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United States District Court,
E.D. New York.
Jerome MOORE, Plaintiff,
v.
Michael J. ASTRUE, Commissioner of Social Security, Defendant.

No. 07-cv-5207(NGG).
Aug. 21, 2009.

West KeySummary**Social Security and Public Welfare 356A 142.10**

356A Social Security and Public Welfare
356AII Federal Insurance Benefits in General
356AII(C) Procedure
356AII(C)1 Proceedings in General
356Ak142.10 k. Findings and Conclusions. Most Cited Cases

Social Security and Public Welfare 356A 143.65

356A Social Security and Public Welfare
356AII Federal Insurance Benefits in General
356AII(C) Procedure
356AII(C)2 Evidence
356Ak143.30 **Disability** Claims, Evidence as to
356Ak143.65 k. Medical Evidence of **Disability**, Sufficiency. Most Cited Cases

An administrative law judge (ALJ) failed to abide by the treating physician rule when, in social security **disability** proceedings, the ALJ concluded that the claimant retained the residual functional capacity (RFC) to perform sedentary work, while refusing to give controlling weight to the treating physician. The ALJ failed to provide good reasons for giving the treating physician RFC less than controlling weight, and discounted the treating physician's opinion in all of two sentences. 20 C.F.R. § 404.1527(d)(2)-(6).

Jeffrey D. **Delott**, Jericho, NY, for Plaintiff.

Social Security Administration-Generic, F. Franklin Amanat, United States Attorneys Office, Brooklyn, NY, for Defendant.

MEMORANDUM & ORDER

NICHOLAS G. GARAUFIS, District Judge.

***1** Jerome Moore ("Plaintiff") seeks judicial review pursuant to the Social Security Act (the "Act"), 42 U.S.C. § 405(g), of the final determination of the Commissioner of Social Security (the "Commissioner") denying his application for **Disability** Insurance Benefits ("DIB"). (Docket Entry # 1.) Plaintiff moves for judgment on the pleadings, and seeks to have the case remanded solely to calculate benefits. (Docket Entries10, 11.) The Commissioner cross-moves for judgment on the pleadings seeking to affirm his decision. (Docket Entries12, 13.) For the reasons that follow, the court denies the Commissioner's Motion, but grants Plaintiff's Motion in part, to the extent that the matter is remanded to the Commissioner for further administrative proceedings consistent with this opinion.

I. BACKGROUND

Plaintiff claims that he became disabled on May 28, 2002 as a result of back injuries he incurred while performing work as a

cable installer and bender for Lucent Technology. (Transcript of the Record ("Tr."), at 208-12.) Plaintiff was out of work following the injury, but in 2003 he attempted to return; he discontinued his employment, however, on or about April 15, 2003. (*Id.* at 206.) He had been assigned a desk job, but was ultimately sent home because managers observed that he was in pain. (*Id.* at 225.) On March 8, 2005, Plaintiff filed for DIB. (*Id.* at 13, 38.)

A. Plaintiff's Medical History

1. *2002*

On May 29, 2002, Plaintiff sought treatment at J.R. Medical & Diagnostic Services, ("J.R.Medical")-a working group of physicians-for lower back pain in his lumbar region.[FN1] (*Id.* at 81-82, 213.) During his medical visit, Plaintiff reported lower back pain, but no radiating pain or numbness. (*Id.* at 82.) His symptoms included hypoaesthesia[FN2] in the L3-L4 area, with no antalgic gait,[FN3] tenderness when palpated in the L5-S1 joint, and a decreased range of motion in the lower back area. (*Id.* at 84, 86.)

> FN1. "A normal human vertebral column consists of thirty-three vertebrae labeled according to their position and region (in descending order, cervical ('C1' through 'C7'), thoracic ('T1' through 'T12'), lumbar ('L1' through 'L5'), sacral ('S1' through 'S5') and coccygeal ('Co1' through 'Co4')). The fifth lumbar vertebra, for example, is labeled 'L5.' The space between the fifth lumbar and first sacral vertebrae, for example, is labeled 'L5-S1.' " *Friedman v. Astrue,* No. 07 Civ. 3651(NRB), 2008 WL 3861211, at * 2 n. 4 (S.D.N.Y. Aug.19, 2008) (citing *Dorland's Illustrated Medical Dictionary* 2079 (31st ed.2007)).
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> FN2. Hypoaesthesia is "diminished sensitivity to stimulation." *Webb v. Apfel,* No. 98-CV-791 EF, 2000 WL 1269733, at *7 (W.D.N.Y. Feb.8, 2000) (*citing Stedman's Medical Dictionary* 832 (26th ed.1995)).
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> FN3. "An antalgic gait is one in which the stance phase of walking is shortened on one side due to pain on weight bearing." *Rodriguez v. Astrue,* No. 02 Civ. 1488(BSJ)(FM), 2009 WL 1619637, at * 6 n. 23 (S.D.N.Y. May 15, 2009) (citation omitted).

Plaintiff continued to receive treatment at J.R. Medical throughout 2002, visiting Dr. Elizabeth Efthimiou on several occasions. (*See id.* at 80 (June 28 visit), 79 (week of July 19 visit), 78 (August 26 visit).) In order to rule out herniated nucleus pulposus,[FN4] Dr. Efthimiou requested medical testing for Plaintiff's lumbar region-including an MRI, a temperature gradient study, an SSEP test, a Comparative Muscle Test, and a Lower Extremity Neurometer test. (*Id.* at 80, 90.) In June of 2002, Plaintiff underwent a lumbar MRI. (*Id.* at 100, 173, 177.)

> FN4. "A herniated nucleus pulposus is a slipped disk along the spinal cord. The condition occurs when all or part of the soft center of a spinal disk is forced through a weakened part of the disk. Other names for herniated nucleus pulposus is [sic] lumbar radiculopathy, cervical radiculopathy." *Corson v. Astrue,* 601 F.Supp.2d 515, 526 n. 29 (W.D.N.Y.2009) (citation omitted).

