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

VERN BREITEL — CIVIL ACTION

v. :
:
JO ANNE B. BARNHART, :
Commissioner of the Social
Security Administration — No. 00-CV-3892

MEMORANDUM AND ORDER

McLaughlin, J. — January 22, 2002

This case arises from the denial of the application of the plaintiff, Vern Breitel, for disability benefits under Title II of the Social Security Act, 42 U.S.C. §§ 401-433. The plaintiff seeks benefits for the period of time between June of 1991 and December of 1992. The plaintiff has filed a motion for summary judgment, or, in the alternative, for remand, and the defendant Commissioner of the Social Security Administration ("Commissioner") has filed a cross-motion for summary judgment. Because I find that the Commissioner's denial of the plaintiff's application was not based on substantial evidence, I will grant the plaintiff's motion for remand.

I. Procedural History

The plaintiff applied for social security disability

benefits on September 2, 1992, alleging that he became disabled on June 3, 1991 by reason of a fracture of his right knee and depression. The plaintiff's initial application was denied by the state agency responsible for disability determinations, and his request for reconsideration was denied as well. The plaintiff requested a hearing before an administrative law judge ("ALJ"). The ALJ upheld the Commissioner's denial. The plaintiff sought review by the appeals council, which remanded the case to the ALJ. The ALJ then remanded to the state agency, which awarded benefits starting on December 14, 1992.

The plaintiff then filed a second request for a hearing, challenging the state agency's denial of benefits for the period from June 3, 1991 through December 13, 1992. A hearing was held before the same ALJ who denied the plaintiff's original application. The ALJ denied the plaintiff's application for benefits for the 18-month period prior to December of 1992, and the appeals council affirmed the ALJ.

The plaintiff subsequently brought this case. After the plaintiff and the Commissioner filed their motions for summary judgment, the case was referred to a United States Magistrate Judge for a Report and Recommendation ("R & R"). On November 28, 2001, the Magistrate Judge issued a R & R finding that every significant aspect of the ALJ's opinion was supported by substantial evidence and recommending that summary judgment be

entered in favor of the Commissioner.

The plaintiff has objected to the Magistrate Judge's R & R on several grounds. He argues that the ALJ's finding that his testimony concerning his pain was not fully credible was not supported by substantial evidence. He also argues that the ALJ's findings that his depression was not severe and that he was capable of light work and therefore not disabled were not supported by substantial evidence. Finally, the plaintiff argues that the Commissioner committed a reversible error of law by not considering the impact of the side effects of the medication that he was taking.

11. Personal and Medical History

The record contains the following evidence relating to the plaintiff's condition from June of 1991 through December of 1992. The plaintiff was an automotive district sales manager when he fell off of a ladder on June 3, 1991 and fractured his proximal right tibia, lateral tibial plateau and spinous process. See R. 153, 166, 176. The plaintiff testified at length as to the pain caused by the injury, as well as to the limitations it imposed. See R. 111-115. In addition, the plaintiff's contemporaneous complaints of pain and loss of function are extensively documented in his medical records. See, e.g., R. 170,

186-196, 204, 207.

The record contains the treatment notes of Dr. Arnold J. Jules which date from the injury through December 2, 1991. See **R. 170-176.** Dr. Jules' notes document the treatment the plaintiff received as well as the stages of healing of his **knee.**

On June **3, 1991,** Dr. Jules noted that the plaintiff was to elevate and immobilize his knee, to apply intermittent ice and to refrain from all weight-bearing activity. See R. **176.** The plaintiff was required to stay non-weight bearing from June 3rd to July **12, 1991.** On June **21, 1991,** the plaintiff was prescribed Darvocet and Dolobid for pain. ***An*** x-ray taken on that date revealed "the fracture in good alignment and position." R. 175.

