UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

DELORES A. VENTURA,	:	
PLAINTIFF,	:	
v.	:	No. 3:04CV1401 (SRU)(WIG)
JO ANNE B. BARNHART, COMMISSIONER, SOCIAL SECURITY ADMINISTRATION,	:	
DEFENDANT.	:	

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RECOMMENDED RULING ON PENDING MOTIONS

Plaintiff, Delores A. Ventura, has brought this action under § 205(g) of the Social Security Act, 42 U.S.C. § 405(g), seeking review of a final decision of the Commissioner of the Social Security Administration denying her disability insurance benefits. Plaintiff claims that she became disabled on or about October 15, 1997,[1] due to chronic pain and other residual effects of multiple osteochondroma and abdominal adhesive disease. She has now moved for an order reversing the decision of the Commissioner **[Doc. # 12]**. The Commissioner has answered, filed the administrative record, and has moved for an order affirming the decision of the Commissioner **[Doc. # 17]**. For the reasons set forth below, the Undersigned recommends that the Commissioner's decision should be reversed and remanded for further hearings in accordance with this ruling.

[1] See Note 6, infra.

I. Standard of Review

The district court may "enter, upon the pleadings and transcript of the record,[2] a judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing." 42 U.S.C. § 405(g).

Judicial review of the Commissioner's final decision denying social security benefits, however, is limited. Yancey v. Apfel, 145 F.3d 106, 111 (2d Cir. 1998). It is not the court's function to determine de novo whether the claimant was disabled. See Schaal v. Apfel, 134 F.3d 496, 501 (2d Cir. 1988). Rather, a district court must review the record to determine first whether the correct legal standard was applied and then whether the record contains "substantial evidence" to support the decision of the Commissioner. 42 U.S.C. § 405(g) ("The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive...."); see Bubnis v. Apfel, 150 F.3d 177, 181 (2d Cir. 1998); Balsamo v. Chater, 142 F.3d 75, 79 (2d Cir. 1998). To determine whether the Commissioner's decision is supported by substantial evidence, the court must consider the entire record, examining the evidence from both sides. Williams v. Bowen, 859 F.2d 255, 258 (2d Cir. 1988).

Substantial evidence need not compel the Commissioner's decision; rather substantial evidence need only be that evidence that "a reasonable mind might accept as adequate to support [the] conclusion" being challenged. Veino v. Barnhart, 312 F.3d 578, 586 (2d Cir. 2002) (internal quotation marks and citations omitted). Thus, the role of this court is not to decide the facts anew, nor to reevaluate the facts, nor to substitute its judgment for that of the Commissioner

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[2] Citations to the administrative record are referred to throughout this opinion as "R." followed by the page number.

but, rather to determine whether substantial evidence of record supports the Commissioner's decision.

In her motion to reverse the decision of the Commissioner, Plaintiff argues that there was substantial evidence in the record demonstrating that she was disabled before her date last insured, December 31, 1998. Plaintiff's argument misinterprets the role of the district court in reviewing the decision of the Commissioner. Under the standard of review set forth above, absent an error of law, this court must uphold the Commissioner's decision if it is supported by substantial evidence even if this court might have ruled differently. See Eastman v. Barnhart, 241 F. Supp. 2d 160, 168 (D. Conn. 2003); see also Rutherford v. Schweiker, 685 F.2d 60, 62 (2d Cir.1982), cert. denied, 459 U.S. 1212 (1983); see generally Hon. Thomas P. Smith & Patrick M. Fahey, Some Points on Litigating Title II and Title XVI Social Security Disability Claims in United States District Court, 14 Quinnipiac L. Rev. 243, 249 (Summer 1994); 4 Soc. Sec. Law & Prac. § 55.59 (Thomson/West Dec. 2005). Substantial evidence may support more than one conclusion. See generally 4 Soc. Sec. Law & Prac. § 55.59; Guilliams v. Barnhart, 393 F.3d 798, 801 (8th Cir. 2005). Thus, a reviewing court may not reverse the Commissioner's decision merely because substantial evidence supports a different conclusion. 4 Soc. Sec. Law & Prac. § 55.59; Bitsacos v. Barnhart, 353 F. Supp. 2d 161, 163 (D. Mass. 2005). Indeed, the district courts have been admonished not to substitute their views of the evidence for that of the Commissioner. 4 Soc. Sec. Law & Prac. § 55.59; Perez v. Barnhart, 415 F.3d 457, 460 (5th Cir. 2005); White v. Barnhart, 415 F.3d 654, 659 (7th Cir. 2005).

Thus, the standard this reviewing court must apply is not whether substantial evidence supports Plaintiff's claim that she was disabled on her date last insured but, rather, absent an

error of law, whether substantial evidence supports the decision of the Commissioner that Plaintiff was not disabled, as that term is defined by the Social Security Act.

II. Procedural Background

Plaintiff applied for Disability Insurance Benefits on April 18, 2002, alleging a disability commencing on October 15, 1997[3] (R. 55-57). Her application states that she was disabled due to pain and depression,[4] and that she had stopped working because of pain in her right shoulder, back and arm. She stated that she is always in pain, which has increased since the time she last worked (R. 67-96). Her State of Connecticut disability questionnaire indicates that she experiences pain when she sits "for a period of time" or moves her arm "a lot," and that she has had difficulty with concentration. Her condition affects her ability to sit, stand, squat, reach, lift, and use her hands. She is right-handed and ever since part of her right shoulder was removed, she has experienced increased pain when using her right hand, which tires quickly when writing. She used a splint, prescribed by her orthopedist, to help with her arm pain. She also has had trouble with her memory (R. 97-108). In response to the symptom questionnaire, she described her symptoms as "limited movement of the right arm, neck, shoulder, lower back and legs; always in pain; depressed with scars on [her] body" (R. 109). She stated that she experiences these symptoms everyday, and on a good day, and rates them as a three to five on a ten-point scale, and as a nine on a bad day. She reported that she has had to limit her movement because

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[3] See Note 6, infra.

[4] The first medical records relating to Plaintiff's depression are dated 2002, nearly four years after her date last insured. There is no prior medical evidence to support a claim of depression. The ALJ found Plaintiff's depression to be a "non-severe impairment" since it was not medically determinable prior to the date last insured (R. 16). See 20 C.F.R. § 404.1529. Plaintiff has not appealed that portion of the ALJ's ruling.

of these symptoms. Rest and use of a sling make her symptoms better. At the time she completed the questionnaire, she was taking medications for depression, sleep, and pain (R. 110).

Plaintiff was last insured for disability purposes on December 31, 1998, thus requiring that she demonstrate the onset of disability on or before the "date last insured." 42 U.S.C. § 423(c)(1). Her application was denied on May 24, 2002 (R. 23-26), and upon reconsideration was denied a second time. Plaintiff then filed a request for a hearing before an ALJ (R. 33). ALJ Deirdre R. Horton held a hearing on December 11, 2003, at which Plaintiff, represented by counsel, testified (R. 750A-90).[5] On March 19, 2004, the ALJ rendered her decision finding that Plaintiff was not entitled to disability insurance benefits because, as of her date last insured, Plaintiff had the residual functional capacity to perform certain sedentary work, including her past relevant work as a data entry clerk (R. 9-20). Plaintiff then timely filed a request for review by the Appeals Council (R. 8). The Appeals Council denied her request for review (R. 5-7), thus, making the ALJ's decision the final decision of the Commissioner. Lisa v. Secretary of Health & Human Services, 940 F.2d 40, 42 (2d Cir. 1991). This appeal ensued.

III. Factual Background

A. Personal History

Plaintiff was born on July 14, 1969 (R. 756). She was twenty-eight (28) years old as of the date of onset of her alleged disability. She has an eleventh grade education (R. 758). Her past work experience includes working as a data entry clerk, bookkeeper, and cashier (R. 758-

[5] The ALJ noted that John Axline, M.D., was originally scheduled to testify at the hearing as an independent medical examiner but, at the time of the hearing, he had not had an opportunity to review all of Plaintiff's medical evidence. The ALJ determined that a supplemental hearing to take Dr. Axline's testimony was not necessary to resolve any medical questions or clarify any medical evidence (R. 12).

61). Her last full-time job was in 1997[6] as a data entry clerk for Grolier, where she worked for a year and a half (R. 759). This job required her to write and/or complete reports, stand, sit, reach, write, type, or handle small objects, lift up to 10 pounds, and frequently lift less than 10 pounds (R. 70). She testified that she had difficulties performing that job because she could not sit for long periods of time, she had to miss a lot of work, and she could not keep up with her workload (R. 759). After receiving two warnings, she was terminated (R. 759-60). Prior to her data entry job, she had done bookkeeping, which also required her to drive to pick up clients' mail and make bank deposits. Following surgery on her right shoulder, she could not drive or sit for long periods of time, and she had difficulty using the computer on her right side. She also had difficulty holding a pen, reaching for things, and filing. She lost that job after a year because her employer needed someone more reliable, and Plaintiff said she was not that person (R. 760-61). She had also tried working as a cashier several times but none of these jobs lasted more than a year or year-and-a-half. She had difficulty reaching, bagging, and standing for long periods of time, and she had to miss a lot of time from work for her surgeries and because she was not feeling well (R. 761-62). She quit these jobs because it was not worth the pain that working caused her (R. 762). The only employment she has had since 1998 was in 2001 when she worked as a part-time cashier at a deli two hours a day, two days a week. However, she had difficulty performing that job due to pain in her arm (R. 787-90).

Her earnings records show that for the five years preceding the onset of her disability,

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[6] Although Plaintiff testified that she was employed with Grolier until 1998, the records from her employer indicate that her last date of employment was November 17, 1997 (R. 117). The ALJ used November 15, 1997, as her last date of work and her onset of disability date (R. 13).

