UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND

HARLEN DAVID O., Plaintiff,	:	
v.	:	C.A. No. 18-17WES
NANCY A. BERRYHILL, ACTING COMMISSIONER OF SOCIAL SECURITY, Defendant.	:	

REPORT AND RECOMMENDATION

PATRICIA A. SULLIVAN, United States Magistrate Judge.

This appeal from the adverse disability decision of the Commissioner focuses on a lumbar spinal MRI finding that "[c]lumping of the nerve roots is consistent with arachnoiditis."[1] ECF No. 16-2 at 7. The MRI, which I will refer to as the "new MRI," was performed on December 1, 2016, five days before the hearing conducted by the Administrative Law Judge ("ALJ"); however, it was never mentioned or presented to the ALJ. Rather, six months later, together with other imaging done at Open MRI NE, it was proffered to the Appeals Council, which refused to review the case and refused to consider or exhibit the submission[2] based on its determination that the new evidence did not show a reasonable probability that it would change the outcome of the decision. Plaintiff Harlen David O. now argues that the Appeals Council

[1] "Spinal arachnoiditis 'describes a pain disorder caused by the inflammation of the arachnoid, one of the membranes that surround and protect the nerves of the spinal cord.'" Curry v. Berryhill, 3:15-cv-00244-LRH-WGC, 2017 WL 1404312, at *3 n.3 (D. Nev. Apr. 18, 2017) (quoting *Arachnoiditis Information Page*, THE NATIONAL INSTITUTE OF NEUROLOGICAL DISORDERS AND STROKE, https://www.ninds.nih.gov/Disorders/All-Disorders/Arachnoiditis-Information-Page (last visited by that court April 4, 2017)). Arachnoiditis is "characterized by adhesive thickening of the arachnoid which may cause intermittent ill-defined burning pain and sensory dysesthesia, and may cause neurogenic bladder or bowel incontinence when the cauda equina is involved." 20 C.F.R. Part 404, Subpt. P, App. 1, § 1.00(K)(2)(a).

[2] Because the Appeals Council declined to exhibit the new MRI, it is not part of the administrative record, but is in the record before the Court because Plaintiff attached the entire Open MRI NE submission to his opening brief. ECF No. 16-2. It is referenced in this report and recommendation by the ECF citation.

erred in failing to make the new MRI part of the administrative record and to consider it. Citing Seavey v. Barnhart, 276 F.3d 1, 11-12 (1st Cir. 2001), he contends that the Court should find that the new MRI, considered with the other evidence of record, constitutes overwhelming proof that Plaintiff's lumbar spine was so profoundly impaired during the period in issue as to meet the stringent criteria of the Listing for Disorders of the spine (1.04). He therefore asks that the matter be remanded to the Commissioner for an award of benefits.

In addition to his claim of error by the Appeals Council, Plaintiff challenges several findings of the ALJ. He argues that the ALJ's Step Three findings that his right knee impairment did not meet or equal either Listing 1.02A (Major dysfunction of a joint) or Listing 14.09A (Inflammatory arthritis) and that his cognitive incapacity did not meet or equal Listing 12.04A1 (Depressive disorder) all lack the support of substantial evidence. He also challenges the ALJ's residual functional capacity ("RFC")[3] determination, contending that it was error to rely on the answer of the vocational expert ("VE") to a hypothetical that omitted limitations on Plaintiff's ability to use his right hand.

Based on these claims, Plaintiff has moved to reverse the Commissioner's decision denying Disability Insurance Benefits ("DIB") under 42 U.S.C. § 405(g) of the Social Security Act (the "Act"). Defendant Nancy A. Berryhill ("Defendant") has filed a motion for an order affirming the Commissioner's decision. The matter has been referred to me for preliminary review, findings and recommended disposition pursuant to 28 U.S.C. § 636(b)(1)(B). Having reviewed the all of the Open MRI NE submission, the entire administrative record and the parties' arguments, I recommend that Plaintiff's Motion for Judgment Reversing and/or

[3] Residual functional capacity is "the most you can still do despite your limitations," taking into account "[y]our impairment(s), and any related symptoms, such as pain, [that] may cause physical and mental limitations that affect what you can do in a work setting." 20 C.F.R. § 404.1545(a)(1).

Remanding the Decision of the Acting Commissioner (ECF No. 16) be DENIED and Defendant's Motion for an Order Affirming the Decision of the Commissioner (ECF No. 18) be GRANTED.

I. Background[4]

A. Evidence and Opinions Up to and Including File Review by SSA Experts

Born in 1969, Tr. 198, Plaintiff completed not just high school, but also IT training. Based on these accomplishments, he worked very successfully for many years both as an IT employee and as a self-employed network system designer, among other jobs.[5] Tr. 191, 198, 201-04. Married for many years, Plaintiff has two young children. After he stopped working on November 4, 2014, (the date of alleged onset), Plaintiff continued to be able to care for his children, drive (except during "flares"), cook, do chores, shop, play the guitar, and go to church. Tr. 209-16. While he was still working, Plaintiff began to suffer from various of the impairments now in issue. Because of the complexity of Plaintiff's medical picture, each is described separately.

Diabetes and Substance Abuse. Prior to the period in issue, Plaintiff was diagnosed with diabetes and alcohol abuse. In connection with these diagnoses, in 2013 and early 2014, treating physicians noted Plaintiff's poor diet and lack of exercise and expressed concern that he was at serious risk of liver failure or cardiac disease. Tr. 278-86, 376. However, by 2014, Plaintiff was in recovery from substance abuse, while by April 2015, the neurologist, Dr. Meryl Goldhaber, noted that Plaintiff's diabetes had come under control through weight loss and diet. Nevertheless, Dr. Goldhaber attributed Plaintiff's foot pain to neuropathy likely caused by

[4] As indicated in the text, this exposition of the background is based on both the administrative record and the new evidence submitted to the Appeals Council.

[5] Plaintiff also successfully sold an invention for which he receives an ongoing royalty stream. Tr. 53.

diabetes and alcohol abuse and listed prior alcohol abuse among possible causes of Plaintiff's claimed cognitive deficits. Tr. 308-09.

Chronic Lyme. Plaintiff alleges that he has suffered from chronic Lyme for twenty years. Tr. 631. He claims that he was misdiagnosed initially, id., but then, despite no rash, a normal brain MRI, Tr. 287, and although (as the state agency ("SSA") physician experts noted), "lyme titers not diagnostic," Tr. 88, 103, by 2012, he was diagnosed with chronic Lyme, also referred to as "Neuro Lyme," Tr. 361, or "Lyme Encephalomyelitis," Tr. 291. It is not clear from the record precisely when and by whom these diagnoses were made. During the period in issue, Plaintiff's primary care physician, Dr. James Gloor, prescribed long-term antibiotic treatment for chronic Lyme, including prolonged intravenous administration of antibiotics by "PICC" line. E.g., Tr. 324. Plaintiff attributed his progressive joint, shoulder, elbow, hip, knee, ankle, neck and "[s]ome back pain," as well as what he considers to be a material degradation in his cognitive functioning (especially memory), to "chronic lyme disease." Tr. 588.