On July **12,** 1991, an x-ray was performed which revealed "further healing" and the plaintiff progressed to partial weight bearing with crutches. Id. On July 26, 1991, Dr. Jules wrote in a letter that the plaintiff's fracture was healed in good alignment and position with no effusion and that he had stability. See R. **169.** He wrote that the plaintiff still required a cane outside the house but could go without inside; the doctor also prescribed physical therapy three times a week. See R. **169, 182.** The plaintiff continued in physical therapy through December of 1991. His doctor advised him to work out in the pool five to seven days a week, in addition to his three days

a week of formal physical therapy. See R. 169, 172.

On August 16, 1991, Dr. Jules noted that the plaintiff had "a good ROM of the knee. He has no effusion. He has full extension. His muscle tone is fair to good." R. 173. On October 7, 1991, Dr. Jules again noted that the plaintiff had no effusion and full extension, but stated that an MRI would be done to rule out a meniscal injury because the plaintiff was complaining of "discomfort when he cuts and pivots." R. 172. The plaintiff also complained of "difficulty walking steps if he is trying to carry any packages." Id.

On October 8, 1991, the plaintiff was given an MRI. See R. 184. It revealed the fracture but showed no definite evidence of a meniscal tear or of ligamentous injuries. Dr. Jules noted on October 24, 1991 that in view of the plaintiff's "negative MRI and excellent objective findings I feel that he should progress along and return to work in the near future.'' R. 171. On November 1, 1991, Dr. Jules wrote that he felt that the plaintiff was "coming to the end of his disability[.]" Id.

On December 2, 1991, Dr. Jules wrote that he could not explain the plaintiff's severe pain. See R. 170. He recommended that the plaintiff get a second opinion and continue with physical therapy in the meantime. He noted that there might be a problem that was not showing on the MRI, and that the plaintiff

might require diagnostic operative arthroscopy.

In addition to Dr. Jules' notes, the record contains letters written by two doctors who evaluated the plaintiff in December of 1991. The first doctor, Joseph **P.** Guagliardo, D.O., concluded that "[f]rom all the evidence that I can see it seems as though this fracture is healed at the present time . . . It was explained to the patient that he had a severe fracture in his knee, that it was nondisplaced and that as time goes on the knee will eventually become stronger." R. **201**. He noted mild anterior laxity and recommended that the plaintiff continue with physical therapy.

The second doctor, Amelia L.A. Tabuena, M.D., found that the plaintiff suffered from an unresolved knee sprain, and recommended that post-traumatic arthritis and reflex sympathetic dystrophy be ruled out. See R. 205. Dr. Tabuena made seven treatment recommendations, including a bone scan, physical therapy, and non-steroidal anti-inflammatory medication.

On January 3, **1992,** the plaintiff was given a bone scan. See R. 206. Dr. Michael Steltz interpreted the results of the scan and noted that they revealed a radiolucency at the site of the fracture which could represent a small area of non-union. On January 14, 1992, the plaintiff was given an MRI. See R. 183. Dr. Harold Strunk noted that the fracture line remained visible

but was less prominent than it was in October, when the plaintiff's initial **MRI** was done. Dr. Strunk noted that the **MRI** revealed the possibility of some osteochondrosis or avascular necrosis as well as a possible meniscal tear.

The record contains a treatment note written by Dr. Paul L. Weidner on February 3, 1992. See R. 207. Dr. Weidner noted that the plaintiff's tibial plateau was not completely healed. He wrote that an **MRI** showed bruising and avascular necrosis. Dr. Weidner recommended that the plaintiff ***go*** back on a cane or crutches, stay on anti-inflammatories and ice his knee at the end of each day. Dr. Weidner noted that the plaintiff might eventually need an arthroscopic examination but that he did not need one at that time.

The record also contains the notes of Dr. N.B. Stempler, who performed arthroscopic surgery on the plaintiff on July 13, 1992. See **R.** 219-220. After the surgery, Dr. Stempler diagnosed the plaintiff with femoral chondritis, plica synovialis and degenerative joint disease. During the surgery, the doctor removed "the plica and much of the redundant synovium," shaved the medial femoral condyle, which revealed Grade II and **III** eburnation and denution, and shaved the tibial plateau "smooth **somewhat."** R. 219. **The plaintiff's meniscus was found to be** intact.

