

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

CHARLESTON

KATHY L. FRYE,

Plaintiff,

v.

CASE NO. 2:07-cv-00208

MICHAEL J. ASTRUE,

Commissioner of Social Security¹,

Defendant.

PROPOSED FINDINGS AND RECOMMENDATION

This is an action seeking review of the final decision of the Commissioner of Social Security denying the Plaintiff's application for disability insurance benefits ("DIB") and supplemental security income ("SSI"), under Titles II and XVI of the Social Security Act, 42 U.S.C. §§ 401-433, 1381-1383f. By standing order, this case was referred to this United States Magistrate Judge to consider the pleadings and evidence, and to submit proposed findings of fact and recommendation for disposition, all pursuant to 28 U.S.C. § 636(b)(1)(B). Presently pending before the court are Plaintiff's Brief in Support of Judgment on the Pleadings, Defendant's Brief in

¹ On February 12, 2007, Michael J. Astrue became the Commissioner of Social Security. Under Fed. R. Civ. P. 25(d)(1) and 42 U.S.C. § 405(g), Michael J. Astrue is automatically substituted as the defendant in this action.

Support of his Motion for Summary Judgment², and Plaintiff's Response to Defendant's Brief.

Plaintiff, Kathy L. Flatford Frye (hereinafter referred to as "Claimant"), protectively filed applications for SSI and DIB on December 18, 2000, alleging disability as of December 17, 1999, due to severe headaches, manic depression and anxiety disorder. (Tr. at 79, 447.) The claims were denied initially and upon reconsideration. (Tr. at 36-40, 42-45, 447.) On September 20, 2001, Claimant requested a hearing before an Administrative Law Judge ("ALJ"). (Tr. at 46.) The hearing was held on August 16, 2002, before the Honorable David Antrobus. (Tr. at 374-97.) By decision dated September 5, 2002, the ALJ determined that Claimant was not entitled to benefits. (Tr. at 14-24.) The ALJ's decision became the final decision of the Commissioner on July 11, 2003, when the Appeals Council denied Claimant's request for review. (Tr. at 6-9.) Claimant appealed to federal court, and on July 6, 2004, the presiding District Judge, upon recommendation from the undersigned, remanded this matter pursuant to the fourth sentence of 42 U.S.C. § 405(g). (Tr. at 478-79, 480-81, 482-90.) On July 30, 2004, the Appeals Council vacated the previous decision of the

² The court notes that Defendant refers to a motion for summary judgment, but did not actually file one in this case. The court reminds the parties that pursuant to Local Rule of Civil Procedure 9.4(a), the parties need not file motions/briefs in support of judgment on the pleadings. Instead, Plaintiff should file "a brief in support of the complaint," while Defendant files "a brief in support of the defendant's decision." Local Rules of the United States District Court for the Southern District of West Virginia, Local Rule of Civil Procedure 9.4(a).

ALJ and remanded the case to the ALJ for further proceedings. (Tr. at 491.) On September 6, 2005, following remand by the District Court, the ALJ conducted an administrative hearing. (Tr. at 648-56.) On January 27, 2006, the ALJ again denied benefits. (Tr. at 447-59.) On February 1, 2007, the Appeals Council declined to assume jurisdiction. (Tr. at 408-09.) On March 30, 2007, Claimant brought the present action seeking judicial review of the administrative decision pursuant to 42 U.S.C. § 405(g).

Under 42 U.S.C. § 423(d)(5) and § 1382c(a)(3)(H)(i), a claimant for disability benefits has the burden of proving a disability. See Blalock v. Richardson, 483 F.2d 773, 774 (4th Cir. 1972). A disability is defined as the "inability to engage in any substantial gainful activity by reason of any medically determinable impairment which can be expected to last for a continuous period of not less than 12 months" 42 U.S.C. § 423(d)(1)(A).