In 2015, Dr. Gloor referred Plaintiff to a neurologist, Dr. Meryl Goldhaber, to evaluate the neurological effects of chronic Lyme. Tr. 303. She assessed the foundational diagnosis, noting a report of tick bites, but no rash and no improvement with a month-long course of antibiotics. Id. Her examinations produced largely normal results, except for the observation of swollen and painful joints with subcutaneous nodules; she found that, while Plaintiff's gait was narrow, both gait and coordination were essentially intact,[6] while the brain MRI was normal. Tr. 306-08, 597-601. Dr. Goldhaber concluded that Plaintiff's pain was likely caused by the painful and flaring joint nodules, for which she prescribed NSAIDs. Tr. 308. She found Plaintiff's memory complaints to be "atypical for degenerative dementias" and suggested they might be

[6] This characterization of Dr. Goldhaber's findings comes from the analyses by the SSA physicians. See Tr. 88, 103.

caused by past alcohol abuse or by "his anti-depressants." Id. She recommended that Plaintiff discuss weaning off such medications, as well as that he undergo neuropsychological testing. Id. Based on her own observations, she concluded that Plaintiff had "only occasional word finding difficulties." Tr. 306, 593-95. Dr. Goldhaber referred Plaintiff to a rheumatologist for further consideration of what she considered was the significant source of pain – the subcutaneous nodules. Tr. 309.

Gout. At some time long prior to the onset of disability, Plaintiff had been diagnosed with gout. Tr. 278, 303. Within the period of alleged disability, Dr. Goldhaber referred Plaintiff to Dr. Saskia Cooper, a rheumatologist, to consider the cause of the subcutaneous nodules. Dr. Cooper saw Plaintiff in June 2015; she noted "joint pain" and that "[h]e has flares of increased pain and swelling." Tr. 411. Her physical examination resulted in the finding of normal strength and "no significant deformity except" for observations of "unassisted antalgic gait" with decreased left hip flexion and joint tenderness, nodules and tophi[7] affecting the shoulder, elbow, wrist, hand, toe, knees and hip. Tr. 412. She ordered an array of x-rays, which showed moderate osteoarthritis in the shoulder, hips, elbow and knee, and mild osteoarthritis in the foot and hand. Tr. 432-48. Her differential diagnoses included "sarcoidosis, tophi [gout], and amyloidosis." Tr. 413. However, after the x-rays were taken, there is a gap in treatment, in that Plaintiff apparently did not return until January 2016, when he started treatment with a different rheumatologist, Dr. Nida Chaudhary.

Lumbar Spine. Prior to the period of alleged disability, Plaintiff suffered from lumbar disc disease. In the early 2000s, he had a lumbar laminectomy at L4-5 following which he

[7] "Uric acid deposits called tophi develop in cartilage tissue, tendons, and soft tissues. These tophi usually develop only after a patient has suffered from [gout] for many years." Moore v. Colvin, No. 4:14-CV-674-CEJ, 2015 WL 4958363, at *5 n.6 (E.D. Mo. Aug. 19, 2015) (quoting http://www.nlm.nih.gov/medlineplus/ency/imagepages/19833.htm (last visited by that court Apr. 30, 2015)).

returned to work. Tr. 404. Ten years later, in 2013, he was seen by Dr. William Brennan for stabbing low back pain and mildly antalgic gait following a fall down stairs. Tr. 675. Based on an MRI performed on April 15, 2013, that showed a herniated disc at L5-S1, Dr. Brennan scheduled Plaintiff for surgery in August 2013. Dr. Brennan ordered another MRI just before the surgery; the second MRI was done on August 7, 2013. Tr. 675-91. The August 7, 2013, MRI, as well as Dr. Brennan's treating and surgical notes, are all in the administrative record. The April 2013 MRI is not; it was submitted to the Court with the Open MRI NE materials. ECF No. 16-2 at 17-18.

As pertinent to what is in issue now, the April 2013 MRI showed the disc problem at L5-S1 on which Dr. Brennan planned to do surgery, as well as evidence of the prior laminectomy and a possible nerve root issue at L4-5. ECF No. 16-2 at 18. Dr. Brennan's notes do not reflect any concerns about the L4-5 MRI nerve root findings. The pre-surgery MRI, done on August 7, 2013, makes a new observation at L4-5: "mild arachnoiditis." Tr. 686. A few days later, on August 13, 2013, Dr. Brennan proceeded with the surgery on L5-S1 as planned. Tr. 685. Dr. Brennan's notes assign no clinical significance to any of the August 2013 MRI findings, including no mention of the new reference to "mild arachnoiditis" at L4-5.

Within a little over a week post-surgery, Dr. Brennan noted that Plaintiff's "leg pain immediately resolved after surgery," as well as that he was encouraged to walk and complained only of "moderate back pain." Tr. 681. Within a month of the surgery, Plaintiff was largely recovered, with "[g]ood mobility[,] [n]egative straight leg raise" and only "mild soreness." Tr. 682-83. After the lumbar spine surgery, Plaintiff resumed working and continued for more than a year until November 4, 2014, his alleged onset date. The medical record from the period of Plaintiff's recovery in October 2013 continuously until shortly before the ALJ hearing in

November 2016 makes no reference to pain in the lumbar area of the spine, nor does any treating source order any new lumbar imaging study or prescribe any treatment related to lumbar spinal difficulties.

Mental and Cognitive Health. For mental health treatment during 2014, Plaintiff was seen for several months by a psychiatrist, Dr. Wasim Rashid, who diagnosed him with PTSD and alcohol dependence in remission, but found him to be "clinically stable," with relatively normal mental status findings, including "euthymic" mood and "broad-range" affect. Tr. 291-92, 297-98. In 2015, Dr. Goldhaber performed mental status examinations, which yielded all normal findings, including "[a]ttention span and concentration normal." Tr. 418. Dr. Cooper's examination also included mental status – she noted, "appropriate mood and affect." Tr. 412. Otherwise, Plaintiff had a "longstanding" mental health counseling history, but the counsellor's records were not produced, despite counsel's "heroic efforts," Tr. 46, while medication for depression and ADD was prescribed, apparently by Dr. Gloor. Nevertheless, in his notes, Dr. Gloor consistently opined that Plaintiff's ADD was stable. Tr. 647, 763. Nor do the Gloor notes[8] record clinical observations regarding depression. E.g., Tr. 386 (listing diagnosis of depression but no reference to a mental status examination).

