UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

CIVIL ACTION NO. 07-11386-GAO

HOLLIS B. CRANMER,
Plaintiff

v.

MICHAEL J. ASTRUE, Commissioner of the Social Security Administration
Defendant.

OPINION AND ORDER
August 5, 2008

O'TOOLE, D.J.

The plaintiff, Hollis Cranmer, appeals the denial of supplemental Social Security and disability insurance benefits. Cranmer originally applied for disability insurance benefits and supplemental Social Security on February 2, 2005. (Administrative Transcript at 46-48 [hereinafter Record].) The application was denied on August 16, 2005. (Id. at 32-35.) Cranmer asked for reconsideration on October 8, 2005. (Id. at 36-37, 69-75.) On January 31, 2006, the original decision was affirmed. (Id. at 38.) He then requested a hearing before an Administrative Law Judge ("ALJ"), and one was held on November 27, 2006 (Id. at 22-26), after which the ALJ issued a written decision finding that the plaintiff was not disabled because he could successfully transition to work which exists in significant numbers in the national economy. (Id. at 14-19.) The plaintiff appealed the ALJ's decision to the Appeals Council, which denied the request for review on June 22, 2007, (Id. at 6-8.), and he then brought this case.

I. Factual History

Cranmer claims that from January 28, 2005 he has been unable to work because of injuries sustained to his left knee. (Id. at 51.) Prior to those injuries, the plaintiff was employed as a bouncer at various nightclubs, a part driver/mechanic, and a security guard. (Id. at 52.) Because the only issue raised in this case relates to whether the ALJ properly considered Cranmer's limitations due to injuries to his left knee, only that portion of his medical history is recited below.

1. Left Knee

In total, Cranmer had five arthroscopic surgeries on his left knee. Cranmer underwent arthroscopic surgery for the first time to repair the meniscus in his left knee on March 2, 2004. (Id. at 207.) Dr. William Mulroy performed a second arthroscopic surgery on January 31, 2005 at the Newton-Wellesley Hospital. (Id. at 92-98.) Dr. Mulroy's post-operative report states:

> Inspection of the patellofemoral joint revealed the patellofemoral articular cartilage was pristine. The suprapatelar, medial and lateral gutters were intact. Inspection of the lateral compartment revealed lateral meniscus intact to probing and visualization. The lateral articular surfaces were intact. The intercondylar notch was inspected. The ACL and PCL had a normal appearance. Inspection of the medial compartment revealed incomplete healing or retearing of the tear of the medial meniscus with evidence of 2 Fast-T-Fix tabs present. The portion that had not healed was in the mid third. A vertical tear was incompletely healed. A portion of the inner two-thirds of the meniscus was excised along with 2 of the Fast-T-Fix fixation buttons. The remaining meniscus was tapered and trimmed and showed a smooth transition. The posterior horn portion of the tear had healed completely. The more anterior portion of the repair had healed as well.

(Id. at 97.)

In March of 2005 Cranmer re-injured his left knee when he stepped on a golf ball while on a miniature golf course. (Id. at 90, 240). As a result, Cranmer had a third arthroscopic surgery on April 11, 2005 which was again performed by Dr. William Mulroy at the Newton-Wellesley

Hospital. (Id. at 85-91.) After the surgery, Dr. Mulroy noted that Cranmer had a horizontal cleavage tear, posterior horn, medial meniscus and partial tear of anterior cruciate ligament ("ACL") without significant instability with testing. (Id. at 90.)

On May 31, 2005, the plaintiff saw Dr. Anthony A. Schepsis, a Professor of Orthopedic Surgery at Braintree Hospital for a consultation regarding his left knee. (Id. at 125.) After a physical examination, Dr. Schepsis's Assessment and Plan consisted of:

> Status post meniscectomy with a question of chondral defect or ACL functional instability.
>
> The other thing that I notice with him is that he has marked quad atrophy and I agree wholeheartedly with his doctor at that at this time he needs an intensive course of physical therapy to really build up his strength. He should continue following with his doctor since I think he is being rendered excellent care and he is making the appropriate recommendations.

(Id.)

On October 13, 2005 Dr. Arthur F. Christiano of Boston Knee and Shoulder examined and developed a physical therapy plan for the plaintiff to strengthen his left quadricep muscles in attempts to remedy the atrophy. (Id. at 108-09.) In addition to routine physical therapy, Dr. Christiano concurred with Cranmer's use of a knee brace to provide stability. (Id. at 108.) Notes from the Boston Knee and Shoulder dating from September and October 2005 state that the "brace is helping," (id. at 186), and that he feels "much better" with the brace. (Id. at 187.) Dr. Christiano noted that if the plaintiff continued to be symptomatic after three months of therapy, then perhaps ACL reconstruction should be considered. (Id. at 109.)