Plaintiff had no earnings in 1992, and earned approximately $789 in 1993, $2,283 in 1994, $1,237 in 1995, $6,699 in 1996, and $7,457 in 1997 (R. 59-63).

At the time of the hearing, Plaintiff's right arm was in a sling to keep pressure off of her neck and shoulder. She has had the sling since her shoulder surgery in December 1995 (R. 762).

B. Plaintiff's Testimony Concerning Her Medical Condition

At the hearing, Plaintiff testified that, following her shoulder surgery in December of 1995, the pain she had been experiencing worsened (R. 784). If she stands for more than fifteen minutes, she gets muscle spasms in her back, her feet feel like they are on fire, and she has "pins and needles" down her legs and in her fingers (R. 763). When she stands up, she feels nauseous at first (R. 763). She can only sit for ten minutes at a time. After that, she becomes uncomfortable. Her body always hurts. She has bad episodes of pain twice a month, which require her to stay in bed for three days at a time (R. 763). In an effort to relieve the pain, she uses hot packs and ice on her back, and she takes baths six or seven times a day and showers three to five times a day (R. 763-64, 766). She has approximately two to three "good" days a week where she can tolerate the pain, "it's just my body aches, it's not like a pain-pain, it's more like discomfort" (R. 764). The other days are not good days (R. 764). She described the pain in her legs, back, hands, shoulder and neck as a "seven" when its bad, but when it is really bad, she cannot even move her neck and her whole body "feels like it just shut down" (R. 766). She spends approximately ten hours a day lying down on the couch, in her bed, or in the bathtub (R. 776).

She also gets very bad migraines three to four times a week. The headaches usually last for three to five hours, sometimes all night, and only go away if she throws up, which she has

difficulty doing because of throat surgery she had several years ago (780-81). She takes Imitrex for her headaches (R. 781).

She has a very difficult time sleeping because of the pain in her legs and hands, which feels like fire (R. 764-65). She takes two to three Tylenol PM's every night, as well as Ambien or Remeron, which are prescription medications for sleep, and she still has to sleep with five pillows (R. 764-66).

Plaintiff testified that she sometimes drives her daughter to school, which is less than a mile from her house (R. 768). However, she has difficulty sitting when she drives. She also has to drive with her left hand and keep her left leg elevated, because otherwise she experiences "pins and needles" (R. 763). After a few minutes, she has to switch arms to drive (R. 768-69).

She testified that her condition has also affected her memory. She has a hard time remembering things and has to write everything down (R. 772-73). She described herself as "very depressed" (R. 773). "Everything just gets to [her], the scars. [Her] whole body is full of scars from [her] toes all the way up both sides" (R. 773). She had been seeing a psychiatrist for a year (R. 785). She does not feel that she can be a wife to her husband or a mother to her daughter (R. 773). She cannot do things for her daughter that she would like to do, and she often has to call her husband at work to ask him to come home because she is not able to stay by herself (R. 774). She and her husband fight a lot, especially when she does not feel well (R. 774). Then everything bothers her and she is very depressed (R. 774).

Plaintiff is right-handed and has difficulty holding things with her right hand. For example, she cannot hold a blow dryer or brush (R. 772). She has difficulty dressing herself and needs help with buttons, lifting her shirt over her head, and tying her shoes (R. 774).

Because of the repeated surgeries on her feet, she has trouble walking. She sees her podiatrist, Dr. Fein, every eight weeks to have him scrape underneath the bones in her feet to relieve the pressure so that her toes won't curl (R. 775). She can only walk the length of a hallway (R. 776). She feels pressure in her leg and most of the time walks with a limp (R. 776). She can hardly walk up stairs, four stairs at the most (R. 776).

Her sister comes over to her house four to five nights a week to help with the household chores, including cleaning and laundry, which Plaintiff stopped doing about four and one-half years ago because she was not able to lift the wet clothes (R. 777-78, 782). She is able to wash some of the dishes, but experiences pain after leaning over the sink for more than five minutes. She also cannot handle glasses because of her inability to grip them and she has broken too many (R. 778). Plaintiff also cannot perform vacuuming because she cannot move her harm back and forth and she cannot cut with scissors (R. 779).

C. Plaintiff's Medical Records

The administrative record contains over 630 pages of medical records. The following is a chronological summary of Plaintiff's medical history taken from these records.

1. Plaintiff's Medical History Prior to Her Date Last Insured

Plaintiff suffers from multiple congenital osteochondromatosis, which is a genetic disorder marked by the presence of multiple bony tumors, called osteochondroma[7] that consist of

[7] Steadman's Medical Dictionary (27th ed. 2000) defines "osteochondroma" as

> a benign cartilaginous neoplasm that consists of a pedicle of normal bone (protruding from the cortex) covered with a rim of proliferating cartilage cells; may originate from any bone that is preformed in cartilage, but is most frequent near the ends of long bones, usually in patients 10-25 years of age; the lesion is

projecting bone capped by cartilage projecting from the lateral contours of endochondral bones (bones formed from cartilage). Dorland's Illustrated Medical Dictionary 1199-1200, 552 (28th ed. 1994).[8] It often results in distorting musculature and joints. Plaintiff has suffered from this condition since early childhood and, as discussed more fully below, has undergone numerous surgeries on various parts of her body to remove bony tumors once they became symptomatic, generally as a result of the tumor's pressing on a nerve (R. 783-84) .

On May 30, 1972, Plaintiff had her first surgery at the age of three at Newington Children's Hospital for multiple osteochondromatosis, involving excision of the entire proximal one-half of the fibula of the left leg (R. 406 - 407A). She was hospitalized for two weeks. The discharge summary notes that Plaintiff had other osteochondromata that were not bothering her at the time, located primarily on the right humerus, the right scapula, left femur distally, right femur proximally with involvement of the metatarsals and metacarpals (R. 406).

In 1976, she was seen by Dr. Curtis at Newington Children's Hospital for curvature of the right middle finger. Dr. Curtis explained to her mother that the large osteochondromas should not be removed unless they were causing Plaintiff pain or they showed unusual growth (R. 408). He noted that the osteochondroma were of a very large base and he would have to do an extensive resection to get all of them out and there would be significant danger of damaging the

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> frequently not noticed, unless it is traumatized or of large size; multiple osteochondromas are inherited and referred to as hereditary multiple exostoses.

[8] Another definition of "osteochondromatosis" is "multiple hereditary exostosis" which in turn is defined as "the presence of multiple exostoses in the long bones of children due to a hereditary defect of ossification in cartilage, resulting in severe skeletal deformity and stunting of growth." Melloni's Illustrated Medical Dictionary 157, 351 (2d ed. 1985).

growth plate if the surgery were performed at that time (R. 408).

Two years later, Plaintiff was seen by Drs. Clark and Renshaw for increased curvature of the right middle finger and of the left toes. She was also having occasional pain about the left knee and had noted a new prominence about the left proximal arm which was pain-free. The doctors observed a 15° curvature of the right middle finger, which also had a bony prominence. She had only 45° of flexion of the index finger due to a bony block. The doctors also observed a bony prominence on the left humerus and right humerus and on the femur and tibia. Plaintiff was also noted to have a deviation in the middle toe of her left foot with a bony prominence. X-rays revealed multiple osteochondromas, but no sign of malignant degeneration (R. 408).

Two and one-half years later, Plaintiff was seen at Newington Children's Hospital by Drs. Barrasso and Renshaw. For the past several months she had been experiencing pain in her left knee and had also noted increased curvature of the middle right finger and her left toes. The doctors' examination revealed 22° of curvature of the middle finger, limited flexion of the index finger to 35°, and the same osteochondromas as in 1978 (R. 409).

The following year, in September 1982, she was seen for complaints of pain in her third and fourth toes of the left foot. A large osteochondroma was causing the third toe to rub against the fourth toe, with resulting pain (R. 409). Plaintiff underwent a second surgery at Newington Hospital by Drs. Harrington and Renshaw on October 28, 1982, to remove a large osteochondroma on the third digit of her left foot that was creating a pressure area over the fourth digit (R. 413). She was hospitalized for four days and discharged in a leg cast with a longitudinal pin through the phalanx (R. 411-17). In December 1982, she began full ambulation (R. 416).

Her third osteochondroma surgery was performed by Dr. Lewis at Mt. Sinai Hospital in New York in April of 1993 for excision of a large osteochondroma (4 cm. X 5 cm.) with multiple small caps, on her right pelvis (R. 118-34). She was hospitalized for six days (R. 118). Following the surgery, Plaintiff complained of pain and numbness in her right thigh. She was referred to Dr. Samuel Markind, a neurologist, for a neurological consultation. She stated that the pain that she had experienced since March vanished initially after the surgery but then returned (R. 153-54). Dr. Markind's impression was meralgia paresthetica[9], most likely caused by compression of the nerve from the excised mass as well as possible surgical insult to the nerve (R. 587-88). A nerve conduction study, EMG, dated August 31, 1993, confirmed mild right neuralgia paresthetica (R. 151, 158, 589-90). Three years later, in 1996, Plaintiff reported that she was still experiencing occasional tingling in the distribution of the right lateral femoral cutaneous nerve (R. 151).

Plaintiff's fourth osteochondroma surgery was on December 30, 1993, at Danbury Hospital by Dr. Fein, her podiatrist, for a hammertoe deformity on the fifth digit of her left foot (R. 390, 418). Dr. Fein prescribed Demoral for pain (R. 391).

In December 1994, Plaintiff again saw Dr. Fein for pain in the fifth digit of her left foot. Dr. Fein debrided the inflamed area and discussed with her further surgical options (R. 391).

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[9] "Meralgia Paresthetica" is a disease marked by paresthesia (an abnormal touch sensation, such as burning, prickling, or formication, often in the absence of external stimulus), pain and numbness in the outer surface of the thigh, in the region supplied by the lateral femoral cutaneous nerve, due to entrapment of the nerve at the inguinal ligament. It is also called Bernhardt's disease or paresthesia, Bernhardt-Roth disease, and Roth-Bernhardt disease. Dorland's Illustrated Medical Dictionary at 1014, 1234.