Based on Plaintiff's complaints of cognitive and mental health impairments, a consulting examination was performed by an SSA psychologist, Dr. Louis Cerbo, on June 9, 2015. Tr. 404. Dr. Cerbo's interview established that Plaintiff reported decreased energy, childhood abuse and mild-to-moderate depression. Tr. 408-09. The testing revealed that Plaintiff is intelligent, in the high average range, and that his achievements are at the post-high-school level for all academic areas tested, as well as that Plaintiff has appropriate concentration, except for mild-to-moderate

[8] These notes are handwritten and very difficult to read.

word retrieval difficulties with the short-term memory becoming compromised by an ambiguous task. Tr. 407-08.

SSA Opinions. All of the foregoing evidence (except the April 2013 MRI) was reviewed initially and on reconsideration by two SSA expert physicians (Drs. Laurelli and Green) and two SSA expert psychologists (Drs. Gordon and Harris). In the file that they considered were references to the history of two surgeries on the lumbar spine, both of which were followed by a return to work; the review file included Dr. Brennan's 2013 notes and the August 2013 MRI finding of mild arachnoiditis at L4-5. Collectively, SSA file reviewers focused on the following symptoms and conditions: alcohol abuse and diabetes; gout, including the nodules (tophi) that flared and caused swelling and "exquisite" pain in the extremities and joints; osteoarthritis based on x-rays, including of the hands; swelling in the knees and knuckles; chronic Lyme as treated by Dr. Gloor, although they noted, "[n]o objective evidence of Lyme disease"; fatigue; limitations of attention and concentration; cognitive and memory impairment; and depression and PTSD. Tr. 84-86, 99-102. They also found that Plaintiff's statements regarding the intensity and severity of his symptoms were not substantiated by the objective medical evidence. Tr. 86, 102.

Based on their evaluation of the record, the SSA experts assessed Plaintiff to be capable of light work, with additional exertional and postural limits, coupled with limitations on memory, understanding, concentration and the ability to work without interruption and to adapt to work-place changes, leaving him with the functional capacity to perform only uncomplicated work with regular breaks. Tr. 87-90, 102-05. Despite the allegations and evidence (including x-rays and clinical descriptions of tophi) of various hand and wrist symptoms, which the SSA physicians specifically referenced in their analysis and "[a]dditional [e]xplanation[s]," they did

not include any functional limitations on the ability to manipulate or push/pull with the hands. Tr. 103. Plaintiff's claim was denied on reconsideration on December 30, 2015.

B. Medical Records and Opinion Evidence Generated After SSA Experts' File Review and Before ALJ's Decision

After an apparent gap in treatment in the second half of 2015 and after the final SSA file review was completed in December 2015, Plaintiff began treating with a new rheumatologist, Dr. Nida Chaudhary. Dr. Chaudhary examined the x-rays taken six months before on the order of Dr. Cooper and found them "unremarkable" in that they reflected only mild arthritis. Tr. 636. Consistent with Dr. Cooper, she tentatively diagnosed gout, including that Plaintiff's pain was from the nodules, which were tophi caused by gout. Tr. 636. To confirm the diagnosis, she decided to biopsy one of the nodules. Tr. 640. The nodule biopsy was done in April 2016 and confirmed the diagnosis of gout. Tr. 698. Dr. Chaudhary noted that Plaintiff was "suspicious of this diagnosis." Tr. 717. Nevertheless, she began to prescribe gradually increasing doses of medication to treat the causes of gout. Tr. 720, 725, 808, 813. Dr. Chaudhary declined to address the diagnosis of chronic Lyme disease. Tr. 636.

As of March 2016, Plaintiff saw Dr. Chaudhary during a "flare"; he told her that he had daily joint pain in his hands and knee and that he took NSAIDs. Tr. 637. He reported that the "current flare began about a week ago" and "[o]ver the last week his symptoms gradually improved and completely resolved," except the shoulder. Id. On examination, Dr. Chaudhary observed that the right shoulder, hip and knee are "exquisitely tender to gentle palpation." Tr. 639. In April 2016, Dr. Chaudhary's examination notes record that it was the shoulder, elbow and wrist that were "exquisitely tender," although Plaintiff declined medication and advised Dr. Chaudhary that pain "is tolerable." Tr. 643-44. In May 2016, Dr. Chaudhary noted that Plaintiff's "[e]xam is relatively normal," Tr. 720, except that she observed a new symptom –

Plaintiff's increasing cervical pain. After an MRI in June 2016 confirmed serious disc issues in the neck, Plaintiff had neck surgery in September 2016 and achieved a "good result." Tr. 727, 735, 791. The physical therapist to whom plaintiff was referred for treatment (Erin Reynolds of Tru-Care) predicted "fairly good outcomes." Tr. 792. None of these records make any reference to pain in or emanating from the lumbar area of the spine. See Tr. 720 ("most concerned about the neck pain").

During the early months of 2016, Plaintiff continued to see Dr. Gloor. In February and April 2016, Dr. Gloor found that Plaintiff's ADD was stable and that he was feeling "pretty well." Tr. 647-49; see Tr. 651 ("today is a good day"). Nevertheless, in response to Plaintiff's request that he "also needs a physical capacity eval for court," Tr. 649, Dr. Gloor sent Plaintiff to Tru-Care Physical Therapy to have a special purpose evaluation. This evaluation was performed by a physical therapist, Susan Hammond. Ms. Hammond was not otherwise involved in any of Plaintiff's treatment.

Ms. Hammond's March 2016 report begins with her summary of Plaintiff's subjective report to her of his symptoms, which he attributed to "chronic lyme disease." Tr. 588. Plaintiff told Ms. Hammond that he lost memory and passed out due to stress, pain and cognitive dysfunction; that he is "symptomatic in the right shoulder, elbow, fingers, R hip, knee, ankle," with pain in "L toe, L ankle, L hip and neck"; and that he can walk for less than five minutes, cannot stand at all and can sit for less than thirty minutes without "aggravating pain," after which he "requires position changes." Id. As to the spine, Ms. Hammond's summary of Plaintiff's statement reflects only "[s]ome back pain as well." Id. In reliance on these subjective statements, her observations of antalgic gait, flexed knee stance and "little to no push off on the R LE," Tr. 589, as well as her examination, Ms. Hammond concluded that Plaintiff can stand or

walk for less than one hour, can sit for less than two hours at one time, can lift only up to five pounds frequently and cannot use the right hand at all for grasping, manipulation or pushing/pulling. Tr. 587.

In the same time frame, also in connection with his application, Plaintiff saw a psychologist, Dr. Frank Sparadeo, for a neuropsychological evaluation. As noted in Dr. Sparadeo's April 1, 2016, initial diagnostic interview, this was not treatment-based testing; rather, the "Referral Reason" was because Plaintiff was "[t]rying to be eligible for SSDI – [s]uffers from Lyme Disease, PTSD." Tr. 631. In contrast to the contemporaneous Hammond report, at the first encounter, Dr. Sparadeo observed "normal posture and gait"; he also found that "affect was full and mood stable." Id.