On November 3, 2005, the plaintiff underwent a magnetic resonance imagining ("MRI") of his left knee at Newton-Wellesley Hospital. (Id. at 159.) The MRI revealed that there was mild medial joint compartment narrowing, (id. at 159, 188), but in all other respects the knee appeared normal.

Dr. Mulroy performed a fourth arthroscopic procedure on the plaintiff's knee at Newton-Wellesley Hospital on March 13, 2006. (Id. at 160-65.) The only abnormality recorded was "small inner edge tearing, horizontal cleavage-type of the mid third [medial meniscus] toward the posterior third junction." (Id. at 164.) Those small horizontal cleavage tears were resected. (Id.)

It appears that Cranmer continued to experience pain in his left knee and so he underwent a fifth arthroscopic surgery for internal derangement October 17, 2006. (Id. at 182.)

2. Functional Assessments

Dr. Jo Ann Jones completed a physical residual functional capacity assessment on August 1, 2005. (Id. at 99-107.) Her primary diagnosis was left knee derangement which limited the plaintiff's exertional capabilities to lifting and/or carrying up to ten pounds frequently, but only occasionally lifting and/or carrying up to twenty pounds. (Id. at 100.) He could stand and/or walk (with normal breaks) for a total of at least two hours in an eight-hour workday and sit (with normal breaks) for a total of about six hours in an eight-hour workday. (Id.) She further concluded that he had "limited" ability to push and/or pull (including operation of hand and/or foot controls) using his lower extremities. (Id.) As for postural limitations, Dr. Jones found that the plaintiff could frequently climb, balance, and stoop, but only occasionally kneel, crouch, and crawl. (Id. at 101.)

On January 18, 2006, Dr. David H. Cahan completed a Consultative Examination Report for the Massachusetts Rehabilitation Commission Disability Determination Services. (Id. at 144-45.) Of significance, Dr. Cahan noted that the plaintiff has "a very major issue with his left knee" that causes him "chronic pain in the knee, and has significant disability." (Id. at 144.) He assessed that:

> Functionally, [Cranmer] can walk ¼ block to maybe ½ block with his crutches, less without his crutches. Negotiating stairs is quite difficult for him. He tends not to go shopping, relying on his girlfriend or perhaps his father with whom he lives. He can lift and carry only 5-10 pounds He can mop and vacuum 10 minutes or so, but cannot do this for longer because of his knee problems.

(Id.)

A second physical residual functional capacity assessment was completed by Dr. Phyllis Sandell on January 23, 2006. (Id. at 146-53.) Dr. Sandell concluded that Cranmer's exertional limitations left him able to lift and/or carry up to twenty pounds only "occasionally," though he could "frequently" lift and/or carry up to ten pounds. (Id. at 147.) Similar to Dr. Jones's assessment, Dr. Sandell found that Cranmer could stand and/or walk (with normal breaks) for a total of at least two hours in an eight-hour workday, sit (with normal breaks) for a total of about six hours in an eight-hour workday, (id.), and push and/or pull (including operation of hand and/or foot controls) in a limited fashion through use of his lower extremities. (Id.) As for his postural limitations, Dr. Sandell found that Cranmer could "occasionally" climb ramps or stairs, balance, stoop, kneel, crouch, and crawl, but should "never" climb ladders, ropes, or scaffolds. (Id. at 148.) Dr. Sandell concluded that Cranmer could perform a sedentary job. (Id.)

II. Legal Analysis

After applying the traditional five-step process required under 20 C.F.R. § 416.920, the ALJ found that the plaintiff was not disabled within the meaning of the Social Security Act. The ALJ found that the injuries to his knees were a "severe" impairment. (Id. at 15.) The ALJ then found that the plaintiff had no impairment which met the criteria of any of the listed impairments described in Appendix 1 of the Regulations. (Id. at 17.) Therefore, the ALJ addressed whether the plaintiff could perform either his former jobs or others in the economy. The ALJ concluded that although the plaintiff was precluded from performing any of his past relevant work, (id. at

19), he could still perform other jobs within the national and state economy such as a dispatcher, shipping clerk, or order clerk. (Id.) Accordingly, the ALJ concluded that the plaintiff was not disabled.