In the course of these visits, Plaintiff was diagnosed with medical ailments affecting his lower back, including myofascial pain syndrome,[FN5] low back syndrome, a lumbar sprain/strain, and lumbar disc displacement and prescribed physical therapy for these conditions. (*See id.* at 78, 80, 89.) Moreover, following many of these visits, Dr. Efthimiou updated Plaintiff's **disability** status in connection with New York State Workers' Compensation ("Workers' Compensation") forms. (*Id.* at 78-80.)

FN5. "Myofascial pain syndrome is [a] condition characterized by chronic pain in the muscle tissues, similar to fibromyalgia. MPS is sometimes the aftermath of injury. Pain medication, anti-inflammatory medication, and therapies aimed at relaxing the muscles tissues (such as massage, chiropractic, and some forms of acupuncture) have been reported as beneficial." *Carrier-Titti v. Astrue*, No. 06-CV-0647 (VEB), 2009 WL 1542553, at *5 n. 8 (N.D.N.Y. June 1, 2009) (citation omitted).

***2** Late in 2002, Plaintiff was referred to a specialist, neurologist Dr. K.R. Shetty. (*See id.* at 93.) On October 14, 2002, at his first appointment with Dr. Shetty, Plaintiff complained not only of lower back pain, but also of neck pain radiating into his left arm, and weakness and tingling in his left hand. (*Id.* at 95.) Dr. Shetty conducted a neurological exam, and found that Plaintiff displayed a positive Tinel's sign [FN6] and a positive straight leg raising sign on the left side.[FN7] (*Id.* at 97.) On October 21, Dr. Shetty diagnosed Plaintiff with cervical and lumbar radiculitis [FN8] as well as carpal tunnel syndrome. (*Id.* at 93.) Dr. Shetty completed a Workers' Compensation billing form. (*Id.* at 94.)

FN6. "Tinel's sign is a 'tingling sensation in the distal end of a limb when percussion is made over the site of a divided nerve. It indicates a partial lesion or the beginning regeneration of the nerve. [It is also called] formication sign and distal tingling on percussion.' " *Fox v. Comm'r of Soc. Sec.*, Civ. No. 6:02-CV-1160 (FJS/RFT), 2009 WL 367628, at *6 n. 3 (N.D.N.Y. Feb.13, 2009) (*quoting Dorland's Illustrated Medical Dictionary* 1527 (28th ed.1994)).

FN7. "Straight leg raising, also known as a Lasè gue test, is a means of diagnosing nerve root compression, which can be caused by a herniated disc. The patient lies flat while the physician raises the extended leg. If the patient feels pain in the back at certain angles (a 'positive test'), the pain may indicate herniation." *Gonzalez v. Comm'r of Soc. Sec.*, No. 08-CV-2314(CPS), 2009 WL 803121, at * 3 n. 6 (E.D.N.Y. Mar.25, 2009) (citation omitted).

FN8. Radiculitis is " '[i]nflammation of the root of a spinal nerve, especially of that portion of the root which lies between the spinal cord and the intervertebral canal.' " *Bromback v. Barnhart*, No. 03 Civ. 4945(NRB), 2004 WL 1687223, at * 3 n. 8 (S.D.N.Y. July 28, 2004) (*quoting Dorland's Illustrated Medical Dictionary* 1404 (28th ed.1994)).

2. *2003*

In the first half of 2003, Plaintiff returned to J.R. Medical several times. (*See id.* at 72-75 (June 2 visit), 76 (April 1 visit), 77 (January 9 visit).) Doctors there continued to diagnose him with lower back injuries and to update Plaintiff's **disability** status on Workers' Compensation forms. (*Id.* at 72, 77.)

On January 9, 2003, Dr. Jose Rodriguez of J.R. Medical referred Plaintiff to neurologist Dr. Hugh Xian. (*Id.* at 77, 116.) On January 20, 2003, Dr. Xian conducted a neurological examination. (*Id.* at 117.) He found tenderness in Plaintiff's lumbar paraspinal muscles and a positive straight leg raising test on his left side, but no abnormal gait. (*Id.*) After evaluating Plaintiff's deep tendon reflexes,[FN9] Dr. Xian recorded 1+ in the biceps and triceps, 2+ in the knee jerks, 1+ in the left ankle jerk, and an absent right ankle jerk. (*Id.*) There were no limitations on Plaintiff's neck motion. (*Id.*)

> FN9. "Deep tendon reflexes are tested to examine for abnormalities in muscles, sensory neurons, lower motor neurons, and the neuromuscular junction; acute upper motor neuron lesions; and mechanical factors such as joint disease .... These reflexes are often rated on a scale of zero to five, where one, two, and three, indicate normal reflexes, and zero, four and five are considered abnormal. A rating of zero indicates the reflex is absent." *Rockwood v. Astrue,* 614 F.Supp.2d. 252, 258 n. 4 (N.D.N.Y.2009) (internal quotation marks and citations omitted).

On January 20, 2003, Dr. Xian diagnosed lumbar degenerative disc disease and lumbar radiculopathy. (*Id.*) He also recommended an MRI of Plaintiff's cervical region. (*Id.*) Dr. Xian prescribed Neurontin to Plaintiff.[FN10] (*Id.*) He conducted a follow-up visit with Plaintiff on March 24, 2003, diagnosing Plaintiff with radiculopathy in the S1 area of his back. (*Id.* at 102.) Dr. Xian also examined Plaintiff on July 23, 2003, (*id.* at 98), and found negative readings on a cervical MRI performed on Plaintiff. (*Id.*) By this time, Plaintiff was not taking Neurontin to manage his pain because "he felt he got no benefit" from the medication. (*Id.*)

> FN10. "Neurontin is a preparation of gabapentin, an anticonvulsant used as adjunctive therapy in the treatment of partial seizures." *Fernandez v. Astrue,* No. 1.06-CV-00479 (LEK), 2009 WL 961492, at * 4 n. 6 (N.D.N.Y. Apr.7, 2009) (*citing Dorland's Illustrated Medical Dictionary* 764, 1287 (31st ed.2007)).