In his final evaluation, Dr. Sparadeo reported intellectual and cognitive testing results that are similar to those reported by Dr. Cerbo, including that Plaintiff has high average intellectual capacity and that he achieved high average or better results on some tests of attention and memory, while other attention and memory tests showed difficulties. Tr. 703-04. Overall, apart from attention/concentration, Dr. Sparadeo's testing resulted in the finding of no cognitive degradation: "all other domains were in the normal range." Tr. 712. Nevertheless, Dr. Sparadeo also found Plaintiff to be socially isolated and recommended that he would benefit from training to increase his engagement in exercising and stretching and from treatment for depression and PTSD, as well as that he should address pain management with a psychologist. Tr. 708, 712, 713. Despite these findings, Dr. Sparadeo concluded that "this patient is unable to work at any level due to the presence of impaired attention/concentration, depression, chronic pain and anxiety." Tr. 712.

Shortly before Plaintiff's ALJ hearing on December 6, 2016, Dr. Gloor referred Plaintiff to the Warwick Pain Clinic. On November 4, 2016, Plaintiff was examined by a nurse practitioner, to whom he complained of pain "described as aching, burning, sharp, shooting, stabbing, and throbbing." Tr. 852. For the first time since 2013, the physical examination findings focused on Plaintiff's lumbar spine; the findings include moderate tenderness and decreased flexion and extension, with positive straight leg raise on one side and antalgic gait. Tr. 854. Concerned that the pain might be radicular from the lumbar spine, the nurse practitioner ordered what is referred to in this report and recommendation as the new MRI.

The new MRI was performed on December 1, 2016, just five days before the ALJ hearing, at the same agency that had done the August 2013 MRI (Open MRI NE). The principal finding now in issue is at L4-5: "Clumping of the nerve roots is consistent with arachnoiditis and similar to prior study." ECF No. 16-2 at 27. The parties agree that the referenced "prior study" is the August 2013 MRI, which was reviewed by Dr. Brennan before he proceeded with the surgery at L5-S1: "L4-5: . . . There are findings of mild arachnoiditis." Tr. 686. No imaging was done of Plaintiff's lumbar spine between the 2013 and 2016 studies; during that period, the record reflects that Plaintiff made no complaint about pain or tenderness in the lumbar spine to any treating source.[9]

On the same day it was performed, Plaintiff's counsel requested a copy of the report in a letter to Open MRI NE. ECF No. 16-2 at 2. The new MRI report was signed and became available on December 2, 2016, just four days before the ALJ hearing. At the hearing, the ALJ asked, "[a]ny objection to any of these documents or any others marked as proposed exhibits?"

[9] Plaintiff mentioned "[s]ome back pain" to the non-treating physical therapist, Ms. Hammond, in March 2016. Tr. 588.

Tr. 46. Despite Plaintiff's awareness of the new MRI having just been performed, Plaintiff's counsel answered:

> I have no objection to the exhibits. I just wanted to point out for the record that Mr. [O.] has a long-standing counseling history with a Grace Dulude.

Id. While mentioning the unavailable counseling records, counsel failed to advise the ALJ that a new MRI had just been done and that a request for it was pending. Also, during the hearing, Plaintiff did not argue that he had experienced lumbar spinal pain at any time during the period of alleged disability. Rather, Plaintiff's opening statement highlighted the cervical spine surgery and noted the past lumbar surgeries in 2003 and 2013, but otherwise focused on gout, Lyme disease and osteoarthritis based on the 2015 x-rays. Tr. 48. During his testimony, Plaintiff did not describe the pain as intense, except during flares "that'll happen every couple of months at most" (or more frequently). Tr. 54-55. He stated that he had not taken Fentanyl for "eight or nine" months and had not taken Percocet at all, as well as that "[t]he amount of pain that I'm in on a day-to-day basis in my joints would be considered moderate by doctors." Tr. 54-57. During flares, Plaintiff testified that he could not stand even for two minutes and that sitting is a problem: "I have to keep moving." Tr. 54, 61.

On December 15, 2016, nine days after the ALJ hearing, the new MRI was delivered to Plaintiff's counsel. For six months, Plaintiff's counsel did nothing; he did not attempt to make it part of the administrative record or bring its existence to the attention of the ALJ.

C. The ALJ's Decision

Unaware of the existence of the finding of arachnoiditis in the new MRI, the ALJ held Plaintiff's claim under advisement for almost four months, finally issuing his decision on April 5, 2017. At Step Two, the decision accepts as severe Plaintiff's inflammatory arthritis (gout), osteoarthritis, Lyme disease, depression and anxiety. At Step Three, the ALJ found that

Plaintiff's symptoms did not meet or equal Listings 1.02 (Major dysfunction of a joint), 1.04 (Disorders of the spine), 12.02 (Neurocognitive disorders), 12.04 (Depressive, bipolar and related disorders), 12.06 (Anxiety and obsessive-compulsive disorders), and 14.09 (Inflammatory arthritis). In rejecting Listing 1.04, the ALJ noted that the evidence does not show "[s]pinal arachnoiditis, confirmed by . . . appropriate medically acceptable imaging, manifested by severe burning or painful dysesthesia, resulting in the need for change in position or posture more than once every 2 hours." Tr. 14.

Moving on to the RFC, the ALJ afforded great weight to the SSA experts but little weight to the non-treating sources, Dr. Sparadeo and Ms. Hammond, although the ALJ added further limits to Plaintiff's ability to function based on his difficulties in dealing with others. Tr. 16, 24-25. The ALJ also discounted Plaintiff's statements and testimony about the intensity of his symptoms. Tr. 19. The resulting RFC permits light work with additional limits. Tr. 17-18. Based on this RFC, the ALJ determined that Plaintiff was "not disabled" in reliance on the testimony of the VE that at least five jobs would be available. Tr. 27-28. With no hand-use limits in the SSA opinions, with little weight afforded to the Hammond report (the only source opining to the inability to use the right hand), and with Plaintiff's subjective complaints of hand pain discounted, the ALJ did not include any hand limits in the RFC. The ALJ's decision was based on the availability of the VE's jobs, all but one of which would be precluded if Plaintiff was unable to use his right hand. See Tr. 76.

