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

GWENDOLYN WILLIS	:	
	:	CIVIL ACTION
	:	
v.	:	
	:	
	:	
JO ANNE BARNHART, COMMISSIONER, SOCIAL SECURITY ADMINISTRATION	:	NO. 03-CV-5387
	:	

SURRICK, J. **DECEMBER 30, 2004**

MEMORANDUM & ORDER

Presently before the Court is Plaintiff Gwendolyn Willis's Motion for Summary Judgment (Doc. No. 10) and Defendant Jo Anne Barnhart's, Commissioner, Social Security Administration, Response and Cross-Motion for Summary Judgment. (Doc. No. 13.) For the following reasons, Plaintiff's Motion will be granted and Defendant's Motion will be denied.

I. Factual and Procedural History

Plaintiff Gwendolyn Willis ("Willis") files the instant Motion to challenge the denial by the Commissioner of the Social Security Administration ("Commissioner") of her claim for Disability Insurance Benefits ("DIB") and Supplemental Security Income ("SSI") under Titles II and XVI of the Social Security Act, 42 U.S.C.A. §§ 401-33, 1381-83c (West 2004). (Doc. No. 10 at 1.) Willis filed a claim for DIB and SSI on December 20, 2001. (Tr. at 61-63, 313 (hereinafter "Tr.").) The Commissioner's state agency denied her claim initially, and she filed a timely request for a hearing. (Tr. at 51-54, 313.) An Administrative Law Judge ("ALJ") held a hearing on September 11, 2002, at which time Willis and Dr. Steve Gummerman, a vocational

expert ("VE"), testified. (*Id.* at 20-47.) On October 25, 2002, the ALJ issued a decision denying Willis's DIB and SSI claims. (*Id.* at 310-21.) The Appeals Council denied Willis's request for review. (*Id.* at 5-7.)

In 2001, Willis was a sixty (60) year old woman, who was approximately sixty-six (66) inches tall and weighed 248 pounds. (*Id*. at 262.) She previously had worked as a billing clerk and a medical secretary. (*Id*. at 71.) Willis's medical records indicate that she underwent a partial lateral meniscectomy[1] and chondroplasty[2] of the left knee on September 19, 1995, (*id.* at 116) post excision of the fragment of her fifth metatarsal with reattachment of her peroneus brevis tendon of her right foot on June 19, 1996, (*id*. at 132) left endoscopic carpal tunnel release on March 18, 1998, (*id*. at 146) and bilateral rotator cuff repairs on September 10, 1999, and October 20, 1999 (*id*. at 173, 182). On September 19, 2001, a right knee MRI showed extension tricompartment osteoarthritis,[3] maceration[4] of the medial and lateral menisci,[5] and an old anterior cruciate ligament tear. (*Id*. at 215, 286.)

On October 2, 2001, Willis's primary care physician, John Yardney, M.D., performed a

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[1]Stedman's Medical Dictionary ("Stedman's") defines a meniscectomy as an "excision of a meniscus, usually from a knee joint." Thomas Lathrop Stedman, Stedman's Medical Dictionary 855 (1982).

[2]Stedman's defines chondroplasty as "reparative or plastic surgery of cartilage." *Id.* at 272.

[3]Stedman's defines osteoarthritis as "a degenerative or hypertrophic arthritis, which may be either primary or secondary to trauma or other conditions." *Id*. at 1002.

[4]Stedman's defines maceration as "softening by the action of a liquid." *Id.* at 823.

[5]Stedman's defines medial menisci as "faliciform cartilage; attached to the lateral border of the upper articular surface of the tibia," *id.* at 855, and lateral menisci as "external semilunar fibrocartilage; attached to the lateral border of the upper articular surface of the tibia." *Id.*

preoperative evaluation for her left total knee replacement. (*Id*. at 190.) He noted her past medical history of diabetes, hyperlipidemia, morbid obesity, osteoarthritis, autoimmune thyroiditis and depression. (*Id*.) Upon physical examination, Dr. Yardney found she had severe pain in her left knee. (*Id*.) On October 8, 2001, Willis's orthopedic surgeon, Joseph Vernace, M.D., performed a left knee replacement at Bryn Mawr Hospital. (*Id*. at 197.) Willis underwent physical therapy at Bryn Mawr Rehabilitation from October 13, 2001, through October 18, 2001. (*Id.* at 287-89.)

In November, 2001, Willis began physical therapy at the Pain Relief and Physical Therapy Center. (*Id.* at 206-07.) Willis was progressing well in physical therapy (*id.* at 205), and even attempted to go back to work for half days during the week of November 26, 2001 (*id*. at 212),[6] but had to stop her physical therapy treatment when, on December 10, she suffered from acute "sciatica pain in her left buttock and left leg." (*Id*. at 205.) Her physical therapist noted that he was not able to perform physical therapy due to "the acuteness of her radicular symptoms." (*Id*.) He noted that Willis could not tolerate any other position than lying on her right side, with a pillow between her knees. (*Id*.) He also noted that she "ambulates with single point cane, antalgic gait[7] due to radicular[8] and knee symptoms." (*Id*.) The physical therapist

[6]Willis explained that she tried to go back to her position as medical secretary, but found it too painful. (Tr. at 33.) She explained that "[I] couldn't hold my leg up. I couldn't put it down. . . . It was more painful trying to figure out a way to sit." (*Id*.)