The Social Security Regulations establish a "sequential evaluation" for the adjudication of disability claims. 20 C.F.R. §§ 404.1520, 416.920 (2006). If an individual is found "not disabled" at any step, further inquiry is unnecessary. Id. §§ 404.1520(a), 416.920(a). The first inquiry under the sequence is whether a claimant is currently engaged in substantial gainful employment. Id. §§ 404.1520(b), 416.920(b). If the claimant is not, the second inquiry is whether claimant suffers from a severe

impairment. Id. §§ 404.1520(c), 416.920(c). If a severe impairment is present, the third inquiry is whether such impairment meets or equals any of the impairments listed in Appendix 1 to Subpart P of the Administrative Regulations No. 4. Id. §§ 404.1520(d), 416.920(d). If it does, the claimant is found disabled and awarded benefits. Id. If it does not, the fourth inquiry is whether the claimant's impairments prevent the performance of past relevant work. Id. §§ 404.1520(e), 416.920(e). By satisfying inquiry four, the claimant establishes a prima facie case of disability. Hall v. Harris, 658 F.2d 260, 264 (4th Cir. 1981). The burden then shifts to the Commissioner, McLain v. Schweiker, 715 F.2d 866, 868-69 (4th Cir. 1983), and leads to the fifth and final inquiry: whether the claimant is able to perform other forms of substantial gainful activity, considering claimant's remaining physical and mental capacities and claimant's age, education and prior work experience. 20 C.F.R. §§ 404.1520(f), 416.920(f) (2006). The Commissioner must show two things: (1) that the claimant, considering claimant's age, education, work experience, skills and physical shortcomings, has the capacity to perform an alternative job, and (2) that this specific job exists in the national economy. McLamore v. Weinberger, 538 F.2d 572, 574 (4th Cir. 1976).

In this particular case, the ALJ determined that Claimant satisfied the first inquiry because she has not engaged in

substantial gainful activity since the alleged onset date. (Tr. at 450.) Under the second inquiry, the ALJ found that Claimant suffers from the severe impairments of migraine headaches, lumbar and cervical strain with myalgia, chronic bronchitis, depression, a generalized anxiety disorder, a post traumatic stress disorder and a panic disorder. (Tr. at 450.) At the third inquiry, the ALJ concluded that Claimant's impairments do not meet or equal the level of severity of any listing in Appendix 1. (Tr. at 451.) The ALJ then found that Claimant has a residual functional capacity for sedentary work, reduced by nonexertional limitations. (Tr. at 451.) As a result, Claimant cannot return to her past relevant work. (Tr. at 457.) Nevertheless, the ALJ concluded that Claimant could perform jobs such as cashier, telephone interviewer and dispatcher, which exist in significant numbers in the national economy. (Tr. at 458.) On this basis, benefits were denied. (Tr. at 459.)

Scope of Review

The sole issue before this court is whether the final decision of the Commissioner denying the claim is supported by substantial evidence. In Blalock v. Richardson, substantial evidence was defined as

"evidence which a reasoning mind would accept as sufficient to support a particular conclusion. It consists of more than a mere scintilla of evidence but may be somewhat less than a preponderance. If there is evidence to justify a refusal to direct a verdict were the

case before a jury, then there is 'substantial evidence.' "

Blalock v. Richardson, 483 F.2d 773, 776 (4th Cir. 1972) (quoting Laws v. Cellebreze, 368 F.2d 640, 642 (4th Cir. 1966)). Additionally, the Commissioner, not the court, is charged with resolving conflicts in the evidence. Hays v. Sullivan, 907 F.2d 1453, 1456 (4th Cir. 1990). Nevertheless, the courts "must not abdicate their traditional functions; they cannot escape their duty to scrutinize the record as a whole to determine whether the conclusions reached are rational." Oppenheim v. Finch, 495 F.2d 396, 397 (4th Cir. 1974).

A careful review of the record reveals the decision of the Commissioner is not supported by substantial evidence.

Claimant's Background

Claimant was forty-two years old at the time of the first administrative hearing. (Tr. at 377.) Claimant completed the ninth grade and obtained her GED. (Tr. at 377, 178.) In the past, she worked as an apparel inspector and as a carpet factory grade person, inspector and ticket clerk. (Tr. at 378.)

The Medical Record

The court has reviewed all evidence of record, including the medical evidence of record, and will summarize the medical evidence of record around and after her date of alleged onset in December of 1999.