The plaintiff claims that the ALJ erred in the third step by summarily dismissing his argument that his knee injury met or equaled a listed impairment in Appendix 1 of the Regulations, specifically Listing 1.08. Listing 1.08 states in full:

> 1.08 Soft tissue injury (e.g., burns) of an upper or lower extremity, trunk, or face and head, under continuing surgical management, as defined in 1.00M, directed toward the salvage or restoration of major function, and such major function was not restored or expected to be restored within 12 months of onset. Major function of the face and head is described in 1.000.

20 C.F.R., pt. 404, subpt. P, app. 1. To meet Listing 1.08, the plaintiff must satisfy five conditions: (1) soft tissue injury, (2) to an upper or lower extremity, trunk, or face and head, (3) under continuing surgical management, as defined in 1.00M,[1] (4) directed toward the salvage or restoration of major function, (5) such major function not restored or expected to be restored within twelve months of onset.

The ALJ's only discussion regarding Listing 1.08 consisted of the following paragraph:

> The claimant has no impairment which meets the criteria of any of the listed impairments described in Appendix 1 of the Regulations (20 C.F.R., Part 404, Subpart P, Appendix 1). No treating or examining physician has mentioned

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[1] 1.00M states in turn:

> Under continuing surgical management, as used in 1.07 and 1.08, refers to surgical procedures and any other associated treatments related to the efforts directed toward the salvage or restoration of functional use of the affected part. It may include such factors as post-surgical procedures, surgical complications, infections, or other medical complications, related illnesses, or related treatments that delay the individual's attainment of maximum benefit from therapy. When burns are not under continuing surgical management, see 8.00F.

20 C.F.R., pt. 404, subpt. P, app. 1

> findings equivalent in severity to the criteria of any listed impairment. The attorney argues that the claimant meets Listing 1.08. However, that listing is for the evaluation of soft-tissue injury to the head, face, trunk, or extremities, such as burns. This case is more properly evaluated under listings 1.02 and 1.03.

(R. at 17.) It appears that the ALJ determined that the plaintiff's injury to his left knee did not satisfy the first element – i.e., it was not a "soft tissue injury."[2]

Although Listing 1.08 does not define "soft tissue injury," it is clear from the text that "burns" are not the exclusive type of injury intended to be covered by Listing 1.08, but is rather listed as an illustrative example.[3] At least one dictionary defines "soft tissue injury" as:

> Bodily injury confined solely to the soft tissue for the purpose of this section means, injury in the form of sprains, strains, contusions, lacerations, bruises, hematomas, cuts, abrasions, scrapes, scratches, and tears confined to the muscles, tendons, ligaments, cartilages, nerves, fibers, veins, arteries and skin of the human body.

The Sloane-Dorland Annotated Medical-Legal Dictionary 381 (1987).

The plaintiff's knee injuries comprise of a meniscal tear and a partial tear of his ACL. The meniscus is "[a] crescent-shaped fibrocartilaginous structure of the knee, the acromio-and sternoclavicular and the temporomandibular joints." Stedman's Medical Dictionary 1089 (26th ed. 1995). A ligament, in general, is "[a] band or sheet of fibrous tissue connecting two or more bones, cartilages, or other structures, or serving as support for fasciae or muscles," id. at 964, and the ACL is the ligament that "extends from the anterior intercondylar area of the tibia to the

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[2] Furthermore, because the ALJ here expressly explained why Listing 1.08 was not met – because the type of injury sustained is more appropriately considered under Listing 1.02 or Listing 1.03 – the reasoning of Arsenault v. Barnhart, No. Civ. 03-108-B, 2004 WL 1013381 (D.N.H. May 4, 2004), where the ALJ offered no explanation for his rejection of the Listing, is inapposite.

[3] There is some evidence that Listing 1.08 was revised to make clear that burns are encompassed by the Listing. Revised Medical Criteria for Determination of Disability, Musculoskeletal System and Related Criteria, 66 Fed. Reg. 58010, 58019.

posterior part of the medial surface of the lateral condyle of the femur." Id. at 965. Based on those general dictionary definitions, both a meniscal tear and a partial tear of the ACL may qualify in a very broad sense as a soft tissue injury. See Allard v. Chater, NO 96-C-4646, 1997 WL 573400, at *15 (N.D. Ill. Sept. 11, 1997) (remanding so that the ALJ can consider whether the claimant's knee injuries comprising of a torn ligament and a possible torn meniscus were sufficient to meet the requirements of Listing 1.13, which was the precursor to Listing 1.08).