[7]Stedman's defines an antalgic gait as "a characteristic [gait] resulting from pain on weight bearing in which the stance phase of [gait] is shortened on the affected side." Stedman's at 569.

[8]Stedman's defines radicula as a "spinal nerve root." *Id.* at 1186. While the physical therapist wrote "radicular" in his report, we assume he meant radicula.

recommended a medical/orthopedic evaluation of her lower back because "[h]er pain was very acute." (*Id*.)

On December 11, 2001, Dr. Vernace examined Willis in an emergency visit due to her back pain. (*Id*. at 211.) Dr. Vernace injected her with Kenalog and Lidocain and noted that she was suffering from left sciatica and marked tenderness at her SI joint. (*Id*.)

On December 14, 2001, Dr. Yardney referred Willis to Dr. Benjamin Auerbach, D.O., for lumbar spinal care. (*Id*. at 262.) Dr. Auerbach noted that Willis suffered from sciatic neuralgia,[9] which extended mostly to her left superficial peroneal nerve, and also to her sural nerve and posterior thigh. (*Id*.) He noted that her pain was severe, that she was placed on a 50-50-40-40 prednisone[10] taper by Dr. Vernace, and that she was taking MS Contin and Vicodin. (*Id*.) He added that her pain increased when standing and walking and was especially symptomatic when transferring from sitting to standing. (*Id*.) He summarized that his impression was Willis had a left L5 radiculopathy,[11] secondary to lumbar disc herniation.[12] (*Id.* at 263.) He prescribed Vioxx and said he would perform an MRI of her lumbar spine. (*Id*.) The MRI on the same date showed minimal to moderate disc herniation with left foraminal

[9]Stedman's defines neuralgia as "pain of a severe, throbbing, or stabbing character in the course or distribution of a nerve." *Id.* at 943.

[10]Stedman's defines prednisone as "a dehydrogenated analogue of cortisone with the same actions and uses." *Id.* at 1133.

[11]Stedman's defines radiculopathy as a "disease of the spinal nerve roots." *Id.* at 1187.

[12]Stedman's defines herniation as "[f]ormation of a protusion." *Id.* at 643.

encroachment and superior extrusion, and discogenic[13] change at L2-3 through L5-S1 levels. (*Id*. at 208.)

On December 18, 2001, Dr. Auerbach examined Willis and diagnosed her with L5 radiculopathy secondary to L4-5 left herniated disc. (*Id*. at 210.) He recommended that she "undergo a fluroscopically guided foraminally based epidural steroid injection." (*Id*.) He recommended that she continue with the MS Contin and Vicodin, and start Vioxx once she finishes the prednisone taper. (*Id*.) He added that given the size of her extruded disc, these interventional measures may be quite temporary and she may need a lumbar discectomy. (*Id*.) On January 4, 2002, Dr. Auerbach wrote:

> Ms. Willis is currently under my care for low back pain and left leg pain secondary to a large left L4-5 herniated disc. Because of her symptoms it would be of great assistance to her if she could continue the utilization of a wheelchair while she is under treatment with fluoroscopically guided foraminally based epidural steroid injections.

(*Id*. at 261.) On January 8, 2002, Willis saw Dr. Vernace for severe right shoulder pain. (*Id*. at 209.) He noted that she had poor range of motion in her right shoulder and injected it. (*Id*.) On January 14, 2002, Dr. Auerbach wrote that Willis "has a left paracentral disc herniation with small extrusion at L4-5 which is compressing the left L5 nerve root resulting in L5 lumbar radiculopathy." (*Id*. at 258.) He noted that she is to "have a second left L5-S1 intervertebral foraminally based fluoroscopically guided lumbar epidural steroid injection . . . continue with the Vioxx, MS Contin and Vicodin." (*Id*.) He added that if she does not improve, "she is going to have to give serious consideration to surgical decompression, which given her multiple

[13]Stedman's defines discogenic as "[d]enoting a disorder originating in or from the intervertebral disc." *Id.* at 402.

musculoskeletal comorbities in surgery she is understandably trying to avoid." (*Id*.)

On January 18, 2002, Dr. Yardney examined Willis and noted "[s]he has been at home and mostly disabled because of back pain." (*Id*. at 274.) He stated that she walks slowly using a cane and that she is concerned about pain in her right shoulder. (*Id*.)

