UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

Ana L. Velazquez,	:	
	:	
Plaintiff,	:	NO. 3:02cv1264 (MRK)
	:	
v.	:	
	:	
	:	
Jo Anne Barnhart, Commissioner,	:	
Social Security Administration,	:	
	:	
Defendant.	:	

MEMORANDUM AND ORDER

Plaintiff Ana Velazquez seeks review of the Commissioner's decision denying her Supplemental Security Income (SSI) benefits under Section 205(g) of the Social Security Act, 42 U.S.C. §405(g). *See* Motion for Reversal or Remand [doc. #10]. The Commissioner, in turn, seeks an order affirming the decision [doc. #15]. For the reasons stated below, Plaintiff's motion is GRANTED, Defendant's motion is DENIED, and the decision of the Commissioner is REVERSED and REMANDED for further proceedings consistent with this opinion.

I.

Plaintiff Ana Velazquez applied for SSI benefits on August 13, 1999, claiming major depression, personality disorder, borderline intellectual functioning, headaches, asthma, back

pain, and carpal tunnel syndrome.[1] Administrative Record ("Record") [doc. #7], at 16-17. Plaintiff is now 38 years old and has a seventh grade education, though she later completed a high school equivalency diploma. *Id.* at 44-45, 241. She was born in Puerto Rico and speaks and reads very little English. *Id.* at 45. She has only about three months of work experience in her life, and none in the past few years. *Id.* at 45-46.

An Administrative Law Judge ("ALJ") held a hearing (the "Hearing") on Plaintiff's request for benefits on January 9, 2001. *Id.* at 38-56. At the hearing, Plaintiff testified that she suffers from depression, and that she stays in her room most of the time, eats very little, hardly sleeps, and cries all the time. *Id.* at 47, 54. She also stated that she has pain in both hands, can only walk a block or two, can stand for only fifteen minutes, can lift about a pound, and cannot be anywhere where "there is a lot of noise and a lot of people." *Id.* at 48-50.

As is relevant here, Plaintiff initially sought treatment from Dr. Mario Perez, a psychiatrist, in the summer of 1997, after experiencing feelings of depression for over a year. *Id.* at 240. She reported at that time many of the symptoms she later testified to at the Hearing, and stated that she had attempted suicide at least two times, including overdosing on psychotropic medication, and cutting her wrist. *Id.* She denied then having any hallucinations or homicidal ideation. *Id.* Dr. Perez prescribed medication for Plaintiff and asked her to return for further treatment, but she did not return to Dr. Perez's care at that time. *Id.* at 242.

Plaintiff returned to Dr. Perez in October of 1999, complaining again of feeling depressed

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[1] Plaintiff's counsel conceded at oral argument that her physical problems alone (apart from her psychological problems) would probably not in themselves be grounds for a disabled classification or for reversing the decision of the ALJ. The Court agrees and accordingly will not discuss Ms. Velazquez's physical condition but will instead focus this opinion on her psychological difficulties and the ALJ's treatment of those psychological difficulties.

and anxious for the previous few months. *Id.* at 276. After an examination, Dr. Perez diagnosed Plaintiff with Major Depressive Disorder, Recurrent, Moderate, as well as a Personality Disorder NOS (that is, "not otherwise specified"), and indicated that she suffered from Borderline Intellectual Functioning as well, though he placed a question mark next to this diagnosis on his medical report.[2] *Id.* This time, Plaintiff continued her treatment with Dr. Perez, seeing him regularly for at least the next year, and taking Zoloft, Effexor, and other medications that Dr. Perez prescribed. *Id.* at 278-80.

In December 1999, Plaintiff was evaluated by Dr. Gloria Losada-Paisey, a clinical psychologist, after a referral by the Connecticut Bureau of Disability Determination Services. *Id.* at 143. Dr. Losada-Paisey did not state in her report the duration of her evaluation or whether she reviewed Plaintiff's medical records in connection with her evaluation. In her report following the evaluation, Dr. Losada-Paisey stated that Plaintiff did not "demonstrate neurovegetative signs of depression" during the interview, and that her mood was "euthymic, with appropriate affect." Dr. Losada-Paisey also noted that:

> During the interview, she smiled and was cooperative. Ms. Velazquez was fully oriented as to time, place, and person. She was able to recall one of three objects after a few minutes' delay. She did not perform serial 7s (subtraction), but was able to spell "tree" in Spanish backwards, and she was able to follow a three-step command. Her reproduction of an abstract design was perfect, with good line quality and without tremors. She was also able to write a complete, grammatically correct sentence, without misspellings, while maintaining her eyes closed.

