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

PATRICIA WHITE	:	
	:	
Plaintiff,	:	
	:	CIVIL ACTION
v.	:	
	:	
JO ANNE B. BARNHART, Commissioner of the Social Security Administration,	:	NO. 05-2856
	:	
Respondent	:	

MEMORANDUM

Baylson, J. **February 9, 2006**

Plaintiff Patricia White ("Plaintiff' or "White") seeks judicial review of the decision of the Commissioner of the Social Security Administration denying her claim for disability benefits ("DIB") under Title II of the Social Security Act, 42 U.S.C. §§ 401-433 ("the Act"). Presently before this Court are the parties' cross-motions for summary judgment.

I. Background and Procedural History

Plaintiff is a 46 year old woman, having been born on February 5, 1962. (R. at 38). Plaintiff's primary previous work experience is as a nurse's aid, a home health aide and as a medical billing clerk. (R. at 336-338). She completed high school and two years of college. (R. at 55).

On March 28, 2003, White filed an application for DIB, alleging disability as of May 9, 2000. (R. at 38-40). She last met the insured status requirements set forth in the Social Security Act on December 31, 2000 ("date last insured"), meaning she must prove that she was disabled on or prior to that date. (R. at 46). Therefore, the relevant time period for determining disability in this case begins in May, 2000 and ends in December, 2000.

Following an initial denial by the Social Security Administration, Plaintiff timely requested a hearing before an Administrative Law Judge ("ALJ") (R. at 33). A hearing was held before ALJ

William J. Reddy on July 14, 2004 (R. at 315-346), and on July 22, 2004, the ALJ issued a decision denying Plaintiff's application (R. at 14-21). After the Appeals Council denied Plaintiff's request for review, Plaintiff sought judicial review of the Commissioner's decision in this Court. She filed a motion for summary judgment on November 2, 2005 (Doc. No. 8) and Defendant, the Commissioner of the Social Security Administration ("Commissioner"), filed a cross-motion for summary judgment on December 28, 2005 (Doc. No. 13). Plaintiff then filed a Response in Opposition to the Commissioner's motion on January 17, 2006 (Doc. No. 14).

A. History of Treatment for Physical Impairments

Plaintiff contends that she has been unable to work since May 9, 2000, asserting she has carpal tunnel syndrome in both hands, depression and anxiety, a back problem, swelling of her feet and knees and burning on the right side of her body. (R. at 38, 49). White testified that she has pain in both arms from her fingers up to her elbow, and that since May 2000, she has worn braces on both wrists. (R. at 322). She claims she takes Percocet and Darvocet, but they cause drowsiness and constipation which makes it necessary to sleep during the day. (R. at 324, 334). Plaintiff also claims of feeling persistently depressed and anxious since May, 2000, and even experienced the radio and television speaking to her directly. (R. at 335). She testified that her primary care physician prescribed anti-depressant and anti-anxiety medications (R. at 321), and contends she continues to have depression problems. (R. at 320, 336). Since her date last insured, once in 2002 and again in 2003 (R. at 282-297), she indicated she has twice required psychiatric hospitalization. (R. at 97-100, 282-297, 321). She also testified that she had difficulties standing and walking because of swelling and water on her knees (R. at 324-25) and complains of low back problems, (R. at 326). White testified that she can only sit for fifteen minutes to one-half hour, can stand for one-half hour and then must sit, stand or lay down because she swells up. (R. at 325-27). She stated she can walk two or three blocks and with braces, can lift ten to fifteen

pounds. (R. at 324-25).