On February 12, 2002, Willis's symptoms had not improved. (*Id*. at 256.) Dr. Auerbach stated "she has had no improvement of her left L5 dysesthetic pain after her second foraminally based fluoroscopically guided lumbar epidural steroid injection." (*Id*.) He added that his impression is "left paracentral disc herniation with extrusion at L4-5 with L5 lumbar radiculopathy." (*Id*.) Dr. Auerbach referred Willis to Dr. James A. Kenning, M.D., a neurosurgeon, for consideration of surgical decompression. (*Id*.)

On March 20, 2002, Dr. Kenning examined Willis and wrote to Dr. Auerbach:

> This 60-year-old medical secretary was seen in consultation for low back and left lower extremity pain. The patient dates the onset of her symptoms to late October following her left total knee replacement when she developed left buttock pain that began to radiate anterolaterally into the thigh without any specific inciting cause. This pain has remained persistent over the last four months despite oral corticosteroid nonsteroidal anti-inflammatory agents, and selective nerve blocks.

(*Id*. at 250.) He added that the MRI showed "four level degenerative disc disease with loss of disc height and disc desiccation at all levels extending from L2-3 distally." (*Id*. at 251.) A March 25, 2002, CT Scan of the lumbar spine showed spinal stenosis,[14] disc herniation, and discogenic change. (*Id*. at 233.)

On March 29, 2002, Willis was admitted to Lankenau Hospital for a left L4-5 microdiscectomy and nerve root compression performed by Dr. Kenning. (*Id*. at 235, 243-44.)

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[14]Stedman's defines stenosis as "a stricture of any canal." *Id.* at 1336.

One month later, on May 1, 2002, Dr. Kenning examined Willis and noted that while she "appears to be relieved of the worst of her sharp left sciatica . . . she does complain of grumbly low back pain which is occasionally severe and associated with a vague discomfort that radiates . . . into both thighs." (*Id*. at 247.) Dr. Kenning noted, "overall, she seems to [have] marginal results [from] surgery . . . [which was] not a huge surprise given her substantial analgesic requirement prior to surgery and her body habitus." (*Id*.)

On May 8, 2002, Dr. Auerbach completed a disability questionnaire at the request of the Social Security Administration. (*Id*. at 253-55.) He wrote, "[t]his patient is totally disabled in my opinion." (*Id*.) He explained his diagnosis was "Lumbar Herniated Disc with L5 Radiculopathy." (*Id*.) He wrote that her history was "Rotator Cuff tendonopathy, degenerative joint disease ("DJD") in her knees and hips, multiple orthopedic surgeries," and that she was taking MS Contin. (*Id*.) He added, "[p]lease review medical records." (*Id*.)

On May 20, 2002, Willis saw Dr. Vernace and complained of pain in both knees after falling on May 14, 2002. (*Id*. at 302.) Dr. Vernace noted that she ambulated with a cane. (*Id*.) A right knee x-ray revealed that she had moderately advanced DJD and her left knee was stable. (*Id*.)

On June 17, 2002, Willis saw Dr. Vernace and complained of a flare-up of her right knee pain. (*Id*. at 301.) He noted that she had advanced DJD of the right knee and was eight months post left total knee arthroplasty. (*Id*.) He recommended intra-articular injection of Kenalog, Novocain, and Depo Medrol, application of ice to the area, continuation of pain medications, and a right total knee arthroplasty. (*Id*.)

On July 25, 2002, Dr. Vernace wrote:

> Her right knee is becoming increasingly painful. It is not improving with corticosteroid injections. She is nearly bone-on-bone medially and she is bone-on-bone in the patellofemoral joint.
>
> We are going to proceed with a right total knee replacement on Monday 8/5/02. She has recently been through a left total knee replacement.

(*Id*. at 300.)

On August 5, 2002, Willis underwent a total right knee replacement. (*Id*. at 304.) She was admitted to Bryn Mawr Rehabilitation Hospital from August 8, 2002, to August 15, 2002. (*Id*. at 296-98.) Her functional status at discharge was that she "was able to ambulate up to 150 feet with a rolling walker." (*Id*. at 296.)

On August 20, 2002, two weeks after her total right knee replacement, Dr. Vernace noted that "[s]he is having a lot of pain" and her range of motion in her knee was "lagging behind." (*Id*. at 299.)

On September 11, 2002, at the Hearing before the ALJ, Vocational Expert ("VE") Dr. Gummerman testified. The ALJ asked the VE, "[i]f you assume that all of the Claimant's testimony is fully credible, would there be any occupations including past work that would be possible?" (*Id*. at 41.) The VE answered, "I don't believe there would be." (*Id*.)