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[2] Counsel for both parties agreed at oral argument that Dr. Perez's use of a question mark signified his as-yet unverified suspicion that the patient suffered from the disorder next to which the question mark was affixed and that it did not indicate doubt that Plaintiff suffered from the disorder. That is, the question mark meant only that the diagnosis was as-yet untested or unproven and that the physician needed to explore it further. Counsel for both parties agreed that the question mark did not signify that the particular diagnosis was questionable, as opposed to merely as-yet undetermined.

Id. Dr. Losada-Paisey indicated that "other than the above-noted recollection of one of three objects, there was no evidence of immediate or remote memory impairment," and she concluded her report by stating that "Ms. Velazquez does not appear to be suffering from a major mental illness or affective disorder at this time. The diagnostic impression is Adjustment Disorder with Depressed mood." *Id.* at 144. Dr. Losada-Paisey did not testify at the Hearing, but her report was placed into the record.

Dr. Perez completed an assessment form in connection with Plaintiff's application for Social Security benefits on March 27, 2000. *Id.* at 163. Dr. Perez again stated his diagnosis as: "Major Depressive Disorder, Recurrent, Severe," "Personality Disorder NOS," and "Borderline Intellectual Functioning," and once again placed a question mark next to the last diagnosis. *Id.* Dr. Perez described Plaintiff's mood as "somewhat depressed and anxious," and rated her judgment and insight as fair to poor. *Id.* at 164. He noted that although Plaintiff was able to make simple calculations, she was unable to state the sequence of sevens, and that though she claimed to be forgetful, she had a good memory of personal events. *Id.* He also stated that her stress tolerance was poor, and that she was anxious and had poor concentration. *Id.* at 165.

Dr. Perez also completed a medical report, including a mental residual functional capacity assessment (an "RFC"), on June 22, 2000. *Id.* at 265-72. Dr. Perez repeated his diagnosis of "Major Depressive Disorder, Recurrent and Severe," and stated that she was "feeling depressed and tired," and still suffering from anxiety. *Id.* at 266. On the RFC, Dr. Perez indicated that Plaintiff was "markedly limited" in the following areas:

The ability to understand and remember detailed instructions.

The ability to carry out detailed instructions.
The ability to maintain attention and concentration for extended periods.
The ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.
The ability to 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.
The ability to set realistic goals or make plans independently of others.

The instructions to the RFC state that the term "markedly limited" should be used "when the evidence supports the conclusion that the individual cannot usefully perform or sustain the activity." *Id.* at 270. Dr. Perez also indicated that Plaintiff was "moderately limited" in other areas:

The ability to remember locations and work-like procedures.
The ability to understand and remember very short and simple instructions.
The ability to carry out very short and simple instructions.
The ability to sustain an ordinary routine without special supervision.
The ability to make simple work-related decisions.
The ability to respond appropriately to changes in the work setting.
The ability to be aware of normal hazards and take appropriate precautions.
The ability to travel in unfamiliar places or use public transportation.

Id. at 270-71. The instructions state that the term "moderately limited" should be used "when the evidence supports the conclusion that the individual's capacity to perform the activity is diminished." *Id.* at 270. At the hearing, the ALJ specifically requested on two separate occasions that Dr. Perez provide an RFC, stating "I would really like to get Dr. Perez to commit himself." *Id.* at 47, 55. Though this RFC was completed before the hearing, it appears that it was not introduced as evidence at the time of the hearing and was added to the record at some point before the ALJ issued his decision.

On November 27, 2000, Dr. Perez sent a letter to the Connecticut Department of Social

Services stating that Plaintiff had been receiving psychiatric treatment with him for "Major Depressive Disorder, Recurrent, Severe with Psychotic Symptoms and also Panic Disorder with Agoraphobia." He stated unequivocally that in his opinion, "she is unable to work." *Id.* at 285. Dr. Perez did not testify at the Hearing, although his records and reports were included in the record.

