impairment or combination of impairments. 20 C.F.R. § 416.920(c). If not, the claimant is determined not to be disabled. Id. At step three, the Commissioner must determine whether claimant’s severe medical impairment(s) meet or equal the severity of any impairment listed in 20 C.F.R. Part 404, Subpart P, Appendix 1. 20 C.F.R. § 416.920(d). If so, the claimant is disabled. Id. If the claimant’s impairment(s) do not meet a listed condition, the Commissioner proceeds to step four to determine whether a claimant retains the residual functional capacity (RFC) to perform her past relevant work. 20 C.F.R. §416.920(e)-(f). If the claimant retains such capacity, she is not disabled. If not, the Commissioner proceeds to step five. At this final step, the burden of production shifts to the Commissioner to demonstrate that there are jobs existing in significant numbers in the national economy that the claimant can perform, “consistent with her medical impairments, age, education, past work experience and residual functional capacity.” Plummer, 186 F.3d at 428; 20 C.F.R. §416.920(e), (g).

C. The ALJ’s Decision

In this case, the ALJ’s analysis reached the fifth step, at which she concluded that while Plaintiff could not return to her past relevant work, there are jobs existing in significant numbers in the national economy that Plaintiff can perform.

Plaintiff seeks remand of the matter for a *de novo* hearing pursuant to 42 U.S.C. § 405(g), fourth sentence, on the grounds that the ALJ erred by 1) failing to properly assess the testimony of

Plaintiff's son; 2) failing to provide an adequate explanation for finding Plaintiff's testimony not credible; 3) failing to properly assess all of Plaintiff's impairments or the combined effect of Plaintiff's impairments. Plaintiff argues in the alternative for remand of the matter pursuant to 42 U.S.C. § 405(g), sixth sentence. This decision does not reach Plaintiff's alternative argument for remand of the matter.

1. *The ALJ failed to properly assess the testimony of Plaintiff's son.*

An ALJ must consider and weigh all non-medical evidence presented. Burnett v. Comm'r of Social Security, 220 F.3d 112, 122 (3d Cir. 2000) (citing Cotter v. Harris 642 F.2d 700, 707). An ALJ is required to explain why probative evidence has been rejected. Cotter, 642 F.2d at 706-7 (“[T]here is a particularly acute need for some explanation by the ALJ when s/he has rejected relevant evidence or when there is conflicting probative evidence in the record”). While pain and other subjective symptoms must be consistent with objective medical evidence, an ALJ has an obligation to explain why she is rejecting non-medical testimony presented. Burnett, 220 F.3d at 122 (citing Hartranf v. Apfel, 181 F.3d 358, 362 (3d Cir. 1999); Van Horn v. Schweiker, 717 F.2d 817, 873 (3d Cir. 1983)).

Here, the ALJ made no finding as to the credibility of Mr. Jackson. The ALJ's opinion only recounts a portion of his testimony, some of which supports his mother's testimony regarding her functional limitations and her claim for disability benefits. (R. 18.) The ALJ did not meet her obligation to explain how, if at all, she considered or rejected Mr. Jackson's testimony. By failing to make a finding on Mr. Jackson's credibility, this court cannot determine whether the portions of Mr. Jackson's testimony not mentioned in the ALJ's decision were disregarded for an appropriate

reason, an inappropriate reason or simply ignored. See Califano, 642 F.2d at 707. Therefore this court must remand the matter for factual findings on Mr. Jackson's credibility.

2. *Substantial evidence does not support the ALJ's assessment of Plaintiff's credibility.*

To be credible, subjective complaints of pain must bear some relationship to the Plaintiff's physical status, as demonstrated by objective medical findings, diagnoses, and opinions. See Baerga v. Richardson, 500 F.2d 309 (3d Cir. 1974); see also 20 C.F.R. §§ 416.1529, 416.926, 416.929. An ALJ may discredit complaints of pain where (1) there is contrary medical evidence in the record, and (2) the ALJ explains the basis for rejecting the complaints. See Mason v. Shalala, 994 F.2d 1058, 1067 (3d Cir. 1993). If medical signs or laboratory findings show that Plaintiff has a medically determinable impairment that could produce pain, the ALJ must consider all available evidence, including Plaintiff's statements, to determine whether and how the symptoms limit her capacity to work. See 20 C.F.R. § 416.929(c)(1).

