IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF DELAWARE

MAETROYE MERCER,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Civil Action No. 00-740-SLR
	)	
JO ANNE B. BARNHART, Commissioner of Social Security,[1]	)	
	)	
Defendant.	)	

Neilson C. Himelein, Esquire, Community Legal Aid Society, Inc., Wilmington, Delaware. Counsel for Plaintiff.

Colm F. Connolly, United States Attorney, Judith M. Kinney, Assistant United States Attorney, United States Attorney's Office, Wilmington, Delaware. Counsel for Defendant. Of Counsel: James A. Winn, Regional Chief Counsel, Allyson Jozwik, Assistant Regional Counsel, Social Security Administration, Philadelphia, Pennsylvania.

MEMORANDUM OPINION

Dated: January 17, 2002
Wilmington, Delaware

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[1]Jo Anne B. Barnhart became the Commissioner of Social Security, effective November 14, 2001, to succeed Acting Commissioner Larry G. Massanari, who succeeded Commissioner Kenneth S. Apfel. Pursuant to Fed. R. Civ. P. 25(d)(1) and 42 U.S.C. § 405(g), Jo Anne B. Barnhart is automatically substituted as the defendant in this action.

ROBINSON, Chief Judge

I. INTRODUCTION

Plaintiff Maetroye Mercer filed this action against Jo Anne B. Barnhart,[2] the Commissioner of Social Security, on August 10, 2000. Plaintiff seeks judicial review, pursuant to 42 U.S.C. § 405(g), of a decision by the Commissioner denying her claim for disability insurance benefits under Title II of the Social Security Act, 42 U.S.C. §§ 401-403. Currently before the court are plaintiff's motion for summary judgment (D.I. 16) and defendant's cross-motion for summary judgment (D.I. 19). For the reasons that follow, the court shall grant plaintiff's motion for summary judgment and deny defendant's cross-motion for summary judgment.

II. BACKGROUND

A. Procedural History

On May 19, 1994, plaintiff filed applications for a period of disability and disability insurance benefits under Title II of the Social Security Act, 42 U.S.C. § 401 et seq., and for supplemental security income based on disability under Title XVI of the Act, 42 U.S.C. § 1381 et seq. (D.I. 11 at

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[2]Jo Anne B. Barnhart became the Commissioner of Social Security, effective November 14, 2001, to succeed Acting Commissioner Larry G. Massanari, who succeeded Commissioner Kenneth S. Apfel. Pursuant to Fed. R. Civ. P. 25(d)(1) and 42 U.S.C. § 405(g), Jo Anne B. Barnhart is automatically substituted as the defendant in this action.

84-87) Plaintiff alleges an inability to work since June 28, 1986 as a result of a motor vehicle accident, in which she suffered neck, arm, and low back injuries; degenerative arthritis in the hip and legs; and post traumatic stress. (Id. at 29) Plaintiff's claims were denied both initially and upon reconsideration. (Id. at 29, 88) On April 21, 1995, plaintiff filed a timely request for a hearing before an administrative law judge ("ALJ") which was subsequently held on November 21, 1996. (Id. at 29)

Plaintiff had filed applications for Title II and Title XVI benefits on three prior occasions. (Id. at 30) Plaintiff filed concurrent applications under Titles II and XVI on April 29, 1987, which were denied at the initial determination level on June 30, 1987, and at the reconsideration level on October 26, 1987. (Id.) Plaintiff filed a second set of concurrent applications on February 9, 1988 which were denied at the initial determination level on March 18, 1988. (Id.) Plaintiff again filed a set of concurrent applications on September 6, 1990, which were initially denied on November 29, 1990, and denied at the reconsideration level on April 4, 1991. (Id.) In the most recent application, plaintiff argued that the prior applications should be reopened and incorporated into the 1994 disability evaluation. (Id.)

On November 19, 1997, the ALJ issued a partially favorable decision. (Id. at 29-39) The ALJ found no condition for good cause to reopen plaintiff's prior applications and denied her request. (Id. at 30-32) In considering the entire record, however, the ALJ found the following:

1. The claimant last met the disability insured status requirements of the Act on December 30, 1991.

2. The claimant has not engaged in substantial gainful activity since 1986.

3. The medical evidence establishes that claimant has the following severe impairments: 1) marked deformity of the proximal right femur with flattening of the head, coxa vara right hip deformity, and significant narrowing of the hip joint space; 2) mild disc herniation in the cervical spine at C5-6 with radiculopathy to the right upper extremity; 3) mild disc bulge at L3-4, L4-5, advanced osteoarthritis at L4-5, and post-traumatic lumbar strains; and 4) a major depressive disorder.

4. Evaluating the period that begins June 28, 1986 and concludes on May 18, 1994, the severity of claimant's impairments singularly or in combination, did not medically meet or equal the severity requirements for any impairment contained in Appendix 1, Subpart P, Regulations No. 4.

5. Comparing claimant's subjective complaints with the entire evidence of record, I find her symptomatology is in part credible. Claimant's allegations that on or about May 19, 1994, she experienced "disabling" pain and discomfort in her hip so severe that the symptoms precluded

performance of basic work related activities is supported by the medical evidence. However, to the extent claimant has alleged that prior to May 1994, she was unable to work, these complaints are less than fully credible.

6. Prior to May 19, 1994, the claimant had the residual functional capacity to perform work-related activities that did not require exertion above the light exertional level: lifting and carrying more than 10 pounds frequently and 20 pounds occasionally, more than occasional performance of postural activities (i.e., climbing, balancing, stooping, kneeing, crouching and crawling), and only moderate exposure to unprotected heights (20 CFR 404.1545 and 416.945).