Medical records indicate that on August 1, 2000, Plaintiff complained of carpal tunnel syndrome ("CTS") to her family doctor, Dr. Michael Helzner, D.O. (R. at 122). On September, 25, 2000, a Dr. T. Robert Takei, M.D., an orthopedist, performed surgery on White for CTS on her right wrist. (R. at 304). She participated in physical therapy to rehabilitate her right hand from October 18, 2000 to at least December, 2000. (R. at 305-314). A November 9, 2000 report from Plaintiff's occupational therapist ("OT") to Dr. Takei indicated complaints of left hand numbness and pain and requested a left wrist splint for night use. (R. at 309). During a follow-up visit with Dr. Takei on November 15, 2000, she reported continued tenderness in her right hand and forearm and CTS symptoms in her left hand. Dr. Takei also recommended use of a splint on her left hand. (R. at 139). He also recommended that White return to light duty work. (R. at 139). Treatment notes by Dr. Helzner for November 21, 2000 report that Plaintiff complained of right wrist CTS symptoms and that "the left hand is also flaring up." (R. at 121).

Dr. Donald F. Leatherwood II, M.D., another orthopedist, examined Plaintiff on December 22, 2000. White reported the surgery did not help her. She complained of continued pain, numbness, and tingling in her hands and forearms, with right greater than left arm symptoms (but noted an increase of symptoms in the left arm). Upon testing, Plaintiff had negative Tinel's signs bilaterally and mildly positive to equivocal carpal tunnel compression test bilaterally. (R. at 136-37). Dr. Leatherwood noted on February 7, 2001 that follow-up electromyography (" EMG") testing revealed moderate left carpal tunnel syndrome and on May 22, 2001, that an EMG showed right carpal tunnel syndrome as well. (R. at 134, 131). On May 2, 2001, a Dr. Renee Scharf, M.D., a physiatrist (a doctor who specializes in physical medicine and rehabilitation) wrote to Dr. Leatherwood that Plaintiff complained of "severe numbness and tingling in all the fingers of her left hand" and had similar symptoms in the right despite her September, 2000 surgery. (R. at 93). In July 2001, Leatherwood performed repeat carpal tunnel

release surgery on Plaintiff's right hand (R. at 129-130), which according to his treatment notes resulted in significant improvement for several months (R. at 125-29), although symptoms began returning in 2002. (R. at 123-24).[1]

A review of the record shows Plaintiff reported some low back pain to Dr. Helzner on August 1, 2000. On January 16, 2001, Plaintiff for the first time reported some knee pain to him, and his treatment notes include a diagnosis of DJD (degenerative joint disease) of the knee. (R. at 120). Then, on February 7, 2001, she complained to Dr. Leatherwood of "spontaneous" swelling and pain to the left knee. (R. at 134). An examination showed Plaintiff had full range of motion in her knee, but mild chronic synovitis and medial joint line tenderness. X-rays showed no abnormalities of the knee. The doctor concluded she "appears to have an arthritic flare-up of the left knee," and prescribed Naprosyn. (R. at 134). During a March 13, 2001 visit to Dr. Helzner, Plaintiff again reported knee pain, but the doctor found no edema in her legs, but noted a diagnosis of DJD. (R. at 120). On April 4, 2001, Leatherwood also summarily noted the presence of "left knee swelling." (R. at 132).

A Physical Residual Functional Capacity Assessment completed by a State Agency Disability Examiner on May 9, 2003 noted that Plaintiff complained of CTS in both hands, but right worse than left. The examiner concluded that, as of her date last insured, Plaintiff had the residual functional capacity ("RFC") to perform light work,[2] including the ability to stand, walk and/or sit about six hours in

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[1]Additional treatment notes for a period well after Plaintiff's last insured date document CTS symptoms in both hands. <u>See, e.g.</u> notes from Dr. Steven Rosen, M.D. of Fox Chase Pain Management Associates (R. at 141-42, 144), and notes from notes from Dr. Helzner, June 4, 2001 (R. at 118), June 8, 2001 (R. at 117), August 28, 2001 (R. at 115), February 15, 2002 (R. at 110), and March 22, 2002 (R. at 109).

[2]Light work is defined as "involv[ing] 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); S.S.R. 83-10, 1983 WL 31251, *5-6.

an eight-hour workday, but with no concentrated exposure to extreme cold, wetness, vibration, or hazards. He found no manipulative limitations and no specific functional limitations related to White's left-sided CTS. (R. at 182-189).

