SOCIAL SECURITY ADMINISTRATION

Office of Disability Adjudication and Review
SSA Office of Hearings
Suite 450
1441 Main Street
Springfield, MA 01103-1449

Date: October 26, 2017

[redacted]

Notice of Decision – Fully Favorable

I carefully reviewed the facts of your case and made the enclosed fully favorable decision. Please read this notice and my decision.

Another office will process my decision. That office may ask you for more information. If you do not hear anything within 60 days of the date of this notice, please contact your local office. The contact information for your local office is at the end of this notice.

If You Disagree With My Decision

If you disagree with my decision, you may file an appeal with the Appeals Council.

How To File An Appeal

To file an appeal you or your representative must ask in writing that the Appeals Council review my decision. You may use our Request for Review form (HA-520) or write a letter. The form is available at www.socialsecurity.gov. Please put the Social Security number shown above on any appeal you file. If you need help, you may file in person at any Social Security or hearing office.

Please send your request to:

Appeals Council
Office of Disability Adjudication and Review
5107 Leesburg Pike
Falls Church, VA 22041-3255

Time Limit To File An Appeal

You must file your written appeal **within 60 days** of the date you get this notice. The Appeals Council assumes you got this notice 5 days after the date of the notice unless you show you did

Suspect Social Security Fraud?
Please visit http://oig.ssa.gov/r or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

See Next Page

not get it within the 5-day period.

The Appeals Council will dismiss a late request unless you show you had a good reason for not filing it on time.

What Else You May Send Us

You or your representative may send us a written statement about your case. You may also send us new evidence. You should send your written statement and any new evidence **with your appeal**. Sending your written statement and any new evidence with your appeal may help us review your case sooner.

How An Appeal Works

The Appeals Council will consider your entire case. It will consider all of my decision, even the parts with which you agree. Review can make any part of my decision more or less favorable or unfavorable to you. The rules the Appeals Council uses are in the Code of Federal Regulations, Title 20, Chapter III, Part 404 (Subpart J).

The Appeals Council may:

- Deny your appeal,
- Return your case to me or another administrative law judge for a new decision,
- Issue its own decision, or
- Dismiss your case.

The Appeals Council will send you a notice telling you what it decides to do. If the Appeals Council denies your appeal, my decision will become the final decision.

The Appeals Council May Review My Decision On Its Own

The Appeals Council may review my decision even if you do not appeal. They may decide to review my decision within 60 days after the date of the decision. The Appeals Council will mail you a notice of review if they decide to review my decision.

When There Is No Appeals Council Review

If you do not appeal and the Appeals Council does not review my decision on its own, my decision will become final. A final decision can be changed only under special circumstances. You will not have the right to Federal court review.

See Next Page

If You Have Any Questions

We invite you to visit our website located at www.socialsecurity.gov to find answers to general questions about social security. You may also call (800) 772-1213 with questions. If you are deaf or hard of hearing, please use our TTY number (800) 325-0778.

If you have any other questions, please call, write, or visit any Social Security office. Please have this notice and decision with you. The telephone number of the local office that serves your area is (866)964-5061. Its address is:

Social Security
70 Bond Street
Springfield, MA 01104-3402

Addison C. S. Masengill
Administrative Law Judge

Enclosures:
Form HA-L15 (Fee Agreement Approval)
Decision Rationale

cc: Marshall T. Moriarty
Moriarty Law Firm
34 Mulberry Street
Springfield, MA 01105

SOCIAL SECURITY ADMINISTRATION
Office of Disability Adjudication and Review

ORDER OF ADMINISTRATIVE LAW JUDGE

IN THE CASE OF	CLAIM FOR
[redacted] (Claimant)	Period of Disability and Disability Insurance Benefits
(Wage Earner)	[redacted] (Social Security Number)

I approve the fee agreement between the claimant and her representative subject to the condition that the claim results in past-due benefits. My determination is limited to whether the fee agreement meets the statutory conditions for approval and is not otherwise excepted. I neither approve nor disapprove any other aspect of the agreement.