In his progress notes, which date from July to November of 1992, Dr. Stempler notes that the plaintiff experienced some improvement from surgery but still had pain. See R. 210-211. He advised the plaintiff to continue his exercise program as well as physical therapy and TENS therapy, and he prescribed the medication Orudis. On November 10, 1992, the doctor noted that the plaintiff had developed bursitis, had a laterally inserted patella and appeared to have a painful glide path. The doctor recommended "aggressive therapy and treatment for the bursitis." R. 210. It was Dr. Stempler's opinion that the plaintiff might be a candidate for lateral release if more conservative treatments continued to fail.

In September of 1992, Dr. Watson Gutowski reported that he had treated the plaintiff for obesity from August 13, 1991 through August of 1992. See R. 227-229. He reported that the plaintiff had lost weight and that he continued to take weight-loss medication and was expected to lose more.

The record also contains physical therapy evaluations dated May 7, 1992, July 30, 1991 and October 20, 1992, and physical therapy progress notes covering August 22, 1991 through December 2, 1991 and May 11, 1992 through May 21, 1992. See R. 177-178, 181, 185-198, 208-209, 324-325. Finally, the record contains a medical source statement prepared by Dr. Stempler on

October 9, 1992, and a residual functional capacity assessment prepared by a state agency expert on October 27, 1992. See R. 232-246.

Dr. Stempler diagnosed the plaintiff with degenerative joint disease of the right knee and stated that he would expect him to suffer from chronic recurrent pain. He stated that the plaintiff had the following physical restrictions: he could only occasionally lift ten pounds; he could stand and walk less than two hours; he had a limited ability to push and pull in his lower extremities; and he should never climb, balance, stoop, kneel, crouch or crawl. The plaintiff had no impairment in his ability to sit. Dr. Stempler also wrote that the plaintiff should avoid heights, moving, temperature extremes and humidity.

The state agency medical expert also appears to have diagnosed the plaintiff with degenerative joint disease of the right knee, although his handwriting is somewhat hard to read. He opined that the plaintiff could occasionally lift twenty pounds and could frequently lift ten pounds, that **he** could stand and walk for about six hours in an eight-hour workday, that he could sit for about six hours in an eight-hour workday, and that he had an unlimited ability to push and pull hand and foot controls.

III. Discussion

An applicant for social security benefits must show that he or she is unable "to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." 42 U.S.C. § 423(d)(1)(A). The Social Security Administration engages in a sequential, five-step inquiry to determine disability. 20 C.F.R. 404.1520.

First, the Commissioner determines whether the claimant is engaged in "substantial gainful activity." 20 C.F.R. 404.1520(b). If not, the Commissioner asks whether the claimant has a "severe impairment" that meets the 12-month durational requirement. 20 C.F.R. 404.1520(c). In this case, the ALJ found that the plaintiff did not engage in substantial gainful activity during the 18-month period at issue, and that the medical evidence indicated that he suffered from a severe impairment during that time. The ALJ found that the plaintiff had "a severe impairment secondary to degenerative joint disease of the right knee," but that his depression was "non-severe." R. 19.

If a claimant is found to have a severe impairment, the Commissioner proceeds to the third step in the sequence, which is determining whether the claimant's impairment meets or equals an impairment listed in Appendix 1 of sub-part P of Part 404 of 20

C.F.R. See 20 C.F.R. 404.1520(d). In this case, the ALJ found that the plaintiff's impairment did not meet or equal any of the listed musculoskeletal impairments. The listings' criteria for a fracture of the tibia include "solid union not evident on X-ray and not clinically solid, when such determination is feasible, and return to full weight-bearing status did not occur or is not expected to occur within 12 months of onset." 20 C.F.R. 404, Subpt. P, App. 1.11. The ALJ found that: "Based upon the claimant's testimony regarding his activity level, his abilities are inconsistent with presumptive disability." R. 20.