B. History of Treatment for Mental Impairments

With regard to a mental impairment, medical records indicate that in February 2000, Plaintiff reported feeling depressed and anxious to Dr. Helzner, who prescribed Xanax, an anti-anxiety medication. (R. at 122). On November 21, 2000, Dr. Helzner prescribed Paxil, used to treat depression and anxiety, and in January 2001, he prescribed Restoril. (R. at 121, 120). There is no indication in the record that Plaintiff sought therapy or other mental health treatment during the relevant period.[3] A Psychiatric Review Technique was completed by non-examining state agency psychologists John D. Chiampa, Ph.D., who in May, 2003 concluded that there was insufficient evidence of any mental impairment between May, 2000 and December, 31, 2000.[4]

II. Contentions of the Parties

In her Motion for Summary Judgment, Plaintiff contends the ALJ erred in failing to classify her left-sided CTS, knee impairment, back pain and depression/anxiety as "severe" impairments. (Pl.'s Mot. Summ. J. at 6-7). As a result, she asserts the hypothetical question posed to the vocational expert ("VE") posited limitations only flowing from her right-sided CTS, and not all the impairments supported by the

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[3]In a May 2, 2001 letter from Dr. Scharf to Dr. Leatherwood, Scharf reported that although White "diagnosed herself as post-traumatic stress, . . . [she] denies seeing a therapist to help her cope with this."

[4]Additional medical records and testimony document severe mental health problems for periods well before and well after Plaintiff's last insured date. For example, she allegedly underwent electroshock treatments in 1985. (R. at 225, 328-29). Also, Plaintiff was admitted to Friends Hospital for psychiatric treatment for major depressive disorder with suicidal ideation and psychotic features from April 25, 2002 until May 23, 2002, (R. at 97-100) and again from June 27, 2003 to July 11, 2003. (R. at 282-297). Treatment records from Ira H. Solomon, Ph.D., a licensed clinical psychologist, reveal ongoing treatment for major depression from September 7, 2002 through March 4, 2004 (R. at 221-248).

record. Accordingly, she argues the VE's response was insufficient and the ALJ's decision is not supported by substantial evidence. (Pl.'s Mot. Summ. J. at 21-22).

The Commissioner counters that the ALJ evaluated all the evidence in the record, and had substantial evidence to conclude that, during the relevant period, Plaintiff's only severe ailment was right-sided CTS. Specifically, she asserts that Plaintiff had minimal, very conservative treatment for left-handed CTS prior to December 31, 2000 and a state agency physician found no functional limitations related to Plaintiff's left hand. (Resp.'s Mot. Summ. J. at 6-8). With regard to knee problems, there is a complete lack of treatment prior to December 31, 2000; the first time she reported any problem was in January 2001. (Resp.'s Mot. Summ. J. at 8-10). Finally, given the large gaps in medical treatment records with regard to her alleged mental illness, Plaintiff failed to meet her burden that her psychological limitations precluded all work prior to her last date insured. (Resp.'s Mot. Summ. J. at 10-13). Accordingly, the ALJ's hypothetical included all of the limitations pre-dating White's last date insured that were established by the record. (Resp.'s Mot. Summ. J. at 14).

III. Legal Standard

The standard of review of an ALJ's decision is plenary for all legal issues. Schaudeck v. Comm'r of Soc. Sec. Admin., 181 F.3d 429, 421 (3d Cir. 1999). The scope of the review of determinations of fact, however, is limited to determining whether or not substantial evidence exists in the record to support the Commissioner's decision. Id. As such, "[t]his Court is bound by the ALJ's findings of fact if they are supported by substantial evidence on the record." Plummer v. Apfel, 186 F.3d 422, 427 (3d Cir. 1999). Where "an agency's fact finding is supported by substantial evidence, reviewing courts lack power to reverse . . . those findings." Monsour Med. Ctr. v. Heckler, 806 F.2d 1185, 1191 (3d Cir. 1986). "Substantial evidence does not mean a large or considerable amount of evidence but rather such relevant evidence as a reasonable mind might accept as adequate to support a

conclusion." Hartranft v. Apfel, 181 F.3d 358, 360 (3d Cir. 1999).