Plaintiff returned to see Dr. Fein in May of 1995 with an inflamed porokeratosis[10] under the second metatarsal of the left foot. The area was tender to touch, and Dr. Fein debrided the inflamed skin (R. 391). In November, he saw her again, this time for inflamed porokeratosis and associated capsulitis[11] bilaterally. She also had fissured heels bilaterally, inhibiting her ability to walk. He again debrided the inflamed skin (R. 391).

On November 5, 1995, Dr. LaGratta, with Danbury Orthopedic Associates, saw Plaintiff, who presented with a "many-month history of progressively worsening presently severely disabling pain radiating from the right side of her neck to her right shoulder and down her right upper arm" (R. 194). She had been treated with a sling and swathe and oral anti-inflammatories without relief (R. 194). Dr. LaGratta observed slightly limited neck motion and abnormally decreased sensitivity on the back of her right hand with a feeling of diffuse weakness (R. 194). In November 1995, Plaintiff underwent an open biopsy of a large osteochondroma on the right scapula and another right scapular biopsy at Presbyterian Hospital in New York City. On December 12, 1995, Plaintiff underwent a resection of a large malignant osteochondroma and medial upper portion of the right scapula at Columbia Presbyterian Hospital by Dr. Marcove. The craniomedial aspect of the right scapula and trapezius muscle were removed (R. 419-506). Plaintiff was hospitalized for four days.

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[10] "Porokeratosis" is a rare, chronic, progressive autosomal dominant skin disorder, seen most often in males, usually first appearing in early childhood, and characterized clinically by the presence of crater-like patches with central atrophy and an elevated thick keratotic border that enlarge to form circinate, serpiginous, or gyrate lesions, and histologically by a cornoid lamella. Dorland's Illustrated Medical Dictionary at 1335.

[11] "Capsulitis" is the inflammation of a capsule. Dorland's Illustrated Medical Dictionary at 261.

In January, 1996, she was referred to Danbury Orthopedic Associates because of a tender bony mass in the anterior aspect of the right pubis causing tenderness in the groin area. X-rays revealed multiple osteochondromata involving the neck of the femora and lesions involving both pubic bones. She was referred for an MRI (R. 192).

In August 1996, she was seen by Dr. Fein's office for inflamed skin on her left foot, which was inhibiting her ability to walk. The doctor noted that she also had fissured heels. He debrided the "deformities" and instructed Plaintiff to return in two months (R. 389).

That same month, she presented at Danbury Orthopedic Associates with complaints of "burning radiating down the right shoulder to the right arm and hand," which had occurred over the past few weeks without any recent trauma. Examination revealed that her right shoulder was drooped. The doctor's impression was "probably right brachial plexitis,[12] status-post traction following previous extensive bony and soft tissue resection" (R. 192). The doctor recommended that she use a sling for her arm and take oral anti-inflammatories. She was referred for another neurological consultation.

In October, 1996, Plaintiff was again see by Dr. Markind for evaluation of right shoulder pain radiating into her arm and hand, which she had been experiencing since July. She said that the pain caused her to drop things, and she had difficulty sleeping. She was taking Percocet for pain and Ambien for sleep (R. 151, 585-86). Nerve conduction studies were normal (R. 156). Two weeks later, Plaintiff reported that her right shoulder pain remained the same (R. 150, 584).

In December, 1996, she presented at Danbury Orthopedic Associates with a one-to-two-

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[12] "Plexitis" is the inflammation of a network of nerves. "Brachial" pertains to the arm. Dorland's Illustrated Medical Dictionary at 222, 1307.

day history of pain in the right thigh, at times radiating down to her knee. She demonstrated tenderness and discomfort with the terminal ranges of motion. X-rays revealed a rather large osteochondroma with a large soft tissue cap at the proximal right femur. The doctor recommended treating her symptomatically (R. 191). The following day, Dr. LaGratta took new x-rays of the lower femur, which showed multiple osteochondromata. His impression was that her pain was neurologic, which might be the result of regeneration of the previously injured nerve or scar formation or entrapment of the nerve. He recommended a trial of Medrol DosPak and Percocet for pain (R. 190).

In January, 1997, plaintiff saw Dr. Lowy complaining of painful lesions on her feet. Dr. Lowy's examination revealed edema, hyperkeratosis,[13] inflammation and pain on palpatation. He debrided the lesions on both feet and padded the pressure points (R. 388).

In April, 1997, Plaintiff again saw Dr. LaGratta for thigh pain, which had begun atraumatically two weeks earlier and had increased in severity with occasional paresthesia particularly when she was standing or walking. On examination, the doctor noted that Plaintiff's trunk motion was limited. Extension of her spine caused slight radiation of pain through her thigh on the right. An MRI was obtained, revealing herniation or stenosis in the lumbar spine and an osteochondroma impinging on the right-sided nerve. He prescribed Ultram for pain and referred her to Dr. Markind for a neurological consultation (R. 189).

Dr. Markind saw Plaintiff on April 29, 1997, for her right low back pain, which she had been experiencing for the past few weeks, as well as pain in her right hip, both anteriorly and

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[13] "Hyperkeratosis" is hypertrophy or an enlargement of the corneous layer of the skin. Dorland's Illustrated Medical Dictionary at 795, 802.

posteriorly. She reported that her right shoulder pain was essentially unchanged since October 1996. Dr. Markind noted that the scar tissue from her shoulder surgery possibly involved the right dorsal scapular nerve. Also, the MRI scan of the pelvis showed multiple osteochondromata, one of which was likely impinging on the right sciatic nerve (R. 148). He ordered an EMG study of the right lower extremity, a nerve conduction study of the shoulder, and told her to continue the Ultram prescribed by Dr. LaGratta and to commence chronic pain management with Prozac (R. 149, 581-83).

In July 1997, Plaintiff again was seen by Dr. La Gratta for complaints of intermittent achy pain in the right side of her neck and parascapular area as well as low back pain. His examination of her revealed weakness in the right parascapular area and slightly limited neck motion. Examination of her back showed mild tenderness with diminished trunk motion. His impression was muscular weakness, and low back strain with underlying disc pathology, obesity and muscular imbalance. In addition to the Ultram that she was taking, physical therapy was recommended (R. 189).

Plaintiff was then seen at Danbury Orthopedics in August for pain and tenderness over a bunion of the left foot. She had been having difficulty wearing any type of shoe. The doctor's examination revealed that she had hallux valgus.[14] This was confirmed by x-ray, which also showed osteochondromata on the 2nd, 3rd, 4th, and 5th metatarsals (R. 188). Day surgery was then performed at Danbury Hospital on September 2, 1997, on the first digit of the left foot with an insertion of a pin in the dorsal portion (R. 188, 333-34, 507). Plaintiff saw Dr. LaGratta for

[14] "Hallux Valgus" is angulation of the great toe, or first toe, away from the midline of the body, or toward the other toes. The great toe may ride over or under the other toes. Dorland's Illustrated Medical Dictionary at 730.

follow-up three days later, at which time she continued to complain of pain. An antibiotic was prescribed and she was instructed to keep the foot non-weight-bearing (R. 187). Plaintiff was seen again four more times over the next six weeks for pain, swelling, and removal of the pin (R. 186-87).

In February, 1998, Plaintiff saw Dr. LaGratta for a "repeat discussion in reference to her painful tender pelvic osteochondroma" (R. 186). Plaintiff reported that the one on the right pubic area was very bothersome. After undergoing a "rather extensive multispecialty evaluation," her gynecologist, Dr. Zamore, concluded that the mass was symptomatic. However, her urologist, Dr. Beck, and his partner, Dr. Gorelick, were not convinced that the osteochondroma were causing Plaintiff's pain (R. 316-17). After Dr. LaGratta consulted with Plaintiff, she decided to have the right mass removed, which she considered "very symptomatic," but not the left mass (R. 185). On March 30, 1998, Plaintiff had a seventh surgery to remove an osteochondromata of the right pubic area (R. 185).

In early July 1998, she was again evaluated by Dr. LaGratta for back pain in the lumbar area. She also complained of ongoing deformity of her previously operated right scapula. Dr. LaGratta notes indicate that he made her aware that this would be a "permanent problem." He recommended therapy, strengthening, and a home exercise program (R. 184).

Two weeks later, she was seen again by Dr. LaGratta for significant pain in the posterior aspect of the proximal left thigh, particularly bothersome when she sat on a toilet seat. She also described occasional radiating pain up and down the thigh. His examination revealed a large, two-inch, bony mass protruding from the posterior aspect of the left proximal femur with tenderness around the mass and pain on rotation because of the mass (R. 183). On July 28, 1998,

she underwent her eighth surgery at Danbury Hospital for the excision of this large osteochondroma on the right femur, which had been causing "intermittent snapping and occasional shock-like pain radiating down to her foot and leg" (R. 183, 312-13, 508-10).[15] Dr. LaGratta noted at her follow-up appointment that her "preop" symptoms were gone (R. 183). She was seen three more times over the next few weeks for slight wound dehiscence (R. 182-83).

On October 14, 1998, Plaintiff, who had suffered eight years of heavy irregular bleeding and dysmenorrhea,[16] despite a dilation and curettage (D&C) in 1996 and hormonal therapy, a cervical intraepithelial neoplasia in 1995, and electrosurgical excision procedure, underwent a total abdominal hysterectomy at Danbury Hospital, where she was hospitalized for five days (R. 308-10, 511-14). One day following her discharge, she was re-admitted to the hospital with complaints of persistent vomiting, fever, and severe abdominal pain. She was hospitalized for five days and discharged. Her diagnosis was "mechanical obstruction of bowel post total abdominal hysterectomy" (R. 300-05, 515-19).