The fourth step in the sequence is determining whether the claimant's impairment prevents him or her from doing his or her "past relevant work." 20 C.F.R. 404.1520(e). This involves assessing the claimant's residual functional capacity. The ALJ found that the plaintiff's past work as an automotive salesperson was "heavy level semiskilled work" and that the plaintiff did not retain the residual functional capacity to return to it. R. 22.

The final step in the sequence involves the question of whether the claimant's impairment prevents him or her from doing other work that exists in the national economy. See 42 U.S.C. § 423(d)(2)(A); 20 C.F.R. 404.1520(f). The burden is on the Commissioner at this final stage to prove that, given the claimant's age, education, and past work experience, and considering his or her impairment, there is work that he or she

could do. See Plummer v. Apfel, 186 F.3d 422, 428 (3d Cir. 1999). In this case, the ALJ concluded that the plaintiff was capable of doing "light" work, based in part on his conclusion that the plaintiff's testimony as to the extent of his pain was not fully credible. R. 23. Light work is work that:

> involves lifting no more than 20 pounds at a time with frequent lifting **or** carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls.

20 C.F.R. 404.1567(b).

The ALJ presented a vocational expert and asked him two hypothetical questions.[1] First, he asked whether, assuming that the plaintiff could lift at most twenty pounds, could stand and walk for a total of six hours in an eight-hour day and could sit for six or more hours in an eight hour day, there was work that he could do. See R. 116. The ALJ also asked the vocational expert whether the plaintiff could find work if he was only capable of lifting up to ten pounds and could only stand and walk up to two hours in an eight-hour day. See R. 117. The

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[1] In coming to his decision, the ALJ declined to rely solely on the Commissioner's Medical-Vocational Guidelines, or "grids," because he found that the plaintiff had "significant **nonexertional** limitations." R. 23. The ALJ did not specify what the plaintiff's non-exertional limitations were and none appeared **to** be incorporated into the hypothetical questions he asked the vocational expert.

vocational expert testified that under either hypothetical there was work that the plaintiff could do. Under the first, it would be light work and under the second, solely sedentary work.

This Court must uphold the findings of the Commissioner if they are supported by "substantial evidence." 42 U.S.C. §§ 405(g) and **1383**(c)(3). Substantial evidence means more than a 'mere scintilla," such that a reasonable person would accept it as adequate. Fargnoli v. Massanari, 247 F.3d 34, 38 (3d Cir. 2001). "Where the ALJ's findings of fact are supported by substantial evidence, [this Court] is bound by those findings, even if [it] would have decided the factual inquiry differently." Id.

The plaintiff's objection regarding the ALJ's finding that his depression was not severe will be denied. Aside from the plaintiff's testimony that he began to exhibit symptoms of depression during the 18-month period at issue, there is no record evidence that he was clinically depressed during that time. He was not diagnosed until later, and he did not begin treatment until later. The ALJ's findings regarding the plaintiff's credibility and regarding his capacity to do light work, on the other hand, are sufficiently problematic that they merit remand.'

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[2] Because the Court is reversing on other grounds, the issue (continued...)

In cases where there is a medically-determinable impairment that could reasonably produce pain, and there is no contrary medical evidence, the ALJ is obligated to credit the claimant's complaints of pain. See Mason v. Shalala, 994 F.2d 1058, 1067-1068 (3d Cir. 1993). Here, the ALJ found that there was a medically determinable impairment that could reasonably produce pain. However, he discounted the plaintiff's testimony as to the extent of the pain.

The ALJ did not fully credit the plaintiff's complaints of pain for several reasons. First, the ALJ found that "[t]he claimant was inconsistent with his statements in the documentary evidence and at the hearing which does not reflect well on his credibility." R. 21. The ALJ noted that although the plaintiff "testified that he did nothing other than go to doctor appointments and physical therapy sessions," this was inconsistent with other evidence of "degree of activities of daily living." Id.