In his decision denying Plaintiff's claim for SSI benefits, the ALJ also relied on forms Plaintiff had submitted to the State of Connecticut Disability Determination Services – one dated October 13, 1999; and another dated March 24, 2000. *Id.* at 114-34. These forms were filled out for Plaintiff by her friend Gloria Colon because Plaintiff cannot read English. The forms mostly detail Plaintiff's physical symptoms, but they also include statements about Plaintiff's daily routines. Ms. Colon wrote on the forms that Plaintiff states: she has no problem bathing, dressing, or performing other grooming; she prepares her own meals; she does laundry and other household chores by herself; she handles her own finances; she goes to church three or four times a week; and she goes shopping once a month. *Id.* at 115-18, 124-27. On both forms, Ms. Colon wrote that Plaintiff states that she hardly goes out anywhere and that she avoids speaking to people. *Id.* at 120, 129. The March 2000 form recites that Plaintiff has problems paying attention, that she gets distracted easily and is unable to finish things she starts, and that her 19-year-old son helps her with her daily activities. *Id.* at 125, 130.

On July 24, 2001, the ALJ issued a 11-page decision denying Plaintiff's request for SSI benefits. *Id.* at 16-26. The ALJ first found that Plaintiff's "borderline intellectual functioning is not a medically determinable impairment," based on the fact that Dr. Perez wrote a question mark next to the diagnosis and the fact that Plaintiff successfully obtained a high school equivalency

diploma. *Id.* at 18. The ALJ did find, however, that Plaintiff had major depression, personality disorder, a back impairment, and bilateral carpal tunnel syndrome, and that these impairments qualify as "severe" under 20 C.F.R. §416.920(b). *Id.* at 25. Nonetheless, the ALJ concluded that Plaintiff had no impairment that met the criteria of the impairments listed in the Federal Regulations, and that no treating or examining physician made findings "equivalent in severity to the criteria of any listed impairment." *Id.* at 18. The ALJ rejected Dr. Perez's conclusion that Plaintiff is unable to work on the ground that such a conclusion is reserved for the Commissioner. In addition, the ALJ stated that Dr. Perez's conclusion was not entitled to significant weight in light of Dr. Perez's June 22, 2000 RFC, which, according to the ALJ, showed that Plaintiff had some work-related abilities. *Id.* at 20.

In finding that Plaintiff had the residual functional capacity to perform the requirements of work existing in the national economy, the ALJ determined that the record evidenced that Plaintiff "has maintained the ability for self-care and activities of daily living." *Id.* at 22. The ALJ determined that Plaintiff's allegations of pain were "not credible," and noted that "claimant's allegations that she is incapable of all work activity [are] not credible, because of significant inconsistencies found in both her testimony and in information she provided to both treating and examining sources, when viewed against the objective medical evidence." *Id.* at 23. The ALJ concluded that "the claimant has at times experienced only a slight restriction of activities of daily living and slight difficulties in maintaining social functioning. The claimant may seldom experience deficiencies of concentration, persistence, or pace and there is no evidence of an episode of deterioration or decompensation in work or work-like settings." *Id.*

The ALJ noted that he had "considered the opinions of the state agency medical

consultants," which would include Dr. Losado-Paisley, but had not "accorded great weight to their opinions, since they were rendered without the benefit of more recent medical records and without an opportunity to obtain testimony from the claimant." *Id.* He concluded that "considering claimant's age, educational background, and residual functional capacity, she is capable of making a successful adjustment to work that exists in significant numbers in the national economy," including the positions of assembler (lighting fixtures) and wireworker. *Id.* at 24.

The ALJ's decision became the final decision of the Commissioner when the Social Security Administration's Appeals Council concluded, in a letter dated May 9, 2002, that "there is no basis under [the Appeals Council] regulations for granting your request for review." *Id.* at 5.[3] The present case was filed on May 17, 2002. Compl. [doc. #2].

II.

The standard of review this Court must use in evaluating the Commissioner's decision is well established." A district court may set aside the Commissioner's determination that a claimant is not disabled only if the factual findings are not supported by 'substantial evidence' or if the decision is based on legal error." *Shaw v. Chater*, 221 F.3d 126, 131 (2d Cir. 2000). "'Substantial evidence' has been defined by the Supreme Court as 'more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.'" *Pratts v. Chater*, 94 F.3d 34, 37 (2d Cir. 1996) (quoting *Richardson v. Perales*, 402

[3]Insofar as the ALJ's decision has become the decision of the Commissioner, references in this opinion to either the ALJ's decision or the Commissioner's decision refer to the decision issued by the ALJ on July 24, 2001.

U.S. 389, 401 (1971)).