YOU MAY REQUEST A REVIEW OF THIS ORDER AS INDICATED BELOW

Fee Agreement Approval: You may ask us to review the approval of the fee agreement. If so, write us within 15 days from the day you get this order. Tell us that you disagree with the approval of the agreement and give your reasons. Your representative also has 15 days to write us if he or she does not agree with the approval of the fee agreement. Send your request to this address:

Aaron M. Morgan
Regional Chief Administrative Law Judge
SSA ODAR Regional Ofc
Suite 565
10 Causeway Street
Boston, MA 02222-1001

Fee Agreement Amount: You may also ask for a review of the amount of the fee due to the representative under this approved fee agreement. If so, please write directly to me as the deciding Administrative Law Judge within 15 days of the day you are notified of the amount of the fee due to the representative. Your representative also has 15 days to write me if he/she does not agree with the fee amount under the approved agreement.

You should include the social security number(s) shown on this order on any papers that you send us.

/s/ Addison C. S. Masengill
Addison C. S. Masengill
Administrative Law Judge

October 26, 2017
Date

SOCIAL SECURITY ADMINISTRATION
Office of Disability Adjudication and Review

DECISION

IN THE CASE OF

[redacted]
(Claimant)

(Wage Earner)

CLAIM FOR

Period of Disability and Disability Insurance Benefits

[redacted]
(Social Security Number)

JURISDICTION AND PROCEDURAL HISTORY

This case is before the undersigned on a request for hearing dated August 29, 2016 (20 CFR 404.929 *et seq.*). The claimant appeared and testified at a hearing held on August 30, 2017, in Springfield, MA. Zachary T. Fosberg, an impartial vocational expert, also appeared at the hearing. The claimant is represented by Marshall T. Moriarty, an attorney.

The claimant is alleging disability since November 20, 2014.

The claimant submitted or informed the Administrative Law Judge about all written evidence at least five business days before the date of the claimant's scheduled hearing (20 CFR 404.935(a)).

ISSUES

The issue is whether the claimant is disabled under Sections 216(i) and 223(d) of the Social Security Act. Disability is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment or combination of impairments that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

There is an additional issue whether the insured status requirements of Sections 216(i) and 223 of the Social Security Act are met. The claimant's earnings record shows that the claimant has acquired sufficient quarters of coverage to remain insured through September 30, 2020. Thus, the claimant must establish disability on or before that date in order to be entitled to a period of disability and disability insurance benefits.

After careful review of the entire record, the undersigned finds that the claimant has been disabled from November 20, 2014, through the date of this decision. The undersigned also finds that the insured status requirements of the Social Security Act were met as of the date disability is established.

APPLICABLE LAW

See Next Page

Under the authority of the Social Security Act, the Social Security Administration has established a five-step sequential evaluation process for determining whether an individual is disabled (20 CFR 404.1520(a)). The steps are followed in order. If it is determined that the claimant is or is not disabled at a step of the evaluation process, the evaluation will not go on to the next step.

At step one, the undersigned must determine whether the claimant is engaging in substantial gainful activity (20 CFR 404.1520(b)). Substantial gainful activity (SGA) is defined as work activity that is both substantial and gainful. If an individual engages in SGA, she is not disabled regardless of how severe her physical or mental impairments are and regardless of her age, education, or work experience. If the individual is not engaging in SGA, the analysis proceeds to the second step.

At step two, the undersigned must determine whether the claimant has a medically determinable impairment that is "severe" or a combination of impairments that is "severe" (20 CFR 404.1520(c)). An impairment or combination of impairments is "severe" within the meaning of the regulations if it significantly limits an individual's ability to perform basic work activities. An impairment or combination of impairments is "not severe" when medical and other evidence establish only a slight abnormality or a combination of slight abnormalities that would have no more than a minimal effect on an individual's ability to work (20 CFR 404.1522; Social Security Rulings (SSRs) 85-28 and 16-3p). If the claimant does not have a severe medically determinable impairment or combination of impairments, she is not disabled. If the claimant has a severe impairment or combination of impairments, the analysis proceeds to the third step.