After continuing to complain of lower back pain radiating into his right leg, Plaintiff received a lumbar epidural steroid injection[FN11] from Dr. Masoom Qadeer of J.R. Medical on June 7, 2003. (*Id.* at 175-76.) Plaintiff reported that lifting and moving exacerbated his pain. (*Id.* at 176.)

> FN11. "An epidural steroid injection is typically used to alleviate chronic low back and/or leg pain .... [I]t can provide sufficient pain relief to allow the patient to progress with their rehabilitation program." *Perez v. Barnhart,* 415 F.3d 457, 465 n. 9 (5th Cir.2005) (internal quotation marks and citation omitted).

3. *2004*

Plaintiff continued to visit his doctors at J.R. Medical throughout 2004. (*Id.* at 68,

(October 28 visit), 69 (week of July 12 visit), 70 (June 15 visit), 71 (March 11 visit).) At each of these visits, doctors diagnosed Plaintiff with lower back injuries, and provided Plaintiff's **disability** status on Workers' Compensation forms. (*Id.* at 68, 69, 70, 71.)

***3** On April 12, 2004, Plaintiff visited neurosurgeon Dr. Salvatore Palumbo on referral from Dr. Rodriguez. (*Id.* at 100-01.) Plaintiff complained of back pain but Dr. Palumbo observed that there were no radiculopathic or myelopathic features to this pain. (*Id.* at 101.) Dr. Palumbo found the Plaintiff's lumbar MRI of June 2002 within normal limits. (*Id.* at 100.) While Plaintiff displayed moderate tenderness when palpated along the lumbar spine, sensation remained intact to light touch. (*Id.*) Dr. Palumbo noted symmetric deep tendon reflexes of 2+, and full muscle power in all groups. (*Id.*) He diagnosed lumbago.[FN12] (*Id.* at 118.)

FN12. "Lumbago is low back pain." *Riley v. Astrue,* No. 06 Civ. 7762(JSR), 2008 WL 2696259, at * 7 n. 8 (S.D.N.Y. July 7, 2008) (*citing Dorland's Illustrated Medical Dictionary* 956 (27th ed.1988)).

Finally, Dr. Palumbo made an appointment for Plaintiff to visit with a pain management specialist, Dr. Luis M. Fandos, to relieve his chronic lower back pain through facet blocks.[FN13] (*Id.* at 101.) Dr. Palumbo recommended that Plaintiff continue physical therapy, because he found surgery to be unnecessary. (*Id.*) Around the time of his appointment with Dr. Palumbo, Plaintiff began a drug treatment of Bextra and a muscle relaxer.[FN14] (*Id.* at 100.)

FN13. "The facet joints are often affected by degenerative disk disease. They are the small joints along the back of the spine that allow the spine to be flexible. Facet blocks involve the injection of steroids into the area of the joint, in order to relieve pain and inflammation." *Smith v. Cont'l Cas. Co.,* 450 F.3d 253, 255 n. 1 (6th Cir.2006) (citation omitted).

FN14. "Bextra was a non-steroidal anti-inflammatory drug prescribed to relieve symptoms of osteoarthritis and rheumatoid arthritis." *Suarez v. Comm'r of Soc. Sec.*, No. 06 Civ. 2868(HBP), 2009 WL 874041, at * 2 n. 6 (S.D.N.Y. Mar.26, 2009) (citation omitted).

On June 30, 2004, Dr. Fandos evaluated Plaintiff for what Plaintiff characterized as "severe lower back pain." (*Id.* at 172.) Dr. Fandos found severe point tenderness and a very limited range of motion in the lumbar region with trigger points, a mildly positive straight leg raise, no Babinski's sign,[FN15] and mildly positive Patrick's[FN16] and Gowers'[FN17] signs. (*Id.* at 173 .) Plaintiff's deep tendon reflexes were 1+ symmetrically, and there was normal motor strength in all muscle groups tested. (*Id.*) Dr. Fandos recorded Plaintiff's assertion that his pain was greatly exacerbated when sitting, standing, or picking up objects. (*Id.* at 172.) He noted that Plaintiff was taking no medication and recommended facet block treatments. (*Id.* at 173.)

FN15. "Babinski's sign is the loss or lessening of the Achilles tendon reflex in sciatica." *Riley,* 2008 WL 2696259, at * 8 n. 12 (*citing Dorland's Illustrated Medical Dictionary* 1520 (27th ed.1988)).

FN16. "Patrick's test is used to de-

termine whether a patient suffers from arthritis of the hip joint." *Beerthuis v. Comm'r of Soc. Sec.*, No. 1:07-cv-344, 2008 WL 3850734, at * 7 n. 3 (W.D.Mich. Aug.13, 2008) (citation omitted).

FN17. "Gowers Disease [for which the sign tests] is a spasmodic affection of the muscles of the lower extremities." *Nazario v. Astrue*, No. 07-61833-CIV, 2009 WL 347424, at * 4 n. 4 (S.D.Fla. Feb.11, 2009) (citation omitted).

4. *2005*

In 2005 Plaintiff returned to J.R. Medical and began treatment with Dr. Stephanie Bayner. (*See id.* at 165 (March 16 visit), 180 (January 21 visit).) In addition to Plaintiff's diagnosis of a lumbar region injury, Dr. Bayner diagnosed Plaintiff with cervical and thoracic radiculopathy. (*Id.* at 165, 180-81.) She completed a Workers' Compensation Board form on March 16, 2005. (*Id.* at 165.)

On April 25, and October 4, 2005, Dr. Bayner observed that Plaintiff suffered from pain and decreased range of motion in his neck, and left shoulder through left hand areas-in addition to his lumbar injury. (*Id.* at 150-54, 166-68.) As Dr. Efthimiou had in 2002, Dr. Bayner observed hypoaesthesia-this time in the T1, C5-C8, and L4, L5, and S1 regions of Plaintiff's back. (*Id.* at 169.) In addition to filling out Workers' Compensation Board forms, Dr. Bayner requested that Plaintiff receive a cervical MRI in connection with his Workers' Compensation claim. (*Id.* at 154.)