The record includes evidence that predates Claimant's onset in

December of 1999, most of which the court has not summarized herein except as follows. Claimant underwent a CT scan of the head on July 24, 1997, and it was normal. (Tr. at 278.) P. Patel, M.D. examined Claimant on February 9, 1998, and diagnosed chronic migraines and chronic depression. (Tr. at 304.) The record includes treatment notes and other evidence from Kimberly K. Smith M.D., who treated Claimant in 1997, and 1998, for her migraine headaches. (Tr. at 307-27.) Claimant underwent an MRI and MRA of the head and neck on February 9, 1998, and they were negative. (Tr. at 302-03.)

The record includes handwritten treatment notes from M. Aslam Sandvi, M.D. (of Dalton, Georgia) dated September 10, 1997, through July 14, 2000. Claimant received individual psychotherapy. (Tr. at 121-60.) In 1997, Dr. Sandvi diagnosed major depression, single episode, severe, generalized anxiety disorder on Axis I and made no Axis II diagnosis. He rated Claimant's GAF at 45. (Tr. at 153.) Treatment notes from late 1999 and 2000 are difficult to read; they do not appear to state additional or different diagnoses. (Tr. at 121-25.)

The record includes treatment notes from Pankaj B. Patel, M.D. (also of Dalton, Georgia) dated August 7, 1997, through October 19, 1999. (Tr. at 328-32.)

On June 10, 1999, Claimant reported to the emergency room with complaints of a headache on and off for four or five days.

Claimant had a history of migraine headaches and was diagnosed with migraine headaches. (Tr. at 115.) Claimant reported to the emergency room on September 7, 1999, again with complaints of headaches. (Tr. at 118.)

Claimant reported to the emergency room on November 29, 2000, complaining of migraine headaches. (Tr. at 161.)

Claimant reported to the emergency room on December 27, 2000, complaining of headaches and a near syncopal episode. Claimant was out of Klonopin. (Tr. at 166.)

On December 29, 2000, Claimant reported to the emergency room again complaining of migraines. In addition, after the hearing in September of 2005, Claimant underwent a consultative physical examination in November of 2005. (Tr. at 641-47.) Claimant had had a migraine for three days and reported blurred vision and vomiting. Claimant reported an MRI in June of 2000, was normal. Mohamad Sadek, M.D. diagnosed chronic migraine, anxiety disorder and reactive depression. (Tr. at 170.)

The record includes a treatment note dated January 3, 2001, from Harts Health Clinic. Claimant wanted a referral for her nerves. She had been taking Midrin and Klonopin for her migraines. Claimant was diagnosed with anxiety/depression and prescribed Paxil. (Tr. at 172.)

On January 17, 2001, Gregory Elkins, M.D. completed a West Virginia Department of Health and Human Resources General Physical

(Adults) form on which he indicated that Claimant suffers from anxiety/depression and migraine cephalgias. He opined that Claimant could not work. Dr. Elkins stated that Claimant's psychological problems were her most limiting problems. (Tr. at 174-75.)

On March 13, 2001, Robert G. Martin, M.A. examined Claimant at the request of the State disability determination service. Claimant reported that she suffers from panic attacks occurring twice a month and lasting up to two full days at a time. They are usually followed by migraine headaches. Claimant reported low mood and poor sleep without medication. (Tr. at 179.) Claimant began receiving mental health treatment three years ago. (Tr. at 180.) Mr. Martin diagnosed panic disorder without agoraphobia and dysthymic disorder on Axis I. Mr. Martin questioned whether Claimant's panic attacks actually last up to two days, but indicated her reported symptoms meet the diagnostic criteria for a panic disorder. (Tr. at 185.)

On March 21, 2001, a State agency medical source completed a Psychiatric Review Technique form and opined that Claimant's mental impairments were not severe. (Tr. at 188-201.)

On April 2, 2001, Rodolfo Gobunsuy, M.D. examined Claimant at the request of the State disability determination service. Dr. Gobunsuy diagnosed chronic bronchitis (Claimant is a longtime smoker). Claimant was not on bronchodilator therapy. Her lungs

were clear. She had no emphysema. There was no clubbing of the fingernails. Claimant had a history of low back pain. The range of motion in the back was satisfactory. Claimant had no nerve root involvement. There was no numbness in the legs. At a minimum, Dr. Gobunsuy indicated that Claimant had chronic lumbar strain. (Tr. at 206.)