At step three, the undersigned must determine whether the claimant's impairment or combination of impairments is of a severity to meet or medically equal the criteria of an impairment listed in 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 404.1520(d), 404.1525, and 404.1526). If the claimant's impairment or combination of impairments is of a severity to meet or medically equal the criteria of a listing and meets the duration requirement (20 CFR 404.1509), the claimant is disabled. If it does not, the analysis proceeds to the next step.

Before considering step four of the sequential evaluation process, the undersigned must first determine the claimant's residual functional capacity (20 CFR 404.1520(e)). An individual's residual functional capacity is her ability to do physical and mental work activities on a sustained basis despite limitations from her impairments. In making this finding, the undersigned must consider all of the claimant's impairments, including impairments that are not severe (20 CFR 404.1520(e) and 404.1545; SSR 96-8p).

Next, the undersigned must determine at step four whether the claimant has the residual functional capacity to perform the requirements of her past relevant work (20 CFR 404.1520(f)). The term past relevant work means work performed (either as the claimant actually performed it or as it is generally performed in the national economy) within the last 15 years or 15 years prior to the date that disability must be established. In addition, the work must have lasted long enough for the claimant to learn to do the job and have been SGA (20 CFR 404.1560(b) and 404.1565). If the claimant has the residual functional capacity to do her past relevant work, the

See Next Page

claimant is not disabled. If the claimant is unable to do any past relevant work or does not have any past relevant work, the analysis proceeds to the fifth and last step.

At the last step of the sequential evaluation process (20 CFR 404.1520(g)), the undersigned must determine whether the claimant is able to do any other work considering her residual functional capacity, age, education, and work experience. If the claimant is able to do other work, she is not disabled. If the claimant is not able to do other work and meets the duration requirement, she is disabled. Although the claimant generally continues to have the burden of proving disability at this step, a limited burden of going forward with the evidence shifts to the Social Security Administration. In order to support a finding that an individual is not disabled at this step, the Social Security Administration is responsible for providing evidence that demonstrates that other work exists in significant numbers in the national economy that the claimant can do, given the residual functional capacity, age, education, and work experience (20 CFR 404.1512(f) and 404.1560(c)).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

After careful consideration of the entire record, the undersigned makes the following findings:

1. **The claimant's date last insured is September 30, 2020.**

2. **The claimant has not engaged in substantial gainful activity since November 20, 2014, the alleged onset date (20 CFR 404.1520(b) and 404.1571 *et seq.*).**

3. **The claimant has the following severe impairments: a history of breast cancer, back pain due to degenerative disc disease, bilateral knee pain due to degenerative osteoarthropathy, chronic headaches, asthma, hypertension, depressive disorder, and anxiety disorder (20 CFR 404.1520(c)).**

The documented medical evidence of record consists of clinical findings, which, when considered in the aggregate, support a conclusion that the impairments mentioned above cause more than minimal limitations in the claimant's ability to perform basic work activities during the period being adjudicated as required by SSR 85-28. The claimant's functional limitations are reasonably related to breast cancer, back pain due to degenerative disc disease, bilateral knee pain due to degenerative osteoarthropathy, chronic headaches, asthma, hypertension, depressive disorder, and anxiety disorder (Exhibits 1F-14F).

4. **The claimant does not have an impairment or combination of impairments that meets or medically equals the severity of one of the listed impairments in 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 404.1520(d), 404.1525 and 404.1526). Special consideration has been given to Listings 1.04, 3.00, 4.00, 11.00, 12.04, 12.06, and 13.10.**

The claimant does not meet or equal the severity requirements of any listed impairment. The undersigned notes Listing 1.02 was particularly considered in the evaluation of this decision. Although there is evidence that the claimant suffers from bilateral knee pain due to degenerative osteoarthropathy, there is no evidence of a major dysfunction of a joint characterized by gross

See Next Page

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, and findings on appropriate medically acceptable imaging of joint space narrowing, bony destruction, or ankylosis of the affected joint; with involvement of one major peripheral weight-bearing joint (i.e., hip, knee, or ankle), resulting in inability to ambulate effectively; or 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 required by listing 1.02. Therefore, the claimant does not meet the necessary requirements for Listing 1.02.