IV. Discussion

To determine whether an individual is disabled, the regulations proscribe a five-step analysis. 20 C.F.R. § 404.1520(a); Ramirez v. Barnhart, 372 F.3d 546, 550-51 (3d Cir. 2004). The fact-finder must determine: (1) if the claimant currently is engaged in substantial gainful employment; (2) if not, whether the claimant suffers from a "severe impairment;" (3) if the claimant has a "severe impairment," whether that impairment meets or equals those listed in 20 C.F.R. Part 404, Subpart P, Appendix 1, and thus are presumed to be severe enough to preclude gainful work; (4) whether the claimant can still perform work he or she has done in the past ("past relevant work") despite the severe impairment; and (5) if not, whether the claimant is capable of performing other jobs existing in significant numbers in the national economy in view of the claimant's age, education, work experience and RFC. Id. If there is an affirmative finding at any of steps one, two, four or five, the claimant will be found "not disabled." 20 C.F.R. § 404.1520(b)-(f). See also Brown v. Yuckert, 482, U.S. 137, 140-42 (1987). The Plaintiff carries the initial burden of demonstrating by medical evidence that he or she is unable to return to his or her former occupation. Dobrowolsky v. Califano, 606 F.2d 403, 406 (3d Cir. 1979). Once the Plaintiff has done so, the burden shifts to the Commissioner to show the existence of substantial gainful employment the claimant could perform. Id.

A. The ALJ's Conclusions

In reviewing the evidence in this case, the ALJ concluded that during the relevant period, between May 9, 2000 and December 31, 2000, Plaintiff's CTS on the right side was a "severe" impairment. (R. at 15). However, he found that White's alleged left-side CTS, low back and knee problems, and mental impairments were not severe for the adjudicatory period. Nonetheless, the ALJ found that right-side CTS was severe enough to keep Plaintiff from doing her prior jobs in medical

billing, as a nurse's assistant or as a home health aide, but that Plaintiff's complaints that these conditions were totally disabling was "exaggerated." (R. at 18-20). Instead, the ALJ found that she still had the ability to perform the physical exertional and non-exertional requirements of a range of light level work.[5] (R. at 20). Further, the ALJ concluded that based on this RFC, as well as her age, education and work experience, White is capable of performing other jobs existing in significant numbers in the national economy, including working as a retail sales clerk, a file clerk or an information clerk. (R. at 19, 21).

A. Substantial Evidence Does Not Support the ALJ's Finding that White's Only Severe Impairment Prior to her Last Date Insured was Carpal Tunnel Syndrome on the Right Side

Plaintiff challenges the ALJ's determinations at the second and fifth steps of the analysis. As to the second step, the ALJ found that White had only one severe impairment between May 9, 2000 and December 31, 2000 – carpal tunnel syndrome on the right side. (R. at 15). Citing Third Circuit caselaw that the threshold showing that a condition is "severe" at step two is minimal, Plaintiff contends the ALJ erred in failing to classify her left-side CTS, knee impairment, back pain and depression/anxiety as "severe" impairments. (Pl.'s Mot. Summ. J. at 6-7).

In McCrea v. Commissioner of Social Security, 370 F.3d 357 (3d Cir. 2004), the Third Circuit recently opined as the showing an applicant must make to establish that an impairment is "severe" at Step Two in the sequential evaluation of disability process. The Court stated:

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[5] The ALJ specifically found "the claimant had the residual functional capacity to lift and/or carry twenty pounds occasionally and ten pounds frequently, to stand and/or walk for a total of six hours in an eight-hour workday, and to sit for a total of six hours, provided that work did not require her to climb ladders, ropes or scaffolds or to crawl. The claimant had the capacity to perform no more than frequent (that is one-third to two-thirds of an eight-hour day) fingering and no repetitive motion activities, such as typing or keyboarding, with the right upper extremity. Concentrated (frequent) exposure to extremes in cold temperature, wetness, vibration, and hazards, such as moving machinery and unprotected heights should have been avoided." (R. at 17)