2. Plaintiff's Medical History After Her Date Last Insured

In 1999, in March, May, September, and December, Plaintiff was treated by Dr. Fein for inflamed porokeratosis on her feet, which were painful and interfered with her ability to walk (R. 387-88).

In April, 1999, she was seen on an emergency basis at Danbury Orthopedics for sharp

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[15] The records from Danbury Hospital indicate that the osteochondroma was located on the right proximal posterior femur (R. 312, 508). Dr. LaGratta's office notes dated August 7, 1998, indicate a "large osteochondroma posterior left proximal femur" (R. 183).

[16] "Dysmenorrhea" refers to painful menstruation. Dorland's Illustrated Medical Dictionary at 516.

pain in her right knee, occasional burning in the heel, and numbness in her hands. The doctor's impression was tenosynovitis[17] of the right knee, secondary to lateral osteochondroma (R. 182). The doctor recommended limited weight bearing, crutches, knee immobilizer, Tylenol #3, Motrin, and restriction of activity and high-impact loading (R. 182).

In June, Plaintiff was evaluated by Dr. LaGratta again for a tender bump on the right upper humerus, aggravated by shoulder activity, and for pain in the left thumb. His examination revealed a bony hard prominence over the anterior proximal one-third of the right humerus. X-rays revealed multiple osteochondromata, including a fairly large one anteriorly. X-rays of the left thumb revealed a slight deformity of the joint with small osteochondromata. Surgery was scheduled for excision of the large mass in the right humerus and left thumb (R. 181). On August 24, 1999, osteochondroma on her left thumb and right upper humerus were removed at Danbury Hospital by Dr. LaGratta (R. 181, 289-90, 520-21).

In October 1999, Plaintiff saw Dr. LaGratta with complaints of discomfort in the right middle finger and discomfort and burning in both anterior thighs (R. 180).

On December 9, 1999, she was evaluated by Dr. LaGratta for intermittent sharp pain in the right thigh associated with intermittent bilateral numbness and paresthesia of both feet. She also complained of headaches and discomfort in her back. Dr. LaGratta referred her to Dr. Markind for a neurological consultation (R. 179). Dr. Markind's records indicate that Plaintiff had been experiencing burning pain for over a month in her feet, right thigh, head, and lower back. Plaintiff reported having difficulty sleeping because of the pain. Dr. Markind ordered a

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[17] "Tenosynovitis" refers to inflammation of a tendon sheath. Dorland's Illustrated Medical Dictionary at 1668.

brain MRI, cervical spine x-ray, ENMG study of her lower extremities, physical therapy, and prescribed Amitriptyline (R. 144-45, 578-80). A month later on follow-up, Plaintiff reported continuing pins-and-needles sensation and burning in the low back region with radiation into the lower extremities (R. 143). X-rays revealed degenerative disc disease and spondylosis[18] at C5-6 (R. 143).

In February, April, May, June and August of 2000, Plaintiff was seen by Dr. Fein for inflamed porokeratosis on both feet, which were extremely painful and inhibited her ability to walk. He treated these by debriding the inflamed skin (R. 383-87).

In March, 2000, Plaintiff was seen by Dr. LaGratta for right shoulder and right posterior thigh pain. On physical examination, she exhibited tenderness with slightly restricted range of motion of her shoulder and pain with hip flexion. Her x-rays revealed osteochondromatosis of the iliac and right proximal femur (R. 178).

In April, 2000, Plaintiff was twice seen by Dr. Markind for pain in her right upper arm and right posterior thigh, which had caused her to go to the emergency room two weeks earlier. Nerve conduction studies performed on April 11, 2000, demonstrated electrical evidence of mild neurapraxia[19] involving the right peroneal and posterior tibial motor nerves (R. 139-40, 575-76).

Three months later, in July, she was seen again by Dr. Markind for pain in the right arm, primarily in the shoulder area, and in her right leg. She was taking Trazodone and Celebrex. An

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[18] "Spondylosis" generally refers to degenerative changes due to osteoarthritis. Dorland's Illustrated Medical Dictionary at 1564.

[19] "Neurapraxia" refers to a failure of conduction in a nerve in the absence of structural changes, due to blunt injury, compression, or ischemia (deficiency of blood in a part, usually due to functional constriction or actual obstruction of a blood vessel)." Dorland's Illustrated Medical Dictionary at 1127 & 861.

x-ray showed numerous osteochondromas of the right knee and femur. Dr. Markind's impression was multiple osteochondromata, right peroneal neuropraxia and right lateral knee pain secondary to osteochondroma, and right upper arm pain secondary to osteochondromata. He prescribed Celebrex, Tylenol #3, weaned her off Trazodone and commenced Neurontin. He recommended that she follow-up with Dr. LaGratta (R. 574). She saw Dr. LaGratta several weeks later, again complaining of pain in the right parascapular area, right upper humeral area. She complained of pain with activity and limited range of motion of her neck. She had been taking Neurontin, which provided some relief. On examination, she exhibited tenderness diffusely over these areas. The doctor noted that she was scheduled to undergo breast reduction surgery in September. He prescribed Oxycotin (R. 177).

On September 1, 2000, she was evaluated by Dr. LaGratta for slight tenderness over the upper sternal area. After x-rays were taken, the doctor's impression was anterior sternal pain, probably secondary to osteochondroma. He recommended heat and anti-inflammatories (R. 177). On September 5, 2000, Plaintiff had breast reduction surgery performed by Dr. Mascardo to alleviate the pain and pressure on her neck, shoulders, and torso (R. 135-136, 159-66, 525-29).

On April 9, 2001, Dr. Zamore performed a laparoscopy on Plaintiff for a right ovarian hemorrhagic cyst, with multiple adhesions to the anterior abdominal wall (R. 272). On April 25, 2001, Plaintiff was evaluated by Dr. LaGratta for tightness in her right shoulder and tightness and stiffness in her lower back. The doctor's impression was overuse tendinitis of the right shoulder and low back strain, underlying osteochondromata (R. 173).

Due to pelvic pain that she continued to experience, Plaintiff underwent another exploratory laparotomy on June 25, 2001, which revealed extensive adhesions in her abdominal

cavity. Dr. Zamore performed the surgery. Plaintiff then underwent a lysis of the adhesions, right oophorectomy,[20] and partial omentectomy.[21] She was hospitalized for five days and discharged with Dilaudid for pain (R. 258-61, 530-33).

On September 6, 2001, Plaintiff was seen by Dr. LaGratta because of discomfort in the right side of her neck to her shoulder, aggravated by neck motion. The examination revealed a deformity of the shoulder post-surgery. The doctor's impression was "traction neuritis of the right neck and brachial plexus secondary to loss of soft tissue, bone, and strength status post prior surgery" (R. 171). He prescribed physical therapy and Oxycontin (R. 171).

In February, June, August and November 2001, Dr. Fein say Plaintiff for inflamed porokeratosis on her right and left feet, which limited her ability to walk. Dr. Fein excised the porokeratosis and debrided the lesions (R. 381-84).

At age 32, Plaintiff had her fifteenth surgery on September 20, 2001, for the excision of painful osteochrondromata from both her right and left wrists, distal radii, at Danbury Hospital by Dr. LaGratta (R. 169-70, 252-53, 534). On follow-up, the doctor noted that she had done well (R. 168).

In February, 2002, Plaintiff was seen by Dr. LaGratta "because of her statement of total body failure" (R. 616). She complained of a bump in her anterior skull, weakness, stiffness in her neck and her right shoulder, associated with weakness of her right hand (R. 167). The

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[20] "Oophorectomy" is the removal of the ovaries. Dorland's Illustrated Medical Dictionary at 1179.

[21] "Omentectomy" is the excision of all or part of the omentum, a fold of the peritoneum extending from the stomach to the adjacent organs in the abdomen. Dorland's Illustrated Medical Dictionary at 1175.

doctor's examination revealed a two-centimeter sebaceous cyst in the anterior left frontal area, which was unchanged from January 2000. Her shoulder was described as having an "obvious deformity status post prior resection surgery." On examination, she exhibited limited trunk motion, slight pain, and slight tenderness in the right paralumbar area. The doctor's diagnosis was weakness and deformity of the right shoulder and degenerative lumbar disk disease with radiculitis (R. 167). He recommended physical therapy and a neurologic evaluation (R. 616).

On March 19, 2002, after two emergency room visits due to severe constant abdominal pain (R. 226, 214, 235), Plaintiff underwent emergency surgery by Dr. Zamore to remove adhesions and to repair hemorrhagic ovarian cysts. There was extensive lysis of multiple adhesions on the anterior abdominal wall (R. 207-10, 228, 248, 379, 535-36, 549, 551-54, 672). Plaintiff was discharged after five days.

In April, Dr. LaGratta recommended that she use a sling to relieve the persistent pain and numbness in her right shoulder and neck, which he described as "traction neuritis, traction tendinitis, muscular weakness status post muscular resection and bony resection" (R. 617). He noted that she was not able to do any heavy lifting, pushing, pulling or overhead activity as a result of her earlier shoulder surgery, which left her with a permanent partial impairment of the dominant right upper extremity (R. 166, 617).

On May 9, 2002, Plaintiff had surgery on the fifth digit of her right foot for a "hammertoe deformity" at Danbury Hospital by Dr. Fein (R. 202-05, 377, 564-66). On June 6, 2002, Dr. LaGratta evaluated Plaintiff for complaints of lower back pain. Her trunk motion was guarded and limited. He recommended heat and bed rest and prescribed Vicodin (R. 618).

On December 13, 2002, Plaintiff saw Dr. LaGratta for discomfort in her right shoulder.