7. Prior to May 19, 1994 the claimant had the residual functional capacity to perform the limited range of light work (20 CFR 404.1567 and 416.967)

8. Comparing the claimant's residual functional capacity with the requirements of her past work as a data entry operator and secretary, she retained the ability to perform her past relevant work.

9. Therefore, for the period commencing June 28, 1986 and concluding May 18, 1994, claimant was not under a disability as defined by the Act and Regulations.

10. Commencing May 19, 1994, but not prior thereto, the severity of the claimant's right hip impairment diagnosed as a marked deformity in the proximal right femur, coxa vara right hip deformity, with significant narrowing of the hip joint space, met the requirements of section 1.03 A, Appendix 1, Subpart P, Regulations No. 4 (20 CFR §§ 404.1525 and 416.925).

11. The claimant has been under a "disability," as defined in the Social Security Act, since May 19, 1994, but not prior thereto (20 CFR §§

404.1520(d), (e), (f) and 416.920(d), (e), and (f)).

(Id. at 37-38). Plaintiff was found to be disabled as of May 19, 1994 and met the disability requirements for Supplemental Security Income benefits as of that date; however, plaintiff was denied Social Security Disability Insurance ("SSDI") benefits because her disability was established after the date that she was last insured for SSDI purposes. (Id.)

In determining that plaintiff was disabled as of May 19, 1994, the ALJ relied on the progressive severity of plaintiff's right hip coxa vara deformity as documented in her medical records and gave great weight to the consultative report of Dr. Herman Stein dated June 19, 1996, which compared June 19, 1996 and June 15, 1994 x-ray studies of plaintiff's hip. (Id. at 35-6) The ALJ found that "the conclusions reached by Dr. Stein are insightful and provide a longitudinal basis upon which the progressive severity of claimant's hip deformity can be evaluated." (Id. at 35) The ALJ inferred that the 1996 report from Dr. Stein represented plaintiff's clinical condition as of her application filing date (May 19, 1994), because Dr. Stein had concluded that the marked deformity of the right hip was unchanged since the June 1994 x-ray study. (Id.) The ALJ also relied on a medical progress report from December 14, 1994 that described limitations in

the hip's range of motion and in which the treating physician noted significant arthritis with dysplastic acetabulum and discussed possible fusion or total hip replacement. (Id. at 36) The ALJ then compared Dr. Stein's report and the December 14, 1994 medical progress report to the criteria in medical listing 1.03A for arthritis of a major weight bearing joint due to any cause. Based on this evidence, the ALJ determined that "[plaintiff's] right hip coxa vera [sic] deformity meets the requirements of listing 1.03A in Appendix 1" and thus plaintiff had been under a disability since May 19, 1994.

In contrast, the ALJ concluded that, prior to May 19, 1994, plaintiff's musculoskeletal impairments (including the cervical and lumbar spine impairments as well as the hip impairment) did **not** meet or equal the medical severity requirements for medical listing 1.03 or 1.05, or any other listing, in Appendix 1. (Id. at 34) However, in reaching this conclusion, the ALJ cited only to specific medical records regarding the spinal impairments; she did not cite any specific medical evidence in support of her decision that the hip failed to meet listing requirements. (Id. at 33-4)

After concluding that plaintiff's impairments did not meet any medical listing prior to May 19, 1994, the ALJ reviewed evidence of plaintiff's residual functional capacity

and concluded that she was capable of performing her past relevant work as a data entry operator or secretary up through May 18, 1994. (Id. at 34-5) In making her decision, the ALJ relied on the residual functional capacity determinations of the agency physicians as well as "numerous" medical reports indicating that plaintiff could return to light duty or sedentary work. (Id. at 34-5) The ALJ also considered plaintiff's allegations that, on or about May 19, 1994, disabling pain and discomfort precluded her from working. (Id. at 34) While the ALJ concluded that plaintiff's complaints were credible and supported by the evidence on or about May 19, 1994, the ALJ determined that plaintiff's complaints about her condition prior to May 19, 1994 were "less than fully credible." (Id. at 34)

On April 20, 2000, the Appeals Council denied plaintiff's request for review, stating that "the [ALJ's] decision stands as the final decision of the Commissioner . . . ." (Id. at 4) In reaching its decision, the Appeals Council made the following findings: (1) there was no abuse of discretion; (2) there was no error of law; (3) the ALJ's decision was supported by substantial evidence; (4) there were no policy or procedural issues affecting the general public interest; and (5) there was no new evidence submitted that might have

required a re-evaluation of plaintiff's application. (Id.) Plaintiff now seeks review of this decision before this court pursuant to 42 U.S.C. § 405(g).

B. Facts Evinced at the Administrative Law Hearing

According to plaintiff's testimony at the hearing, plaintiff was born on August 25, 1951. (Id. at 50) She is single with one child. (Id. at 84, 50) She graduated from high school and attended college for one and one-half years, and she has received vocational training at a computer communication school. (Id. at 50-54) Plaintiff was periodically employed prior to June 28, 1986 as a clerk for Wilmington Trust Bank, a data processor for DuPont, and a receptionist for Unique Office Supplies. (Id. at 51-55) Plaintiff testified that she was involved in a car accident in June 1986, and due to injuries to her neck, right arm, back, and left leg sustained in the accident, plaintiff has not worked since June 28, 1986. (Id. at 59)

Plaintiff asserted that she has suffered from right hip pain since childhood as a result of a coxa vara deformity. (Id. at 54, 56, 58) In 1962, plaintiff underwent surgery to try to correct the problem, and a pin was placed in her right hip. (Id. at 58) As a result of this surgery and other medical complications, plaintiff spent a total of seven years,

from ages 6 to 13, in a hospital. (Id.)