Doctors performed two diagnostic tests on Plaintiff in 2005. First, on October 19, 2005, Plaintiff underwent an EMG/NCV test which showed bilateral C5-C6 radiculopathies, and, at the "wrist level," bilateral median and ulnar nerve entrapment.[FN18] (*Id.* at 192.) Second, on October 27, 2005, Plaintiff had an MRI of the cervical spine. (*Id.* at 196.) According to radiologist Dr. Joel Himelfarb, Plaintiff suffered from posterior disc bulges at the C2-C7 levels. (*Id.*) In addition, Dr. Himelfarb observed "straightening of the curvature of the cervical spine with some loss of the normal lordosis."[FN19] (*Id.*)

FN18. "Nerve entrapment refers to a nerve being caught, such as within a scar, and 'squeezed.' " *Maniscalco v. Cia. De Navegacion Golfo Azul, S.A.*, No. 78 Civ. 4590(BN), 1988 WL 18905, at * 9 n. 7 (S.D.N.Y. Feb.25, 1988) (citation omitted).

FN19. Lordosis refers to the "curvature of the lower back." *Gonzalez*, 2009 WL 803121, at * 5 n. 7 (*citing Stedman's Medical Dictionary* 1032 (27th ed.2000)).

***4** In connection with his DIB claim, Plaintiff received a consultative examination for the Social Security Administration ("SSA") from Dr. Mohammed Asif Iqbal on May 23, 2005. (*Id.* at 119-23.) Plaintiff told Dr. Iqbal that a past MRI showed that he had a bulging disk and that he had received an epidural injection to relieve back pain. (*Id.* at 119.) Plaintiff also stated that he had experienced intermittent pain in the neck area that did not interfere with his daily activities. (*Id.*) He explained that he was able to walk up to a half mile before feeling pain in his leg and back. (*Id.*) Plaintiff further described his pain as arising during long periods of standing, sitting, or acts of bending. (*Id.*)

Dr. Iqbal observed that Plaintiff had a

slow gait, walked on his heels and toes with mild difficulty, squatted three-fourths of a full squat, moved with no assistive devices, and could get into and out of a chair without difficulty. (*Id.* at 120.) Plaintiff displayed full grip strength, and a full range of motion in the cervical spine with no spasms. (*Id.*) He demonstrated normal range of motion in the shoulders, elbows, forearms, wrists, and fingers. (*Id.*) According to Dr. Iqbal, despite experiencing pain, Plaintiff appeared to be in "no acute distress" and was given a stable prognosis. (*Id.*) A radiologist, Dr. Pesho S. Kotval, consulted on Plaintiff's exam with Dr. Iqbal by examining Plaintiff's cervical and lumbar spinal X-rays. (*Id.* at 123.) According to Dr. Kotval, Plaintiff displayed a straightened "cervical lordotic curvature" but "no bony or disc space pathology." (*Id.*)

On June 13, 2005, Dr. Iqbal completed a "Physical Residual Functional Capacity Assessment" form. (*Id.* at 124-29.) He concluded that Plaintiff could occasionally lift or carry up to 50 pounds, could frequently lift or carry up to 25 pounds, could stand and/or walk up to six hours in an eight-hour workday, could sit for up to 6 hours in an eight-hour workday, and could push and/or pull for an unlimited amount of time. (*Id.* at 125.) Plaintiff's claimed limitations on walking, sitting, standing, and lifting were deemed credible, but not to the extent claimed by Plaintiff. (*Id.* at 128.) Plaintiff was found to have only a "mild limitation with prolonged standing and moderate limitation with prolonged walking ... [and] ... moderate limitation lifting weight." (*Id.*) Dr. Iqbal deemed his determination to be consistent with those of other doctors in Plaintiff's medical file. (*Id.*)

5. *2006*

Plaintiff had several medical visits in 2006. On April 28, 2006, Dr. Bayner again diagnosed Plaintiff with cervical and lumbar radiculopathy, and cervical disk displacement based on MRI results. (*Id.* at 148.) According to Dr. Bayner's exam notes, Plaintiff suffered from pain and decreased range of motion in the neck, left shoulder, and lumbar regions. (*Id.* at 143.)

On May 25, 2006, Plaintiff underwent an MRI on the lumbrosacral spine. (*Id.* at 197.) According to neuroradiologist Dr. Michele Rubin, who reviewed Plaintiff's MRI at the medical office where Plaintiff had the test performed, Plaintiff suffered from "mild developmental lumbar facet hypertrophy [FN20] in L2-L3 through L5-S1, with "dorsolateral canal encroachment at L3-L4 and L4-L5." (*Id.*) Dr. Rubin concluded that Plaintiff suffered from "lumbar scoliosis and exaggerated lordosis, which may be related to muscle spasm/pain and mild/borderline developmental lumbar spinal stenosis." [FN21] (*Id.* at 198.)

> FN20. "If the facet joint becomes too swollen and enlarged, it may block the openings through which the nerve roots pass, causing a pinched nerve. This condition is called facet hypertrophy." *Loren v. Astrue*, 553 F.Supp.2d 281, 283 n. 1 (N.D.N.Y. Apr.22, 2008) (internal quotation marks omitted) (citation omitted).
>
> FN21. "Spinal stenosis is a 'narrowing of the vertebral canal, nerve root canals, or inter-vertebral foramina of the lumbar spine caused by encroachment of bone upon the space; symptoms are caused by compression of the cauda equine and include pain, paresthesias, and neurogenic claudication.' " *Rock-*

wood, 614 F.Supp.2d. at 260 n. 13 (*quoting Dorland's Ilustrated Medical Dictionary* 1795 (31st ed.2007)).

6. *2007*

***5** On January 18, 2007, Dr. Steven Calvino performed a consultative examination for SSA on Plaintiff. (*Id.* at 130-32.) Plaintiff complained of chronic lower back pain that would worsen with prolonged sitting, walking, or carrying. (*Id.* at 130.) He stated to Dr. Calvino that he could cook as needed and shower and dress independently, but that he could not shop or clean his home. (*Id.*) After a physical examination revealing no abnormalities, Dr. Calvino concluded that, although Plaintiff was suffering from "chronic low-back pain," he did not suffer from a **disability** affecting his capacity to perform his regular work duties. (*Id.* at 132.)