This Court may not overturn the Commissioner based on its own view of the evidence, but must evaluate whether the Commissioner's conclusion meets the 'substantial evidence' standard. *Mongeur v. Heckler*, 722 F.2d 1033, 1038 (2d Cir. 1983). "To determine whether the findings are supported by substantial evidence, the reviewing court is required to examine the entire record, including contradictory evidence and evidence from which conflicting inferences can be drawn." *Id.* "Although the standard of review generally implies a deference to the expertise of the agency, the courts retain a responsibility . . . to reverse and remand if the Secretary's decision is not supported by substantial evidence." *Rivera v. Schweiker*, 717 F.2d 719, 723 (2d Cir. 1983) (internal quotation and citations omitted). Moreover, the "deferential standard of review is inapplicable . . . to the [Commissioner's] conclusions of law. 'Where an error of law has been made that might have affected the disposition of the case, this court cannot fulfill its statutory and constitutional duty to review the decision of the administrative agency by simply deferring to the factual findings of the ALJ.' Failure to apply the correct legal standards is grounds for reversal." *Townley v. Heckler*, 748 F.2d 109, 112 (2d Cir. 1984) (quoting *Wiggins v. Schweiker*, 679 F.2d 1387, 1389 n. 3 (11th Cir. 1982)).

The Social Security Administration has established a five-step process for determining whether a claimant is disabled:

> (i) At the first step, we consider your work activity, if any. If you are doing substantial gainful activity, we will find that you are not disabled.
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> (ii) At the second step, we consider the medical severity of your impairment(s). If you do not have a severe medically determinable physical or mental impairment that meets the

duration requirement in § 404.1509, or a combination of impairments that is severe and meets the duration requirement, we will find that you are not disabled.

(iii) At the third step, we also consider the medical severity of your impairment(s). If you have an impairment(s) that meets or equals one of our listings in appendix 1 of this subpart and meets the duration requirement, we will find that you are disabled.

(iv) At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. If you can still do your past relevant work, we will find that you are not disabled.

(v) At the fifth and last step, we consider our assessment of your residual functional capacity and your age, education, and work experience to see if you can make an adjustment to other work. If you can make an adjustment to other work, we will find that you are not disabled. If you cannot make an adjustment to other work, we will find that you are disabled.

20 C.F.R. § 404.1520.

The ALJ easily dispensed with the first two steps, concluding that Plaintiff was not performing any substantial gainful activity, and that Plaintiff's impairments qualified as severe. The ALJ then stated summarily that Plaintiff did not have an impairment that meets any of the listed impairments. However, the ALJ provided no explanation of how he arrived at this conclusion and made no subsidiary findings of fact to support his conclusory statement.[4] The

[4]Record, at 18 ("The claimant has no impairment that meets the criteria of any of the listed impairments described in Appendix 1 of the Regulations (20 CFR, Part 404, Subpart P,

parties agree that if Plaintiff suffers from an impairment that falls under a listing, she automatically qualifies as disabled. *See* 20 C.F.R. §404.1520 (a)(4)(iii).

A. Listed Impairments

Plaintiff argues that she meets the listing for affective disorders, 20 C.F.R. Part 404, Subpart P, Appendix 1, ¶12.04, and should thus qualify as disabled. The affective disorders listing is described as being "[c]haracterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life: it generally involves either depression or elation." *Id.*

To qualify as an affective disorder under Paragraph 12.04, a claimant must meet the requirements of both subpart A and subpart B.[5] Under subpart A, claimant must demonstrate the symptoms of either depressive syndrome, manic syndrome, or bipolar syndrome. The depressive syndrome heading, which is the area under which Plaintiff might qualify, requires a demonstration of at least four of the following symptoms: "(a) Anhedonia, or pervasive loss of interest in almost all activities; or (b) Appetite disturbance with change in weight; or (c) Sleep disturbance; or (d) Psychomotor agitation or retardation; or (e) Decreased energy; or (f) Feelings of guilt or worthlessness; or (g) Difficulty concentrating or thinking; or (h) Thoughts of suicide;

Appendix 1). Furthermore, no treating or examining physician has mentioned findings equivalent in severity to the criteria of any listed impairment.").