The undersigned notes Listing 1.04 was particularly considered in the evaluation of this decision. Although there is evidence that the claimant has been diagnosed with degenerative disc disease, there is no evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss accompanied by sensory or reflex loss and positive straight-leg raising test; spinal arachnoiditis; or lumbar spinal stenosis. Therefore, the claimant does not meet the necessary requirements for listing 1.04.

The undersigned notes Listing 3.03 was also particularly considered in the evaluation of this decision. Although a review of the medical evidence of record confirmed that the claimant suffers from asthma, it revealed no evidence of asthma with chronic asthmatic bronchitis or attacks, in spite of prescribed treatment and requiring physician intervention, occurring at least once every two months or at least six times a year. Therefore, the claimant does not meet the necessary requirements for listing 3.03.

The claimant does not meet or equal the severity requirements of any listed impairment. The undersigned notes Listing 13.10 was particularly considered in the evaluation of this decision. Although there is evidence that the claimant has a history of breast cancer, the claimant does not meet the necessary requirements for Listing 13.10.

The severity of the claimant's mental impairments, considered singly and in combination, do not meet or medically equal the criteria of Listings 12.04, 12.06, and 12.15. In making this finding, the undersigned has considered whether the "paragraph B" criteria are satisfied. To satisfy the "paragraph B" criteria, the mental impairments must result in at least one extreme or two marked limitations in a broad area of functioning that are: understanding, remembering, or applying information; interacting with others; concentrating, persisting, or maintaining pace; or adapting or managing themselves. A marked limitation means functioning in this area independently, appropriately, effectively, and on a sustained basis is seriously limited. An extreme limitation is the inability to function independently, appropriately or effectively, and on a sustained basis.

In understanding, remembering, or applying information, the claimant has mild limitations. When the claimant completed her function report, she stated that her conditions affected her memory and her ability to complete tasks, but did not state that her conditions affected her memory or her ability to understand or follow instructions (Exhibit 12E). When the claimant presented for the consultative examination, her memory was grossly intact. She was able to recall two of three items after a brief delay. The claimant appeared to be of above average

See Next Page

intelligence. There was no evidence of cognitive problems that were apparent during the evaluation (Exhibit 7F).

In interacting with others, the claimant has moderate limitations. When the claimant completed her function report, she stated did not have any problems getting along with family, friends, neighbors, or others. She noted that she spent time with others, but only attended doctors' appointments on a regular basis (Exhibit 12E). However, at the hearing, the claimant testified that she grapples with depression and anxiety. She testified that she does not belong to any social clubs or organizations. A review of the medical evidence of record confirmed that the claimant had been diagnosed with major depressive disorder and anxiety disorder. When the claimant presented for the consultative examination, she reported that she worried about how to cover her medical bills, she experienced a lot of anxiety, and her sleep was disrupted at night (Exhibit 7F).

With regard to concentrating, persisting, or maintaining pace, the claimant has moderate limitations. When the claimant completed her function report, she did not state that her conditions affected her ability to concentrate (Exhibit 12E). However, a review of the medical evidence of record confirmed that the claimant had been diagnosed with major depressive disorder and anxiety disorder. When the claimant presented for the consultative examination, she reported that she was a "little slow" (Exhibit 7F).

As for adapting or managing oneself, the claimant has experienced mild limitations. Despite her impairments, the claimant is generally able to manage activities of daily living. When the claimant completed her function report, she stated that she was able to shop by computer and handle her finances. The claimant stated that she tried to read on a daily basis (Exhibit 12E). At the hearing, the claimant testified that she is able to take care of her personal care needs.

Because the claimant's mental impairments do not cause at least two "marked" limitations or one "extreme" limitation, the "paragraph B" criteria are not satisfied.