D. Submissions to and Decision of the Appeals Council

On June 27, 2017,[10] Plaintiff forwarded Plaintiff's complete file from Open MRI NE to the Appeals Council. It includes the MRIs that were already part of the administrative record –

[10] A letter transmitting these materials on this date is not in the record. This date is based on the representation in Plaintiff's brief to the Appeals Council. Tr. 262.

the August 2013 MRI of the lumbar spine showing mild arachnoiditis; the normal 2014 brain MRI ordered in connection with the diagnosis of chronic Lyme; and the June 2016 MRI of the neck that quickly led to successful cervical surgery. Tr. 287, 686, 727. The remaining MRIs in this submission do not appear in the administrative record; they include a 2004 lumbar MRI, the April 2013 lumbar MRI and the December 1, 2016, lumbar MRI (the new MRI).[11] ECF No. 16-2 at 6, 13, 26. On August 11, 2017, Plaintiff submitted a lengthy brief to the Appeals Council asking it to treat the Open MRI NE records, and particularly the new MRI, as "new and material" evidence pertinent to the relevant period that poses a reasonable probability that it would change the outcome because the new MRI's finding of arachnoiditis at L4-5 meets one of the diagnostic criteria in Listing 1.04 (Disorders of the spine). Tr. 259-76; see 20 C.F.R. § 404.970(b). This brief also argued that the Appeals Council should award benefits because the evidence establishes that Plaintiff's impairments meet or equal Listings 1.02, 14.09 and 12.04, as well as that his hand limitations preclude the jobs opined to by the VE.

The Appeals Council denied Plaintiff's request for review. Tr. 1. For most of Plaintiff's arguments, it simply found that the "reasons do not provide a basis for changing the Administrative Law Judge's decision." Id. As to the argument focused on the new MRI and other material from Open MRI NE, it ruled as follows:

> You submitted medical records from Open MRI of NE Warwick dated December 11, 2004 to December 1, 2016 (18 pages). We find this evidence does not show a reasonable probability that it would change the outcome of the decision. We did not consider and exhibit this evidence.

Tr. 2. None of the Open MRI NE submission to the Appeals Council became part of the administrative record.

[11] There is also a 2010 shoulder MRI that is not in issue. ECF No. 16-2 at 15.

II. Standard of Review

The Commissioner's findings of fact are conclusive if supported by substantial evidence. 42 U.S.C. § 405(g). Substantial evidence is more than a scintilla – that is, the evidence must do more than merely create a suspicion of the existence of a fact, and must include such relevant evidence as a reasonable person would accept as adequate to support the conclusion. Ortiz v. Sec'y of Health & Human Servs., 955 F.2d 765, 769 (1st Cir. 1991) (per curiam); Rodriguez v. Sec'y of Health & Human Servs., 647 F.2d 218, 222 (1st Cir. 1981); Brown v. Apfel, 71 F. Supp. 2d 28, 30 (D.R.I. 1999). Once the Court concludes that the decision is supported by substantial evidence, the Commissioner must be affirmed, even if the Court would have reached a contrary result as finder of fact. Rodriguez Pagan v. Sec'y of Health & Human Servs., 819 F.2d 1, 3 (1st Cir. 1987); see also Barnes v. Sullivan, 932 F.2d 1356, 1358 (11th Cir. 1991); Lizotte v. Sec'y of Health & Human Servs., 654 F.2d 127, 128 (1st Cir. 1981).

The determination of substantiality is based upon an evaluation of the record as a whole. Brown, 71 F. Supp. 2d at 30; see also Frustaglia v. Sec'y of Health & Human Servs., 829 F.2d 192, 195 (1st Cir. 1987); Parker v. Bowen, 793 F.2d 1177, 1180 (11th Cir. 1986) (court also must consider evidence detracting from evidence on which Commissioner relied). Thus, the Court's role in reviewing the Commissioner's decision is limited. Brown, 71 F. Supp. 2d at 30. The Court does not reinterpret the evidence or otherwise substitute its own judgment for that of the Commissioner. Id. at 30-31 (citing Colon v. Sec'y of Health & Human Servs., 877 F.2d 148, 153 (1st Cir. 1989)). "[T]he resolution of conflicts in the evidence is for the Commissioner, not the courts." Id. at 31 (citing Richardson v. Perales, 402 U.S. 389, 399 (1971)). On the other hand, if correcting a legal error clarifies the record so that an award or denial of benefits is the clear outcome, the Court may so order. Seavey, 276 F.3d at 11-12.

The court may remand a case to the Commissioner for a rehearing under sentence four of 42 U.S.C. § 405(g); under sentence six of 42 U.S.C. § 405(g); or under both sentences. Seavey, 276 F.3d at 8. To remand under sentence four, the court must either find that the Commissioner's decision is not supported by substantial evidence, or that the Commissioner incorrectly applied the law relevant to the disability claim. Id. at 9. After a sentence four remand, the court enters a final and appealable judgment immediately, and thus loses jurisdiction. Freeman v. Barnhart, 274 F.3d 606, 610 (1st Cir. 2001).

In contrast, sentence six of 42 U.S.C. § 405(g) provides:

> The court . . . may at any time order additional evidence to be taken before the Commissioner of Social Security, but only upon a showing that there is new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding.

42 U.S.C. § 405(g). To remand under sentence six, the claimant must establish: (1) that there is new, non-cumulative evidence; (2) that the evidence is material, relevant and probative so that there is a reasonable possibility that it would change the administrative result; and (3) there is good cause for failure to submit the evidence at the administrative level. See Jackson v. Chater, 99 F.3d 1086, 1090-92 (11th Cir. 1996); Maldonado v. Berryhill, C.A. No. 16-659 WES, 2018 WL 406420, at *3 (D.R.I. Jan. 12, 2018). With a sentence six remand, the parties must return to the court after remand to file modified findings of fact. Maldonado, 2018 WL 406420, at *3. The court retains jurisdiction pending remand and does not enter a final judgment until after the completion of remand proceedings. Id.; Courtemanche v. Astrue, No. CA 10-427M, 2011 WL 3438858, at *2-3 (D.R.I. July 14, 2011), adopted, 2011 WL 3421557 (D.R.I. Aug. 4, 2011).

III. Disability Determination

The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in

death or which has lasted or can be expected to last for a continuous period of not less than twelve months. 42 U.S.C. § 416(I); 20 C.F.R. § 404.1505. The impairment must be severe, making the claimant unable to do previous work, or any other substantial gainful activity which exists in the national economy. 42 U.S.C. § 423(d)(2); 20 C.F.R. §§ 404.1505-1511.

The ALJ must follow five steps in evaluating a claim of disability. See 20 C.F.R. § 404.1520. First, if a claimant is working at a substantial gainful activity, the claimant is not disabled. 20 C.F.R. § 404.1520(b). Second, if a claimant does not have any impairment or combination of impairments that significantly limit physical or mental ability to do basic work activities, then the claimant does not have a severe impairment and is not disabled. 20 C.F.R. § 404.1520(c). Third, if a claimant's impairments meet or equal an impairment listed in 20 C.F.R. Part 404, Appendix 1, the claimant is disabled. 20 C.F.R. § 404.1520(d). Fourth, if a claimant's impairments do not prevent doing past relevant work, the claimant is not disabled. 20 C.F.R. § 404.1520(e)-(f). Fifth, if a claimant's impairments (considering RFC, age, education and past work) prevent doing other work that exists in the local or national economy, a finding of disabled is warranted. 20 C.F.R. § 404.1520(g). Significantly, the claimant bears the burden of proof at Steps One through Four, but the Commissioner bears the burden at Step Five. Wells v. Barnhart, 267 F. Supp. 2d 138, 144 (D. Mass. 2003) (five step process applies to both DIB and SSI claims).