II. Legal Standard

The Social Security Act provides that "any individual, after any final decision of the Commissioner of Social Security made after a hearing to which he was a party, . . . may obtain a review of such a civil action" in federal district court. 42 U.S.C.A. § 405(g) (West 2004). The ALJ's decision is the final decision of the Commissioner if the Appeals Council denies a request for review, as in the instant case. *Sims v. Apfel*, 530 U.S. 103, 106-07 (2000); *Mathews v. Apfel*,

239 F.3d 589, 592 (3d Cir. 2001). The Act provides that "the court shall have the power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the case for a rehearing." 42 U.S.C.A. § 405(g) (West 2004).

We must affirm the Commissioner's decision if it is supported by "substantial evidence" in the record. *Id.*; *see also Smith v. Califano*, 637 F.2d 968, 970 (3d Cir. 1981). The Third Circuit defines "substantial evidence" as "more than a mere scintilla." *Smith*, 637 F.2d at 970. "It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." (citations omitted). *Id.* The Third Circuit has stated:

> This oft-cited language [defining substantial evidence] is not, however, a talismanic or self-executing formula for adjudication; rather, our decisions make clear that determination of the existence *vel non* of substantial evidence is *not* merely a quantitative exercise. A single piece of evidence will not satisfy the substantiality test if the Secretary ignores, or fails to resolve, a conflict created by countervailing evidence. Nor is evidence substantial if it is overwhelmed by other evidence (e.g., that offered by treating physicians) . . . . The search for substantial evidence is thus a qualitative exercise without which our review of social security disability cases ceases to be merely deferential and becomes instead a sham.

Kent v. Schweiker, 710 F.2d 110, 114 (3d Cir. 1983).

III. Discussion

The Social Security Act defines disability[15] in terms of the effect a physical or mental

[15] The Social Security Act defines a disability as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." 42 U.S.C.A. § 423(d)(1)(A) (West 2004).

impairment has on a person's ability to function in the workplace. *Heckler v. Campbell*, 461 U.S. 458, 459-60 (1983). It provides DIB and SSI only to those claimants who "are unable to 'engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment.'" *Id.* at 460 (quoting 42 U.S.C. § 423(d)(1)(A)). When evaluating a claim for disability benefits, the Commissioner applies a five-step sequential analysis.[16] 20 C.F.R. § 404.1520 (2004); *Sykes*, 228 F.3d at 262. In the instant case, the ALJ found that Willis is not entitled to a period of disability, and not eligible for DIB or SSI. (Tr. at 321.) While the ALJ determined that Willis's allegations regarding her limitations were credible, and that Willis "has an impairment or combination of impairments considered 'severe' based on the requirements in the Regulations 20 C.F.R. §§ 404.1520(b) and 416.920(b)" (*id*. at 320), he concluded that she had the residual functional capacity[17] to perform her past work as billing clerk and medical secretary (*id*. at 320-21), and therefore did not qualify for DIB or SSI. (*Id*.) The ALJ disregarded Willis's treating orthopedic specialist Dr. Auerbach in favor of the DDS reviewing physician, who did not examine Willis. The ALJ also cited the VE's testimony that a hypothetical

[16]In order to determine whether a claimant qualifies for DIB and SSI, an ALJ must follow a five-step evaluation: (1) if the claimant is performing substantial gainful work, she is not disabled; (2) if the claimant is not performing substantial gainful work, her impairment(s) must be severe before she can be found to be disabled; (3) if the claimant is not performing substantial gainful work and has a severe impairment that has lasted or is expected to last for a continuous period of at least twelve months, and her impairment (or impairments) meets or medically equals a listed impairment, she is disabled; (4) if the claimant's impairment does not prevent her from doing her past relevant work, she is not disabled; and (5) if the impairment prevents her from performing her past relevant work, if other work exists in the economy that accommodates her residual functional capacity and vocational factors, she is not disabled. 20 C.F.R. §§ 404.1520, 416.920 (2004).

[17]The Code of Federal Regulations defines "residual functional capacity" as the most an individual can still do despite her limitations. 20 C.F.R. § 404.1545(a)(1) (2004).

individual with Willis's residual functional capacity and vocational factors could return to claimant's past relevant work. (*Id*. at 319-20.) Finally, the ALJ explained that Willis's testimony "is not inconsistent with a series of temporary, acute conditions not meeting the 12-month durational requirement for disability under the Social Security Act." (*Id*. at 319.) We will address each of these factors in turn.

A. Medical Evidence

The ALJ stated that he would not give the opinion of Dr. Auerbach, Willis's treating orthopedic specialist, controlling weight because Dr. Auerbach stated, "[t]his patient is totally disabled in my opinion." (*Id*. at 316.) The ALJ found that, "Doctor Auerbach's opinion addresses the ultimate issue reserved to the Commissioner rather than claimant's functional capacities, and may also not represent an opinion regarding claimant's condition over a continuous period of at least twelve months." (*Id*. at 316-17.) The Code of Federal Regulations provides that:

> We will assess your residual functional capacity based on all of the medical and other evidence . . . . [B]efore we make a determination that you are not disabled, we are responsible for developing your complete medical history, including arranging for a consultative examination(s) if necessary, and making every reasonable effort to help you get medical reports from your own medical sources.