The undersigned has considered whether the "paragraph C" criteria are satisfied. In this case, the evidence fails to establish the presence of the "paragraph C" criteria. Nothing in the record demonstrates that the claimant's mental disorder is "serious and persistent." In does not demonstrate evidence of a medically documented history of the existence of the mental disorder over a period of at least two years and evidence of both medical treatment, mental health therapy, psychosocial supports, or a highly structured setting that is ongoing and that diminishes the symptoms and signs of the claimant's mental disorder and minimal capacity to adapt to changes in the claimant's environment or to demands that are not already part of the claimant's daily life.

The limitations identified in the "paragraph B" criteria are not a residual functional capacity assessment but are used to rate the severity of mental impairments at steps 2 and 3 of the sequential evaluation process. The mental residual functional capacity assessment used at steps 4 and 5 of the sequential evaluation process requires a more detailed assessment. The following residual functional capacity assessment reflects the degree of limitation the undersigned has found in the "paragraph B" mental functional analysis.

See Next Page

The record does not establish the medical signs, symptoms, laboratory findings or degree of functional limitation required to meet or equal the criteria of any listed impairment and no acceptable medical source designated to make equivalency findings has concluded that the claimant's impairment(s) medically equal a listed impairment.

5. The claimant has the residual functional capacity to perform sedentary work as defined in 20 CFR 404.1567(a) except that the claimant is limited to work involving simple, routine tasks. She is unable to operate foot or leg controls. The claimant is unable perform direct overhead lifting or reaching. She is limited to work involving no more than incidental exposure to extremes of cold, vibration, heat, fumes, dust, gases, and humidity. The claimant is limited to work involving no more than occasional coworker or public conduct. She is limited to work requiring no more than frequently grasping, pinching, or twisting with the hands.

In making this finding, the undersigned has considered all symptoms and the extent to which these symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence, based on the requirements of 20 CFR 404.1529 and SSR 16-3p. The undersigned also considered opinion evidence in accordance with the requirements of 20 CFR 404.1527.

In considering the claimant's symptoms, the undersigned must follow a two-step process in which it must first be determined whether there is an underlying medically determinable physical or mental impairment(s)--i.e., an impairment(s) that can be shown by medically acceptable clinical or laboratory diagnostic techniques--that could reasonably be expected to produce the claimant's pain or other symptoms.

Second, once an underlying physical or mental impairment(s) that could reasonably be expected to produce the claimant's pain or other symptoms has been shown, the undersigned must evaluate the intensity, persistence, and effects of the claimant's symptoms to determine the extent to which they limit the claimant's work-related activities. For this purpose, whenever statements about the intensity, persistence, or functionally limiting effects of pain or other symptoms are not substantiated by objective medical evidence, the undersigned must consider other evidence in the record to determine if the claimant's symptoms limit the ability to do work-related activities.

A review of the documentary evidence of record revealed that the claimant alleged being disabled since November 20, 2014 due to her history of breast cancer, two herniated spinal discs, fatigue, depression, and joint pain experienced in her hips, thighs, and knees (Exhibits 1E, 2E, The claimant stated that she had worked as an accounting consultant and bartender in the past. She stated that she stopped working on September 5, 2015 due to her medical condition (Exhibits 2E, 3E, 4E, 8E, 10E, and 14E). The claimant explained that she had been experiencing pain in her back, hips, and knees since October 2014, which was constant in nature and necessitated her to take Hydromorphone (Exhibit 6E).

Due to her impairments, the claimant stated that she was able to partake in limited activities of daily living. She stated that her condition affected her ability to lift, squat, bend, stand, reach, walk, sit, kneel, climb stairs, and complete tasks. The claimant stated that she could walk less

See Next Page

than one block before needing to stop and rest. She stated that her ability to pay attention depends on how her day is going and her level of anxiety. The claimant stated that her conditions affect her ability to dress, bathe, shave, and use the toilet. She stated that she did not prepare her own meals. The claimant stated that she did not perform any household chores. She stated that she was unable to drive. She noted that she was able to go shopping, but noted that she did so via the computer. The claimant stated that she was able to handle her finances (Exhibit 12E). A review of the third party function report completed by [redacted] confirmed that the claimant was able to partake in limited activities of daily living (Exhibit 13E).