On March 6, 2007, Dr. Bayner observed that Plaintiff displayed cervical and lumbar pain symptoms similar to her previous exams, and diagnosed cervical and lumbar back injuries based upon MRI diagnostic testing results. (*Id.* at 133-39.) She prescribed Vicodin and physical therapy. (*Id.* at 133, 137.)

On March 21, 2007, Dr. Stephanie Bayner completed a Medical Assessment of Ability to Do Work-Related Activities form ("Treating Physician RFC") (*Id.* at 183.) She concluded that Plaintiff could carry 10 pounds occasionally and 5 pounds frequently. (*Id.*) According to Dr. Bayner, Plaintiff could stand 2 hours per day and without interruption for 30 minutes, and could sit for 2 hours per day or up to 20 minutes at a time. (*Id.* at 184.) Plaintiff could occasionally climb, stoop, and crouch, could frequently balance, and could never kneel or crawl. (*Id.*) Plaintiff had a limitation with pushing or pulling. *Id.* In making these findings, Dr. Bayner cited MRI results and Plaintiff's answers to questions. (*Id.* at 183-84, 229.) Dr. Bayner noted that the earliest date that Plaintiff displayed the symptoms resulting in the 2007 Treating Physician RFC was January 22, 2005, the time at which Dr. Bayner became Plaintiff's treating physician. (*Id.* at 183.)

B. Procedural History

Plaintiff filed an application for Social Security **Disability** benefits on March 8, 2005. (*Id.* at 38.) In his application, he stated that he could not sit, stand, walk or lift for any extended period of time because of a lower back injury. (*Id.* at 65.)

On June 21, 2005, SSA notified Plaintiff that it had denied his claim. (*Id.* at 31.) On July 23, 2005, SSA received Plaintiff's request for a hearing by an Administrative Law Judge. (*Id.* at 30.) At his hearing on March 29, 2007, before Administrative Law Judge Michael S. London (the "ALJ"), Plaintiff stated that the onset of his **disability** occurred on April 15, 2003, and not on May 28, 2002, as initially filed. (*Id.* at 202, 206.) At the time of the hearing, Plaintiff was still claiming Worker' Compensation benefits. (*Id.* at 207.)

At the hearing before the ALJ, Plaintiff complained of pain in his neck and shoulders extending down toward his lower back. (*Id.* at 209-11.) Plaintiff stated that this pain existed from the time he injured himself bending cable in 2002. (*Id.* at 212.) He characterized his neck pain as constant, and said that it was aggravated by activities such as sitting and walking-and that it hurt him as he gave his testimony. (*Id.* at 213-14.) Plaintiff admitted to taking Vicodin every other night, as well as a Neuropac-a combination of Prevacid and "another pill just inside of it for the pain in

the back"-during the day. (*Id.* at 216-17.) He stated that he has "regularly" done so for a "couple" of years. (*Id.* at 216.)

***6** Plaintiff further testified that he was prescribed physical therapy for bulging disks. (*Id.* at 215.) He stated, however, that the only therapy he engaged in was a knee bend, because he found other physical therapy to be too painful. (*Id.* at 231.) Plaintiff confirmed that he was sent to a neurologist, who informed Plaintiff that he did not need surgery and that he should continue his physical therapy despite Plaintiffs belief that it was ineffective. (*Id.* at 216.)

Plaintiff also complained of pain in his lower back attributed to herniated disks. (*Id.* at 211, 217-18.) Plaintiff stated that he experienced pain getting out of bed, sitting, and walking after more than one block. (*Id.* at 219-20.) He informed the ALJ that he tried to stretch to relieve the pain from walking. (*Id.* at 220.) Physical therapy and an epidural failed to relieve these symptoms. (*Id.* at 220-21.) Plaintiff also asserted that his condition deteriorated in 2005, after his visit to Dr. Iqbal. (*Id* . at 221.) Plaintiff testified that, after he had assured Dr. Iqbal he could walk a half-mile, his pain worsened, limiting his ability to walk. (*Id.* at 222.)

Plaintiff stated that his doctor as of the hearing date was Dr. Stephanie Bayner, a member of J.R. Medical, which Plaintiff had visited since the onset of his injury on May 29, 2002. (*Id.*) Plaintiff testified that, since the time of his **disability** onset date, he has spent his days watching television and using his computer. (*Id.* at 233-34.) He admitted that he is able to cook his own meals (although a friend shops for his food), can occasionally clean his apartment, and can see friends when they come over to visit. (*Id.* at 233-34.) Plaintiff stated that he finds daily activities, such as washing dishes and shaving, to be painful. (*Id.* at 214-15.) He testified, however, that he drove himself to his appearance before the ALJ. (*Id.* at 230-31.)

The ALJ denied Plaintiff's benefit request, and on October 20, 2007, the Appeals Council denied Plaintiff's request for review, making the ALJ's decision the Commissioner's final determination on Plaintiff's claim. (*Id.* at 3-6.) Plaintiff has sought review in this court.

II. DISCUSSION

A. Standard of Review

A district court may set aside the determination of the Commissioner only if it is " 'based upon legal error or is not supported by substantial evidence.' " *Rosa v. Callahan,* 168 F.3d 72, 77 (2d Cir.1999) (*quoting Balsamo v. Chater,* 142 F.3d 75, 79 (2d Cir.1998)). "Substantial evidence ... is 'more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.' " *Id.* (*quoting Pratts v. Chater,* 94 F.3d 34, 37 (2d Cir.1996)).

B. Determining Disability

"To be 'disabled' under the Act and therefore entitled to benefits, a claimant must demonstrate an '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.' " *Id.* (*quoting* 42 U.S.C. § 423(d)(1)(A)). Additionally, "an individual's impairment must be 'of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experi-

ence, engage in any other kind of substantial gainful work which exists in the national economy.' " *Id.* (*quoting* 42 U.S.C. § 423(d)(2)(A)).