Plaintiff testified that she was currently receiving treatment for her right hip at the Orthopedic Clinic at the Wilmington Hospital. (Id. at 62) Her doctor had discussed having hip replacement surgery, but plaintiff did not want to undergo this surgery until she could no longer walk. (Id. at 62-3) Plaintiff expressed fear of having to endure another body cast, as she did as a child. (Id.)

Plaintiff claimed that she continuously experiences pain in her right hip, which she described as "a toothache that nags." (Id. at 56) In addition, plaintiff experiences sharp pains that shoot from inside her right hip down the outside of her leg. (Id. at 54) Throughout the hearing, plaintiff had to get up and reposition herself as a result of shooting pains in her right hip. (Id.) She testified that she uses a cane to walk and that the pain prevents her from walking more than one half of a block to one block without stopping. (Id. at 59)

Plaintiff testified that, as a result of injuries sustained in the 1986 car accident (and later aggravated in car accidents in 1992 and 1995), she suffers from stiffness in her neck and that when she turns her neck often, the pain shoots into her head and causes headaches or causes pain to

travel into her arm. (Id. at 59, 64) Plaintiff complained of right arm tremors and numbness, which cause her to drop whatever she is holding. (Id. at 65-6) Plaintiff also suffers from stiffness and spasms in her back. (Id. at 69) This pain increases when plaintiff engages in too much activity, such as bending, mopping, or sweeping, or sits too long. (Id. at 70) As a result of the pain, plaintiff has difficulty concentrating. (Id. at 56)

Plaintiff testified that she uses pain medications to help relieve the pain in her hip and back. At the time of the hearing, plaintiff was taking Relafin and Motrin (800 milligrams) for pain. (Id. at 60) The Motrin helps to relax the plaintiff, but it does not completely relieve the pain. (Id.) The Motrin causes plaintiff to be tired, so she often lays down when she takes this medication. (Id. at 60, 61, 62) She has been prescribed other pain medications such as Advil, Tylenol, and Soma. Some of these medications make her drowsy. (Id. at 62)

Plaintiff stated that she does the cooking, giving herself enough time to take breaks, and light housework. (Id. at 76-77) She usually drives her son to school in the morning. (Id. at 76) She relies on her son to help her with household chores such as laundry and grocery shopping. (Id.

at 77) She has no social life other than occasionally visiting friends and family members. (Id. at 74) Plaintiff spends the day sleeping, watching television, or listening to music. (Id. at 75)

Plaintiff also testified that due to the pain caused by her injuries and hip deformity she suffers from depression. (Id. at 73) She claimed the depression causes sleeplessness. (Id.) She stated that she does not want to be around other people because it makes her think of things she can no longer do. (Id.)

C. Vocational Evidence

At the hearing, the ALJ found the plaintiff's past relevant work to be that of a data entry operator and a secretary. (Id. at 35) The ALJ consulted the Dictionary of Occupational Titles ("DOT") to classify plaintiff's employment. (Id.) The DOT describes both data entry operator (at 209.687-010) and secretary (at 201.362-030) as semiskilled sedentary work. (Id.)

D. Medical Evidence[3]

1. Right Hip Coxa Vara Deformity

Medical records indicate that plaintiff began to limp at three years of age and a coxa vara deformity was diagnosed on her right side in February 1958. (Id. at 141) Plaintiff was admitted to the A.I. DuPont Hospital on January 15, 1962, for possible surgery for her deformity. (Id.) An examination of plaintiff's hip showed that: abduction was possible to 30 degrees on the right and 90 degrees on the left; internal rotation was possible to 10 degrees on the right and 30 degrees on the left; and external rotation to 20 degrees on the right and 45 degrees on the left. (Id. at 142) Doctors tried to correct the deformity by surgically placing a pin in her hip. (Id. at 58)

On July 5, 1963, plaintiff was examined by Dr. Theodore Bledsoe of the A.I. DuPont Hospital, who noted that the metallic screw placed in plaintiff's hip during surgery had

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[3]Defendant argues that only medical evidence from April 1991 to December 1991 should be considered on this appeal; this is the time period not covered by previous social security applications and within which plaintiff was still eligible for Title II benefits. However, medical evidence prior to April 4, 1991 (the date that the most previous disability application was denied) bears on the progressive nature of plaintiff's disability. The ALJ considered this evidence as part of her decisionmaking process, and it is appropriate for the court to do so as well.

not changed position and there had been no significant change in the hip and pelvis since the previous examination. (Id. at 144) Plaintiff was examined again on February 7, 1966, by Dr. James Conway of the A.I. DuPont Hospital; Dr. Conway noted that besides normal growth, there was little change in the appearance of the plaintiff's hip deformity since the examination in 1963. (Id. at 143) The coxa vara deformity was still apparent. (Id.)

Plaintiff's hip was examined again on November 5, 1982, by Dr. Myung Soo Lee, a radiologist at the A.I. DuPont Hospital. (Id. at 171-72) Dr. Lee found that the "acetabulum shows advanced degenerative joint changes . . . includ[ing] periaticular cyst formation in the distal ilium, just above the acetabular roof and in the collapsed and flattened femoral head . . . . The hip joint space is also narrow. These degenerative joint changes have progressed much since the last examination of 2/2/76." (Id. at 171)

Because of discomfort in her right hip, plaintiff was examined on March 24, 1986 by Dr. Gordon Howie of the A.I. DuPont Hospital. (Id. at 337) Upon examination, Dr. Howie found that plaintiff walked with a Trendelenburg gait and had marked wasting of her right thigh muscles, but showed no fixed flexion deformity. (Id.) He found the following limitations

of motion in her hip: abduction to 30 degrees, internal rotation to 25 degrees, and external rotation to 30 degrees. (Id.) An x-ray showed cystic change and reduction of joint space compared to an x-ray taken in 1977. (Id.)