She complained that her right arm felt heavy and weak and that she experienced occasional numbness and tingling in her entire hand and arm. His examination revealed the deformity of the scapular area post surgical excision of the bone and muscle. "The right arm is dependent secondary to loss of scapular function." He noted diffuse tenderness about the humerus. X-rays revealed small sedentary osteochondromata. He recommended heat and a sling and referred her for a neurological consultation (R. 621).

Plaintiff was seen by Dr. Markind in neurological consultation on January 10, 2003, for pain she was experiencing primarily in the right upper arm. She reported that the pain radiated to the forearm and to the entire hand. For three months, she had also been experiencing right neck discomfort, which she described as a sharp pain. She also reported that her right hand tired with writing and that she has decreased sensation in the right hand, which caused her to drop things. She complained of chronically poor sleep, frequent headaches, migraine headaches associated with nausea, vomiting, photophobia, and phonophobia. His neurological examination of her was normal, as were the nerve conduction studies of the right upper limb. He recommended physical therapy, Magnesium tablets, Zomig for her migraines, and Valerian, a herbal preparation, for sleep (R. 568-73).

In May, 2003, she saw Dr. Fein, her podiatrist, for inflamed skin on the soles of both feet, which were painful and limiting her ability to walk. Dr. Fein performed a sharp debridement of the inflamed skin (R. 600). She returned in August with similar complaints and a similar treatment was performed (R. 601). In October, Plaintiff saw Dr. Fein for the same problem, but this time with fissuring. The area was red and tender. She was unable to walk due to the discomfort. Again, he performed a sharp debridement of the inflamed skin (R. 602).

In June 2003, Plaintiff saw Dr. LaGratta for a "traumatic pain" in the low back radiating to the left buttock and thigh. She described her left thigh as "hypersensitive." His examination of her revealed that she had gained weight. Her trunk motion was distinctly guarded and limited. X-rays revealed a slight bony overgrowth on the lateral side of L-5, S-1, and osteochrondromata of the left hip. His impression was left lumbar radiculitis[22] with underlying osteochondromata. Dr. La Gratta recommended a physical therapy evaluation, prescribed Tylenol with Codeine as needed for pain and Ultram (R. 623).

Plaintiff was seen by Dr. Richmond Hubbard, a psychiatrist, for depression on April 16, 2002, April 23, 2002, November 20, 2003, and November 25, 2003 (R. 624-28). He stated that it was his opinion that her depression related to her multiple physical problems (R. 392). However, having only seen her three times, he made no judgment as to her disability and stated that she never engaged in treatment (R. 392).

A state agency physician who reviewed Plaintiff's medical records in May 2002 concluded that, as of her date last insured, December 31, 1998, she had the residual functional capacity to perform work at a medium level of exertion and should have been able to return to her prior work (R. 365-72). A second state agency physician concluded that Plaintiff should have been able to do work requiring a light level of exertion, which did not require overhead lifting with the right arm, and therefore was not disabled prior to her date last insured (R. 393-402).

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[22] "Radiculitis" is the inflammation of the root of a spinal nerve, especially of that portion of the root which lies between the spinal cord and the intervertebral canal. Dorland's Illustrated Medical Dictionary at 1404.

IV. Discussion

A. "Disability" under the Social Security Act

In order to establish an entitlement to disability benefits under the Social Security Act, a claimant must prove that she is "disabled" within the meaning of the Act. A claimant may be considered disabled only if she cannot perform any substantial gainful work because 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 at least twelve months. 42 U.S.C. § 423(d)(1)(A); Shaw v. Chater, 221 F.3d 126, 131 (2d Cir. 2000). The impairment must be of such severity that the claimant is not only unable to do her previous work but, additionally, considering her age, education, and work experience, she cannot engage in any other kind of substantial gainful employment which exists in the national economy, regardless of whether such work exists in the immediate area where she lives, or whether a specific job vacancy exists for her, or whether she would be hired if she applied for work. 42 U.S.C. § 423(d)(2)(A); see Heckler v. Campbell, 461 U.S. 458, 460 (1983). "Work which exists in the national economy" means work which exists in significant numbers either in the region where she lives or in several regions in the country. 42 U.S.C. § 423(d)(2)(A).

The Social Security Administration has promulgated regulations that set forth a sequential, five-step process for evaluating disability claims. 20 C.F.R. § 404.1520. First, the ALJ must determine whether the claimant is currently working. 20 C.F.R. § 404.1520(b). If the claimant is currently employed, the claim is disallowed. Id. If the claimant is not working, as a second step, the ALJ must make a finding as to the existence of a severe mental or physical impairment that significantly limits the ability to do basic work activities; if none exists, the

claim is denied. 20 C.F.R. § 404.1520(c). Once the claimant is found to have a severe impairment, the third step is to compare the claimant's impairment with those in Appendix 1 of the regulations (the "Listings"). 20 C.F.R. § 404.1520(d); Bowen v. Yuckert, 482 U.S. 137, 141 (1987). If the claimant's impairment meets or equals one of the impairments in the Listings, the claimant is presumed to be disabled. 20 C.F.R. § 404.1520(d); see Schaal, 134 F.3d at 501; Berry v. Schweiker, 675 F.2d 464, 467 (2d Cir. 1982). If the claimant's impairment does not meet or equal one of the listed impairments, as a fourth step, she will have to show that she does not possess the "residual functional capacity" ("RFC")[23] to perform her past relevant work. 20 C.F.R. § 404.1520(e). If the claimant cannot perform her former work, the burden then shifts to the Commissioner to show that the claimant is prevented from doing any other work. Butts v. Barnhart, 388 F.3d 377, 383 (2d Cir. 2004), amended on other grounds on reh'g, 416 F.3d 101 (2d Cir. 2005). A claimant is entitled to receive disability benefits only if she cannot perform any alternate gainful employment. 20 C.F.R. § 404.1520(f); see Perez v. Chater, 77 F.3d 41, 46 (2d Cir. 1996). This final step entails consideration of the claimant's age, education, work experience, and her residual functional capacity to work. 20 C.F.R. § 404.1520(f).

The initial burden of establishing disability is on the claimant. 42 U.S.C. § 423(d)(5); see Green-Younger v. Barnhart, 335 F.3d 99, 106 (2d Cir. 2003). Once the claimant demonstrates

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[23] "Residual functional capacity" ("RFC") refers to what a claimant can still do in a work setting despite the physical and mental limitations caused by her impairments, including related symptoms such as pain. In assessing an individual's RFC, the ALJ is to consider her symptoms (such as pain), signs and laboratory findings together with the other evidence. See 20 C.F.R. § 404.1545. "Ordinarily, RFC is the individual's maximum remaining ability to do sustained work activities in an ordinary work setting on a regular and continuous basis, and the RFC assessment must include a discussion of the individual's abilities on that basis. A 'regular and continuing basis' means 8 hours a day, for 5 days a week, or an equivalent work schedule." Social Security Regulations (SSR) 96-8p; see Melville v. Apfel, 198 F.3d 45, 52 (2d Cir. 1999).

that she is incapable of performing her past work, the burden shifts to the Commissioner to show that the claimant has the residual functional capacity to perform other substantial gainful activity in the national economy. See Butts v. Barnhart, 416 F.3d 101, 103 (2d Cir. 2005); Curry v. Apfel, 209 F.3d 117, 123 (2d Cir. 2000); Bapp v. Bowen, 802 F.2d 601, 604 (2d Cir. 1986); Parker v. Harris, 626 F.2d 225, 231 (2d Cir. 1980).

In evaluating the nature and severity of a claimant's impairment, the ALJ is required to give the opinion of a treating physician controlling weight if it is well supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with other substantial evidence in the record. Rosa v. Callahan, 168 F.3d 72, 78-79 (2d Cir. 1999); 20 C.F.R. § 404.1527(d)(2). In analyzing a treating physician's report, the ALJ cannot arbitrarily substitute his or her opinion for a competent medical opinion. Rosa v. Callahan, 168 F.3d at 79; Balsamo v. Chater, 142 F.3d at 81. When the ALJ gives less weight to a treating physician's medical opinion, he or she must provide the reasons for doing so. 20 C.F.R. § 404.1527(d)(2). However, while the ALJ must consider the opinions of a treating physician as to the nature and severity of a claimant's impairments, the legal determination of a claimant's residual functional capacity is reserved for the Commissioner. Snell v. Apfel, 177 F.3d 128, 133 (2d Cir. 1999); 20 C.F.R. § 404.1527(d)(2), (e)(1) (reserving for the Commissioner the responsibility for making the determination about whether a claimant meets the statutory definition of disabled).

B. The ALJ's Decision

After reviewing the extensive medical evidence of record, focusing primarily on the records from the date of alleged onset, November 15, 1997, to the date last insured, December 31, 1998, the ALJ found that Plaintiff had the following severe impairments:

osteochondromatosis, post multiple osteochondroma resections with residual pain (R. 16). While she found these to be "severe"impairments, she did not consider them to be severe enough to meet or medically equal, either singly or in combination, one of the impairments listed in the Appendix 1, Subpart P, Regulations No. 4 (R. 16). The ALJ found that Plaintiff's depression, the residual abdominal adhesions and her gastrointestinal distress, her chronic headaches, and her degenerative disc disease of the cervical spine were "non-severe" impairments, "as they [were] not demonstrated prior to the date last insured by any medical evidence of record" (R. 16).[24] The ALJ then considered whether Plaintiff retained the residual functional capacity to perform her past relevant work or other work existing in significant numbers in the national economy. Relying on the State agency physicians' May and September 2002 assessments of her limitations (Ex. 8F and 11F), and after considering all of the clinical evidence and observations from all treating sources, as well as Plaintiff's testimony at the hearing, the ALJ concluded that, prior to the date last insured, Plaintiff retained the residual functional capacity to perform a range of sedentary work, with occasional postural limitations and limited overhead lifting with the right arm (R. 18). Thus, the ALJ concluded that Plaintiff retained the functional capacity to return to her past relevant work as a data entry clerk, as she performed it (R. 19). Having made this finding at step four of the sequential evaluation process, the ALJ never reached the fifth question of whether Plaintiff retained the residual functional capacity to perform other substantial gainful

[24] The ALJ did concede that after Plaintiff's date last insured, she experienced an exacerbation of symptoms and accompanying reduction in residual functional capacity, including significant decrease in her residual functional ability caused by the onset of depression, gastrointestinal symptoms due to abdominal lesions, a significant increase in pain due to the proliferation of osteochondromas, and the increased shoulder pain, which led to the breast reduction surgery. However, the ALJ held that, because these were demonstrated by medical evidence after the date last insured, they were not "pertinent" to the period at issue (R.18-19).

activity existing in the national economy (R. 19).