20 C.F.R. § 404.1545(a)(3) (2004). Moreover, 20 C.F.R. § 416.912 also provides:

> (e) Recontacting medical sources. When the evidence we receive from your treating physician . . . or other medical source is inadequate to determine whether you are disabled, we will need additional information to reach a determination or a decision. To obtain the information, we will take the following actions.
>
> (1) We will first recontact your treating physician . . . or other medical sources to determine whether the additional information we need is readily available. We will seek additional evidence or clarification from your

> medical source when the report from your medical source contains a conflict or ambiguity that must be resolved, [or] the report does not contain all of the necessary information . . . . We may do this by requesting copies of your medical source's records, a new report, or a more detailed report from your medical source, including your treating source, or by telephoning your medical source.

Id. Furthermore, Social Security Ruling ("SSR") 96-2p[18] provides that the term "controlling weight" is used "to describe the weight we give to a medical opinion from a treating source that must be adopted." SSR 96-2p. SSR 96-2p adds that "opinions from sources other than treating sources can never be entitled to 'controlling weight.'" *Id.* Moreover, SSR 96-5p states that:

> Because treating source evidence (including opinion evidence) is important, if the evidence does not support a treating source's opinion on any issue reserved to the Commissioner and the adjudicator cannot ascertain the basis of the opinion from the case record, the adjudicator must make 'every reasonable effort' to recontact the source for clarification of the reasons for the opinion."

Id.

In the instant case, the ALJ rejected entirely the opinion of Willis's treating physician. On May 8, 2002, Dr. Auerbach completed a disability questionnaire at the request of the Social Security Administration. (Tr. at 253-55.) He wrote that, "[t]his patient is totally disabled in my opinion." (*Id*.) He explained his diagnosis was "Lumbar Herniated Disc with L5 Radiculopathy." (*Id*.) He described her history as, "Rotator Cuff tendonopathy, degenerative joint disease ("DJD") in her knees and hips, multiple orthopedic surgeries," and he noted that she was taking MS Contin. (*Id*.) He added, "[p]lease review medical records." (*Id*.) Nevertheless, the ALJ stated, "[Dr. Auerbach] provided no rationale for his opinion." (*Id*. at 316.) We disagree. Dr. Auerbach listed his diagnoses followed by the term, "[p]lease review medical

[18]Social Security Rulings "are binding on all components of the Social Security Administration. These rulings represent precedent final opinions and orders and statements of policy and interpretations that [the SSA] ha[s] adopted." 20 C.F.R. § 402.35(b)(1) (2004).

records." Rather than entirely disregarding Dr. Auerbach's opinion, the ALJ should have made a reasonable effort to ascertain the basis for Dr. Auerbach's opinion that Willis is "totally disabled" by contacting him as provided in SSR 96-5p. In addition, the ALJ did not comply with SSR 96-2p, which provides that "opinions from sources other than treating sources can never be entitled to 'controlling weight,'" SSR 96-2p, because he accorded controlling weight to the DDS reviewing physician. (Tr. at 317.)

If the ALJ had contacted Dr. Auerbach or any of Willis's numerous other treating physicians, he would have learned that the doctors noted that Willis's pain increased when standing and walking and was especially symptomatic when transferring from sitting to standing. (*Id*. at 262.) SSR 83-12 provides that:

> The individual may be able to sit for time, but must then get up and stand or walk for awhile before returning to sitting. Such an individual is not functionally capable of doing either the prolonged sitting contemplated in the definition of sedentary work (and for the relatively few light jobs which are performed primarily in a seated position) or the prolonged standing or walking contemplated for most light work.

SSR 83-12. Moreover, if the ALJ had contacted Willis's treating physician, he could have required Dr. Auerbach to elaborate on the phrase, "see medical records," rather than stating, "Doctor Auerbach's opinion . . . may also not represent an opinion regarding claimant's condition over a continuous period of at least twelve months." (Tr. at 316-17.) He could have determined whether Willis's level of pain had, in fact, lasted for a continuous period of not less than 12 months as required by 42 U.S.C.A. § 423(d)(1)(A) (West 2004).

Finally, even if the ALJ did not wish to provide Dr. Auerbach's opinion controlling weight, SSR 96-2p provides:

> Adjudicators must remember that a finding that a treating source medical opinion is not well-supported . . . or is inconsistent with the other substantial evidence in the case record means only that the opinion is not entitled to 'controlling weight,' not that the opinion should be rejected. Treating source medical opinions are still entitled to deference and must be weighed using all the factors provided in 20 C.F.R. 404.1527 and 416.927. In many cases, a treating source's medical opinion will be entitled to the greatest weight and should be adopted, even if it does not meet the test for controlling weight.