Also on March 24, 1986, Dr. Leslie Grissom conducted an x-ray study of plaintiff's hip and compared it with Dr. Lee's study conducted on November 5, 1982. (Id. at 170) Dr. Grissom found:

> [T]here is evidence of aseptic necrosis with flattening and broadening of the femoral head and shortening of the femoral neck. There is marked degenerative change with cyst formation on both sides of the joint. The joint space is narrowed superiorly . . . . Compared with the previous examination [of November 5, 1982], the appearance of the femoral head and the acetabulum are unchanged. The joint space appears a little more narrow than on the previous examination.

(Id. at 170)

In June 1989, Delaware Curative Workshop conducted a functional musculoskeletal evaluation of plaintiff. (Id. at 274-83) At that time, plaintiff was limited to internal rotation of her right hip to 25 degrees and external rotation of her hip to 25 degrees. (Id. at 277)

In a December 1994 test at the Medical Center of Delaware, plaintiff was found to be limited to internal rotation of the right hip to 20 degrees and external rotation to 30 degrees. (Id. at 516) Other limitations found at the

December 1994 exam were abduction active range of motion ("AROM") of 30 degrees, passive 40 degrees; and flexion AROM 20 degrees, passive 85 degrees. (Id.) The treating physician concluded that plaintiff had "significant arthritis with dysplastic acetabulum" and discussed hip fusion or total hip replacement as possible treatment options. (Id.)

Plaintiff's hip was examined on June 19, 1996 by Dr. Herman Stein of the Medical Center of Delaware. (Id. at 519) This examination was compared to an examination from June 15, 1994.[4] (Id.) From his examination, Dr. Stein noted "evidence of a marked deformity of the proximal right femur with flattening of the head and . . . a coxa vara deformity," "deformity of the right acetabulum," "significant narrowing of the hip joint space," and "multiple cysts on both sides of the hip joint." (Id.) He also noted the presence of a metallic screw projecting over the proximal right femur. (Id.) He concluded that there was a "marked deformity of the right hip, unchanged since June 1994" and that "no acute process [was] identified." (Id.)

When plaintiff requested review by the Appeals Council, she submitted an additional report from Dr. Stein. (Id. at

[4]The report from the examination of June 15, 1994, is not contained in the record.

12) This report compared four studies done on plaintiff's hip.[5] (Id.) In all four studies, Dr. Stein found evidence of significant narrowing of the right hip joint space, flattening and sclerosis of the right femoral head, and subchondral cystic lucencies on the femoral and acetabular sides of the hip joint space. (Id.) Dr. Stein noted, however, that the coxa vara deformity seen on the 1994 and 1996 x-rays was not apparent on the study in 1982.[6] (Id.) Dr. Stein's report concluded that "prominent changes in the right hip, described on studies of 1994 and 1996, can be seen on earlier studies in 1986 and 1982 with hip joint space narrowing, irregularity of the femoral head, sclerosis and subchondral cyst formation." (Id.)

Several other doctors commented on the condition of plaintiff's hip or her complaints of pain in the course of medical examinations, although these examinations appeared to focus on the neck, arm, and back problems caused by the 1986 car accident. In a February 1988 examination by Dr. Donald H. Morgan, which was completed at the request of the social

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[5]The report compared the following studies: Dr. Stein's June 19, 1996 x-ray study; an x-ray study dated June 15, 1994; Dr. Grissom's x-ray study of March 24, 1986; and Dr. Lee's x-ray study of November 5, 1982.

[6]The November 5, 1982 radiologist report mentions the coxa vara deformity. (Id. at 172)

security administration, plaintiff complained of atrophy in her right thigh, gait disturbance, and intermittent "toothache" pain in the right lateral thigh. (Id. at 406-7) Plaintiff also described a history of job losses due to that pain and other pain. (Id.) Dr. Morgan observed that during the examination plaintiff was able to get out of a chair by lightly pushing on an armrest and that plaintiff could get on and off the examination table without difficulty, with or without a footstool. (Id. at 408)

In an April 19, 1989 report from Dr. Jerry L. Case, which was completed at the request of an attorney, the doctor described plaintiff as walking with a normal gait and opined that she was capable of light work. (Id. at 436) In a follow-up report dated April 5, 1991, Dr. Case noted that a review of clinical records showed plaintiff had complained of discomfort in the lower back and right hip as far back as 9/16/83 and had been treated with physical therapy. (Id. at 431)

In commenting on the March 1986 studies of the hip, Dr. Case observed that "X-rays of the pelvis at that time showed cystic changes and narrowing of the joint space of the right hip." (Id. at 432) Dr. Case also reviewed an April 7, 1988 evaluation of plaintiff at Rehabilitation Consultants, Inc.

(Id.) At that examination, "[i]t was felt that the patient demonstrated minimal limitation for continuous standing and walking, and when allowed to alternate between sitting, standing and walking at will, she appeared capable of remaining active for a complete eight hour day." (Id.) Plaintiff was also described as moving "very slowly" during the 1988 exam and "displayed submaximal effort" during the evaluation. (Id.)