IV. Analysis

A. Alleged Errors by the ALJ

Seeking remand pursuant to sentence four of 42 U.S.C. § 405(g), Plaintiff argues that, at Step Three, the ALJ acted without the support of substantial evidence when he erroneously failed

to conclude that the right knee impairment met the requirements of Listings 1.02A[12] and 14.09A,[13] and that the mental impairment of depression met Listing 12.04A1.[14] Plaintiff also contends that the ALJ erred in not including hand limitations in his RFC. Each of these arguments founders because the ALJ's findings are based on substantial evidence that was carefully and appropriately evaluated by the ALJ, who examined each Listing and considered all of the conflicting evidence regarding Plaintiff's hands. Brown, 71 F. Supp. 2d at 30-31.

---

[12] The Listing 1.02A criteria are:

> Major dysfunction of a joint(s) (due to any cause): Characterized by gross anatomical deformity (e.g., subluxation, contracture, bony or fibrous ankylosis, instability) and chronic joint pain and stiffness with signs of limitation of motion or other abnormal motion of the affected joint(s), and findings on appropriate medically acceptable imaging of joint space narrowing, bony destruction, or ankylosis of the affected joint(s). With:
>
> A. Involvement of one major peripheral weight-bearing joint (i.e., hip, knee, or ankle), resulting in inability to ambulate effectively, as defined in 1.00B2b;

20 C.F.R. § Pt. 404, Subpt. P, App. 1, § 1.02A.

[13] As relevant here, Listing 14.09A requires:

> Persistent inflammation or persistent deformity of:
>
> 1. One or more major peripheral weight-bearing joints resulting in the inability to ambulate effectively (as defined in 14.00C6) . . .

20 C.F.R. § Pt. 404, Subpt. P, App. 1, § 14.09A.

[14] The applicable version of Listing 12.04A1 provides:

> Depressive disorder, characterized by five or more of the following:
>
> a. Depressed mood; b. Diminished interest in almost all activities; c. Appetite disturbance with change in weight; d. Sleep disturbance; e. Observable psychomotor agitation or retardation; f. Decreased energy; g. Feelings of guilt or worthlessness; h. Difficulty concentrating or thinking; or i. Thoughts of death or suicide.

20 C.F.R. § Pt. 404, Subpt. P, App. 1, § 12.04A1. The Court notes that, in his decision, the ALJ correctly relied on the version of Listing 12.04 that became effective shortly before the decision, while the examining psychologists relied on the version of Listing 12.04 that was in effect at the time of their review, and Plaintiff's brief relies on the version that was in effect at the time of the administrative hearing. See ECF No. 16-1 at 6 n.6. The Court will review the Commissioner's final decision using the version applied by the ALJ, which is the version in effect "at the time [the Commissioner] issued the decisions." Dames v. Comm'r of Soc. Sec., 743 F. App'x 370, 372-73 (11th Cir. 2018). Neither the parties nor the Court have noted that the differences between the current and prior versions affect what is at issue in this case.

Plaintiff's claims of Step Three error must clear a high hurdle. "The Listing of Impairments ('the List') describes specific impairments of each of the major body systems 'which are considered severe enough to prevent a person from doing any gainful activity.'" Tackett v. Apfel, 180 F.3d 1094, 1099 (9th Cir. 1999) (citing 20 C.F.R. § 404.1525). The Listings' criteria are demanding and stringent, more restrictive than the statutory disability standard so that a claimant who does not qualify at Step Three may still be disabled. Sullivan v. Zebley, 493 U.S. 521, 521 (1990); Elam v. Barnhart, 386 F. Supp. 2d 746, 754-55 (E.D. Tex. 2005). It is the claimant's burden to identify findings that support all of the criteria for a Step Three impairment determination. McCuller v. Barnhart, 72 F. App'x 155, 158 (5th Cir. 2003); 20 C.F.R. § 404.1526(a). If the record shows that some of the required Listing criteria were sometimes present, but not all were simultaneously present for the required continuous twelve-month span, the Listing is not met or equaled. Everngam v. Astrue, Civil No. 08-cv-329-SM, 2009 WL 948654, at *4 (D.N.H. Apr. 6, 2009). Intermittent clinical signs will not suffice. 20 C.F.R. § 404.1526(a); see Biestek v. Comm'r of Soc. Sec., 880 F.3d 778, 784 (6th Cir. 2017) ("medical equivalency is not a refuge for claimants who show only intermittent signs of impairment"), cert. granted on other grounds, 138 S. Ct. 2677 (2018).

Plaintiff's claim that his right knee met or equaled all of the criteria for Listing 1.02A for a simultaneous twelve-month period rests principally on the 2015 x-rays and the many record references to the nodules and joint flares in Dr. Cooper's records, as well as on the Hammond report. He asks the Court to interpret this evidence as establishing "gross anatomical deformity," "chronic joint pain," and "imaging of joint space narrowing," all of which are mentioned in Listing 1.02A as some of the criteria. There are several problems with this argument.

First, Plaintiff ignores that his burden is to demonstrate the existence of every element of Listing 1.02A, starting with the "inability to ambulate effectively," which is defined in 20 C.F.R. Part 404,Subpt P, App'x, § 1.02, as the inability to walk, except with an assistive device such as a walker or a pair of canes. Arrington v. Colvin, 216 F. Supp. 3d 217, 234 (D. Mass. 2016) (despite evidence of antalgic gait, Listing 1.02A cannot be met without evidence that claimant needed assistive device to walk); Sawyer v. Colvin, No. 1:12-cv-231, 2013 WL 1760534, at *3 (D. Me. Mar. 30, 2013) (Listing 1.02A cannot be met absent evidence of prescription for, or consistent use of, assistive device to aid in walking). There is no evidence that Plaintiff ever was prescribed or used an assistive device for walking; further, as both the SSA physicians and the ALJ noted, Plaintiff's daily activities, such as going to stores and to church, undermine Plaintiff's argument that he suffered from the inability to walk effectively. More fundamentally, no treating source ever opined, observed or found that Plaintiff suffers from the "inability to ambulate effectively"; to the contrary, the treating source findings reflect occasional limits on the ability to ambulate, such as the finding of unassisted antalgic gait by Dr. Cooper, as well as the observation of relatively intact ability to ambulate by Dr. Goldhaber. Tr. 412, 601. Even Dr. Sparadeo, though a non-treating source, observed that Plaintiff's gait and posture were normal. Tr. 631. As the ALJ's Step Three finding reflects, this simply does not equate to the inability to walk effectively at all. At bottom, the SSA experts reviewed these and other record references to Plaintiff's gait and ability to ambulate and found that Plaintiff could "stand and/or walk" for a total of four hours over the course of a work day. Tr. 87-88, 102-03. This leaves the ALJ's rejection of a Listing based on the "inability to ambulate effectively" with a solid foundation in the substantial evidence.[15]