C. The ALJ's Decision

***7** The Social Security regulations establish a five-step process for evaluating **disability** claims. Using this framework:

> 1. The Commissioner considers whether the claimant is currently engaged in substantial gainful activity.
>
> 2. If not, the Commissioner considers whether the claimant has a "severe impairment" which limits his or her mental or physical ability to do basic work activities.
>
> 3. If the claimant has a "severe impairment," the Commissioner must ask whether, based solely on medical evidence, claimant has an impairment listed in Appendix 1 of the regulations. If the claimant has one of these enumerated impairments, the Commissioner will automatically consider him disabled, without considering vocational factors such as age, education, and work experience.
>
> 4. If the impairment is not "listed" in the regulations, the Commissioner then asks whether, despite the claimant's severe impairment, he or she has residual functional capacity to perform his or her past work
>
> 5. If the claimant is unable to perform his or her past work, the Commissioner then determines whether there is other work which the claimant could perform. The Commissioner bears the burden of proof on this last step, while the claimant has the burden on the first four steps.

Shaw v. Chater, 221 F.3d 126, 132 (2d Cir.2000).

1. *Step One*

An ALJ must first determine whether a claimant is engaging in substantial gainful activity. "Substantial work activity is work activity that involves doing significant physical or mental activities." 20 C.F.R. § 404.1572(a). "Gainful work activity is work activity that you do for pay or profit. Work activity is gainful if it is the kind of work usually done for pay or profit, whether or not a profit is realized." 20 C.F.R. § 404.1572(b). In this case, the ALJ found that Plaintiff had not engaged in substantial gainful activity since April 15, 2003-accepting Plaintiff's amended onset date of April 15, 2003. (Tr. at 13, 20.) The ALJ accepted that Plaintiff had accumulated earnings-establishing that he had met both the gainful and substantial work tests simultaneously. The parties do not dispute this determination.

2. *Step Two*

At Step Two, an ALJ must determine whether a claimant's impairment is severe. To be severe, an impairment must "significantly [limit the] physical or mental ability to do basic work activities." 20 C.F.R. § 404.1520(c). When a claimant is limited by multiple impairments, SSA will "consider the combined effect of all of [the] impairments without regard to whether any such impairment, if considered separately, would be of sufficient severity." 20 C.F.R. § 404.1523. Here, the ALJ found that Plaintiff had multiple severe impairments: cervical and lumbrosacral degenerative disc disease with radiculopathy. (Tr. at 15.) This determination is undisputed.

3. *Step Three*

At Step Three, an ALJ must determine whether a claimant's impairments meet or

equal the impairments listed in 20 C.F.R. Part 404, Subpart P, Appendix 1. If a claimant meets or equals the listed impairments, the ALJ's inquiry ends with a finding of **disability**. *See* 20 C.F.R. § 404.1520(d). If a claimant does not meet or equal the listed impairments, the inquiry continues. *See* 20 C.F.R. § 404.1520(e). In this case, the ALJ determined-and the parties do not dispute-that Plaintiff's severe impairments did not meet or equal the listing. (Tr. at 15.)

4. *Step Four*

***8** In determining a claimant's RFC at Step Four, an ALJ makes "an administrative assessment of the extent to which a claimant's medically determinable impairment(s), including any related symptoms such as pain, may cause physical or mental limitations that may affect the claimant's capacity to perform work-related physical or mental activities." *Sobolewski v. Apfel*, 985 F.Supp. 300, 309 (E.D.N.Y.1997) (citation omitted). The ALJ must consider the claimant's "ability to sit, stand, walk, lift, carry, push, and pull ... as well as [the] ability to reach, handle, stoop, or crouch ... based on medical reports from acceptable medical sources that include the sources' opinions as to the claimant's ability to perform each activity." *Id.* (citations omitted). In addition, the ALJ must consider that:

> Pain or other symptoms may cause a limitation of function beyond that which can be determined on the basis of the anatomical, physiological or psychological abnormalities considered alone; e.g., someone with a low back disorder may be fully capable of the physical demands consistent with those of sustained medium work activity, but another person with the same disorder, because of pain, may not be capable of more than the physical demands consistent with those of light work activity on a sustained basis. In assessing the total limiting effects of your impairment(s) and any related symptoms, we will consider all of the medical and nonmedical evidence ...

20 C.F.R. § 404.1545(e); *see also Sobolewski*, 985 F.Supp. at 309.

In this case, the ALJ concluded that Plaintiff retained an RFC to perform sedentary work. (Tr. at 15-19.) In reaching this determination, the ALJ refused to give controlling weight to the treating physician. (Tr. at 19.) Moreover, the ALJ found that Plaintiff was not "fully credible." (*Id.*)

On appeal, Plaintiff primarily challenges these two decisions. The court agrees with Plaintiff that the ALJ violated the Treating Physician Rule. Regarding Plaintiff's credibility, the court cannot determine whether, had the ALJ properly utilized the Treating Physician Rule, the ALJ would have credited Plaintiff's subjective complaints or reached a different result. Accordingly, the court does not reach this question but remands the case to provide the ALJ with the opportunity to consider the record under the appropriate legal standards.

i. *Treating Physician Rule*

On March 21, 2007, Dr. Bayner completed the Treating Physician RFC. (Tr. at 183-84.) Dr. Bayner noted that Plaintiff could occasionally lift and/or carry 10 pounds, and frequently lift and/or carry only 5 pounds. (*Id.* at 183.) Plaintiff could only sit for up to 2 total hours a day or 30 minutes at one time in an eight hour workday, and stand for up to 2 total hours a day or 20 minutes at one time in a eight hour workday. (*Id.* at 184.) Plaintiff could frequently balance; occasionally climb, stoop,

and crouch; and could never kneel or crawl. (*Id.*) These limitations place Plaintiff below the capacity to perform sedentary work. *See Perez v. Chater*, 77 F.3d 41, 46 (2d. Cir.1996) (defining sedentary work).