Regarding the plaintiff's daily activities, the ALJ

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[2](...continued)
of the ALJ's failure to make explicit his analysis of the effect of the plaintiff's medications will not be addressed at length. On remand, the ALJ should reconsider his assessment of the record evidence relating to the medication issue and, should he choose to discount the evidence, make clear his reasons for doing ***so.*** See Stewart v. Sec'y of Health Educ. & Welfare, 714 F.2d 287, 290 (3d Cir. 1983).

cited the fact that the plaintiff "testified that he did occasional yard work." R. 21. However, this is not true. The plaintiff testified that he did not do yard work. See R. 106-107. The ALJ also cited the plaintiff's testimony that "he did minimal household chores." R. 21. In fact, the plaintiff testified that he did "virtually zero" household chores and that he did no grocery shopping. R. 109-110.

The ALJ referred to the fact that 'even though [the plaintiff] claimed to be disabled due to right leg problems," "he was driving with no problems." R. 21. The basis for the ALJ's conclusion that the plaintiff was driving with no problems is not clear. The plaintiff testified that the amount of driving he was doing was "very minimal," and that "[f]requency would be - most of the time I was getting around through people driving me, and if I drove anything, it was maybe three to five miles at a clip. I really couldn't sit in the car too long without getting out and walking around." R. 105.

The only other evidence from the relevant time period that relates to the plaintiff's ability to drive is contained in physical therapy progress notes. On September 27, 1991, the plaintiff reported to his physical therapist that he had increased pain on getting out of a car. See R. 194. On October 28, 1991, he reported that he went to New York over the weekend

and his pain was so bad that he could not drive. See R. 191. On November 18, 1991, the plaintiff reported that he had difficulty getting out of the car. See R. 189. Finally, on November 25, 1991, the plaintiff reported that his pain occurred most while driving or getting in and out of his car. See R. 188.

The Court concludes that the ALJ's conclusion that the plaintiff's subjective complaints of pain are not credible because of the "degree of activities of daily living" is not supported by substantial evidence. Even if the plaintiff did do occasional yard work, housework and driving, it would not undermine the credibility of his testimony regarding his pain. As the plaintiff argues, these activities can be structured to be performed at his pace and on his timetable. He would not be likely to have the same flexibility in a work setting.

A second reason given by the ALJ for discounting the plaintiff's pain testimony was that: '[The plaintiff] indicated in his disability report that his tibia fracture did not heal properly and that is why he was disabled but the medical evidence indicates that his fracture healed well with no complications." R. 21. It is not clear from the ALJ's opinion whether the purported inconsistency is noted because it reflects poorly on the plaintiff's credibility or because the fact that the fracture healed well supports a finding that the plaintiff was in less

pain than he says he was. The Court assumes that it is the former, because the statement is made in the context of a discussion of the plaintiff's credibility, and because the ALJ concludes elsewhere that the plaintiff had an impairment that could reasonably be expected to cause the pain that the plaintiff alleges. See R. 20.

The ALJ's holding that the plaintiff's credibility is undercut by his indication in his disability report that his knee did not heal properly is not supported by substantial evidence. The medical evidence as to healing is mixed; in December of **1991**, two doctors examined the plaintiff and found that his knee had healed, but in January and February of 1992, after an **MRI** and bone scan were performed, three doctors found that his knee was not definitely healed. And, in February of 1992, eight months after he was injured, the plaintiff was advised to go back to using a cane; he subsequently needed surgery. Even if the plaintiff's fracture had "healed," his knee had not, at least not in the colloquial sense of the word.

The ALJ also discounted the plaintiff's complaints of pain based on the plaintiff's "minimal treatment regimen." R. **21**. However, the ALJ's conclusion that the plaintiff's treatment regimen was minimal is not **supported by** substantial evidence. In the time period at issue, the plaintiff was told to elevate his

knee, to apply intermittent ice, to keep it in a knee immobilizer unless he was lying down and to refrain from all weight-bearing activity. See R. 176. He was required to stay non-weight bearing from June 3rd to July 12, 1991. He was prescribed Darvocet and Dolobid for pain.