[15] While not necessary to the Court's decision in light of the absence of evidence of the requisite inability to ambulate, it is worth noting that the x-rays on which Plaintiff relies as the foundation for this Listing argument were

The other big problem infecting this argument is the absence of error in the ALJ's determination not to afford controlling weight to the Hammond report, which is the only evidence of record consistent with right knee pain so severe as to affect the ability to walk or stand. Plaintiff's challenge to this aspect of the decision is grounded in the mistaken premise that Ms. Hammond is a treating source, so that her opinion should control and trump the other substantial evidence. See ECF No. 16-1 at 17 n.7. As the ALJ properly noted, the record is unambiguous that Plaintiff was referred to Ms. Hammond by Dr. Gloor "for court," Tr. 25, 649, not for treatment. See Taylor v. Astrue, 899 F. Supp. 2d 83, 88 (D. Mass. 2012) ("treating source" is one who provides patient with medical treatment or evaluation in the course of an ongoing relationship). Consistent with the limited nature of the referral, Plaintiff had just one encounter with Ms. Hammond.[16] Simmons v. Colvin, Civil Action No. 12-145J, 2013 WL 5464614, at *5 (W.D. Pa. Sept. 30, 2013) (no error in discounting opinion based on just one encounter with plaintiff). In any event, as a physical therapist, Ms. Hammond cannot provide a medical opinion entitled to controlling weight. 20 C.F.R. § 404.1513; SSR 06-03p, 2006 WL 2263437, at *2 (Aug. 9, 2006). Further, while not necessary for an examining non-acceptable medical source, the ALJ gave reasons, correctly finding that the Hammond's conclusions were largely based on Plaintiff's extreme subjective report (for example, that he passed out and could not stand at all), as well as they differ significantly from treating source observations, for example, by Dr. Goldhaber (e.g., "Gait: Narrow based, arm swing"; "Tandem Walking: Intact"), Dr. Cooper (e.g., "unassisted antalgic gait"), and Dr. Chaudhary (e.g., "[e]xam is relatively

labelled as "unremarkable," reflective of mild arthritis, by the treating physician (Dr. Chaudhary) who interpreted them. Tr. 636.

[16] Importantly, when Plaintiff was referred to Tru-Care Physical Therapy for treatment, he saw a different physical therapist, not Ms. Hammond.

normal"). See Tr. 412, 601, 720. Indeed, the other non-treating source (Dr. Sparadeo) who saw Plaintiff less than a month after his encounter with Ms. Hammond recorded "normal posture and gait" as descriptive of Plaintiff's ability to ambulate. Tr. 631. I find no error in the ALJ's treatment of the Hammond report.

Plaintiff's alternative Listing argument – that his symptoms met Listing 14.09A based on inflammation or deformity in a weight bearing joint – is focused on the same knee and rests on the same evidence. In this iteration, he argues that his knee is so inflamed by gout and chronic Lyme as to result "in the inability to ambulate effectively." ECF No. 16-1 at 17-18. This argument is unavailing for the same reason – the complete lack of treating-source evidence to support the essential finding that Plaintiff lacked the ability to walk effectively.

Turning next to Plaintiff's mental health Listing argument, I also find no error in the ALJ's rejection of Listing 12.04A1[17] at Step Three. The ALJ's determination is appropriately based on Plaintiff's statements regarding his daily activities, Dr. Cerbo's consultative report, confirmed by similar test results in the Sparadeo report, Dr. Goldhaber's normal mental status examinations, and the psychiatric review done by the SSA psychologists, who examined the record, including the notes of Dr. Rashid, the psychiatrist who found Plaintiff to be clinically stable. Consistent with this evidence, the ALJ found moderate limitations in understanding and attention and concentration based on Plaintiff's documented memory deficits. Tr. 16. Dr. Gloor's post-SSA notation confirms the latter finding – he consistently opined, "ADD stable." Tr. 647, 763.

[17] In evaluating Plaintiff's mental impairments, the ALJ considered and rejected Listings 12.02, 12.04 and 12.06. Tr. 15. Plaintiff challenges only the finding as to Listing 12.04A1, which focuses on depressive disorder.

Nor is there error in the ALJ's determination to afford little weight to the only contrary evidence, Dr. Sparadeo's[18] conclusory finding that Plaintiff "is unable to work at any level due to the presence of impaired attention/concentration, depression, chronic pain and anxiety."[19] Tr. 712. The ALJ correctly noted that the Sparadeo cognitive testing resulted in the essentially same deficits of memory and attention as found by Dr. Cerbo; he relied on both Dr. Cerbo's and Dr. Sparadeo's test results at Step Three and in formulating his RFC. Further, Dr. Sparadeo's pre-testing mental status examination performed during the diagnostic interview resulted in the finding that "affect was full and mood stable," which is inconsistent with the conclusion in his report regarding debilitating depression. Tr. 631. At bottom, there is no error in the ALJ's well-supported decision to afford little weight to the Sparadeo conclusion of depression, anxiety and attention deficit so severe as to be disabling because such findings are inconsistent with Dr. Sparadeo's own testing and initial mental status findings and are starkly contrary to the objective findings of every treating source, including the treating psychiatrist.

Plaintiff's last challenge to the ALJ's decision is focused not on Step Three but on the RFC – he argues that the ALJ failed to account for the evidence of limitations in his ability to use his dominant hand. This argument may be given short shrift. The ALJ carefully marshaled and considered the medical evidence regarding Plaintiff's hand. More importantly, so did the SSA experts, who reviewed various references to tests, observations and subjective complaints

[18] As with Ms. Hammond, Plaintiff mistakenly argues that the ALJ erred in not affording the Sparadeo report the controlling weight that is due to a treating source opinion. ECF No. 16-1 at 19. Like Ms. Hammond, Dr. Sparadeo was not a treating source in that he did not have an ongoing relationship with Plaintiff. His note from his first encounter is pellucid: "Referral Reason: Trying to be eligible for SSDI – Suffers from Lyme Disease [and] PTSD." Tr. 631. While the testing took several sessions, so that there was more than one encounter, Dr. Sparadeo did not form an ongoing relationship with Plaintiff; the ALJ correctly analyzed his report as that of an "examining psychologist." Tr. 25.

[19] This finding in the Sparadeo report is the only evidence supporting Plaintiff's contention that the ALJ erred in not determining that the criteria of Listing 12.04A were met.

regarding the hand and found no need to add RFC limitations based on them. The ALJ properly relied on their assessments of what is extremely complex medical evidence in developing this aspect of the RFC.