SSR 96-2p. We recognize that Dr. Auerbach's statement that Willis is totally disabled is an opinion reserved for the Commissioner or the ALJ. However, we find that the Code of Federal Regulations and Social Security Rulings direct that the ALJ look further to ascertain what tasks Dr. Auerbach and/or Willis's other treating physicians found her capable of physically performing.

B. The Vocational Expert's Testimony

In reviewing the VE's testimony, the ALJ stated that:

> [T]he impartial vocational expert testified, consistently with the Dictionary of Occupational Titles, that a hypothetical individual with the claimant's residual functional capacity and vocational factors, could return to the claimant's past relevant work as billing clerk and as a medical secretary as that occupation is usually performed in the economy.

(Tr. at 319-20.) The ALJ relied on this testimony to determine that Willis retained an ability to work in her prior capacity. (*Id*.) While the ALJ is correct that the VE testified that a hypothetical individual limited to light exertional level work could perform the position of medical secretary or billing clerk, the ALJ omitted the following significant testimony:

ALJ:	If you assume that all of the Claimant's testimony is fully credible, would there be any occupations including past work that would be possible?
VE:	I don't believe there would be.
ALJ:	Could you please state your reasoning please?

VE: Well, the Claimant mentioned being tired, having difficulty standing or walking for any length of time, and complaints of pain and discomfort.

(*Id*. at 41-42.) Furthermore, the ALJ based his original question to the VE about the hypothetical individual on the medical evidence provided by the DDS review physician rather than Wllis's own treating physicians.

The Third Circuit has stated:

> A single piece of evidence will not satisfy the substantiality test if the Secretary ignores, or fails to resolve, a conflict created by countervailing evidence. Nor is evidence substantial if it is overwhelmed by other evidence (e.g., that offered by treating physicians). . . . The search for substantial evidence is thus a qualitative exercise without which our review of social security disability cases ceases to be merely deferential and becomes instead a sham.

Kent, 710 F.2d at 114. The VE's complete testimony, combined with the ALJ's failure to consider the testimony of Willis's treating physicians, compel us to conclude that the ALJ's decision is not supported by substantial evidence.

C. The Twelve-Month Durational Requirement

The ALJ explained that Willis's testimony is "not inconsistent with a series of temporary, acute conditions not meeting the 12-month durational requirement under the Social Security Act." (Tr. at 319.) Plaintiff argues that, in making this determination, the ALJ failed to consider Willis's ability to work on a regular and continuing basis as required by 20 C.F.R. § 404.1545(b) and SSR 96-8p. She cites *Kangas v. Bowen*, 823 F.2d 775, 777 (3d Cir. 1987), which involved a claimant who similarly suffered a series of hospitalizations.[19] In *Kangas*, the Third Circuit stated that "[t]he regulations defining residual functional capacity direct the Secretary to determine a

[19]The claimant was hospitalized six times in a sixteen-month period. *Kangas*, 823 F.2d at 777.

claimant's capacity for work on a *regular* and *continuing* basis." *Id*. (citations omitted). The court added, "[s]imilarly, the Medical-Vocational Guidelines for sedentary work refer to an individual's maximum sustained work capability." *Id.* (citations omitted). The court held that the "Secretary failed to consider [claimant's] frequent need for hospitalization in his finding the [claimant] was not disabled because he could engage in substantial gainful activity." *Id.* at 778. Significantly, the court added, "[a]lthough the medical advisor testified that [claimant] was capable of performing work activity when he was not suffering an exacerbation, 'sporadic or transitory activity does not disprove disability.'" *Id.* (quoting *Smith v. Califano*, 637 F.2d 968, 971-72 (3d Cir. 1981)). The court expounded, "[s]ubstantial gainful activity means performance of substantial services with reasonable regularity . . . ." *Id.* (quoting *Markham v. Califano*, 601 F.2d 533 (10th Cir. 1979)); *see also Chiappa v. Sec'y, Dep't of Health*, 497 F. Supp. 356, 360 (S.D.N.Y. 1980) ("The extent to which a disability may prevent regular work attendance is a relevant factor in determining whether a claimant is able to engage in substantial gainful activity."); *Barats v. Weinberger*, 383 F. Supp. 276 (E.D. Pa. 1974) (providing claimant's ability to do semi-sedentary work on some days, but not with any regularity, would not disqualify her from coverage under the Act).

We are satisfied that Willis's numerous ailments and hospitalizations would certainly have prevented her from regularly attending her employment. Accordingly, we are compelled to remand to the ALJ to determine whether her forced absences from employment would satisfy the twelve-month requirement.