The ALJ stated that her finding did take into account Plaintiff's pain "at least as reported in the objective medical evidence of record," but noted that the clinical records, as of the date last insured, consistently described her pain as moderate, her limitation of motion as mild, and her strength, muscle function, and sensation as good (R. 18). The ALJ further described Plaintiff's testimony that her 1995 shoulder surgery was the primary catalyst in reducing her ability to function as "not entirely credible" because she continued to work at a level of gainful employment until November 1997, almost two years after her shoulder surgery (R. 18). While she noted that Plaintiff had experienced a significant decrease in her residual functional capacity after the date last insured, she found that this was not "pertinent to the period at issue" (R. 18-19).

C. Did the ALJ Apply the Correct Legal Standards And Is Her Decision Supported by Substantial Evidence?

Both sides agree that in order for Plaintiff to prevail on her application for disability insurance benefits, she must have been "disabled," as that term is defined by the Act, on or before December 31, 1998, when her insured status expired. See Lisa, 940 F.2d at 41; Wagner v. Secretary of Health & Human Services, 906 F.2d 856, 860 (2d Cir. 1990); 42 U.S.C. § 423(c)(1). Defendant asserts that the ALJ's finding that Plaintiff could do sedentary work, with some non-exertional limitations, through her date last insured, was supported by the opinion of a State agency reviewing physician and, therefore, is supported by substantial evidence. Plaintiff, on the other hand, argues that the decision of the Commissioner should be reversed because the ALJ's decision is flawed (1) in "disregarding a mountain of medical evidence of chronic pain"; (2) in rejecting Plaintiff's credibility concerning her "pain, chronicity, and functional limitations"; and (3) in holding that the medical evidence after Plaintiff's date last insured was "not pertinent" to

the period of disability at issue or to Plaintiff's residual functional capacity as of the date last insured. (Pl.'s Mem. at 15.)

1. Whether the ALJ Overlooked Significant Evidence in the Record

In her decision, the ALJ found that the clinical records as of Plaintiff's date last insured consistently described her pain as moderate, her limitation of motion as mild, and that she had good strength, good muscle function, and generally good sensation other than some findings of reduced pinprick sensation (R. 18). The ALJ further held that her alleged impairments of, inter alia, abdominal adhesions and resulting gastrointestinal distress and the findings of degenerative disc disease of the cervical spine were "non-severe, as they [were] not demonstrated prior to the date last insured by any medical evidence of record" (R. 16). The court agrees with Plaintiff that these findings by the ALJ ignore what Plaintiff describes as a "mountain of medical evidence." (Pl.'s Mem. at 15.) When Plaintiff's medical records are reviewed in their totality, they paint a far different picture of Plaintiff's level of pain and functional limitations. The court concludes that the ALJ's findings are not supported by substantial evidence.

From her first surgery at the age of three for excision of a large osteochondroma on her left leg through her surgeries in 1998 for the removal of osteochondromata of the right pubic area and right femur, the medical records reflect that these surgeries were performed only when the osteochondroma became sufficiently symptomatic to require excision. Plaintiff's pain is described throughout the medical records as "severe," (R. 345), "significant" (R. 183), "sharp" (R. 182), "chronic" (R. 149), "persistent" (R. 145), "presently severely disabling" (R. 194), "pain which came on atraumatically . . . and appears to have increased in severity" (R. 190), pain which interfered with her sleep (R. 151), "diffuse tenderness" (R. 186), for which Plaintiff was

prescribed various pain medications, anti-inflammatories, and steroids – not "moderate" as found by the ALJ.

The medical records further reveal that from 1993 to her date last insured in 1998, and continuing through 2003, Plaintiff repeatedly was treated by a neurologist, Dr. Markind, because of her consistent complaints of pain. Following the excision of a large osteochondroma on her right pelvis in April of 1993, she was referred to Dr. Markind, a neurologist, whose impression was meralgia paresthetica, most likely caused by compression of the nerve from the excised mass as well as possible surgical insult to the nerve. A nerve conduction study confirmed mild right neuralgia paresthetica. His records indicate that over the next three years, Plaintiff continued to experience tingling.

In late 1995, after many months of progressively worsening pain radiating from the right side of Plaintiff's neck to her shoulder and down her right arm, which Dr. LaGratta described as at the time as "severely disabling," Plaintiff underwent surgery for the removal of a large malignant osteochondroma and the upper portion of her right scapula and trapezius muscle. Following her surgery, the medical records are replete with references to her continuing pain in the right neck, shoulder, arm, and hand.

In August of 1996, she was seen at Danbury Orthopedic Associates because of burning pain, radiating down the right shoulder through her arm and hand. She was again referred to Dr. Markind, her neurologist, because of this pain, which she had been experiencing for four months. She reported that the pain was causing her to drop things and she had difficulty sleeping. She was taking Percocet for pain. A year later, Dr. Markind's records indicate that the pain was essentially unchanged and he noted that the scar tissue from her shoulder surgery possibly

involved the right dorsal scapular nerve.

In the meantime, Plaintiff had also seen Dr. LaGratta at Danbury Orthopedics in late 1996 for pain in her right thigh, which radiated down to her knee. X-rays showed a large osteochondroma as well as multiple osteochondromata. His impression was that the pain was probably neurologic. This pain in her right thigh continued and, in April, 1997, she saw Dr. LaGratta again complaining that the pain had increased in severity in the past two weeks, that she was experiencing pins and needles sensation when walking or standing. The doctor reported that her trunk motion was limited. An MRI revealed herniation or stenosis in the lumbar spine and an osteochondroma impinging on the right sciatic nerve. Three months later, Plaintiff was still seeing Dr. LaGratta for complaints of pain in her neck, shoulder and lower back. His examination revealed weakness in the right shoulder area, diminished trunk motion, low back strain with underlying disc pathology, and muscular imbalance.

In 1998, she saw Dr. LaGratta again for back pain and the “ongoing deformity” of her right scapula, which Dr. LaGratta said would be a “permanent problem,” and for radiating pain in her left thigh. His examination revealed a large bony mass on the femur that was causing pain on rotation, which he removed in July 1998.

In early 1996, Plaintiff also saw her gynecologist, Dr. Zamore, and Dr. LaGratta because of pronounced pain associated with a large mass on the right pelvic bone. A CAT Scan in 1998 demonstrated multiple osteochondromata throughout the pelvic area, with the largest pressing against the wall of the urinary bladder and impinging against the rectus muscle. In March, the right pelvic mass, which Plaintiff felt was "very symptomatic," was removed.

During this period, Plaintiff was also being treated by Dr. Fein, her podiatrist on a regular

basis for pain in her feet caused by osteochondromata, that were making it difficult for her to walk, as well as inflamed skin and fissured heels. She underwent a number of surgeries, including a surgery in August of 1997, on the large toe of her left foot, requiring the insertion of a pin in her foot. Over the next six weeks, she was seen by Dr. LaGratta almost weekly for complaints of pain and swelling.

In October 1998, Plaintiff underwent a total abdominal hysterectomy after eight years of heavy irregular bleeding, painful menstruation, a D&C in 1996, hormonal therapy, and an electrical excision of an intraepithelial neoplasia in 1995. Following her discharge after five days in the hospital, she was readmitted to the hospital for another five days because of pain caused by a mechanical bowel obstruction. These medical records, all pre-dating Plaintiff's date last insured, clearly paint a picture of someone suffering from pain far worse than "moderate."

Additionally, the records make repeated references to "muscle weakness" in her right shoulder area and "diminished trunk motion." And, as described above, there are numerous references in Dr. Fein's records to her difficulties with walking caused by the painful osteochondroma on her feet and the inflammation,

Also, contrary to the ALJ's finding that there was no evidence of nerve compression prior to Plaintiff's date last insured (R. 14), as noted above, the medical records contain several reports of nerve compression supporting Plaintiff's complaints of pain. As early as August 1993, when Plaintiff first saw Dr. Markind for radiating pain in her right thigh, his impression was "Meralgia paresthetica, most likely due to a combination of compression at the lateral femoral cutaneous nerve from the excised mass as well as possible surgical insult to the nerve as it courses through the inquinal ligament" (R. 153). In August 1996, Dr. LaGratta, Plaintiff's orthopedist, saw

Plaintiff for complaints of a burning sensation radiating down the right shoulder to the right arm and hand. The doctor's impression was "brachial plexitis, status post traction" and he recommended use of a sling and oral anti-inflammatories. In December, Plaintiff presented with complaints of right thigh pain, radiating down to the knee. After reviewing x-rays of the affected area, Dr. LaGratta's impression was that the pain was neurologic, which may be the result of regeneration of the previously injured nerve, scar formation, or entrapment of the nerve from a more proximal location. An MRI in April 1997 revealed an osteochondroma which was impinging on the right sciatic nerve.