[5]Claimants now have the option of meeting the requirements of subpart C in order to qualify, but subpart C did not exist at the time when Ms. Velazquez applied for SSI benefits, and both parties agreed that it was inapplicable to the determination here.

or (I) Hallucinations, delusions, or paranoid thinking." *Id.* Dr. Perez's unrebutted medical reports, along with Plaintiff's own testimony, would appear to demonstrate that Plaintiff satisfies the symptoms of (a), (c), (e), (g), and (h). Record at 164, 240, 274, 276. Accordingly, the ALJ's statement that "no treating or examining physician has mentioned findings equivalent in severity to the criteria of any listed impairment," is perplexing, and though the Respondent's counsel indicated at oral argument that the ALJ simply did not credit these findings by Dr. Perez, the ALJ's failure to even acknowledge that Dr. Perez had made such findings raises the concern of this Court.

To satisfy the requirements of subpart B, a claimant must demonstrate that she suffered at least two of the following: "(1) Marked restriction of activities of daily living; or (2) Marked difficulties in maintaining social functioning; or (3) Marked difficulties in maintaining concentration, persistence, or pace; or (4) Repeated episodes of decompensation, each of repeated duration." 20 C.F.R. Part 404, Subpart P, Appendix 1, ¶12.04. Dr. Perez's RFC states very clearly that Plaintiff suffers from criteria (3), and there are indications in the Record that she meets (1) and (2) as well. Record at 240, 270-71.

Given the fact that, on the basis of Dr. Perez's reports alone, Plaintiff's claim appears to satisfy the criteria for the Affective Disorders listing, it is unfortunate indeed that the ALJ did not address in his opinion the reasons why he believed that Plaintiff did not qualify. *Id.* at 18. The ALJ did explicitly find that "the claimant has at times experienced only a slight restriction of activities of daily living and slight difficulties in maintaining social functioning. The claimant may seldom experience deficiencies of concentration, persistence, or pace and there is no evidence of an episode of deterioration or decompensation in work or work-like settings," *Id.* at

23. There, too, however, the ALJ failed to provide detail to support his conclusions. For example, there is no indication why he believed that Plaintiff's "deficiencies of concentration" occur seldomly, when Dr. Perez described her ability to maintain concentration as "markedly limited." *Id.* at 270. It is also unclear why Plaintiff's condition was found to cause "only a slight restriction" in her daily living and social functioning when her testimony was that she stays in her room and cries all the time, needs to take pills in order to sleep, and cannot be anywhere "where there is a lot of noise and a lot of people." *Id.* at 48-49, 54.

The ALJ's failure to provide reasons for his statements leave this Court unable to determine whether his conclusion that Plaintiff's condition does not meet any listing is supported by substantial evidence. In view of the critical nature of that conclusion, the Court cannot affirm the ALJ's decision and instead must remand the case for further proceedings consistent with this opinion, which must include a determination – with specific reasons and findings stated – whether Plaintiff satisfies the listing criteria. *See Berry v. Schweiker*, 675 F.2d 464, 469 (2d Cir. 1982) ("Cases may arise, however, in which we would be unable to fathom the ALJ's rationale in relation to evidence in the record, especially where credibility determinations and inference drawing is required of the ALJ. In such instances, we would not hesitate to remand the case for further findings or a clearer explanation for the decision. Thus, in future cases in which the disability claim is premised upon one or more listed impairments of Appendix 1, the Secretary should set forth a sufficient rationale in support of his decision to find or not to find a listed impairment.").

B. Residual Functional Capacity

Assuming Plaintiff does not qualify under a listed disability, the inquiry moves to the fifth and final step of the SSA's process, because in considering the fourth step, the ALJ found (and this is not challenged here) that insofar as Plaintiff had no past employment, she could not still perform any such work. Record at 23. At the fifth stage, the ALJ is required to examine the claimed impairment, which must be of "such severity that [claimant] is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy," in order to qualify as disabled. 42 U.S.C. § 423(d)(2)(A). At the fifth stage, the burden shifts from the claimant to the Commissioner, who must prove that the claimant's residual functional capacity[6] allows her to perform such work. *Shaw*, 221 F.3d at 132.

The standard for determining residual capacity is multi-faceted. "In determining the claimant's physical ability, or residual work capacity, the Secretary must consider objective medical facts, diagnoses and medical opinions based on such facts, and subjective evidence of pain or disability testified to by the claimant or others. In particular, the Secretary is required to give considerable -- and if uncontradicted, conclusive -- weight to the expert opinions of the claimant's own treating physicians. Moreover, in making any determination as to a claimant's disability, the Secretary must explain what physical functions the claimant is capable of performing." *Ferraris v. Heckler*, 728 F.2d 582, 585 (2d Cir. 1984).