In his 1991 exam, Dr. Case observed that plaintiff walked with a limp on the right side and an examination of the lower back showed "a lumbar scoliosis with pelvis tilt." (Id. at 433) He noted "good flexion of the right hip but limited external rotation." (Id.) One of his diagnoses was "coxa vara right hip." (Id.) Dr. Case also concluded that, although plaintiff was capable of "light work," she would have restrictions imposed for "prolonged standing and walking because of her underlying severe degenerative arthritis in the right hip . . . ." (Id. at 433-4)

Plaintiff was also under the care of Dr. Pierre LeRoy, a neurologist, from at least February 15, 1998 to December 21, 1994, with a gap in treatment between May 1991 and early 1994. (Id. at 188-337) In a May 1, 1991 report, Dr. LeRoy concluded that plaintiff was not able to work until the next office

visit in two months, but she could attend school for 80 minutes a day, five days a week; this continued his previous conclusions dating back to at least 1988 that plaintiff was not able to work. (Id. at 203-4; 205-8, 219, 222-5, 27, 229-31) In his May 1, 1991 exam, Dr. LeRoy in part described plaintiff as having a guarded gait, wearing a half-inch lift in the left shoe, and having trouble sitting for tests at her classes at Del Tech. (Id. at 203) Among other things, he diagnosed her with degenerative arthritis in the right hip. (Id.) Plaintiff also refused nerve block therapy, but the doctor reported the medications prescribed for pain as "effective." (Id.)

During his past treatment of plaintiff, Dr. LeRoy had referred plaintiff to physical therapy, occupational therapy, and vocational rehabilitation programs. (Id. at 219, 220, 225, 233, 270-283) After the May 1991 visit, plaintiff apparently did not see Dr. LeRoy again until 1994. (Id. at 211-218)

2. Other Musculoskeletal Impairments

As noted earlier, plaintiff suffered injuries to her neck, right arm, back and left leg as a result of three car accidents, which occurred June 29, 1986, October 9, 1992, and June 9, 1995. (Id. at 59, 432, 470, 522) The record includes

a number of studies and reports from 1986 through 1995 that document complaints associated with the 1986 and subsequent car accidents, with some studies conducted at the request of insurance companies in conjunction with litigation. (Id. at 188-337, 432-3, 435-6, 470-78, 437-69, 479-85, 522-24) While the ALJ noted that there were conflicting reports concerning plaintiff's spinal ailments, she found that a CT scan of plaintiff's lumbar spine in August 1995 revealed a disc bulge at L-304, L4-5, and L5-S1 and a somewhat advanced osteoarthritis of the l4-5 fact joint on the right side. (Id. at 33, 148)

3. Depression

As a result of the pain from her muscoloskeletal injuries and her hip deformity, plaintiff allegedly suffers from depression. (Id. at 73) Plaintiff began treatment for her depression with Dr. P.C. Desai, a psychiatrist, on September 30, 1988. (Id. at 426) Plaintiff also underwent a psychological examination by Dr. Sue H. Mitchell on April 28, 1989. (Id. at 428) Plaintiff was found to be within the normal range of intelligence by the Wechsler Adult Intelligence Scale. (Id.) On April 18, 1995, plaintiff began attending mental health counseling at Delaware Health and Social Services. (Id. at 531-86) Plaintiff's symptoms have

been diagnosed as a major depressive disorder. (Id.)

4. Residual Functional Capacity

Plaintiff contends that due to her injuries her physical capacities are inconsistent with the demands of sedentary work. (D.I. 14 at 11) The record, however, contains two residual functional capacity assessments completed by the State Disability Determination Service that indicate otherwise. (D.I. 11 at 96-104, 106-14) The first assessment was conducted on October 5, 1994, in connection with the denial of plaintiff's initial claim for disability benefits. (Id. at 106-14) Disability examiner,[7] Dorothy Sharkey, concluded that plaintiff could occasionally lift/carry 20 pounds; frequently lift/carry 10 pounds; stand/walk for a total of about 6 hours in an 8-hour workday; sit about 6 hours in an 8-hour workday; and had unlimited push/pull ability at the light exertional level. (Id. at 108) The examiner found that plaintiff had some occasional postural limitations in climbing, balancing, stooping, kneeling, crouching, and crawling. (Id. at 109) No manipulative, visual, or communicative limitations were noted. (Id. at 110-111) It was noted, however, that plaintiff should avoid concentrated exposure to extreme cold, wetness, humidity, vibration, and

[7]Physician signature illegible.

hazards (i.e., machinery, heights). (Id. at 111)

The second assessment, dated January 26, 1995, was conducted in connection with the denial of plaintiff's request for reconsideration. (Id. at 96-104) This assessment[8] also concluded that plaintiff could occasionally lift/carry 20 pounds; frequently lift/carry 10 pounds; and sit about 6 hours in a n 8-hour workday. (Id. at 98) However, plaintiff's ability to stand/walk was found to be at least 2 hours in an 8-hour workday and her ability to push/pull was found to be limited in the lower extremities due to a congenital right hip deformity. (Id.) Again, some postural limitations were noted. (Id. at 99) The assessment found no manipulative, visual, or communicative limitations. (Id. at 100-101) The assessment noted that plaintiff's only environmental limitation was to avoid moderate exposure to heights. (Id. at 101)

In making her residual functional capacity determination, the ALJ also considered a report from the State of Delaware Department of Labor Division of Vocational Rehabilitation and medical notes from Dr. Pierre LeRoy and Dr. Jerry Case. (Id. at 35) A vocational counselor with the Department of Labor,

[8]Disability examiner and physician signatures are illegible.

Jenny Bernadel, reported in an October 1, 1990 letter that she had interviewed plaintiff in 1989 and had reviewed plaintiff's medical records from Dr. LeRoy and Dr. Desai. (Id. at 135) The counselor also arranged for a general medical evaluation by Dr. Sachdev and a psychological examination by Dr. Sue Mitchell. (Id.) On January 30, 1990, the counselor attended a joint meeting with the Delaware Curative Workshop and plaintiff to discuss the progress of plaintiff's occupational and physical therapy treatments. The counselor reported that the therapist "saw very little improvement . . . after they had provided all possible treatments" and the therapist concluded nothing more could be offered plaintiff. (Id. at 136) As a result of this meeting and a careful review of the case, the counselor "decided to close [plaintiff's] case as employment was not deemed to be possible." (Id.) The counselor observed that plaintiff "had a reduced ability to work as she was still bothered with intense headaches" and that plaintiff "complained of pain over her body that prevented her from having a normal day." (Id.)