In subsequent disability reports, the claimant stated that there had been changes for worse in the claimant's medical condition (Exhibit 9E). She stated that she had been experiencing increased pain in her back and knees, noting that she had undergone back surgery and been administered injections (Exhibit 11E). The claimant stated that her impairments necessitated her to take several medications including, but not limited to Zolpidem, Trazadone, Melatonin, Tylenol, Sertraline, Lorazepam, Abilify, probiotics, Vitamin D, Vitamin B, Glucosamine, Motrin, Tramadol, Vicodin, Sumatriptan, Ibuprofen, Furosemide, and Excedrin (Exhibit 20E).

At the hearing, the claimant testified that she was laid off from work in 2012. She testified that she is disabled due to her physical and mental impairments. She testified that she had been diagnosed with breast cancer in the past, which necessitated her to undergo right sided surgery, present for chemotherapy, and take medications. The claimant testified that she experienced fatigue with chemotherapy and was unable to finish treatment due to side effects she had been experiencing. She testified that she underwent radiation therapy for eight weeks. The claimant testified that she experiences back pain, noting that she underwent lumbar fusion surgery in 2016. She testified that she has taken pain medications, presented for chiropractic treatment and physical therapy, and been administered injections.

The claimant testified that she experiences pain in her hips, knees, and thighs, noting that she may need to undergo total knee replacement surgery in the future. She testified that some of her joint pain results from her chemotherapy treatment. The claimant testified that she has headaches, which necessitate her to take medications. She testified that she suffers from high blood pressure and noted that her legs swell up at times. The claimant testified that she suffers from asthma, which necessitates her to take medications. She testified that she suffers from anxiety and depression, which necessitate her to take medications. The claimant testified that she presented at the emergency department in September 2016 due to her experience of psychiatric symptoms. She testified that she grapples with poor memory and has panic symptoms.

Due to her impairments, the claimant testified that she is able to partake in limited activities of daily living. Though she testified that she is able to dress herself, put her own shoes on, groom herself, and bathe herself, she testified that she does not cook or wash her own clothes. She testified that she does not belong to any social clubs or organizations. The claimant testified that she does not go to church. She noted that she did travel to Ireland for one week to settle her parents' estates. The claimant testified that while traveling, she used a wheelchair in the airport.

See Next Page

After careful consideration of the evidence, the undersigned finds that the claimant's medically determinable impairments could reasonably be expected to cause the alleged symptoms. The claimant's statements concerning the intensity, persistence and limiting effects of these symptoms are reasonably consistent with the medical evidence and other evidence in the record for the reasons explained in this decision.

A review of the medical evidence of record confirmed a history of invasive ductal carcinoma of the right breast (Exhibits 1F, 2F, 3F, 4F, and 12F). On November 20, 2014, an irregular density was noted in the posteromedial quadrant of the claimant's right breast (Exhibit 12F/40). The claimant received 2 cycles of adjuvant chemotherapy followed by 12 doses of weekly Paclitaxel (Exhibits 2F/79, 2F/91, and 12F/21). From August 24, 2015 through October 13, 2015, the claimant underwent radiation therapy. The claimant completed her radiation therapy on October 13, 2015 (Exhibits 2F/106 and 4F/24).

Thereafter, the claimant was prescribed Arimidex (Exhibit 12F/24). Thereafter, the claimant was noted to have had a new lump on her paraspinal area and easy bruising (Exhibit 12F/32). Dual energy x-rays of the lumbar spine and femurs were performed on October 13, 2016 revealed evidence of osteopenia (Exhibit 12F/12). A mammogram on March 22, 2017 revealed evidence of what might represent early suture micro calcifications (Exhibit 12F/10).

Also in terms of the claimant's physical impairments, a review of the medical evidence of record confirmed a history of back pain due to degenerative disc disease and bilateral knee pain due to degenerative osteoarthropathy. A review of treatment records revealed significant objective evidence including, but not limited to soft tissue swelling, crepitus in the patellofemoral joint, tenderness in the right knee, tenderness in the posterior buttock and lower back in the region of the left sacroiliac joint, positive Faber maneuver, mild tenderness in the medial joint line of both knees, positive plantar flexion and dorsiflexion at the left ankle, positive straight leg raising test, and abnormal gait (Exhibits 6F/2, 9F/4, 12F/28, 13F/24, 13F/26, 13F/28, and 13F/34).