Relevant factors in evaluating subjective complaints of pain include: Plaintiff's daily activities; the location, duration, frequency, and intensity of Plaintiff's pain or other symptoms; precipitating and aggravating factors; the type, dosage, effectiveness and side effects of any medications the Plaintiff receives or has received for relief of pain or other symptoms; treatment, other than medication, the Plaintiff receives or has received for relief of pain or other symptoms; and other factors concerning functional limitations and restrictions due to pain or symptoms. 20 C.F.R. § 416.929(c)(3); SSR 96-7p, 1996 WL 374186 (S.S.A. July 2, 1996).

Plaintiff argues that the ALJ did not provide adequate explanation for finding Plaintiff's testimony not credible. The ALJ found that "[t]he [Plaintiff's] allegations and subjective complaints regarding her limitations are not fully credible for the reasons set forth in the body of the decision."

(R. 21.) In the body of her decision, the ALJ explained that

Pursuant to Social Security Ruling 96-7p, I find that the severity of the claimant's subjective complaints are not credible. The claimant certified to the Department of Public Assistance that she is physically able to care for a child. Pursuant to 20 CFR § 416.904, I am not bound by a determination in another forum; I do, however, evaluate it in terms of the claimant's credibility. The records failed to show disabled back pain (e.g. emergency room records show pain of 2 days duration). The MRI of the lumbar spine revealed minimal anterolisthesis of L4-5 secondary to facet, mild bilateral recess narrowing and mild bilateral neural foramen narrowing. The claimant had not had frequent emergency room visits or physician intervention due to her asthma. Although claimant has had elevated blood sugars, there is no mention that her diabetes mellitus is uncontrollable. She does not have a history of diabetic ketoacidosis. Her ophthalmologic examination was not indicative of diabetic neuropathy. At the consultative examination, there was no indication of diabetic neuropathy.

(R. 18.) This is the extent of the ALJ's stated reasons for her credibility determination. While the ALJ engages in other analysis and discussion of Plaintiff's testimony in some detail, it is not clear to the court that she does so for the purpose of assessing Plaintiff's credibility.

At the administrative hearing, Plaintiff testified that she is the legal guardian for a sixteen year old child. (R. 227.) The ALJ asked whether Plaintiff had "to certify that [she] could care for him, which Plaintiff answered affirmatively. (R. 227.) The time period for such "certification" is unclear, as Plaintiff testified only that the child is the son of "a girlfriend that deceased two years ago." (R. 227.)The court finds that such testimony does not support the ALJ's credibility assessment. The timing of this "certification" is unknown. If the "certification" was in fact made two years before the administrative hearing, that would be in January 2003, prior to Plaintiff's alleged onset date of June 2003. Further, there is minimal evidence as to what Plaintiff "certified." Defendant argues that "If Plaintiff's testimony that she spends days upstairs in a recliner in a nightgown were true, it is

unlikely that her guardianship would have been approved." (Def.'s Br. 10.) In addition to ignoring the problem of timing, such an argument is sheer speculation. The ALJ's reliance on this evidence in assessing Plaintiff's credibility is misplaced.

An ALJ is required to consider Plaintiff's daily activities in evaluating subjective complaints of pain. While the ALJ did find that Dr. Hunter's functional assessment, based upon Plaintiff's self-report, is inconsistent with the medical evidence, the ALJ failed to explicitly weigh the testimony of Plaintiff's son regarding her daily activities, as discussed above. Despite Plaintiff's testimony that she suffers multiple side effects from her medications, including daytime drowsiness, the ALJ failed to mention any side effects in her analysis of the evidence. This is inconsistent with the federal regulations and Social Security Ruling 96-7p which explicitly list side effects from medication as a relevant factor in evaluating subjective complaints of pain. See 20 C.F.R. § 416.929(c)(3). Finally, the ALJ's characterization of the evidence of Plaintiff's back pain does not demonstrate that she considered all of the evidence in making her credibility determination. With respect to Plaintiff's complaints of back pain, the ALJ states that the "records failed to show disabling back pain (e.g. emergency room records show pain of 2 days duration)." (R. 18.) As discussed above, the emergency department records indicate that Plaintiff reported suffering from chronic back pain. (R. 138, 190.) For these reasons, the court finds that substantial evidence does not support the ALJ's credibility assessment, and the matter must be remanded for an assessment of Plaintiff's credibility consistent with this opinion.

3. *The ALJ did not properly assess all of Plaintiff's impairments or the combined effect of Plaintiff's impairments.*

Plaintiff argues that the ALJ did not properly assess Plaintiff's alleged impairments, either individually or in combination. At step two of the sequential evaluation process, an ALJ must

determine whether a Plaintiff has a severe impairment or combination of impairments "which significantly limits one's physical or mental ability to do basic work activities." 20 C.F.R. § 404.1520(c), 416.920(c). In determining whether an impairment or combination of impairments are severe, ALJs are instructed that

Great care should be exercised in applying the not severe impairment concept. If an adjudicator is unable to determine clearly the effect of an impairment or combination of impairments on the individual's ability to do basic work activities, the sequential evaluation process should not end with the not severe evaluation step. Rather it should be continued. SSR 85-28, 1985 SSR WL 56856 (S.S.A. 1985).