In medical notes from 1988 through May 1991, Dr. LeRoy opined that plaintiff was not able to work. (Id. at 203-4; 205-8, 219, 222-5, 27, 229-31) In April 1991, Dr. Case concluded that plaintiff was capable of "light work," but that

she would have restrictions imposed for "prolonged standing and walking because of her underlying severe degenerative arthritis in the right hip . . . ." (Id. at 433-4)

III. STANDARD OF REVIEW

"The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, [are] conclusive," and the court will set aside the Commissioner's denial of plaintiff's claim only if it is "unsupported by substantial evidence." 42 U.S.C. § 405(g); 5 U.S.C. § 706(2)(E) (1999); see Menswear Med. Ctr. v. Heckler, 806 F.2d 1185, 1190 (3d Cir. 1986). As the Supreme Court has held,

> "substantial evidence is more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Accordingly, it "must do more than create a suspicion of the existence of the fact to be established.... It must be enough to justify, if the trial were to a jury, a refusal to direct a verdict when the conclusion sought to be drawn from it is one of fact for the jury."

Universal Camera Corp. v. NLRB, 340 U.S. 474, 477 (1951) (quoting NLRB v. Columbian Enameling & Stamping Co., 306 U.S. 292, 300 (1939)).

The Supreme Court also has embraced this standard as the appropriate standard for determining the availability of

summary judgment pursuant to Fed. R. Civ. P. 56:

> The inquiry performed is the threshold inquiry of determining whether there is the need for a trial — whether, in other words, there are any genuine factual issues that properly can be resolved only by a finder of fact because they may reasonably be resolved in favor of either party.
>
> Petitioners suggest, and we agree, that this standard mirrors the standard for a directed verdict under Federal Rule of Civil Procedure 50(a), which is that the trial judge must direct a verdict if, under the governing law, there can be but one reasonable conclusion as to the verdict. If reasonable minds could differ as to the import of the evidence, however, a verdict should not be directed.

Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 250-51 (1986) (internal citations omitted). Thus, in the context of judicial review under § 405(g),

> "[a] single piece of evidence will not satisfy the substantiality test if the [Commissioner] ignores, or fails to resolve, a conflict created by countervailing evidence. Nor is evidence substantial if it is overwhelmed by other evidence — particularly certain types of evidence (e.g., that offered by treating physicians) — or if it really constitutes not evidence but mere conclusion."

Brewster v. Heckler, 786 F.2d 581, 584 (3d Cir. 1986) (quoting Kent v. Schweiker, 710 F.2d 110, 114 (3d Cir. 1983)).

"Despite the deference due to administrative decisions in disability benefit cases, 'appellate courts retain a

responsibility to scrutinize the entire record and to reverse or remand if the [Commissioner]'s decision is not supported by substantial evidence.'" Morales v. Apfel, 225 F.3d 310, 317 (3d Cir. 2000) (quoting Smith v. Califano, 637 F.2d 968, 970 (3d Cir. 1981)). "A district court, after reviewing the decision of the [Commissioner] may, under 42 U.S.C. 405(g) affirm, modify, or reverse the [Commissioner]'s decision with or without a remand to the [Commissioner] for rehearing." Podedworny v. Harris, 745 F.2d 210, 221 (3d Cir. 1984).

IV. DISCUSSION

A. Standards for Determining Disability

Congress enacted the Supplemental Security Income Program in 1972 "to assist 'individuals who have attained age 65 or are blind or disabled' by setting a guaranteed minimum income level for such persons." Sullivan v. Zebley, 493 U.S. 521, 524 (1990) (quoting 42 U.S.C. § 1381).

In Plummer v. Apfel, 186 F.3d 422 (3d Cir. 1999), the Third Circuit outlined the applicable statutory and regulatory process for determining whether a disability exists:

> In order to establish a disability under the Social Security Act, a claimant must demonstrate there is some "medically determinable basis for an impairment that prevents him from engaging in any 'substantial gainful activity' for a statutory twelve-month period."

> . . . The Social Security Administration has promulgated regulations incorporating a sequential evaluation process for determining whether a claimant is under a disability. In step one, the Commissioner must determine whether the claimant is currently engaging in substantial gainful activity. . . . In step two, the Commissioner must determine whether the claimant is suffering from a severe impairment . . . .
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> In step three, the Commissioner compares the medical evidence of the claimant's impairment to a list of impairments presumed severe enough to preclude any gainful work. If a claimant does not suffer from a listed impairment or its equivalent, the analysis proceeds to steps four and five. Step four requires the ALJ to consider whether the claimant retains the residual functional capacity to perform her past relevant work . . . .
>
> If the claimant is unable to resume her former occupation, the evaluation moves to the final step. At this stage, the burden of production shifts to the Commissioner, who must demonstrate the claimant is capable of performing other available work in order to deny a claim of disability . . . .

Id. at 427-8 (internal citations omitted).

At step three of the disability evaluation process, the ALJ determines whether the claimant's impairment matches, or is equivalent to, one of the listed impairments in the applicable regulation, 20 C.F.R. pt. 404, subpt. P, App. 1 (pt. A) (2001). Burnett v. Commissioner of Social Security Administration, 220 F.3d 112, 119 (3d Cir. 2000). "If the impairment is equivalent to a listed impairment, then [the claimant] is *per se* disabled and no further analysis is

necessary." Id. That is, the ALJ presumes the claimant is disabled and entitled to benefits "without inquiring into the claimant's actual ability to perform some level of gainful employment." Pugh v. Bowen, 870 F.2d 1271, 1277 (7th Cir. 1989). Each impairment listed in 20 C.F.R. pt. 404, subpt. P, App. 1 (pt. A) (2001) "is defined in terms of several specific medical signs, symptoms, or laboratory results . . . . For a claimant to show that his impairment matches a listing, it must meet *all* of the specified medical criteria." Sullivan, 493 U.S. at 530 (emphasis in original).