Plaintiff also points out that in making his determination, the ALJ failed to take into account Willis's chronic pain resulting from her surgeries, hospitalizations, and ailments, and

further failed to address the effect of Willis's obesity on these ailments. Addressing Willis's chronic pain, the Code of Federal Regulations provides, "[i]n determining whether you are disabled, we will consider all your symptoms, including pain . . . [including] statements or reports from you, your treating or examining physician, . . . or others. In evaluating the intensity and persistence of your symptoms, including pain, we will consider all of the available evidence, including your medical history." 20 C.F.R. § 416.929 (2004). The Code of Federal Regulations also provides:

> Factors relevant to your symptoms such as pain, which we will consider include:
>
> (i) Your daily activities;
>
> (ii) The location, duration, frequency, and intensity of your pain or other symptoms;
>
> (iii) Precipitating and aggravating factors;
>
> (iv) The type, dosage, effectiveness, and side effects of any medication you take or have taken to alleviate pain or other symptoms;
>
> (v) Treatment, other than medication, you receive or have received for relief of your pain or other symptoms;
>
> (vi) Any measures you use or have used to relieve your pain or other symptoms (e.g., lying flat on your back, standing for 15 to 20 minutes every hour, sleeping on a board, etc.); and
>
> (vii) Other factors concerning your functional limitations and restrictions due to pain or other symptoms.

20 C.F.R. § 416.929(3) (2004). Furthermore, SSR 96-8p provides, "[i]n all cases in which symptoms, such as pain, are alleged, the RFC assessment must contain a thorough discussion and analysis of the objective medical and other evidence, including the individual's complaints of pain and other symptoms." *Id.*

There is overwhelming evidence in this case of the existence of pain. Willis was taking numerous prescription pain medications including, MS Contin, Oxycontin, Vicodin, and Vioxx. At one point, Willis was progressing well in physical therapy (Tr. at 205), and even attempted to go back to work for half days. (*Id*. at 212.) However, she had to discontinue her physical therapy treatment when she suffered acute sciatic pain in her left buttock and left leg on December 10. (*Id*.) Her physical therapist noted that he was not able to perform physical therapy due to "the acuteness of her radicular symptoms." (*Id*.) He noted that Willis could not tolerate any other position than lying on her right side, with a pillow between her knees. (*Id*.) He noted that she "ambulates with single point cane, antalgic gait due to radicula and knee symptoms." (*Id*.) Dr. Vernace injected her with Kenalog and Lidocain for back pain. (*Id.* at 211.) Dr. Auerbach noted that Willis suffered from sciatic neuralgia which extended mostly to her left superficial peroneal nerve, and also to her sural nerve and posterior thigh. (*Id* at 262.) He noted that her pain was severe and that she was placed on a 50-50-40-40 prednisone taper by Dr. Vernace. (*Id*.) He added that her pain increased when standing and walking and was especially symptomatic when transferring from sitting to standing. (*Id*.) On January 4, 2002, Dr. Auerbach wrote:

> Ms. Willis is currently under my care for low back pain and left leg pain secondary to a large left L4-5 herniated disc. Because of her symptoms it would be of great assistance to her if she could continue the utilization of a wheelchair while she is under treatment with fluoroscopically guided foraminally based epidural steroid injections.

(*Id*. at 261.) On January 14, 2002, Dr. Auerbach noted that Willis "has a left paracentral disc herniation with small extrusion at L4-5 which is compressing the left L5 nerve root resulting in

L5 lumbar radiculopathy." (*Id*. at 258.) He noted that she is to "have a second left L5-S1 intervertebral foraminally based fluoroscopically guided lumbar epidural steroid injection [and] . . . continue with the Vioxx, MS Contin and Vicodin." (*Id*.) On January 18, 2002, Dr. Yardney examined Willis and noted, "[s]he has been at home and mostly disabled because of back pain." (*Id*. at 274.) He noted that she walked slowly using a cane and that she was concerned about pain in her right shoulder. (*Id*.) On February 12, 2002, Willis's symptoms had not improved. (*Id*. at 256.) On March 20, 2002, Dr. Kenning examined Willis and wrote to Dr. Auerbach:

> This 60-year-old medical secretary was seen in consultation for low back and left lower extremity pain. The patient dates the onset of her symptoms to late October following her left total knee replacement when she developed left buttock pain that began to radiate anterolaterally into the thigh without any specific inciting cause. This pain has remained persistent over the last four months despite oral corticosteroid nonsteroidal anti-inflammatory agents, and selective nerve blocks.

(*Id*. at 250.) He added that the MRI showed "four level degenerative disc disease with loss of disc height and disc desiccation at all levels extending from L2-3 distally." (*Id*. at 251.) Even after back surgery to relieve her symptoms, Dr. Kenning noted, "[o]verall, she seems to [have] marginal results [from] surgery." (*Id*. at 247.)

When Willis attempted to return to work for half days, she found it too painful. (*Id*. at 32-33.) In response to Willis's statement that all she could do was lie down for most of the day, the ALJ stated, "the fact that claimant lies down much of the day does not impel an inference that she must do so." (*Id*. at 319.) 20 C.F.R. § 416.929 requires consideration of Willis's inability to do more than lie down at home in order to determine whether a claimant's pain is disabling. (*Id*.) The ALJ's decision does not "contain a thorough discussion and analysis of the objective medical and other evidence, including the individual's complaints of pain and other symptoms."