> The burden placed on an applicant at step two **is not an exacting one**. Although the regulatory language speaks in terms of 'severity,' the Commissioner has clarified that an applicant need only demonstrate something beyond a "slight abnormality or a combination of slight abnormalities which would have no more than a minimal effect on an individual's ability to work.'. . . **Any doubt as to whether this showing has been made is to be resolved in favor of the applicant** . . . In short, '[t]he step-two inquiry is a **de minimis screening device** to dispose of groundless claims."

Id. at 360 (emphasis added) (internal citations omitted). Accord Newell v. Comm'r of Soc. Sec., 347 F.3d 541, 546-57 (3d Cir. 2003) ("If the evidence presented by the claimant presents more than a 'slight abnormality,' the step-two requirement of 'severe' is met, and the sequential evaluation process should continue."); S.S.R. 85-28, 1985 WL 56856, at *3.

1. Left-Side Carpal Tunnel Syndrome

Plaintiff argues that ample medical documentation supports her claim that her left CTS had "more than a minimal effect on [her] ability to work." McCrea, 370 F.3d at 360. She cites to treatment notes and/or reports by Dr. Takei, her occupational therapist, Dr. Helzner and Dr. Leatherwood, all from November and December 2000, and all documenting CTS symptoms in her left hand. Further, a February 7, 2001 report by Dr. Leatherwood noted a new EMG test showed moderate left CTS. (Pl.'s Mot. Summ. J. at 7-9). The Commissioner asserts that Plaintiff had minimal, very conservative treatment for left-handed CTS prior to December 31, 2000 and a state agency physician found no functional limitations related to Plaintiff's left hand. (Resp.'s Mot. Summ. J. at 6-8).

Pursuant to the Third Circuit's clear holdings in McCrea and Newell that the threshold showing that a condition is "severe" at step two is minimal, meant to be a *de minimis* screening device to dispose of groundless claims, the Court concludes that substantial evidence does not support the ALJ's determination that Plaintiff's left-sided CTS was not severe. Plaintiff's left hand symptoms were bothersome enough in November and December 2000 to complain to at least four medical professionals,

and these complaints are well documented in the notes of her treating physicians, Dr. Takei, Dr. Helzner, Dr. Leatherwood and White's occupational therapist. Before her last date insured, Plaintiff's occupational therapist reported to Dr. Takei on November 9, 2000 that White had left hand numbness and pain and requested a left wrist splint for night use. (R. at 309). On November 15, 2000, she reported CTS symptoms in her left hand to Dr. Takei, who prescribed the splint for her left hand. (R. at 139). Treatment records by Dr. Helzner on November 21, 2000 noted that Plaintiff's "left hand [CTS] is also flaring up." (R. at 121). When Plaintiff saw Dr. Leatherwood on December 22, 2000, he also documented Plaintiff's increase of symptoms in the left arm, and testing on that day indicated mildly positive to equivocal carpal tunnel compression test in both arms. (R. at 136-37). Finally, shortly after her last date insured, on February 7, 2001, Dr. Leatherwood noted that follow-up electromyography (" EMG") testing revealed moderate left carpal tunnel syndrome. (R. at 134).

Plaintiff's repeated subjective complaints regarding left-sided CTS to her doctors during this period alone was likely enough to establish a "slight abnormality . . . which would ha[d] [at least a] minimal effect on an individual's ability to work." McCrea, 370 F.3d at 360. The ALJ, in his cursory discussion of White's left CTS, completely ignores these repeated and well-documented complaints by White during November and December 2000 to her four treating physicians, as well as the uncontested objective medical evidence by Plaintiff's treating physicians: Dr. Takei's prescription for a left hand splint, and most importantly, the EMG results reported by Dr. Leatherwood. (R. at 15-16). This test, conducted less than a month after White's last date insured,[6] in combination with Dr. Leatherwood's December 22, 2000 test revealing mildly positive to equivocal carpal tunnel compression test in both arms, clearly shows the left-side problem had its genesis prior to her last date insured. Fargnoli v.