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[6]""Residual functional capacity' refers to the claimant's maximum sustained work capability for sedentary, light, medium, heavy or very heavy work. In assessing an individual's RFC, the ALJ is to consider his or her symptoms (such as pain), signs and laboratory findings together with the other evidence." *Michaels v. Apfel*, 46 F. Supp. 2d 126, 135 n.15 (D.Conn. 1999) (citing 20 C.F.R. § 200.00(c)).

Here, at the fifth stage the ALJ found that Plaintiff "has the residual functional capacity to perform a significant range of light work," and that she is thus not disabled. Record at 25-26. Plaintiff challenges that finding as unsupported by substantial evidence in the record. In particular, Plaintiff claims that the ALJ failed to give the proper weight to the opinion of Plaintiff's treating physician, Dr. Perez, and that the ALJ improperly discounted Plaintiff's personal testimony as to her symptoms. These objections will be discussed in turn.

1. Treating Physician Rule. The treating physician rule "mandates that the medical opinion of a claimant's treating physician is 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. This rule stems from the Social Security regulations; "Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. . . . We will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion." 20 C.F.R. §416.927(d)(2).

When the treating physician's opinion is not given controlling weight, the Comissioner must weigh various factors to determine how much weight to give the opinion. These factors

include: "(i) the frequency of examination and the length, nature, and extent of the treatment relationship; (ii) the evidence in support of the opinion; (iii) the opinion's consistency with the record as a whole; (iv) whether the opinion is from a specialist; and (v) other relevant factors." *Schaal v. Apfel*, 134 F.3d 496, 503-504 (2d Cir. 1998).

Here, the ALJ stated that he rejected Dr. Perez's conclusion that Plaintiff was unable to work because "it lacks supportability," pointing to Dr. Perez's findings that Plaintiff had the "ability to understand, remember, and carry out simple instructions, use of judgment, and ability to respond appropriately to supervisors, coworkers, and usual work situations." Record at 20. The ALJ further found that Plaintiff "retains the ability to follow work rules, relate to coworkers, use judgment, interact with supervisors, and maintain adequate attention and concentration," *Id.* at 22, and, as noted *supra*, that "the claimant has at times experienced only a slight restriction of activities of daily living and slight difficulties in maintaining social functioning. The claimant may seldom experience deficiencies of concentration, persistence, or pace and there is no evidence of an episode of deterioration or decompensation in work or work-like settings," *Id.* at 23. He also rejected Dr. Perez's tentative diagnosis of borderline intellectual functioning based on the question mark notation, as well as the fact that Plaintiff had obtained a high school equivalency diploma. *Id.* at 18.

In reaching these conclusions, the ALJ did not give controlling weight to the opinion of Dr. Perez, Plaintiff's treating physician. Dr. Perez concluded from his examinations and treatment of plaintiff for nearly a year that she suffered from severe and recurrent major depression with psychotic features. *Id.* at 266. He also explicitly indicated that Plaintiff had fair to poor judgment, had poor concentration, and was *markedly limited* in her ability to perform activities within a

schedule, maintain regular attendance, be punctual within customary tolerances, and complete a normal workday and workweek without interruptions from psychologically based symptoms. *Id.* at 164-65, 270-71. It bears emphasis that the "markedly limited" designation means that "the evidence supports the conclusion that the individual cannot usefully perform or sustain the activity." *Id.* at 270.

One would have supposed that a treating psychiatrist's unrebutted finding that his severely and recurrently depressed patient, who is also suffering from panic disorder with agoraphobia, *markedly* lacks the ability to maintain regular attendance at a job, perform activities within a schedule, be punctual or complete a normal workday without interruption would be an important consideration in determining whether that patient can work. Yet, the ALJ ignored these findings in reaching his conclusion.[7]

Indeed, from the reasons asserted by the ALJ, it appears that he credited all of the findings Dr. Perez made that involved Plaintiff being "moderately limited" in various ways, but ignored any area in which Dr. Perez found that Plaintiff was "markedly limited." Ultimately, the ALJ nowhere demonstrated that Dr. Perez's opinion was unsupported by medically acceptable diagnostic techniques; nor did the ALJ demonstrate that Dr. Perez's opinion was inconsistent with other substantial evidence in the case record. There is also no indication that the ALJ weighed the various factors required by 20 C.F.R. §404.1527(d)(2).