B. Determination of Plaintiff's Disability Status

In the case at bar, only the third step of the five-part disability determination test is at issue: whether plaintiff's disability met any of the impairments listed in 20 C.F.R. pt. 404, subpt. P, App. 1 (pt. A) (2001) on or before December 31, 1991, the last date for which plaintiff was eligible for Title II disability benefits. Specifically, plaintiff challenges the ALJ's decision that plaintiff's hip impairment (coxa vara deformity/degenerative arthritis) did not meet any listing requirements until May 19, 1994. The ALJ found that the hip impairment met Listing 1.03A on, but not before, May 19, 1994.[9,10] Two aspects of the ALJ's determination warrant the

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[9] Listing 1.03 defines the criteria for "Arthritis of a major weight-bearing joint" (which includes hip):

> With history of persistent joint pain and stiffness with signs of marked limitation of motion or abnormal motion of the affected joint on current physical examination. With:
>
> A. Gross anatomical deformity of hip or knee (e.g., subluxation, contracture, bony or fibrous ankylosis, instability) supported by X-ray evidence of either significant joint space narrowing or significant bony destruction and markedly limiting ability to walk or stand....

20 C.F.R. pt. 404, subpt. P, App. A (pt. A, 1.03) (2001).

[10] Plaintiff does not contest any of the ALJ's other findings, including the ALJ's decision not to reopen any of plaintiff's earlier disability claims and the ALJ's finding that plaintiff's last insured date was December 31, 1991. However, that leaves a period from April 5, 1991 to December

court's consideration: (1) the adequacy of the written opinion supporting the ALJ's disability determination and (2) the ALJ's selection of May 19, 1994 as the disability onset date.

The Third Circuit requires an ALJ in a social security determination "to set forth the reasons for [his or her] decision." Burnett v. Commissioner of Social Security Administration, 220 F.3d 112, 119 (3d Cir. 2000) (citing Cotter v. Harris, 642 F.2d 700, 704-05 (3d Cir. 1981)). In Burnett, the Court criticized the ALJ's listing determination statement as conclusory and thus beyond meaningful judicial review. Burnett, 220 F.3d at 119. The Court vacated and remanded the case to the ALJ "for a discussion of the evidence and an explanation of reasoning supporting a determination that [plaintiff's] 'severe' impairment does not meet or is not equivalent to a listed impairment." Id. at 120. The Court required the ALJ to fully develop the record and explain his finding at step three of the disability review process. Id.

In the case at bar, the ALJ provided a detailed explanation supporting her decision that the hip impairment met Listing 1.03A as of May 19, 1994, citing Dr. Stein's report comparing 1996 and 1994 X-ray studies and a 1994

31, 1991 for which plaintiff was still eligible for disability benefits but had not had a previous claim determination made.

medical progress report showing joint motion limitations and significant arthritis. (D.I. 11 at 35-6) In contrast, the ALJ provided **no** discussion of the evidence supporting her determination that the hip impairment did not meet Listing 1.03A prior to May 19, 1994. (Id. at 34) The ALJ merely concluded:

> Comparing claimant's musculoskeletal impairments [cervical and lumbar spine impairments as well as hip impairment] with medical listings 1.03 and 1.05 in Appendix 1, I conclude that during the period June 29, 1986 to May 18, 1994, that the above musculoskeletal impairments singularly or in combination did not meet or equal the medical severity requirements for the above listings or any listing contained in Appendix 1.

(Id. at 34) The ALJ discussed the medical evidence she considered regarding the cervical and lumbar spine impairments, but cited no medical evidence for the hip impairment. (Id. at 33-4)

In the final paragraph of the opinion's "Evaluation of the Evidence" section, the ALJ inferred that she considered some pre-May 1994 medical evidence regarding the hip impairment when making her determination:

> Assessing the evidence in a context most favorable to her claim, I have found that **the medical evidence documents increasing severity of her right hip deformity** and commencing May 19, 1994, the severity

> of this impairment met the requirements of listing 1.03 A, in Appendix 1.

(Id. at 37) (emphasis added). However, the ALJ did not specify what evidence she considered or why it supported her conclusion that the hip met listing requirements "commencing" May 19, 1994, but not before.[11]

Because the ALJ failed to discuss the medical evidence or explain her reasoning for making the listing determination for the period June 29, 1986 to May 18, 1994, the court concludes that for this reason alone the case must be remanded to the ALJ for reconsideration. However, an additional consideration on remand is whether the ALJ must consult with a medical expert when determining the onset date of plaintiff's disability.

The date that plaintiff's hip impairment met the criteria for Listing 1.03A is critical in determining whether she was

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[11]The defendant points to evidence of residual functional capacity to defend the ALJ's decision. However, the ALJ's discussion of functional capacity evidence from the June 1986 to May 18, 1994 time period has no relevance to the step three listing determination. At this stage of the disability determination, the ALJ presumes the claimant is disabled and entitled to benefits "without inquiring into the claimant's actual ability to perform some level of gainful employment." Pugh, 870 F.2d at 1277. See also 20 C.F.R. § 404.1520(d) (if claimant meets or equals a listed impairment, "we will find [claimant] disabled without considering [his or her] age, education, and work experience").

disabled before December 31, 1991. If the hip impairment met the listing criteria before that date, plaintiff was per se disabled and must be awarded disability benefits automatically. See Burnett, 220 F.3d at 119.