However, as the ALJ noted, there are two other Listings – Listings 1.02 and 1.03 – which specifically address injuries to major weight-bearing joints, such as the knee. Those Listings respectively state:

> 1.02 Major dysfunction of a joint(s) (due to any cause): Characterized by gross anatomical deformity (e.g., subluxation, contracture, bony or fibrous ankylosis, instability) and chronic joint pain and stiffness with signs of limitation of motion or other abnormal motion of the affected joint(s), and findings on appropriate medically acceptable imaging of joint space narrowing, bony destruction, or ankylosis of the affected joint(s). With:
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> A. Involvement of one major peripheral weight-bearing joint (i.e., hip, knee, or ankle), resulting in inability to ambulate effectively, as defined in 1.00B2b;
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> or
>
> B. Involvement of one major peripheral joint in each upper extremity (i.e., shoulder, elbow, or wrist-hand), resulting in inability to perform fine and gross movements effectively, as defined in 1.00B2c.
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> 1.03 Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint, with inability to ambulate effectively, as defined in 1.00B2b, and return to effective ambulation did not occur, or is not expected to occur, within 12 months of onset.

20 C.F.R., pt. 404, subpt. P, app. 1. The medical evidence is undisputed that the cause of the plaintiff's claims of pain while walking and standing are due to the injuries to his left knee. The plaintiff underwent five surgeries, including a meniscal repair. The MRI taken in November 2005 showed mild medial joint compartment narrowing in his left knee, one of the express conditions encompassed by Listing 1.02.

When analyzing whether a claimant has an impairment which meets the criteria of any of the listed impairments described in Appendix 1 of the Regulations, it is perfectly reasonable for an ALJ to refer to the most specific applicable listing, which is what the ALJ did here. This, of course, is hardly a novel proposition. It is a well-established canon of statutory interpretation (which can be extended to regulatory interpretation) that a specific provision trumps a general provision. See Cerqueira v. Am. Airlines, Inc., 520 F.3d 1, 13 (1st Cir. 2008) ("This reading would apply the principle that in statutory interpretation courts give specific language precedence over general language."); 2B Norman J. Singer, Sutherland Statutory Construction § 51.05 at 244-56 (6th ed. 2000). Furthermore, according to the plaintiff's interpretation, any analysis under Listing 1.08 would be the same analysis required of Listing 1.02 in this case, making Listing 1.02 entirely redundant. Consequently, attempting to classify the plaintiff's knee injuries under Listing 1.08 would be an imprudent distortion of the Listings when they clearly account for these injuries under Listing 1.02 or Listing 1.03. Thus, the ALJ's conclusion that Cranmer's limitations were "more properly" considered under Listings 1.02 and 1.03 instead of Listing 1.08 was correct.

In any event, if it were assumed that the plaintiff's knee problem could be properly classified as a "soft tissue injury" within the technical scope of Listing 1.08 the outcome would be the same. As the defendant argues, the ALJ expressly concluded, albeit with respect to Listings 1.02 and 1.03, that the plaintiff could ambulate effectively, and it can therefore be concluded that for the same reasons expressed with respect to those listings, the ALJ would have likewise decided that the plaintiff did not lose function in his left knee and could ambulate effectively as required by Listing 1.08. Ward v. Comm'r of Social Sec., 211 F.3d 652, 656 (1st Cir. 2000) ("[A] remand is not essential if it will amount to no more than an empty exercise."

(citing Dantran, Inc. v. U.S. Dep't of Labor, 171 F.3d 58, 73 (1st Cir.1999); Schaal v. Apfel, 134 F.3d 496, 504 (2d Cir.1998) ("Where application of the correct legal standard could lead to only one conclusion, we need not remand.”))).

The regulations define "functional loss" for the purposes of the Listings as "the inability to ambulate effectively on a sustained basis for any reason…or the inability to perform fine and gross movements effectively on a sustained basis for any reason." 20 C.F.R., pt. 404, subpt. P, app. 1, at 1.00B.2.a. The "inability to ambulate effectively" is in turn defined as "an extreme limitation of the ability to walk; i.e., an impairment(s) that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities." Id. at 1.00B.2.b(1). Therefore, the salvage or restoration of a major function can be viewed as the ability to ambulate effectively. See Vines v. Barnhart, No. A-05-CA-763 SS, 2006 WL 2822177, at * 5 (W.D. Tex. Sept. 28, 2006). The regulations specify that to ambulate effectively:

> individuals must be capable of sustaining a reasonable walking pace over a sufficient distance to be able to carry out activities of daily living. They must have the ability to travel without companion assistance to and from a place of employment or school. Therefore, examples of ineffective ambulation include, but are not limited to, the inability to walk without the use of a walker, two crutches or two canes, the inability to walk a block at a reasonable pace on rough or uneven surfaces, the inability to use standard public transportation, the inability to carry out routine ambulatory activities, such as shopping and banking, and the inability to climb a few steps at a reasonable pace with the use of a single hand rail. The ability to walk independently about one's home without the use of assistive devices does not, in and of itself, constitute effective ambulation.