Moreover, it is important to recall that at this fifth stage of inquiry, it is the Commissioner

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[7]The Court notes again that the ALJ specifically insisted at the hearing that Dr. Perez provide an RFC and commit himself to a recommendation. Record at 47, 55. Dr. Perez did so, and yet the ALJ then inexplicably rejected the RFC and recommendation that he had insisted Dr. Perez provide.

who bears the burden of proof, not the claimant. Yet, the ALJ rejected Dr. Perez's conclusions without any testimony from the physician himself[8] and without any contrary medical testimony or evidence from the Commissioner, let alone the required substantial medical evidence (or overwhelmingly compelling non-medical evidence) to the contrary that is required when an ALJ rejects a well supported opinion of a claimant's treating physician. *See Shaw*, 221 F.3d at 134-35, *Havas v. Bowen*, 804 F.2d 783, 785-87 (2d Cir. 1986).[9]

The ALJ is not a physician and does not have authority (absent considerably more evidence than is presented in this Record) to credit only those aspects of the treating physician's report that support the Commissioner's determination while ignoring all other portions that undermine the Commissioner's determination. *See Rohan v. Chater,* 98 F.3d 966, 971 (7th Cir. 1996) ("As far as discernible from this record, the ALJ simply indulged his own lay view of depression for that of [the treating physician]"). As this Court has stated on another occasion, "the ALJ's approach is not the 'overwhelmingly compelling type of critique that would permit the Commissioner to overcome an otherwise valid medical opinion.'" *Yoxall v. Apfel*, 2001 U.S. Dist. LEXIS 7169, *44 (D. Conn. Mar. 30, 2001) (quoting *Shaw*, 221 F.3d at 134); *see also McBrayer v. Sec. of Health & Human Servs.*, 712 F.2d 795, 799 (2d Cir. 1983) ("The ALJ cannot arbitrarily substitute his own judgment for competent medical opinion."). The Court concludes, therefore,

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[8] "'A corollary to the [treating physician rule is] that the decision maker [has] a duty to seek clarification from a treating physician in the event the physician's report [is] somehow incomplete.'" *Campbell v. Barnhart,* 178 F. Supp. 2d 123, 137 (D. Conn. 2001) (quoting *Geracitano v. Callahan*, 919 F. Supp. 952, 956 (W.D.N.Y. 1997).

[9]The ALJ specifically noted that he was not according great weight to the opinions of the consulting physician, Dr. Losada-Paisey, indicating that he was not rejecting Dr. Perez's opinion in favor of hers. Record at 23.

that the ALJ failed properly to weigh and consider the opinion of Plaintiff's treating physician, thus violating the treating physician rule and committing legal error. *Yoxall*, 2001 U.S. Dist. LEXIS 7169, at *31.

2. Plaintiff's Credibility. Plaintiff also argues that the ALJ failed properly to credit her own testimony regarding her condition. The ALJ found "the claimant's allegations that she is incapable of all work activity to be not credible, because of significant inconsistencies found in both her testimony and in information she provided to both treating and examining sources, when viewed against the objective medical evidence. *Id.* at 23. These inconsistencies apparently stem from the forms that Plaintiff's friend completed for her and that were filed with the Connecticut Disability Determination Service. These forms stated that Plaintiff engaged in a number of basic life activities. *Id.* at 22. The ALJ thus concluded that Plaintiff "at times experienced only a slight restriction of activities of daily living and slight difficulties in maintaining social functioning." *Id.* at 23.

In making a determination regarding a claimant's disability, the ALJ must consider, among other things, "the claimant's subjective evidence of pain and physical incapacity as testified to by himself and others who observed him." *Carroll v. Sec. of Health & Human Servs.*, 705 F.2d 638, 642 (2d Cir. 1983). As this Court has stated, "while 'as a fact-finder, [the ALJ] is free to accept or reject' a claimant's subjective testimony, 'an individual's statements about the intensity and persistence of pain or other symptoms or about the effect the symptoms have on his or her ability to work may not be disregarded solely because they are not substantiated by objective medical evidence.'" *Campbell v. Barnhart*, 178 F. Supp. 2d 123, 134 (D.Conn. 2001) (quoting *Williams ex rel. Williams v. Bowen*, 859 F.2d 255, 260 (2d Cir. 1988) and Social

Security Ruling 96-7p (June 7, 1996)).