On July 12, 1991, the plaintiff was permitted partial weight bearing with crutches. On July 26, 1991, he was prescribed physical therapy three times a week. See R. **182**. He continued in therapy through December of 1991. His doctor advised him to work out in the pool five to seven days **a** week in addition to his three days a week of formal therapy.

The plaintiff also underwent treatment for his obesity, with the aim of alleviating his knee problems during the time period at issue. The obesity treatment included taking medication.

The plaintiff underwent x-rays, MRIs and bone scans throughout the relevant time period. See, e.g., R. 183, 184, 206. In February of 1992, he was advised to go back on crutches, to continue taking anti-inflammatory medication and **to** ice his knee at the end of the day. See R. 207. In July of 1992, he underwent arthroscopic surgery. See R. 219-220. Thereafter, he was instructed to continue his exercise program, was prescribed Orudis and was told to continue TENS therapy. See

R. 211. He was also prescribed physical therapy as well as aggressive therapy and treatment for his bursitis. See R. 210. The plaintiff's treatment regimen over the 18-month period at issue was more than minimal.

The final factor informing the ALJ's credibility finding was the plaintiff's "demeanor as a witness." R. 21. While the ALJ was empowered to weight the plaintiff's testimony in light of his demeanor, the Third Circuit has held that when a claimant's complaint is supported by medical evidence, "the complaints should then be given 'great weight' and may not be disregarded unless there exists contrary medical evidence." Mason, 994 F.2d at 1067-1068. As noted above, the ALJ found that the plaintiff's ailment could reasonably be expected to produce the plaintiff's pain. Given this finding, the ALJ could not disregard the plaintiff's pain based solely on his demeanor, but was required to point to contrary medical evidence.

The ALJ's finding that the plaintiff was capable of light work during the time period at issue is also not supported by substantial evidence. In addition to his credibility findings discussed above, the ALJ based his conclusion on the report of the state agency medical expert, which was prepared on October 27, 1992. See R. 21 and 240. The probative value of this report is questionable. It was prepared more than 16 months into the

18-month period at issue in this case. There is no indication on the form used or in the doctor's notes that he or she was evaluating the plaintiff's past abilities. Rather, the doctor seems to be evaluating the plaintiff's ability to work as of October 27, 1992. This is significant in this case because the plaintiff was injured at the very beginning of the time period at issue and subsequently underwent a variety of forms of treatment including surgery. The doctor's finding that the plaintiff was capable of light work in October of 1992, several months after his surgery, does not necessarily support the inference that he was capable of light work before that time.[3]

The ALJ also based his conclusion that the plaintiff could do light work by citing to the fact that the plaintiff:

> "had a treatment regimen for 4 months which required him to exercise and strengthen his leg. For a short period he had to use a cane to avoid weight bearing on his right leg. However, this was just for a short period of time and [he] was walking in malls for over an hour at time by December, 1991 (Exhibit 15)."

R. 21. In fact, the plaintiff's treatment regimen extended well

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[3] Even if the doctor's report were probative of the plaintiff's abilities prior to October of 1992, the ALJ would have to discount it, at least in part, for the following reasons. First, the doctor did not evaluate the plaintiff in person. See Morales v. Apfel, 225 F.3d 310, 317 (3d Cir. 2000). Second, a form in which a physician's only obligation is to check a box or fill in a blank is "weak evidence at best." Mason, 994 F.2d at 1065.

beyond the four-month period alluded to by the ALJ. In February of **1992**, approximately eight months after his injury, he was advised to return to using a cane or crutches, to continue taking anti-inflammatories and to ice down his knee every night. See R. 207. He eventually required arthroscopic surgery followed by more physical therapy. In addition, in the exhibit cited by the ALJ, the plaintiff complained to his doctor that he could not walk in the mall for more than an hour. See R. 170.