Magnetic resonance imaging of the claimant's left knee on February 2, 2016 demonstrated evidence of a medial meniscal tear, probable lateral meniscal tear, and marked chondromalacia patella with mild lateral subluxation and lateral tilt of the patella and patellar tendinosis, which might be due to abnormal patellofemoral tracking due to a shoulder trochlear notch. It demonstrated evidence of superimposed marked degenerative osteoarthritis of the patellofemoral joint, mild degenerative changes in the lateral compartment of the knee, and moderate effusion (Exhibit 13F/2-3). X-rays of the claimant's sacroiliac joint demonstrated evidence of left sided sacroiliac joint space narrowing as compared to the right (Exhibit 13F/27).

When the claimant met with [redacted] M.D. on March 4, 2016 at the [redacted] Neurosurgery Spine Clinic for evaluation of low back pain dating back to 2007, she reported that her pain had gotten worse over the past year. The claimant described her pain as burning, stabbing, and constant in nature. She rated the intensity of her pain at 8-9/10 (Exhibit 9F/2). A review of progress notes dated March 8, 2016 revealed that the claimant experienced pain when she touched her knees together in bed, her joints felt unstable, her joint usually felt achy, stiff, and swollen, and she heard something clicking (Exhibits 11F/2 and 13F/6). On this date, the claimant was administered an injection in the anterolateral portal of each knee (Exhibit 13F/23).

See Next Page

The claimant underwent a transforaminal lumbar interbody fusion surgery at L5-S1 with decompression and L4-S1 posterior instrumented spinal fusion (Exhibit 9F/8). A review of treatment records provided by the [redacted] Massachusetts confirmed that the claimant experienced intractable back pain with impaired functional mobility in activities of daily living (Exhibit 8F/5). The claimant was admitted to [redacted] on March 25, 2016 to participate in a multi-disciplinary acute rehabilitation course. Shew as discharged from rehab on April 5, 2016 (Exhibit 8F/10). In progress notes dated June 14, 2016, [redacted] PA-C noted that the claimant was status post recent lumbar spine surgery with left sided sacroiliac joint pain. She noted that the claimant appeared to have minimal intra-articular irritability of her left hip and her symptoms seemed to be stemming from her left sacroiliac joint.

[redacted] noted that the claimant was interested in pursuing a cortisone injection and noted that she was also given a prescription for Diclofenac (Exhibit 13F/27). When the claimant presented for evaluation on February 28, 2017, she reported that she experienced pain primarily from the patellofemoral joints. The claimant acknowledged having had a very good response to the injection administered in March 2016 (Exhibit 13F/26). On May 17, 2017, [redacted] M.D. offered impressions of bilateral severe patellofemoral arthrosis, symptomatic on the left than on the right. He noted that the claimant had failed steroid injections (Exhibit 13F/29). The claimant was administered Euflexxa injections on May 17, 2017, May 25, 2017, May 30, 2017 (Exhibit 13F/29-31).

In progress notes dated June 20, 2017, Dr. [redacted] noted that the claimant suffered from internal derangement, which was possibly an exacerbation of patellofemoral arthrosis or a torn medial meniscus (Exhibit 13F/32). The claimant was given Tramadol for pain with instructions and precautions (Exhibit 13F/33). A review of progress notes dated July 10, 2017 revealed that the claimant continued to take Tramadol and Ibuprofen for pain (Exhibit 13F/34). On July 25, 2016, the claimant was given Norco and Tramadol. She was advised to proceed with physical therapy and a consultation for patellofemoral arthroplasty (Exhibit 13F/35).

A review of the medical evidence of record also confirmed a history of migraine headaches and essential hypertension, which have necessitated the use of Fioricet, Triptans, and Ultracet (Exhibits 5F/11, 5F/29, 5F/39, 5F/61, 5F/84, 10F/6, 14F/14, and 14F/21).