On April 11, 2001, a State agency medical source completed a Physical Residual Functional Capacity Assessment and concluded that Claimant could perform medium work with an occasional ability to climb ramps and stairs and a need to avoid concentrated exposure to extreme cold. (Tr. at 213-20.)

The record includes an initial assessment from Prester Center for Mental Health Services dated April 10, 2001. (Tr. at 221-47.) Claimant was diagnosed with panic disorder without agoraphobia and dysthymic disorder on Axis I. An Axis II diagnosis was deferred. Claimant's GAF was rated at 54. (Tr. at 246.)

On September 8, 2001, a State agency medical source completed a Psychiatric Review Technique form and opined that Claimant's panic disorder and dysthymic disorder resulted in no restriction of activities of daily living, moderate difficulties maintaining social functioning, mild difficulties maintaining concentration, persistence and pace and no repeated episodes of decompensation. (Tr. at 248-61.)

The State agency source also completed a Mental Residual

Functional Capacity Assessment and opined that Claimant was moderately limited in the ability to perform activities within a schedule, maintain regular attendance, be punctual within customary tolerances, sustain an ordinary routine without special supervision, work in coordination with or proximity to others without being distracted by them, complete a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods, and interact appropriately with the general public. (Tr. at 262-64.)

On September 11, 2001, a State agency medical source completed a Physical Residual Functional Capacity Assessment and opined that Claimant had no physical limitations. (Tr. at 266-73.)

The record includes treatment notes from Ebenezer Medical Outreach dated February 13, 2001, April 3, 2001, July 17, 2001, and December 13, 2001. Claimant was treated for anxiety/depression and migraine headaches. (Tr. at 274-76.)

The record includes additional treatment notes from Ebenezer Medical Outreach dated February 13, 2001, through April 26, 2002. (Tr. at 334-48.) Claimant was treated for anxiety/depression and myalgia.

X-rays of Claimant's cervical spine on May 13, 2002, were negative. (Tr. at 354.)

On August 24, 2002, Cynthia Clay, a licensed psychologist at

Ebenezer Medical Outreach, stated that Claimant's GAF ranges from 50-55. (Tr. at 357.)

On May 9, 2002, Mareda Reynolds, M.A. examined Claimant at the request of her counsel. (Tr. at 399-403.) Ms. Reynolds diagnosed posttraumatic stress disorder on Axis I and made no Axis II diagnosis. (Tr. at 403.) Ms. Reynolds also completed an assessment on which she opined that Claimant was moderately limited in the ability to maintain attention for extended periods, maintain regular attendance and be punctual within customary tolerances, and accept instructions and respond appropriately to criticism. (Tr. at 404-06.)

On March 4, 2004, Claimant presented to the emergency room because of pain in her left chest and left arm. Claimant had been to the dentist earlier in the day, and she was diagnosed with an infected wisdom tooth. (Tr. at 522.) Carrie Lockhart-Dillard, M.D. diagnosed chest pain, depression and anxiety, an abscessed tooth and hyperlipidemia. (Tr. at 525, 573.)

On May 5, 2005, Claimant reported to the emergency room with complaints of weakness, blurred vision and dizziness. (Tr. at 580.)

A CT scan on February 12, 2005, showed a stable appearance of a partially calcified left high convexity meningioma. (Tr. at 621.) On April 12, 2005, Ijaz Ahmad, M.D. noted that Claimant had a small calcified lesion, which seemed to be a convex meningioma. It had

been stable for several years, and Dr. Ahmad planned to repeat a CT scan in six months. (Tr. at 618.)

The record includes additional treatment notes from Ebenezer Medical Outreach dated February 3, 2005. The assessment was chronic headache/tension vs. migraine vs. meningioma, hyperlipidemia, chronic allergic sinusitis and insomnia. (Tr. at 625.)