Similarly, the court finds that the record does not support the ALJ's finding that, prior to the date last insured, there was no evidence of degenerative disc disease of the cervical spine. In July of 1997, Dr. LaGratta saw Plaintiff for complaints of back pain, which he diagnosed as low back strain with "underlying disc pathology." Plaintiff continued to see Dr. LaGratta and Dr. Markind for complaints of low back pain. Less than a year after her date last insured, X-rays revealed degenerative disc disease and spondylosis at C5-6 (R. 143). As discussed below, even though this x-ray post-dated Plaintiff's date last insured, it is relevant to her medical complaints prior to December 31, 1998.

Last, with respect to the issue of evidence overlooked by the ALJ, Plaintiff argues that the ALJ incorrectly concluded that prior to 1999, there was no evidence of Plaintiff's abdominal adhesions and resulting gastrointestinal distress. Again, the medical records indicate that throughout 1997 and in January of 1998, Plaintiff saw her gynecologist, Dr. Zamore, for complaints of severe pelvic and abdominal pain. In January, 1997, she had gone to the emergency room with complaints of right-sided pain. A phone message from the doctor's

records indicates "severe pain R side; husband states calling ambulance; wife screaming in the background" (R 345). A CAT Scan performed on February 11, 1998, showed a large osteochondroma, pressing on the wall of the urinary bladder and the rectus muscle. The radiologist noted that this same osteochondroma appeared to account for the lesion demonstrated on the 1997 MRI (R. 335-36), which compressed the right sciatic nerve (R. 323). Following Plaintiff's total abdominal hysterectomy in late 1998, Plaintiff was re-admitted to Danbury Hospital the following day with severe abdominal pain. She was hospitalized for five days with a discharge diagnosis of mechanical bowel obstruction status post abdominal hysterectomy. Although the medical records prior to Plaintiff's last date insured do not specifically reference adhesions, there was abundant evidence in the record that Plaintiff had experienced severe abdominal and pelvic pain in the period of her insured status.

Thus, after a thorough review of the medical records, the court finds an abundance of medical evidence that was over looked by the ALJ or which directly contradicts her findings.

2. Whether the ALJ Erred in Rejecting Plaintiff's Credibility Concerning Her Pain and Functional Limitations

The ALJ found "not entirely credible" Plaintiff's testimony that her 1995 shoulder surgery was the primary catalyst in reducing her ability to function based on her ability to continue working for nearly two years after this surgery (R. 18). She found that there was no medical evidence of record that demonstrated that Plaintiff's residual functional capacity deteriorated from 1995 until her date last insured to the extent that Plaintiff was unable to work (R. 18). Nevertheless, she found Plaintiff's testimony "entirely credible as to the extent of her limitations" as of the date of the hearing, but not credible as of the date last insured (R. 18).

In evaluating a claimant's residual functional capacity at step four, the Commissioner

may examine objective medical facts and "statements and reports from [the claimant] and his physicians, relevant to how his impairments and related symptoms affect his ability to work." Butts v. Barnhart, 388 F.3d at 380 (citing 20 C.F.R. § 404.1529). In that regard, the ALJ has discretion to evaluate a claimant's credibility regarding his subjective complaints of pain, but that evaluation must be made in conjunction with an assessment of the medical evidence. See Mimms v. Hecker, 750 F.2d 180, 186 (2d Cir. 1984). Moreover, it is the function of the ALJ and not the reviewing court to appraise the credibility of the claimant. 42 U.S.C. § 405(g); Carroll v. Secretary of HHS, 705 F. 2d 638, 642 (2d Cir. 1983). The ALJ's findings, if supported by substantial evidence, must be affirmed. Balsamo v. Chater, 142 F.3d at 81.

When evaluating a claimant's symptoms and their effect on the individual's functional limitations, the ALJ applies a two-part standard. SSR 96-7p. First, the ALJ must determine whether the medical evidence establishes the presence of an impairment which could reasonably be expected to give rise to the symptoms alleged. If so, the ALJ must then assess the extent to which the symptoms interfere with the individual's ability to perform work-related tasks, considering factors such as the objective medical evidence, the claimant's daily activities, precipitating factors, medications taken, treatment other than medication, and other measures taken by the claimant to relieve the symptoms. Id.

Here, there is no question that the medical evidence established the presence of impairments which could reasonably be expected to give rise to pain. The more difficult issue is the degree to which Plaintiff's pain interfered with her ability to perform work-related tasks.

Plaintiff argues that, in assessing her RFC to perform her past relevant work, the ALJ erred in discrediting her complaints of pain relating to her shoulder surgery simply because she

continued to work for nearly two years following the surgery.

Based on a review of the medical records in their entirety, the court finds that they support Plaintiff's testimony that following her shoulder surgery in 1995 the pain "got worse" and worsened to the point that she had to quit working (R. 784). [25] Repeatedly, between 1996 and 1998, Plaintiff was seen by her orthopedist and neurologist for complaints of shoulder pain, which by 1998, Dr. LaGratta described as a "permanent problem." The medical records reveal that in August of 1996, just eight months after her surgery, she saw her orthopedist for "burning radiating down the right shoulder to the right arm and hand" over the past few weeks. Her doctor diagnosed "probably right brachial plexitis, status-post traction following previous extensive bony and soft tissue resection" (R. 192) and recommended that she take anti-inflammatories and use a sling for her arm. On neurological consultation in October, she described right shoulder pain radiating into her arm and hand, which she had been experiencing since July. She said that the pain caused her to drop things, and she had difficulty sleeping. She was taking Percocet from pain and Ambien for sleep. In April of 1997, Plaintiff reported that her right shoulder pain had remained the same since October 1996. Dr. Markind opined that the scar tissue from her shoulder surgery possibly involved the right dorsal scapular nerve and prescribed Prozac for chronic pain management. Three months later, Dr. LaGratta examined Plaintiff for complaints of pain in her right neck and parascapular area, which showed shoulder weakness and slightly limited neck motion.

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[25] In response to questions from the ALJ, Plaintiff explained that the osteochondromas, or bone tumors, do not cause the pain. The pain she experiences results from the tumor pressing on a nerve and damaging the nerve. The tumor can be removed surgically, but the nerve has already been damaged (R. 784).

Additionally, as discussed above, medical records after December 31, 1998, relate Plaintiff's persistent pain and numbness in her shoulder and neck to her 1995 shoulder surgery. In April, 2002, Dr. LaGratta described the these problems as "traction neuritis, traction tendinitis, muscular weakness status post muscular resection and bony resection" (R. 617), referring to her 1995 shoulder surgery. He further noted that she could not do any heavy lifting, pushing, pulling or overhead activity as a result of her earlier shoulder surgery, which left her with a permanent partial impairment of the dominant right upper extremity (R. 166, 617). Thus, the court finds that the medical records support Plaintiff's testimony that her 1995 shoulder surgery was the catalyst for her ongoing problems with her right neck, shoulder, arm, and hand.

Additionally, while the ALJ discredited her testimony because she worked for a period of time in 1996 and 1997, the court notes that Plaintiff's earning records for the period 1995 through 1997 indicate that Plaintiff was working substantially less than full-time. Her earnings in 1995 were just over $1,200, $6,699 in 1996, and $7,457 in 1997 (R. 59-63).[26] The ALJ used plaintiff's work history to discredit her statement that she was disabled as of November 1997. However, the ALJ did not explore Plaintiff's work during this time frame. Plaintiff testified that she was fired in part because of her excessive absenteeism due to her surgeries, doctors' appointments, and not feeling well enough to come to work. This supports her disability claim

[26] Plaintiff earned $7,304 with her last employer, Grolier, where she was employed from February 28, 1997 to November 17, 1997, at an hourly wage of $8.21. She was scheduled to work 30 hours/week (R. 117). Although her employer did not have records showing when she worked during this time period, simple arithmetic demonstrates that Plaintiff worked less than 30 out of 38 weeks, which appears to corroborate her testimony that she missed a significant amount of time from work because of her surgeries, medical appointments, and sick days. And, in 1996, it appears she worked even less, although the record does not indicate what her hourly wage was at that time.

rather than detracting from it. See Schaal v. Apfel, 134 F.3d at 502.

Accordingly, based on a review of the record in this case, the court concludes that the ALJ's finding that Plaintiff's testimony was not entirely credible in this regard is not supported by the record.

3. Whether the ALJ Afforded Proper Weight to Medical Evidence Post-Dating Plaintiff's Date Last Insured

Plaintiff also challenges the ALJ's decision on the ground that she did not afford proper weight to the medical records post-dating Plaintiff's insured status. The ALJ stated in her decision that the medical records after 1998 were not "pertinent" to the issue of Plaintiff's residual functional capacity demonstrated on the date last insured.

The Second Circuit has held that medical records that post-date the date last insured may be relevant to bolster the credibility of the plaintiff's subjective complaints. See Lisa, 940 F.2d at 44. In Pollard v. Halter, 377 F.3d 183, 193-94 (2d Cir. 2004), the Second Circuit held that medical evidence post-dating the time period at issue could be relevant to the plaintiff's claims where it strongly suggested that during the relevant time period the plaintiff's condition was far more serious than previously thought and that additional impairments existed during this time.

> Indeed, we have observed, repeatedly, that evidence bearing upon an applicant's condition subsequent to the date upon which the earning requirement [i.e. insured status] was last met is pertinent evidence in that it may disclose the severity and continuity of impairments existing before the earning requirement date or may identify additional impairments which could reasonably be presumed to have been present.

Id. at 193-94 (internal quotation marks and citations omitted).

Clearly, Plaintiff's medical records after 1998 bolster the credibility of her complaints and the severity of her condition, which was a congenital, chronic, and progressive disease. In

April 1999, she could not bear weight on her right knee due to the presence of multiple osteochondroma. In September, she underwent surgery to remove painful osteochondroma in her right arm and left thumb. The following month, she was seen by Dr. LaGratta for sharp pain in both thighs, and in December, she saw her neurologist again, this time for pain in her thighs, intermittent numbness on both sides, paresthesia of both feet, headaches, back pain, and difficulty sleeping because of pain. X-rays again revealed degenerative disc disease and spondylosis.