Also in terms of the claimant's physical impairments, a review of the medical evidence of record confirmed a history of asthma (Exhibit 5F/26).

In terms of the claimant's mental impairments, a review of the medical evidence of record confirmed a history of depressive disorder, anxiety disorder, and insomnia, which necessitated the use of medications including Ambien, Zoloft, Melatonin, Trazadone, Sertraline, and Lorazepam (Exhibits 5F/36-39, 5F/58, 5F/61, 7F/3, 14F/14, and 14F/21). When the claimant met with [redacted], Psy.D. for a consultative examination, she presented with symptoms of an adjustment disorder secondary to her medical problems. The claimant reported that she worried about two to cover her medical bills. She reported that she had been experiencing a lot of anxiety, which disrupted her sleep.

See Next Page

The claimant was diagnosed with adjustment disorder with mixed anxiety and depressed mood. [redacted] Psy.D. rated the claimant's Global Assessment Functioning score at 60 (Exhibit 7F/1-4). The undersigned grants great weight to the diagnoses and assessment of Dr. Hunter as she had an opportunity to examine the claimant in person and also interview her. The undersigned notes that her diagnoses and assessment were consistent with a review of the medical evidence of record and the claimant's hearing testimony.

As for the opinion evidence, it is noted that in reaching these conclusions regarding the severity of the claimant's impairments and the resulting limitation in her functioning, the medical source opinions by state medical examiners have been considered (SSR 96-6P) (Exhibits 1A and 3A). These opinions were relied on in denying the claimant's application at the initial and reconsideration levels, and conflict with the residual functional capacity finding reached in this decision. However, there are a number of reasons for not adopting those opinions in full. The DDS opinions were rendered by physicians and consultants who never had the opportunity to examine, or even meet with and question, the claimant.

At the hearing, the claimant testified that she continues to experience pain in her low back and knees, she suffers from symptoms of depression and anxiety, and she has a history of breast cancer. Furthermore, additional medical records have been admitted into the record since the DDS physicians rendered their opinions. The undersigned notes that the claimant continues to grapple with joint pain status post treatment for breast cancer, back pain due to degenerative disc disease, bilateral knee pain due to degenerative osteoarthropathy, chronic headaches, asthma, hypertension, depressive disorder, and anxiety disorder. This fact diminishes the value of the DDS opinions as this new evidence more accurately reflects the current state of the claimant's impairments (Social Security Ruling 96-6p). .

Based upon a thorough review of all of the medical evidence of record, the undersigned is persuaded that the claimant's combination of physical and mental impairments could reasonably be expected to produce the symptoms she alleges to the extent that her impairments are so severe as to preclude the performance of all sustained work activity.

6. The claimant is unable to perform any past relevant work (20 CFR 404.1565).

The claimant has past relevant work as an accounting clerk (sedentary and SVP 5 work). The demands of the claimant's past relevant work exceed the residual functional capacity.

7. The claimant was an individual closely approaching advanced age on the established disability onset date (20 CFR 404.1563).

8. The claimant has at least a high school education and is able to communicate in English (20 CFR 404.1564).

9. The claimant's acquired job skills do not transfer to other occupations within the residual functional capacity defined above (20 CFR 404.1568).

See Next Page

10. Considering the claimant's age, education, work experience, and residual functional capacity, there are no jobs that exist in significant numbers in the national economy that the claimant can perform (20 CFR 404.1560(c) and 404.1566).

Even if the claimant had the residual functional capacity for the full range of sedentary work, a finding of "disabled" would be directed by Medical-Vocational Rule 201.14.

11. The claimant has been under a disability as defined in the Social Security Act since November 20, 2014, the alleged onset date of disability (20 CFR 404.1520(g)).

See Next Page

DECISION

Based on the application for a period of disability and disability insurance benefits filed on September 8, 2015, the claimant has been disabled under Sections 216(i) and 223(d) of the Social Security Act since November 20, 2014.

/s/ Addison C. S. Masengill

Addison C. S. Masengill
Administrative Law Judge

October 26, 2017
Date