Social Security Ruling 83-20[12] states the policy and describes the relevant evidence to be considered when establishing the onset date of disability. The Third Circuit recently interpreted this ruling in a case where the ALJ had to infer the onset date of a slowly progressive psychological

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[12]Social Security Ruling 83-20 states in relevant part:

> The onset date of disability is the first day an individual is disabled as defined in the [Social Security] Act and the regulations. Factors relevant to the determination of disability onset include the individual's allegation, the work history, and the medical evidence . . . .
>
> The medical evidence serves as the primary element in the onset determination . . . . With slowly progressive impairments, it is sometimes impossible to obtain medical evidence establishing the precise date an impairment became disabling. . . . In such cases, it will be necessary to infer the onset date from the medical and other evidence that describe the history and symptomatology of the disease process.
>
> [T]he established onset date must be fixed based on the facts and can never be inconsistent with the medical evidence of record . . . .
>
> How long the disease may be determined to have existed at a disabling level of severity depends on an informed judgment of the facts in the particular case. This judgment, however, must have a legitimate medical basis. At the hearing, the administrative law judge (ALJ) should call on the services of a medical advisor when onset must be inferred. If there is information in the file indicating that additional medical evidence concerning onset is available, such evidence should be secured before inferences are made . . . .

disorder that was alleged to have begun 30 years in the past; adequate medical records from the relevant time period were not available. Walton v. Halter, 243 F.3d 703, 708-10 (3d. Cir. 2001). The Court found that, due to the lack of adequate medical records, it was necessary "to infer the onset date from the medical and other evidence that describe[d] the history and symptomatology of the disease process." Id. at 709 (quoting SSR 83-20). To make such an inference, an informed judgment was required. Id. The Court concluded: "[I]n a situation of this kind [an ALJ] must call upon the services of a medical advisor rather than rely on [his or her] own lay analysis of the evidence." Id.

Similarly, the Fifth Circuit held that "in cases involving slowly progressive impairments, when the medical evidence regarding the onset date of a disability is ambiguous and the Secretary must infer the onset date . . . [t]he Secretary cannot make such an inference without the assistance of a medical advisor." Spellman v. Shalala, 1 F.3d 357, 362 (5th Cir. 1993). The Fourth Circuit agreed, concluding that, while the ALJ need not consult a medical advisor in every case where onset must be inferred, if the evidence is ambiguous, "the ALJ must procure the assistance of a medical advisor . . . ." Bailey v. Chater, 68 F.3d 75, 79 (4th Cir. 1995). The

Bailey Court would allow the ALJ to make the inference without assistance only where "clear evidence document[ed] the progression of [claimant's] condition," or in "the most plain cases." Id. at 79-80.

In the case at bar, the ALJ determined the disability onset date to be May 19, 1994 without assistance from a medical advisor. While the ALJ found clear evidence supporting the existence of plaintiff's disability as of that date, citing the June 1994 X-ray study reviewed by Dr. Stein and a 1994 medical progress report, the ALJ cited no medical evidence to support her conclusion that prior to May 19, 1994 the hip impairment did not meet the listing requirements. (D.I. 11 at 33-4, 35-6) The only significance to the date chosen for disability onset is that it was the date plaintiff filed her claim. (Id. at 35) There is no apparent medical significance to this date. The ALJ acknowledged that the hip impairment was progressive in nature and even noted that the hip was "unchanged" from June 1994 to June 1996. (Id. at 35) However, the ALJ failed to consider when this progressive impairment first reached the point where it met the listing requirements, i.e., the onset date.

Based on the above, the court concludes that the ALJ did not have a legitimate medical basis for the disability onset

date selected and thus lacked substantial evidence supporting her decision that plaintiff was not disabled prior to May 19, 1994. On remand, the ALJ must review the medical evidence relevant to the progression of plaintiff's hip impairment, including the additional report submitted by plaintiff comparing the 1996 and 1994 X-ray studies to the 1982 and 1986 studies, and determine if clear evidence allows her to select a reasonable disability onset date. The onset date must have a legitimate medical basis. If the medical evidence is ambiguous as to the precise date when plaintiff's hip impairment met the listing requirements, then the ALJ must consult a medical advisor to help her determine a reasonable onset date. Moreover, in documenting her decision, the ALJ must discuss the evidence she considered and her reasoning supporting her disability determination. See Burnett, 220 F.3d at 120.

V. CONCLUSION

For the reasons stated above, the court finds that defendant's decision failed to adequately discuss the evidence considered by the ALJ or the reasoning supporting the ALJ's disability determination. In addition, the court finds that the ALJ lacked substantial evidence to support her selection of the disability onset date. Accordingly, the court shall

grant plaintiff’s motion for summary judgment and deny defendant’s motion for summary judgment. An appropriate order remanding the case to the Commissioner shall issue.

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF DELAWARE

MAETROYE MERCER,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Civil Action No. 00-740-SLR
	)	
JO ANNE B. BARNHART, Commissioner of Social Security,	)	
	)	
Defendant.	)	

O R D E R

At Wilmington this 17th day of January, 2002, consistent with the memorandum opinion issued this same day;

IT IS ORDERED that:

1. Plaintiff's motion for summary judgment (D.I. 16) is granted.

2. Defendant's motion for summary judgment (D.I. 19) is denied.

3. The clerk is directed to enter judgment in favor of plaintiff and against defendant.

4. The case is remanded to the Commissioner of Social Security for further proceedings.

5. The clerk is directed to change the caption to reflect the automatic substitution of Jo Anne B. Barnhart as Commissioner of Social Security, pursuant to Fed. R. Civ. P. 25(d)(1) and 42 U.S.C. § 405(g).

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United States District Judge