On November 14, 2005, Kip Beard, M.D. examined Claimant at the request of the State disability determination service. Dr. Beard diagnosed chronic headaches, possible migraine headaches and cervical strain with chronic cervical spine pain. (Tr. at 641.) Dr. Beard completed a Medical Source Statement of Ability to do Work-Related Activities (Physical) and found no limitations. (Tr. at 644-47.)

Claimant's Challenges to the Commissioner's Decision

Claimant asserts that the Commissioner's decision is not supported by substantial evidence because (1) the mental limitations found by the ALJ are not supported by the medical evidence of record; (2) the ALJ's hypothetical question was defective; (3) the ALJ did not properly assess the limitations posed by Claimant's headaches and other nonexertional impairments; and (4) the ALJ did not indicate the weight afforded the opinion of Ms. Reynolds or address the vocational expert's testimony that Claimant could not work given the limitations opined by Ms.

Reynolds. (Pl.'s Br. at 18-24; Pl.'s Reply at 1-3.)

The Commissioner argues that Claimant's appeal "rests on whether the ALJ properly considered Ms. Reynold's report" and whether her report ultimately changed the ALJ's decision. (Def.'s Br. at 7-9.) The Commissioner further asserts that (1) the jobs identified by the vocational expert are consistent with the ALJ's mental residual functional capacity assessment and are in accordance with the remand order; (2) substantial evidence supports the ALJ's residual functional assessment; and (3) the ALJ's pain and credibility analysis is supported by substantial evidence. (Def.'s Br. at 8-17.)

By adoption of the Proposed Findings and Recommendation in 2004, this court determined that the ALJ's decision was not supported by substantial evidence because "the ALJ failed to discuss Ms. Reynolds' report or the vocational expert's testimony that when limitations opined by Ms. Reynolds were included in a hypothetical question, she could identify no jobs." (Tr. at 488.) Because the court proposed remand on those grounds, the court did not address the remaining arguments then raised by Claimant's counsel, or otherwise conduct a substantive analysis.

On remand, the ALJ conducted a supplemental hearing and allowed additional evidence to be submitted into the record. The ALJ decided not to take additional vocational testimony at the administrative hearing. (Tr. at 656.) In his decision, the ALJ

made the same residual functional capacity finding, limiting Claimant to sedentary work and further finding that "despite her pain, anxiety, depression and alleged dizziness secondary to medications, low average intelligence with a verbal I.Q. of 86, a performance I.Q. of 91, and a full scale I.Q. of 88, she can sustain concentration and attention on routine tasks, interact with others, and meet work attendance requirements." (Tr. at 451.)

The ALJ's decision following remand mentions the findings of Ms. Reynolds, both in her examination and on the assessment she completed. (Tr. at 454-55.) However, the ALJ does not clearly address the weight afforded the evidence of record from Ms. Reynolds. As to Dr. Elkins, the ALJ stated "[a]bsent supporting signs, symptoms or restrictions, his opinion has been given minimal weight." (Tr. at 456.) Regarding Ms. Clay, the ALJ stated that "[w]hile Ms. Clay may be the claimant's treating psychologist, her assessment was unaccompanied by any treatment records or counseling notes to support her opinion and therefore it has been given minimal weight." (Tr. at 456.) As to the State agency sources, the ALJ stated that he gave those assessments "limited weight because the consultants did not have the opportunity to observe the claimant or to consider additional medical evidence submitted subsequent to their review of the record." (Tr. at 456.) In comparison, the ALJ had this to say about Ms. Reynolds' opinion:

[e]ven the May 9, 2002, one-time evaluation by psychologist Reynolds suggested generally mild to

moderate limitations due to a post traumatic stress disorder, with the claimant appearing alert, oriented, and cooperative with no signs of abnormal psychomotor activity or impairment of concentration, attention, insight or judgment, and only mild memory deficits.

(Tr. at 456.)