[6]The December 22, 2000 record states Dr. Leatherwood was sending Plaintiff for a left-side EMG, and the next treatment record, on February 7, 2001, reports on the results. Thus, it is not actually clear from the record whether the EMG was actually performed before or after December 31, 2000, Plaintiff's last date insured.

Massanari, 247 F.3d 34, 43 (3d Cir. 2001) (it is an error of law to reject treating physicians' opinions if well-supported by diagnostic evidence and not inconsistent with other medical evidence in the record). Moreover, "any doubt as to whether this showing [should have been] resolved in favor of the applicant." Newell, 347 F.3d at 546-57. Accordingly, the ALJ's decision that Plaintiff's left side CTS was not "severe" was not supported by substantial evidence.[7]

2. Knee Impairment

With regard to knee problems, White avers that treatment notes from Dr. Helzner from January 16, 2001 and March 13, 2001 document her complaints of knee pain, together with Dr. Leatherwood's February 7, 2001 diagnosis that she was having an arthritic flare up is sufficient evidence of a medically determinable "severe" impairment.[8] (Pl.'s Mot. Summ. J. at 11-13). Further, she notes that Dr. Helzner diagnosed her as obese in August and September 2000, and thus is was error for the ALJ not to have considered the impact this obesity may have had on her alleged arthritic condition. The Commissioner counters that there is a complete lack of treatment for knee pain prior to December 31, 2000; the very first time she reported any problem was in January 2001. Further, she notes that Dr. Leatherwood's testing in February 2001 showed normal range of motion and negative x-rays and only mild symptoms.

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[7]The Commissioner's brief in support of its own motion for summary judgment suffers from many of the same infirmities as the ALJ's report. (Resp.'s Mot. Summ. J. at 6-8). The Commissioner does not acknowledge that the Third Circuit requires only a minimal threshold showing at step two in the sequential evaluation, McCrea, 370 F.3d at 360, or that Plaintiff received significant treatment for left-side CTS in November and December 2000, and objective medical tests conducted on December 22, 2000 and before February 7, 2001 confirm genesis of the condition before Plaintiff's last date insured. Thus, like the ALJ, the Commissioner failed to give significant enough weight to the uncontested opinions and medical evidence of Plaintiff's treating physicians. Fargnoli, 247 F.3d at 43.

[8] Plaintiff also notes that on August 1, 2000, she complained of back pain to her doctor. However, she makes no further argument that her back pain was a severe impairment. Given the lack of any other evidence whatsoever of a low back problem, there was substantial evidence for the ALJ to conclude the alleged back pain was not a medically determinable "severe" impairment.

(Resp.'s Mot. Summ. J. at 8-10).

The Court agrees with the Commissioner. In fact, the ALJ specifically weighed all the medical evidence on knee pain, and concluded that it was after the date last insured. Further, he discussed that even those examinations revealed no edema or gross defects in her joints, that she had full range of motion, only "mild" symptoms, and all tests were noted to be normal. Further, Dr. Leatherwood's report on February 7, 2001 of "spontaneous" swelling and pain to the left knee suggests the problem arose suddenly, after the last date insured. In sum, we find no error in the ALJ's decision that Plaintiff's knee pain was not "severe" before December, 31 2000, as it was supported by substantial evidence.

3. Mental Impairments

Finally, Plaintiff submits that the evidence of record confirms her mental impairment was clearly "severe" prior to the expiration of her insured status and that anyway, the ALJ should have called upon a Medical Expert to provide an opinion as to the onset date. She notes that on November 21, 2000, Dr. Helzner recorded that White presented as depressed and he prescribed Paxil. Finally, Plaintiff argues the ALJ failed to take into account the longitudinal history of her mental impairment. (Pl.'s Mot. Summ. J. at 14-16). The Commissioner argues that the entirety of Plaintiff's mental health treatment prior to December 31, 2000 consisted of the prescription of anti-anxiety and anti-depressant medication by her primary care physician. Further, there is no evidence Plaintiff sought, or received, treatment from any mental health professional. (Resp.'s Mot. Summ. J. at 10-13).