The ALJ also based his conclusion on a letter that Dr. Stempler, one of the plaintiff's treating physicians, wrote on March 11, **1993**, in which Dr. Stempler gave his opinion that the plaintiff was not "permanently disabled for all types of gainful employment.', R. 251. This letter, which relates to the plaintiff's status in March of **1993**, is irrelevant **to** the time period at issue here and therefore provides no support for the ALJ's finding that the plaintiff could perform light work.[4]

In coming to his conclusion that the plaintiff could do light work, the ALJ also evaluated a medical source statement

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[4] Even if the doctor's letter were relevant, Dr. Stempler did not conclude that the plaintiff was capable of light work, as the ALJ found, but rather he is not disabled for all types of work. This is consistent with Dr. Stempler's conclusion in **his** medical source statement that the plaintiff suffered from physical limitations which would limit him to sedentary work. See R. **232-239.**

prepared by Dr. Stempler. Ordinarily, the opinion of a treating physician is entitled to more weight than the opinion of a doctor like the state agency expert in this case, who did not even examine the plaintiff. See Morales, 225 F.3d at **317**. In fact, if a treating physician's opinion is "well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in [the] record," it is to be given "controlling weight." 20 **C.F.R.** 404.1527(d)(2). The **ALJ** declined to give controlling weight to Dr. Stempler's report, because he found that it was inconsistent with Dr. Stempler's treatment notes and with the objective medical evidence in the record.[5] See R. 22.

On remand, the **ALJ** may decide that Dr. Stempler's report, which was written on October 9, 1992, is **of** limited probative value because it is only relevant to the final months of the time-period at issue. However, the ALJ should not discount the report on the grounds that it is inconsistent with the doctor's treatment notes. In his medical source statement,

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[5] The **ALJ** also found that Dr. Stempler may have intended his opinion to be temporary, because Dr. Stempler opined that the plaintiff was not totally disabled several months later, in his **letter written in March** of **1993**. **Whether** or **not** Dr. **Stempler** intended the opinion he gave in his medical **source** statement to be temporary is not important; what is important is to what extent he meant for it to apply to the time-period at issue here.

Dr. Stempler states that the plaintiff has degenerative joint disease in his right knee and that he can be expected to experience chronic recurrent pain. See R. 232-239. He states that the plaintiff can perform only very limited work-related physical activities. These conclusions are consistent with his treatment notes.

Dr. Stempler's treatment notes, which begin in July 1992 and end in November of that year, all reference the fact that the plaintiff continued to be in pain. See R. **210-211**. The notes document that Dr. Stempler prescribed Orudis, physical therapy, and exercises, that the plaintiff suffered from bursitis, a laterally inserted patella and a painful glide path, and that there was a possibility of additional surgery in future. These notes do not contradict the doctor's conclusions given in his medical source statement.

For the foregoing reasons, this Court will remand this case to the Commissioner of Social Security for further action consistent with this opinion.

An Order follows.

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

VERN BREITEL		CIVIL ACTION
v.	:	
JO ANNE B. BARNHART Commissioner of the Social Security Administration	:	NO. 00-CV-3892

ORDER

AND **NOW**, this 22nd day of January, 2002, upon consideration of the plaintiff's motion for summary judgment or, in the alternative, for remand (Document #15), the defendant's motion for summary judgment (Document #16), the Magistrate Judge's Report and Recommendation and the plaintiff's objections thereto, and having reviewed the administrative record in the above-captioned case, it is hereby ORDERED and DECREED that the Report and Recommendation is REJECTED, the defendant's motion for summary judgment is **DENIED** and the plaintiff's motion for summary judgment is **DENIED**. The plaintiff's motion for remand to the Social Security Administration is GRANTED. The case shall **be** remanded for further administrative proceedings for the reasons given in a memorandum of today's date.

BY THE COURT:

Mary A. McLaughlin, J.

Som Chambers 1/23/02
Seth Weber Esq.
William Rooker Esq