Later in his decision, the ALJ addressed the vocational expert's testimony that Claimant could not work when Plaintiff's counsel posed various hypotheticals containing (1) limitations from Ms. Reynolds' assessment (Tr. at 391-92); (2) a GAF of 54 as opined by Ms. Clay (Tr. at 392-93); and (3) limitations as opined by the State agency medical source on a Mental Residual Functional Capacity Assessment (Tr. at 394-95):

[i]n response to questions posed by counsel for the claimant, the vocational expert advised that a hypothetical individual with a global assessment of functioning of 54 (with 50-60 reflective of "moderate to serious" symptoms or restrictions), and moderate limitations on completing a normal work week and interacting appropriately with others (per Exhibits 17F [State agency source] and 28F[Note from Ms. Clay]-29F [Ms. Reynolds' report and assessment]), would have difficulty performing the jobs that she identified.

The undersigned reviewed all of the relevant and more persuasive objective medical evidence and functional assessments (discounting, as noted previously herein, the global assessments of functioning of between 50 and 55, and noting that the limitations set forth in Exhibit 17F were suggested by a non-examining source) along with the claimant's less than credible testimony, and concluded that such pain, headaches, dizziness due to medications, anxiety, and depression, that she experiences are mild to moderate in nature in view of her admitted daily activities and functional capabilities. Taking into account the claimant's low average intellectual functioning and based on the testimony of the vocational expert, the undersigned concludes that considering the claimant's age, educational background, work experience, and residual functional capacity, she is capable of

making a successful adjustment to work that exists in the national economy, including the jobs identified by the vocational expert.

(Tr. at 458.)

It certainly can be deduced from the ALJ's findings that he essentially concluded that the assessment by Ms. Reynolds was not entitled to any weight and that he believed the findings by Ms. Reynolds in her report are generally consistent with the residual functional capacity finding he made in his first decision and stood by in the instant decision; thus he saw no need for additional vocational expert testimony. Given the reason for remand, the court expected a more explicit explanation about the weight afforded Ms. Reynolds' opinion on the assessment, particularly in light of the vocational expert testimony. Coupled with the additional errors outlined below, the court is constrained to recommend remand again.

The court proposes that the presiding District Judge remand this matter because the ALJ's findings about the limitations related to Claimant's mental impairments are not supported by substantial evidence. In his decision, the ALJ found that Claimant had the following severe mental impairments: depression, generalized anxiety disorder, post traumatic stress disorder and panic disorder. (Tr. at 450.) In evaluating the "B" criteria at step three of the sequential analysis, the ALJ found that Claimant's severe mental impairments resulted in mild restriction

in activities of daily living, moderate difficulty maintaining social functioning, mild restriction in concentration, persistence and pace and no episodes of deterioration. (Tr. at 451.) This finding was mostly consistent with the opinion of the State agency medical source, although the ALJ indicated he afforded this opinion limited weight. The ALJ found that Claimant had the following residual functional capacity:

due to her lumbar and cervical strain and myalgia, the claimant has the residual functional capacity to sit up to six hours in an eight-hour workday, stand and walk two hours in an eight-hour workday, and lift weights of up to ten pounds frequently. Nonexertionally, despite her pain, anxiety, depression, alleged dizziness secondary to medications, low average intelligence with a verbal I.Q. of 86, a performance I.Q. of 91, and a full scale I.Q. score of 88, she can sustain concentration and attention on routine tasks, interact with others, and meet work requirements.

(Tr. at 451.) This residual functional capacity finding does not reflect any limitation in social functioning, even though the ALJ found that Claimant had "moderate" limitations in social functioning, and her mental impairments are "severe."

Furthermore, the ALJ posed a hypothetical question that does not include the limitations contained in the residual functional capacity finding. Moreover, the hypothetical question was phrased in such a way that a meaningful response from the vocational expert was not possible. The hypothetical question and response are as follows:

Q *** [A]ssume claimant would have the Residual Functional Capacity to perform work activity. She's

classified as a younger individual, has a limited education, in the past has performed unskilled and semi-skilled work. *** In addition ... I want you to assume that I find that she has non-exertional impairments, specifically pain in various body areas as she's indicated here today, notably headaches and pain in the area of her back, chest and neck. The claimant experiences mental anxiety and depression. She has a verbal IQ of 86 a performance IQ of 91, a full-scale IQ of 88 and she has some occasional dizziness due to her medication. Now assume on the one hand that I would find that the non-exertional impairments would exist in a curve, with such frequency and severity as to preclude sustained physical and mental activities on her part. On the other hand, assume I would find that they would be of a mild to moderate nature and not as severe as I just described to you. Now in light of that criteria and that alternative, could she do any of the jobs indicated in the regulations?