***9** The Treating Physician Rule "mandates that the medical opinion of a claimant's treating physician [be] given controlling weight if it is well supported by medical findings and not inconsistent with other substantial record evidence." *Shaw*, 221 F.3d at 134. "When the opinion of a treating physician is not given controlling weight, the ALJ must provide good reasons for not doing so." *Butler v. Comm'r of Soc. Sec.*, No. 07-CV-4972 (NG), 2009 WL 1605352, at * 5 (E.D.N.Y. June 5, 2009) (*quoting Sutherland v. Barnhart*, 322 F.Supp.2d 282, 290 (E.D.N.Y.2004) (internal alteration omitted)).

"Even if the treating physician's opinion is contradicted by substantial evidence and thus is not controlling, the opinion is still entitled to significant weight." *Ellington v. Astrue*, No. 08 Civ. 7366(VM), 2009 WL 2431537, at *7 (S.D.N.Y. Aug.6, 2009). "If not controlling, the proper weight given to a treating physician's opinion depends upon: (1) the length and frequency of the treatment relationship; (2) the nature and extent of the relationship; (3) the amount of evidence the treating physician presents in support of his or her opinion; (4) the consistency of the opinion with the record as a whole; (5) the treating physician's specialization in the relevant area; and (6) other factors." *Id.* (*citing* 20 C.F.R. §§ 404.1527(d)(2)-(6)); *see also Halloran v. Barnhart*, 362 F.3d 28, 32 (2d Cir.2004).

If the ALJ fails to provide good reasons for affording less than controlling weight to the treating physician, or fails to properly consider the factors under the regulations, it is grounds for remand. *See Ellington*, 2009 WL 2431537, at * 7 ("If the ALJ does not articulate 'good reasons' for the weight he accords to a treating physician's opinion, then the district court may remand for a comprehensive explanation of the ALJ's reasoning."); *Butler*, 2009 WL 1605352, at * 5 (remanding in part because an ALJ "analyzed only one of the factors" listed in the regulations).

In this case, the ALJ has failed to provide "good reasons" for giving the Treating Physician RFC less than controlling weight. The ALJ discounted Dr. Bayner's opinion in all of two sentences. First, the ALJ stated that he was discounting Dr. Bayner's opinion because it was "not consistent with [her] own findings." (Tr. at 19.) Yet, the ALJ does not set out what these inconsistencies are. The ALJ's opinion contains summaries of the findings from Dr. Bayner's medical examinations but makes no mention of any specific findings from Dr. Bayner's treatment notes that contradict her opinion with respect to Plaintiff's RFC. This incomplete analysis is insufficient for this court to uphold on review. *See Pratts*, 94 F.3d at 39 ("Remand is particularly appropriate where ... we are 'unable to fathom the ALJ's rationale in relation to the evidence in the record' without 'further findings or clearer explanation for the decision.' ") (*quoting Berry v. Schweiker*, 675 F.2d 464, 469 (2d Cir.1982)).

***10** Second, the ALJ "[failed] to enumerate adequate inconsistencies with other substantial evidence in the record as required by 20 C.F.R. § 404.1527(d)(2)." *Lucas v. Barnhart*, No. 04-2349-cv, 160 F. App'x 69, 71 (2d Cir. Dec.21, 2005). The

ALJ stated that Dr. Bayner's opinion was inconsistent with the findings of the "the neurologist" and cites the medical findings of both Dr. Xian and Dr. Palumbo. (Tr. at 19 (*citing* Tr. 98-101).) In his review of Dr. Xian's examination, the ALJ stated that although Dr. Xian had diagnosed "lumbar degenerative disc disease [and] right S1 radiculopathy," the exam was "otherwise unremarkable." (*Id.* at 17.) He also stated that "the neurologist ... finds no significant features, mostly normal MRI findings and normal reflexes, sensation and motor strength." (*Id.* at 19.) Although the ALJ previously reviewed numerous medical findings of Dr. Bayner (*see id.* at 18-19), there is no description of how Dr. Xian's medical findings contradict Dr. Bayner's medical findings. Dr. Palumbo's examination also appears to be cited by the ALJ, but no discussion is provided concerning how his findings are inconsistent with that of Dr. Bayner.

Moreover, it appears that the particular opinion of Dr. Bayner discounted by the ALJ is her RFC determination that Plaintiff could not engage in sedentary work. (*Id.* at 19 (*citing* Treating Physician RFC).) Yet, it is not at all clear from the ALJ's decision how this medical determination is contradicted by Drs. Xian and Palumbo. Neither Dr. Xian nor Dr. Palumbo specifically opined on Plaintiff's RFC, so the ALJ was not in a position to reach a conclusion regarding their consistency with Dr. Bayner on that issue. *See Carroll v. Sec'y of Health and Human Servs.*, 705 F.2d 638, 643 (2d Cir.1983) (considering a treating physician's RFC uncontradicted by other medical evaluations when none of Plaintiff's other doctors "were [ever] asked what work or activity, such as sedentary employment, [Plaintiff] *could* perform and hence expressed no opinion on that subject") (emphasis in original). If there was some other contradiction that the ALJ was relying upon, he should have stated as much in his decision. Accordingly, the ALJ has not adequately explained his conclusion that Dr. Bayner's opinion was inconsistent with other substantial evidence in the record. FN22

> FN22. Other than the Treating Physician RFC, the only other RFCs in the file are those from consulting examiners Drs. Iqbal and Calvino. Dr. Iqbal found that Plaintiff retained at least the capacity to perform sedentary work, (Tr. at 125, 128), while Dr. Calvino believed that there were "no restrictions" on Plaintiff. (*Id.* at 132.) As Plaintiff correctly notes, the ALJ cannot rely solely on those RFCs as evidence contradicting the Treating Physician RFC. This is because an inconsistency with a consultative examiner is not sufficient, on its own, to reject the opinion of the treating physician. *See Harris v. Astrue*, No. 07-cv-4554 (NGG), 2009 WL 2386039, at *14 (E.D.N.Y. July 31, 2009) (reiterating that "[t]he Second Circuit has repeatedly stated that when there are conflicting opinions between the treating and consulting sources, the 'consulting physician's opinions or report should be given limited weight' " (*quoting Cruz v. Sullivan*, 912 F.2d 8, 13 (2d Cir.1990))).