Here, the ALJ discredited, in addition to the opinion of Dr. Perez discussed earlier, all of Plaintiff's testimony about her inability to leave her bedroom or house for much of the day, her need for assistance from her mother, her friend, and her son, and her frequent crying spells. While he did find that Plaintiff suffered from major depression, which he considered to be a "severe" impairment, the ALJ seems to have found that the fact that she can handle some regular household activities and that she can make it to church three times a week means that she only has a "slight restriction of activities of daily living and slight difficulties in maintaining social functioning." Record at 23.

In reaching these conclusions, the ALJ appears to have relied entirely on the forms Plaintiff provided the Connecticut Disability Determination Service, which included answers by Plaintiff to various questions about her daily routines. These forms, however, are filled out solely with check marks and are considerably less detailed than Plaintiff's testimony at the hearing which fleshed out these answers. Nonetheless, the ALJ seems to have preferred the answers on the forms to the testimony. For example, though Plaintiff indicated on an earlier form that she uses public transportation on her own, does not need help doing household chores, and shops without help, *id.* at 116-18, she stated on a later form that she does need help with chores, which her son provides. *Id.* at 125. And, she testified at the hearing that her mother comes over almost every day to help with her household tasks and that her nineteen-year-old son and her friend Gloria Colon help as well. *Id.* at 49. The reason for the discrepancy regarding the performance of household tasks is unclear: perhaps Plaintiff (or Ms. Colon) thought the question was asking whether Plaintiff was requesting assistance from the state in these tasks. This Court need not

itself investigate the cause of the discrepancy here, but is concerned that the ALJ found no need to inquire about it at the hearing before discounting Plaintiff's testimony in favor of the responses on some of the forms.

Again, the ALJ seems to have taken Plaintiff at her word regarding those functions she is able to perform, while disregarding entirely her testimony regarding what appear to be major functional limitations. In so doing, the ALJ did not rely on any outside objective medical evidence, but reached his own conclusions about Plaintiff's condition and effectively made his own diagnosis that she would "be a little more happy and fulfilled if [she] got out of the house and worked and earned a salary." Transcript of Hearing, Record at 50.

As the Seventh Circuit has stated, "Severe depression is not the blues. It is a mental illness; and health professionals, in particular psychiatrists, not lawyers or judges, are the experts on it. . . . [Plaintiff] is entitled to a decision based on the record rather than on a hunch. The salient fact of record is the testimony of the psychiatrist, a disinterested as well as expert witness. Everything else is rank conjecture." *Wilder v. Chater*, 64 F.3d 335, 337-38 (7th Cir. 1995).

Since the ALJ's decision that Plaintiff was not disabled appears to have been based on both his failure to adhere to the treating physician rule and his improper discrediting of Plaintiff's subjective testimony, the Court concludes that ALJ committed legal error. For this reason, the ALJ's decision denying Plaintiff's claim for SSI benefits must be reversed. *Townley*, 748 F.2d at 112 ("Failure to apply the correct legal standards is grounds for dismissal.").

III.

Even though the Court has decided to reverse the Commissioner's decision, the Court will

not direct judgment for Plaintiff but instead will remand for further development of the administrative record in two main respects. *See, e.g., Williams v. Apfel*, 204 F.3d 48 (2d Cir. 2000) (remanding); *Rosa v. Callahan*, 168 F.3d 72 (2d Cir. 1999) (same). First, at the third step of the SSI analysis, the ALJ is directed explicitly to determine whether Plaintiff's condition qualifies as a listed impairment under 20 C.F.R. Part 404, Subpart P, Appendix 1, and to provide detailed reasons for that determination consistent with this decision. Second, if, after the foregoing determination, the ALJ proceeds to the fifth step of the SSI analysis, the ALJ is directed to consider the opinions of Plaintiff's treating physician (perhaps by even having Dr. Perez testify, 20 C.F.R. § 404.1512(e)(1)) and the testimony of Plaintiff in accordance with the Second Circuit standards discussed in this decision.

Accordingly, Plaintiff's Motion [doc. #10] is GRANTED, and Defendant's Motion [doc. #15] is DENIED. The case is remanded for further proceedings consistent with this opinion.

IT IS SO ORDERED.

/s/ Mark R. Kravitz
U.S.D.J.

Dated at New Haven, Connecticut: February 19, 2004