In March 2000, Plaintiff again saw Dr. LaGratta for right shoulder and thigh pain. After two trips to the emergency room, she was seen by her neurologist, whose nerve conduction studies demonstrated mild neuropraxia. In July, she was again seen by Dr. Markind and Dr. LaGratta for right shoulder and leg pain. She complained of limited range of motion of her neck and pain with activity. In September, she underwent breast reduction surgery to alleviate the pain and pressure on her neck, shoulders, and torso.

Her complaints of shoulder, neck, and back pain continued throughout 2001. Dr. LaGratta's impression was "traction neuritis of the right neck and brahial plexus secondary to loss of soft tissue, bone, and strength post prior surgery." In September, Dr. LaGratta excised painful osteochondromata from her right and left wrists. Plaintiff developed severe abdominal pain caused by extensive adhesions in the abdominal cavity, requiring surgery in June. She continued to see Dr. Fein, her podiatrist for inflamed areas on both feet, which limited her ability to walk.

Throughout 2002, she saw Dr. LaGratta for "total body failure" (R. 616), which he diagnosed as traction neuritis, tendinitis, degenerative lumbar disk disease with radiculitis. He

recommended she use a sling and noted her functional limitations caused by this permanent partial disability of her right shoulder . In March, after two emergency room visits due to severe and constant abdominal pain, Plaintiff underwent emergency surgery by Dr. Zamore to remove multiple abdominal adhesions and to repair hemorrhagic ovarian cysts. And, in May, she had another surgery on her foot for a hammertoe. During 2002, Plaintiff began seeing a psychiatrist for depression.

In 2003, Dr. Markind saw Plaintiff for pain in the right neck, shoulder, arm and hand, and decreased sensation in her right hand that caused her to drop things. She complained of chronically poor sleep, frequent headaches, migraine headaches associated with nausea, vomiting, photophobia, and phonophobia. Repeatedly, she treated with Dr. Fein, her podiatrist, for debridement of the inflamed skin on her feet, which were painful and limited her ability to walk. She also was treated by Dr. LaGratta for a "traumatic pain" in the low back radiating to the left buttock and thigh.

These records lend credence to Plaintiff's testimony at the hearing on December 11, 2003, concerning her symptoms, the amount of time she was required to miss from work, the impact of her 1995 shoulder surgery, the activities that she was unable to perform. They further substantiated the severity and continuity of Plaintiff's impairments existing before her date last insured. See Pollard, 377 F.3d at 193-94.

The ALJ's statement that these were not "pertinent" to Plaintiff's residual functional capacity demonstrated as of the date last insured was error. What is difficult to discern from her decision is to what extent she considered these medical records. She clearly reviewed them and noted that Plaintiff had experienced a significant decrease in her residual functional capacity after

her late last insured. These records, however, should have been considered for purposes of lending credence to Plaintiff's testimony and the severity of her condition prior to her date last insured.

4. Whether the State Agency's Opinion, on Which the ALJ Relied, Was Consistent with the Other Medical Evidence of Record

Defendant argues that the ALJ's determination that Plaintiff retained the RFC to perform her past relevant work was supported by the opinion of the state agency reviewing physician (R. 365-70, 394-401),[27] whose opinion was not contradicted by any of Plaintiff's treating physicians. (Def.'s Br. at 3, 5.) The agency doctor's opinion were based solely on a review of Plaintiff's medical records, the same "raw medical findings," on which Plaintiff relies to support her disability claim. (Def.'s Mem. at 5.)

One of the difficulties with this case is that, although the record contains copious records from Plaintiff's treating physicians with whom she treated for ten years and who were specialists in their fields of medicine, these records contain sparse information on Plaintiff's residual functional capacity. But, these are the same records exclusively relied upon by the agency doctors, who never even examined Plaintiff. To the extent that these records do not support Plaintiff's claims of functional limitations, they also do not support Defendant's reviewing doctors' assessments. For example, the reviewing doctor concluded based on the medical

[27] Dr. Arthur Waldman reviewed Plaintiff's medical records on May 22, 2002, and concluded that Plaintiff could perform work at the medium level of exertion, based on her ability to lift 50 pounds occasionally, 25 pounds frequently, stand and/or walk for 6 hours, sit for 6 hours, an unlimited ability to push and/or pull (R. 365-70). Defendant, however, relies on the second reviewing agency doctor's report, prepared by Dr. Derrick Bailey on September 10, 2002, which, as discussed infra, concluded that Plaintiff was unable to tolerate more than a light level of exertion (R. 393-401).

records that, during the period October 15, 1997, through December 31, 1998, Plaintiff had the "unlimited" ability to push and/or pull, to sit for a total of about six hours out of an eight-hour workday, to stand and/or walk about six hours out of an eight-hour workday, to frequently lift and/or carry 10 pounds and occasionally lift and/or carry 20 pounds (R. 394). The doctor provides absolutely no support for these conclusions. In fact, Question No. 6 on the form, asking the doctor to explain how and why the evidence supports these conclusions, citing specific facts, is left completely blank (R. 394). In terms of manipulative limitations, the reviewing doctor stated that, except for reaching overhead, Plaintiff's ability to perform all others – including reaching in all directions, handling, fingering, feeling -- were unlimited. And, again, no explanation or specific facts supporting these conclusions is provided by the reviewing doctor (R. 398), and Defendant offers no support from the medical records for these conclusions.

Defendant argues that Plaintiff "disregards the fact that the reviewing physician's opinion that she remained able to work until at least the end of 1998 was not contradicted by any contemporaneous opinions of treating and examining physicians." (Def.'s Mem. at 5.) The answer to that charge is quite simple. As the Court recognized in Rosa v. Callahan, 168 F.3d at 81, the records from Plaintiff's treating physicians are exactly what they purport to be: contemporaneous records of their care and treatment of Plaintiff over a ten-year period. To the extent that they fail to do specifically address what work or activities Plaintiff could perform, presumably they were never asked. See also Rosa v. Callahan, Carroll v. Secretary of Health & Human Servs., 705 F.2d 638, 643 (2d Cir. 1983).

Moreover, contrary to the opinions of the agency reviewing doctors are the records from these long-term treating specialists, which show that at various times Plaintiff's right arm was in

a sling; she was having difficulty holding things with her right hand; she was experiencing significant and on-going right neck, shoulder, arm and hand pain; she had permanent curvature of her toes and fingers due to osteochondroma and had difficulty walking; she experienced paresthesia upon standing and walking; she had osteochondroma impinging on the right sciatic nerve; she experienced on-going back pain; x-rays showed disk herniation in her lumbar spine; she experienced recurrent pain in her hips, pelvis and abdomen; she had significant pain in her left thigh particularly when sitting. Yet, the reviewing agency doctors mention none of this. Other than listing a diagnosis of osteochondromatosis and secondary diagnosis of right shoulder pain, they make no reference to any of these medical conditions, symptoms, and limitations that are contained in the medical records and provide no support for their opinions concerning her residual functional capacity. While the opinion of a state agency reviewing doctor may constitute substantial evidence when it provides a reasonable assessment of the other medical evidence in the record, 20 C.F.R. § 404.1527(f), here, that was not the case. Thus, the court finds that the ALJ was not entitled to rely on these opinions, which were not consistent with all the clinical evidence and observations from all treating sources within the evidentiary record, contrary to the ALJ's finding (R. 18).

V. Conclusion

After a careful review of the record, the court concludes that substantial evidence does not support the ALJ's finding that Plaintiff was able to perform her past relevant work as a data entry clerk. Accordingly, the court recommends that the decision of the Commissioner should be reversed. Furthermore, the court reluctantly must recommend remanding this case. Because the ALJ never reached the fifth step in the sequential evaluation process, this case must

be remanded for a determination of whether the Commissioner can carry her burden of showing that Plaintiff, considering her age, education, and work experience, retained the residual functional capacity to engage in other substantial gainful employment which exists in the national economy. See Eastman v. Barnhart, 241 F. Supp. 2d 160, 168 (D. Conn. 2003); see also Johnson v. Heckler, 741 F.2d 948, 952 (7th Cir. 1984). This is a decision that must be made by the ALJ in the first instance, not this court. However, as the Second Circuit noted in Butts v. Barnhart, 388 F.3d at 387, in remanding, this court is "mindful of the often painfully slow process by which disability determinations are made, and that a remand for further evidentiary proceedings (and the possibility of further appeal) could result in substantial, additional delay." (Internal citations and quotation marks omitted). In that case, after years of delay, the Court held imposition of a time limit was "imperative." Id.

In accordance with the Second Circuit's admonition in Butts v. Barnhart, this court recommends that any further proceedings before an ALJ be completed within sixty (60) days of the issuance of the District Court's order and, if that decision is again a denial of benefits, a final decision of the Commissioner be rendered within sixty (60) days of Plaintiff's appeal of the ALJ's decision. If these deadlines are not observed, this court recommends that the District Court's order provide that a calculation of benefits owed to Plaintiff should be made immediately. See Id.

In conclusion, the court recommends that Plaintiff's motion to reverse and/or remand **[Doc. # 12]** should be GRANTED, subject to the time limitations set forth above, and that Defendant's motion to affirm **[Doc. # 17]** should be DENIED. Any objections to this recommended ruling must be filed with the Clerk of the Court within ten (10) days of the receipt

of this order. Failure to object within ten (10) days may preclude appellate review. See 28 U.S.C. § 636(b)(1); Fed. R. Civ. P. 72; D. Conn. L. Civ. R. 72 for Magistrate Judges; FDIC v. Hillcrest Assocs., 66 F.3d 566, 569 (2d Cir. 1995).

SO ORDERED, this 2nd day of February 2006, at Bridgeport, Connecticut.

/s/ *William I. Garfinkel*
WILLIAM I. GARFINKEL
United States Magistrate Judge