The final basis on which the ALJ appears to have rejected Dr. Bayner's opinion is also erroneous. The ALJ asserted that "the [Treating Physician RFC] was based on [Plaintiff's] answers to questions rather than the doctors [sic] own assessment."

(Tr. at 19.) This statement suggests that the ALJ believed that Dr. Bayner did not base her opinions on medical evidence or upon her own findings, but instead simply considered subjective complaints. To the extent the ALJ's decision is based on such a belief, however, it is erroneous. The Treating Physician RFC specifically indicates that Dr. Bayner based her RFC on MRI results. (Tr. at 183-84.) In the Second Circuit, MRI evidence can support an opinion with respect to an RFC. *See Burgess v. Astrue*, 537 F.3d 117, 131 (2d Cir.2008) (determining that "[an] MRI Report on [Plaintiff's] spine was objective evidence that supported [the treating physician's] opinion as to [Plaintiff's] condition."). Moreover, the ALJ identified a history of medical examinations that Dr. Bayner performed upon Plaintiff. (Tr. at 18-19.) To the extent that the ALJ rejected Dr. Bayner's opinion because it was not based on medical evidence, that decision was erroneous.

***11** Based on the foregoing, the ALJ has not provided "good reasons" for rejecting the opinion of Dr. Bayner.[FN23] Even if he had, however, he made no mention of the factors under 20 C.F.R. §§ 404.1527(d). When an ALJ decides that a treating physician's opinion is not to be given controlling weight, he must still assign a weight to that opinion under that regulation. To the extent that Dr. Bayner's opinion was not given controlling weight, the ALJ should have considered the factors under 20 C.F.R. §§ 404.1527(d).

> FN23. The court will not remand solely to calculate benefits. "[I]t is the role of the Commissioner, not the Court, to weigh the evidence, and ... awarding benefits instead of remanding for further proceedings is appropriate in cases where there is 'overwhelming proof' of **disability**." *Ellington*, 2009 WL 2431537, at *7 n. 3 (*quoting Shaw*, 221 F.3d at 135).

In these circumstances, remand for further proceedings is appropriate. The ALJ's conclusory rejection of Dr. Bayner's opinion, based on unsupported inconsistencies, cannot stand in for the analysis required by applicable regulations and case law. In considering whether to credit Dr. Bayner's opinion, or what weight to give it, the ALJ must rely upon the appropriate standards under the Treating Physician Rule. *See Parker v. Harris*, 626 F.2d 225, 235 (2d Cir.1980) (providing that remand is appropriate when "the ALJ has applied an improper legal standard"). Should the ALJ find good reasons that the Treating Physician RFC is not entitled to controlling weight, the ALJ must still assign a weight to the Treating Physician RFC after accounting for the factors outlined in 20 C.F.R. §§ 404.1527(d). *See Clark v. Comm'r of Soc. Sec.*, 143 F.3d 115, 118 (2d Cir.1998).

ii. *Other Issues*

Plaintiff presses several other challenges to the decision of the ALJ. Most notably, Plaintiff contends that the ALJ improperly discounted his subjective complaints of pain. The ALJ discounted these complaints because they were not "supported by the objective medical evidence and are contradicted by his own statements."[FN24] (Tr. at 19.) This determination, however, was undoubtedly affected by the ALJ's rejection of Dr. Bayner's opinion. On remand, the ALJ will need to reconsider his decision not to not to credit Plaintiff's subjective complaints in light of the proper consideration of Dr. Bayner's

opinion under the Treating Physician Rule. *See Rosa*, 168 F.3d at 82 n. 7 ("Because we have concluded that the ALJ was incorrect in her assessment of the medical evidence, we cannot accept her conclusion regarding [Plaintiff's] credibility. The Commissioner must therefore reconsider Rosa's testimony in light of this opinion and in light of the evidence developed on remand."). FN25

FN24. The ALJ chose to discredit Plaintiff subjective complaints after 2005, in part, based upon "MRIs of [Plaintiff's] cervical and lumbrosacral spines, which show no evidence of disc herniations or nerve root impingement." (Tr. at 19.) To the extent this conclusion is based upon the ALJ's lay assessment of the meaning of Plaintiff's MRIs, it was erroneous. An ALJ may not discount Plaintiff's complaints of pain "based solely upon his lay opinion" that the conditions documented in the MRIs cannot have caused the pain complained of. *See Singletary v. Apfel*, 981 F.Supp. 802, 807 (W.D.N.Y.1997). In rejecting Plaintiff's subjective complaints following 2005, the ALJ also appeared to rely on evidence from *before* 2005. (Tr. at 19 (*citing* Tr. 98-102).) To the extent he did so, this was erroneous.

FN25. The court need not consider whether testimony at Plaintiff's Exhibit A should be considered at this point. The ALJ will be given the opportunity to consider admission of the exhibit should it be submitted on remand.

5. *Step Five*

The ALJ bears the burden at Step Five of determining whether a claimant may perform other work in the national economy. An ALJ may look to the applicable medical-vocational guidelines (the "Grids"), which themselves account for the claimant's ALJ-determined RFC, as well as the claimant's age, education, and work experience. *See Zorilla v. Chater*, 915 F.Supp. 662, 667 (S.D.N.Y.1996). On remand, the ALJ will need to make a new determination on Step Four. Once this determination has been made, the ALJ may then need to move on to reconsider Step Five.

III. CONCLUSION

***12** The ALJ failed to abide by the Treating Physician Rule at Step Four of the **disability** determination process. Remand is appropriate to allow the Commissioner, as fact finder, to reconsider the evidence based on the appropriate legal standard. Accordingly, the Commissioner Motion is DENIED. Plaintiff's Motion is GRANTED IN PART, to the extent that the matter is remanded to the Commissioner for further administrative proceedings consistent with this opinion.

SO ORDERED.

E.D.N.Y.,2009.
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Not Reported in F.Supp.2d, 2009 WL 2581718 (E.D.N.Y.)

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