With regard to mental impairments in particular, 20 C.F.R. §§ 404.1520a and 416.920a (2000) dictate that the ALJ's written decision must examine and include a finding as to the claimant's functioning in four broad functional areas: activities of daily living; social functioning; concentration, persistence, or pace; and episodes of decompensation. Allen v. Barnhart, 417 F.3d 396, 400 (3d Cir. 2005); Ramirez, 372 F.3d at 551. When rating the degree of limitation in the first three functional areas,

the ALJ is to use a five-point scale: none, mild, moderate, marked, and extreme. When considering the fourth functional area, the ALJ should apply a four-point scale: none, one or two, three, and four or more. 20 C.F.R. §§ 404.1520a(c)(3)-(4) and 416.920a(c)(3)-(4). However, if the ALJ rates the first three functional areas as "none" or "mild" and "none" in the fourth area, the ALJ will generally conclude that the alleged impairment is not severe. Id. at §§ 404.1520a(d)(1) and 416.920a(d)(1).

Here, substantial evidence supports the ALJ's decision regarding Plaintiff's mental impairment. First, the ALJ's decision includes a specific finding as to the degree of limitation in each of the functional areas and found that Plaintiff's alleged depression and anxiety resulted in no more than "mild" limitation of her activities of daily living, social functioning, and concentration, persistence and pace and found no episodes of decompensation (R. at 16), thus making it appropriate to conclude the impairment is not severe. Id. at §§ 404.1520a(d)(1) and 416.920a(d)(1). He based these conclusions on the limited evidence of treatment for depression by her primary care physician in 2000; records indicate little more than this conclusory diagnosis of depression, making no attempt to opine on the cause, severity or duration of the condition or impact on White' ability to work. He further reasoned that the state agency psychological source found insufficient evidence of a severe mental impairment and that White did not begin formal mental health treatment until 2002, well after her date last insured. The Court is satisfied that the ALJ's finding that Plaintiff's mental impairment was not "severe" before December, 31 2000 was supported by substantial evidence.[9]

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[9]Moreover, contrary to Plaintiff's assertion, the ALJ was not required to seek testimony from a medical expert as to the alleged onset of her mental impairment. The cases cited by Plaintiff, Newell and Walton v. Halter, 243 F.3d 703 (3d Cir. 2001) merely stand for the proposition that when there is a lack of contemporaneous medical evidence from the relevant time period and the alleged impairment is a slowly progressing one, a medical advisor should be consulted to help infer the onset date of the impairment. Newell, 347 F.3d at 549, n.7; Walton, 243 F.3d at 709. Here, medical records from the relevant time period were readily available to support the ALJ's finding, and "both the objective medical records and lay evidence" tended to disprove Plaintiff's allegation of a disabling mental impairment prior to December 31, 2000. Kelley v. Barnhart, 138 Fed. Appx. 505, 509 (3d Cir. 2005) (non-precedential opinion).

B. The ALJ's Hypothetical Question to the Vocational Expert Did Not Properly Account for All of the Plaintiff's Functional Limitations

At the fifth and final step of the analysis, Plaintiff challenges the sufficiency of the ALJ's hypothetical to the vocational expert ("VE"). She asserts that because the question posited limitations only flowing from her right CTS, and not all the significant limitations as to which there was substantial evidence (including left-side CTS, knee pain and her mental impairment), it was error for the ALJ to credit the testimony of the VE. (Pl.'s Mot. Summ. J. at 21-22). Defendant contends that because Plaintiff failed to meet her burden that her psychological limitations and physical conditions other than her right-hand CTS significantly limited her ability to do basic work activities prior to her last date insured, the hypothetical was sufficient. Specifically, the Commissioner argues that as required, the ALJ's hypothetical included all of the limitations pre-dating White's last date insured that were established by the record. (Resp.'s Mot. Summ. J. at 14).