20 C.F.R., pt. 404, subpt. P, app.1, at 1.00B2.b.(2).

The ALJ reviewed the relevant medical history and found that the plaintiff could indeed ambulate effectively. (R. at 18.) The ALJ's finding that the plaintiff can ambulate effectively may be viewed as the equivalent of finding that Cranmer did not lose function of his left knee for purposes of Listing 1.08, and thus, for the purposes of Listings 1.02 and 1.03 as well.

The ALJ's findings are conclusive so long as they are supported by "substantial evidence." See Nguyen v. Chater, 172 F.3d 31, 35 (1st Cir. 1999) (per curiam). Substantial evidence means "'more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.'" Richardson v. Perales, 402 U.S. 389, 401 (1971) (quoting Consolidated Edison Co. v. NLRB, 305 U.S. 197, 229 (1938)). "Although the record may support more than one conclusion, we must uphold the Secretary 'if a reasonable mind, reviewing the evidence in the record as a whole, could accept it as adequate to support his conclusion.'" Shaw v. Sec'y of Health & Human Servs., 25 F.3d 1037 (1st Cir. 1994) (Table), available at 1994 WL 251000, at *4 (quoting Ortiz v. Sec'y of Health & Human Servs., 955 F.2d at 769). Furthermore, where the record may permit conflicting interpretations to be drawn, the Secretary will be affirmed, even if this Court were to reach a different conclusion. Id.

Although the record contains conflicting evidence, there is substantial evidence to support the ALJ's conclusion that Cranmer can ambulate effectively. After the first surgery in the disability period (on January 31, 2005), it appears that the plaintiff was ambulating well enough to walk a miniature golf course at which time he stepped on a golf ball causing reinjury to his left knee. (R. at 240.) Additionally, the objective medical evidence indicates only a mild tearing of the medial meniscus and minor scuffing of the articular cartilage. On at least two occasions, Cranmer's doctors noted that he had full range of motion in his left knee, (R. at 122, 164), and no ligamentous laxity. (R. at 90, 97, 164.) In April 2006, Dr. Mulroy expected improvement in Cranmer's condition when he observed that Cranmer's knee was "healing well but to give it a few more months with the pain." (R. at 212.)

Furthermore, there is no indication from any of his doctors that he should avoid walking, limit it, or use special precautions. This apparently comports with the plaintiff's own behavior. For example, on June 17, 2006, he acknowledged doing "a lot of walking and work around the house, all of which was necessary," but only felt "some increased pain." (R. at 213.) In April of 2006, Cranmer admitted that he "has been trying to walk more." (R. at 212.) Again on July 8, 2006 Cranmer stated that he "was on his feet a lot over the last 2 weeks" and felt increased pain and swelling because of that. (R. at 214.) Coupled with the fact that Cranmer was indeed walking is the fact that the only medication he took to alleviate any pain caused by walking was Percocet or Oxycodine. Moreover, during the entire period of claimed disability, the only assistance used by Cranmer on a regular basis was a knee brace to provide "stability to the knee." (R. at 108.) There is no indication that he ever used a walker and the only passing reference to using crutches was after "he had to be on his feet for a long time" the day before. (R. at 213.)

Furthermore, the functional assessments from Drs. Jones and Sandel concluded that Cranmer could stand and/or walk (with normal breaks) for a total of at least two hours in an eight-hour workday. In light of all this, Dr. Cahan's more negative assessment in January 2006 recedes in persuasive force. I conclude that there is substantial evidence in the record to conclude that the plaintiff can ambulate effectively and, therefore, that the impairment does not meet or equal and applicable Listing. Remand is unnecessary.

The defendant's motion (dkt. no. 10) is GRANTED and the plaintiff's motion (dkt. no. 8) is DENIED. The Commissioner's decision is AFFIRMED.

It is SO ORDERED.

/s/ George A. O'Toole, Jr.
United States District Judge