SSR 96-8p. While the ALJ stated "[c]laimant was generally credible, but her testimony is not inconsistent with a series of temporary, acute conditions not meeting the 12-month durational requirement for disability under the Social Security Act" (Tr. at 319), he did not take into account Willis's and her treating physicians' descriptions of lasting pain. Accordingly, we are compelled to conclude that the ALJ's decision is not supported by substantial evidence because the overwhelming evidence of Willis's pain is consistent with pain lasting at least twelve months.

In addition, Willis challenges the ALJ's failure to consider her obesity in evaluating her disability. (Doc. No. 10 at 11.) Willis argues that the ALJ did not mention her obesity despite the fact that, "this severe disorder is documented throughout the record." (*Id*. at 11 (citing Tr. at 190, 239, 276-78).)[20] Willis cites the case of *Caballero v. Barnhart*, No. 02-CV-7402, 2003 WL 22594256 (E.D. Pa. Sept. 20, 2002). In that case, the ALJ similarly failed to analyze the effects of claimant's obesity. *Id.* at *6. The district court reversed and remanded the ALJ's decision, stating, "[the ALJ's] failure to consider and discuss plaintiff's obesity, either individually or in combination with his joint problems, makes his conclusion that [claimant's] impairments do not meet or equal one of the listed impairments beyond meaningful judicial review" *Id.* at *7 (citations omitted). Also, SSR 02-1p provides:

> [W]e consider obesity to be a medically determinable impairment and remind adjudicators to consider its effects when evaluating disability. The provisions also remind adjudicators that the combined effects of obesity with other impairments can be greater than the effects of each of the impairments considered separately.

[20]Defendant argues that one of the exhibits cited by Plaintiff (Tr. at 276-78) is dated March/April, 2001, which is not the relevant time period before the ALJ (October 5, 2001, through October 25, 2002). (Doc. No. 13 at 11.) We find, however, that evidence of Willis's obesity in March/April, 2001 is relevant because it shows Willis's history of obesity, whether her obesity may have exacerbated her other symptoms, and whether these combined factors may have fulfilled the twelve-month disability requirement.

> They also instruct adjudicators to consider the effects of obesity not only under the listings but also when assessing a claim at other steps of the sequential evaluation process, including when assessing an individual's residual functional capacity.

SSR 02-1p. Defendant argues that Willis had successfully lost thirty pounds over six months. (Doc. No. 13 at 11 (citing Tr. at 190, 275).) However, SSR 02-1p provides:

> Because an individual's weight may fluctuate over time . . . a loss of less than 10 percent of initial body weight is too minor to result in a finding that there has been medical improvement in obesity. However, we will consider that obesity has medically improved if an individual maintains a consistent loss of at least 10 percent of body weight for at least 12 months.

SSR 02-1p. Because Willis has not successfully maintained a consistent loss of at least ten percent of body weight for at least twelve months, we must consider the effect of her obesity on her other impairments. Willis is sixty (60) years old. She is sixty-six (66) inches tall and weighs 248 pounds. (Tr. at 190, 275.) She has had total knee replacements, major back surgery, and constantly suffers from severe pain. After her back surgery, her neurosurgeon stated that "overall she seems to [have] marginal results [from] surgery . . . [which was] not a huge surprise given her substantial analgesic requirement prior to surgery and her body habitus." (*Id*. at 247.) Accordingly, we are compelled to remand this matter to the ALJ so that the record may be more fully developed with regard to the effects of Willis's obesity on her multiple physical problems.

IV. Conclusion

Based upon the foregoing, we conclude the record does not contain substantial evidence to support the ALJ's determination. Accordingly, we will remand to the ALJ for further proceedings consistent with this opinion.

An appropriate Order follows.

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

GWENDOLYN WILLIS	:	
	:	CIVIL ACTION
	:	
v.	:	
	:	
	:	
JO ANNE BARNHART, COMMISSIONER, SOCIAL SECURITY ADMINISTRATION	:	NO. 03-CV-5387
	:	

ORDER

AND NOW, this 30th day of December, 2004, upon consideration of Plaintiff Gwendolyn Willis's Motion for Summary Judgment (Doc. No. 10, No. 03-CV-5387) and Defendant Jo Anne Barnhart's, Commissioner, Social Security Administration, Response and Cross-Motion for Summary Judgment (Doc. No. 13, No. 03-CV-5387), and all papers filed in support thereof and in opposition thereto, it is ORDERED that Plaintiff's Motion is GRANTED and Defendant's Motion is DENIED. This case is REMANDED to the ALJ for further proceedings consistent with this opinion.

IT IS SO ORDERED.

BY THE COURT:

S:/R. Barclay Surrick, Judge

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