The threshold at step two is minimal: "If the evidence presented by the [Plaintiff] presents more than a 'slight abnormality,' the step-two requirement of 'severe' is met, and the sequential evaluation process should continue. Reasonable doubts on severity are to be resolved in favor of the [Plaintiff]." Newell v. Comm'r of Social Security, 347 F.3d 541, 546-47 (3d Cir. 2003).

The ALJ found that Plaintiff's arthritis is severe and that her diabetes mellitus, obesity, hypertension and asthma are not severe. There is no evidence in the ALJ's decision that she considered these medical conditions in combination at step two of the sequential evaluation. This is clearly inconsistent with the regulations promulgated by the Commissioner.

4. *The ALJ failed to make a finding as to Plaintiff's use of a nebulizer machine.*

In this matter the ALJ failed to make a finding as to Plaintiff's alleged nebulizer use. Plaintiff testified that she uses a nebulizer several times a day to help manage her asthma. (R. 217.) Plaintiff's son also testified that his mother uses a nebulizer several times a day, and further testified that he assisted her in setting up the device. (R. 233.) While the medical records from Plaintiff's treating physician are silent on the issue of nebulizer use, the report from consultative physician Dr. Hunter indicates that Plaintiff reported using a nebulizer to treat her asthma. (R. 107.) While the

ALJ found that Plaintiff's testimony was not entirely credible, no specific finding was made as to whether Plaintiff used a nebulizer as suggested by testimony and the medical records, and if so, the extent of such use.

The issue of Plaintiff's nebulizer use is key because of the potential impact of such use on Plaintiff's ability to perform jobs existing in significant numbers in the national economy. This is evidenced by the testimony of the VE. Plaintiff's counsel posed a hypothetical scenario concerning whether "the typical employer at this level [would] allow someone two 20-minute breaks a day to – well, maybe even longer, but to set up a nebulizer and be on a nebulizer for 20 minutes and then break it down and put it away, twice a day?" (R. 242.) As discussed above, the VE stated that a "typical" employer at that level would not permit such breaks for nebulizer use. (R. 242.) Given the potential vocational relevance of nebulizer use by the Plaintiff, the ALJ should have made a specific finding of fact as to whether Plaintiff used a nebulizer, and the extent of such use. The ALJ's finding that Plaintiff's allegations and subjective complaints regarding her limitations were not fully credible does not adequately address the issue of nebulizer use. In light of the evidence regarding nebulizer use, the ALJ's finding that Plaintiff is not disabled is not supported by substantial evidence.

D. Conclusion

The ALJ's determination that Plaintiff was not disabled during the relevant period and that Plaintiff had the capacity to perform light work with an asthma restriction is not supported by substantial evidence. Accordingly, Plaintiff's Motion for Summary Judgment is GRANTED and the matter is REMANDED to the Commissioner pursuant to 42 U.S.C. § 405(g), sentence four, to:

- 1) consider the testimony of Howard Jackson, Plaintiff's son, and provide a specific

- explanation for his credibility assessment;
- 2) properly evaluate the credibility of Plaintiff, and provide a specific explanation for the credibility assessment;
 - 3) properly evaluate the second step of the sequential evaluation, including consideration of Plaintiff's medically determinable impairments in combination;
 - 4) consider the evidence concerning Plaintiff's nebulizer use and make specific findings of fact concerning the extent of such use, if any, and include such use as a specific restriction in a hypothetical question posed to a vocational expert;
 - 5) reevaluate Plaintiff's RFC in light of the credibility reassessment and any new conclusions, obtaining, if necessary, advice from a medical or consulting expert including a functional assessment.

An appropriate order follows.

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

YVONNE JACKSON, : CIVIL ACTION
:
Plaintiff, : NO. 06-6232
v. :
JO ANNE B. BARNHART, :
Commissioner of Social Security, :
:
Defendant. :

JUDGMENT ORDER

AND NOW, this ___ day of March, 2007, in consideration of Plaintiff's Motion for Summary Judgment, Defendant's Response thereto, and the record, it is hereby ORDERED that:

1. Plaintiff's Motion for Summary Judgment is GRANTED; and
2. The above-reference matter is REMANDED for a determination based on evidence consistent with this order and attached memorandum.

BY THE COURT:

JAMES T. GILES J.