Testimony of a VE constitutes substantial evidence for purposes of judicial review only where the hypothetical question posed by the ALJ fairly encompasses *all* of an individual's significant limitations that are supported by the record. Ramirez, 372 F.3d at 552; Chrupcala v. Heckler, 829 F.2d 1269, 1276 (3d Cir. 1987). Further, "great specificity" is required when an ALJ incorporates a claimant's limitations into a hypothetical. Ramirez, 372 F.3d at 554-55 (citing Burns v. Barnhart, 312 F.3d 113, 122 (3d Cir. 2002)).

Here, the ALJ's hypothetical was as follows:

> If you had a hypothetical individual who was limited to light exertional work, who would be 38 years old, a high school plus education and the past work experience [of Plaintiff]. In addition, the hypothetical individual could never climb ladders, ropes or scaffolds or crawl. And in addition, the hypothetical individual would have to avoid concentrated, which is frequent, exposure to extremes in cold temperatures, wetness, vibration and hazards, such as moving machinery and unprotected heights. In addition, the hypothetical individual couldn't do more than frequent fingering with the right, upper extremity . . . [and in addition] couldn't do

> repetitive motion activities with the right hand, such as typing and keyboarding. . . Would there be light, unskilled occupations that would be possible for the hypothetical individual, in your opinion?

(R. at 338-39). As discussed at length *supra*, the Court found the record amply supports that Plaintiff's left-side CTS was also a severe, significant limitation. While the hypothetical incorporates an accommodation limiting fingering and repetitive motion activities for the right, upper extremity, it does not include facts regarding Plaintiff's left hand and arm. Moreover, given the medical evidence, both objective and opinion, as to the severity of Plaintiff's CTS in both hands, it is unclear that Plaintiff would be able to do work involving "frequent" (defined as one third to two thirds of an eight-hour day) fingering with either hand. Thus, the Court finds the VE's opinion deficient because the ALJ's hypothetical question did not reflect all of Plaintiff's functional limitations which were supported by the record. Therefore, the ALJ's conclusion that the Plaintiff is capable of performing certain jobs existing in significant numbers in the national economy was not based on substantial evidence. Accordingly, this case will be remanded.

V. Conclusion

For the foregoing reasons, this Court concludes that substantial evidence supports the ALJ's determination that Plaintiff's knee and mental impairments were not "severe" impairments. However, the ALJ erred in concluding her left-side CTS was not severe. Further, because the ALJ's hypothetical to the VE did not account for left-side CTS, a significant limitation supported by the record, the VE's testimony, and the ALJ's adoption thereof, does not constitute substantial evidence. Accordingly, the Commissioner's Motion for Summary Judgment will be granted in part and denied in part. Similarly, Plaintiff's Motion for Summary Judgment will be will be granted in part and denied in part and we will remand the case for further proceedings in accordance with this opinion.

An appropriate Order follows.

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

PATRICIA WHITE Plaintiff, v. JO ANNE B. BARNHART, Commissioner of the Social Security Administration, Respondent	: : : : : : : : : :	CIVIL ACTION NO. 05-2856

ORDER

AND NOW, this day of February, 2006, after careful and independent consideration of the parties' cross-motions for summary judgment, and review of the record, it is hereby ORDERED that:

1. The Commissioner's Motion for Summary Judgment (Doc. No. 8) is GRANTED IN PART AND DENIED IN PART;

2. The Plaintiff's Motion for Summary Judgment (Doc. No. 13) is GRANTED IN PART AND DENIED IN PART;

3. The case is REMANDED to the Commissioner for an evidentiary hearing in accordance with the foregoing Memorandum. This remand is ORDERED pursuant to the fourth sentence of 42 U.S.C. § 405(g).

4. The Clerk shall mark this case CLOSED.

BY THE COURT:

/s/ Michael M. Baylson

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MICHAEL M. BAYLSON, U.S.D.J.