A Your Honor, with the severe degree of impairment limitation I don't know of any jobs she could do on a sustained basis. If we look more at mild and moderate degrees of limitation, I feel that there would be jobs.

(Tr. at 389-90.)

To be relevant or helpful, a vocational expert's opinion must be based upon consideration of all evidence of record, and it must be in response to a hypothetical question which fairly sets out all of the claimant's impairments. Walker v. Bowen, 889 F.2d 47, 51 (4th Cir. 1989). "[I]t is difficult to see how a vocational expert can be of any assistance if he is not familiar with the particular claimant's impairments and abilities -- presumably, he must study the evidence of record to reach the necessary level of familiarity." Id. at 51. Nevertheless, while questions posed to the vocational expert must fairly set out all of claimant's impairments, the questions need only reflect those impairments that

are supported by the record. See Chrupcala v. Heckler, 829 F.2d 1269, 1276 (3d Cir. 1987). Additionally, the hypothetical question may omit non-severe impairments, but must include those which the ALJ finds to be severe. Benenate v. Schweiker, 719 F.2d 291, 292 (8th Cir. 1983).

The court proposes that the presiding District Judge find that the ALJ's hypothetical question did not include the limitations contained in the residual functional capacity finding, nor did it adequately describe the limitations caused by Claimant's severe mental impairments such that the vocational expert could opine as to whether a significant number of jobs existed despite the impact of Claimant's mental impairments on her ability to work. The ALJ and examining and nonexamining sources agreed that Claimant has "moderate" limitations in social functioning, but in the residual functional capacity finding, the ALJ concluded that Claimant could "sustain concentration and attention on routine tasks, interact with others and meet work attendance requirements." (Tr. at 456.)

Furthermore, the statement in the hypothetical question that Claimant has "mental anxiety and depression" and certain IQ scores provides no indication of the true limitations caused by Claimant's mental impairments. Moreover, as Claimant asserts in her brief, there is little reason to have vocational expert testimony if the vocational expert is asked the kind of hypothetical question cited above, wherein she must assume nonexertional impairments to a

severe degree versus mild to moderate in nature. The court notes that the Commissioner does not address this argument in his brief. Based on the reasons cited above, the court proposes that the presiding District Judge remand this matter for further proceedings.

The court declines to address the remaining arguments raised by counsel, as they can be addressed on remand.

For the reasons set forth above, it is hereby respectfully RECOMMENDED that the presiding District Judge REVERSE the final decision of the Commissioner, and REMAND this case for further proceedings pursuant to the fourth sentence of 42 U.S.C. § 405(g) and DISMISS this matter from the court's docket.

The parties are notified that this Proposed Findings and Recommendation is hereby FILED, and a copy will be submitted to the Honorable Joseph R. Goodwin. Pursuant to the provisions of Title 28, United States Code, Section 636(b)(1)(B), and Rules 6(e) and 72(b), Federal Rules of Civil Procedure, the parties shall have ten days (filing of objections) and then three days (mailing/service) from the date of filing this Proposed Findings and Recommendation within which to file with the Clerk of this court, specific written objections, identifying the portions of the Proposed Findings and Recommendation to which objection is made, and the basis of such objection. Extension of this time period may be granted for good cause shown.

Failure to file written objections as set forth above shall constitute a waiver of de novo review by the District Court and a waiver of appellate review by the Circuit Court of Appeals. Snyder v. Ridenour, 889 F.2d 1363, 1366 (4th Cir. 1989); Thomas v. Arn, 474 U.S. 140, 155 (1985); Wright v. Collins, 766 F.2d 841, 846 (4th Cir. 1985); United States v. Schronce, 727 F.2d 91, 94 (4th Cir. 1984). Copies of such objections shall be served on opposing parties, Chief Judge Goodwin, and this Magistrate Judge.

The Clerk is directed to file this Proposed Findings and Recommendation and to transmit a copy of the same to counsel of record.

June 19, 2008
Date



Mary E. Stanley
United States Magistrate Judge