The only opinion supporting the inability to use the dominant hand is the flawed Hammond report. See Brewer v. Comm'r of Soc. Sec., Case No. 2:17-cv-250, 2017 WL 6806685, at *17 (N.D. Ohio Dec. 19, 2017). As with her other findings, Ms. Hammond's conclusion that Plaintiff lacks strength in the right hand is inconsistent with the treating source findings of normal strength and only mild osteoarthritis in the hand. E.g., Tr. 306 ("5/5 for all groups tested"); see Tr. 84 ("Clinical f/u of carpal tunnel syndrome as this is not severe electrically. . . . Hand x-ray indicated mild base of thumb osteoarthritis."). Similarly, Ms. Hammond's opinion that the dominant hand is unusable for manipulation is inconsistent with the evidence establishing Plaintiff's ability to play the guitar. See Tr. 58, 65 ("I'll play my guitar for ten minutes at a time"); Tr. 210, 215 (current activities include playing guitar). There is no error in the ALJ's decision to afford little weight to Ms. Hammond's opinion that Plaintiff was unable to use the dominant hand.

With a record filled with conflicting evidence regarding the severity and intensity of Plaintiff's hand issues, including clinical findings that supply more than adequate support for the ALJ's decision not to include hand limitations in the RFC, I do not recommend that the Court award benefits pursuant to Seavey, 276 F.3d at 11-12 (award of benefits precluded if conflicting evidence). Nor do I recommend remand for a do-over.

Based on the foregoing, I find that all of the ALJ's challenged findings are adequately grounded in substantial evidence and do not recommend either an award of benefits or remand based on sentence four.

B. Alleged Error by the Appeals Council

Relying on 42 U.S.C. § 405(g), Plaintiff claims that the Appeals Council committed an error of law in declining to consider the new evidence from Open MRI NE, in refusing to review the case and in failing to award benefits based on the new MRI, which he contends is new and material, as well as that "good cause" was shown to justify the failure to submit it to the ALJ. See Mills v. Apfel, 244 F.3d 1, 5 (1st Cir. 2001) (court may review whether Appeals Council's reason for refusing to consider new evidence was mistaken). Based on this error, he asks the Court to order a sentence six remand. See 42 U.S.C. § 405(g). Further, he contends that appropriate consideration of the new MRI, in the context of this record, leads overwhelmingly to the conclusion that all of the criteria of Listing 1.04B[20] are met or equaled; therefore, he asks that the Court's remand be for an award of benefits. See Seavey, 276 F.3d at 11-12.

In this Circuit, Plaintiff's challenge to the Appeals Council's decision faces the high bar set by Mills, which holds that the Appeals Council's decisions should be afforded "a great deal of latitude" and "great deference" so that only a serious mistake or egregious error should result in remand. 244 F.3d at 5-7 (despite slight overstatement of reason for declining review, no remand where "the Appeals Council's action is entirely reasonable, even if its language was not perfectly apt"); Cookson v. Colvin, 111 F. Supp. 3d 142, 149 (D.R.I. 2015) (court may consider new evidence to determine whether Appeals Council's reason for refusing review was

[20] The pertinent Listing criteria may be briefly stated. They are:

> Disorders of the spine . . . , resulting in compromise of a nerve root (including the cauda equina) or the spinal cord. With: . . .
>
> B. Spinal arachnoiditis, confirmed by an operative note or pathology report of tissue biopsy, or by appropriate medically acceptable imaging, manifested by severe burning or painful dysesthesia, resulting in the need for changes in position or posture more than once every 2 hours.

20 C.F.R. § Pt. 404, Subpt. P, App. 1, § 1.04B.

"egregiously mistaken," but must be mindful that denial of review is entitled to "great deference"). As the First Circuit has instructed, "Congress plainly intended that [sentence six] remands for good cause should be few and far between, that a yo-yo effect be avoided – to the end that the process not bog down and unduly impede the timely resolution of social security appeals." Evangelista v. Sec'y of Health & Human Servs., 826 F.2d 136, 141 (1st Cir. 1987).

To explore the viability of Plaintiff's argument, the Court must be guided by the revised version of the regulation governing the Appeals Council's decision regarding whether to review cases denying disability insurance – 20 C.F.R. § 404.970. Effective as of May 1, 2017, 81 FR 90987, the amended rule is the standard applicable to the action of the Appeals Council, which issued its notice of denial on November 15, 2017. Tr. 1. As relevant here, the revised regulation requires the Appeals Council to review a case if it receives "additional evidence that is new, material, and relates to the period on or before the date of the hearing decision, and there is a reasonable probability that the additional evidence would change the outcome of the decision." 20 C.F.R. § 404.970(a)(5); see Medina v. Berryhill, No. 17-cv-1149 SMV, 2018 WL 4466024, at *3 (D.N.M. September 18, 2018). Further, such new evidence will be considered only if the claimant "show[s] good cause for not informing us about or submitting the evidence" to the ALJ because of an unavoidable circumstance beyond the claimant's control, including "[y]ou actively and diligently sought evidence from a source and the evidence was not received or was received less than 5 business days prior to the hearing." 20 C.F.R. § 404.970(b)(3)(iv).

In this case, the Appeals Council did not discuss whether it found Plaintiff's evidence to be "new," "material" or "relat[ing] to the period on or before the date of the hearing decision," 20 C.F.R. § 404.970(a)(5), or whether it found the "good cause" standard to be satisfied, 20

C.F.R. § 404.970(b).[21] Instead, its reason for declining to review the case or to "consider and exhibit" the evidence is its conclusion that the Open MRI NE material "does not show a reasonable probability that it would change the outcome of the decision." Tr. 2; see 20 C.F.R. § 404.970(a)(5).

Plaintiff's challenge to this determination is twofold. First, he contends that the Appeals Council's stated reason makes no sense because the determination regarding a "reasonable probability" clashes with the refusal even to "consider" the new material. Second, he contends that the determination that there is not a reasonable probability that the new material would change the outcome is error because the finding of "arachnoiditis" on an MRI performed during the relevant period supplies the element missing from what otherwise is proof that his symptoms met the criteria of Listing 1.04B. In support of the latter argument, he marshals the following specific evidence that he contends establishes each element:

- "Spinal arachnoiditis" resulting "in compromise of a nerve root" is evidenced by the new MRI taken on December 1, 2016, depicting

[21] Plaintiff invests considerable energy arguing why there was "good cause" for his failure to submit the Open MRI NE evidence to the ALJ. Because the Appeals Council's decision rested only on the "reasonable probability" prong, that is the focus of this report and recommendation. Moore v. Astrue, Civil Action No. 11-cv-11936, 2013 WL 812486, at *14 n.5 (D. Mass. Mar. 2, 2013) (once court concludes that claimant failed to show reasonable probability that new evidence would change outcome, no need to reach "good cause"). Nevertheless, should the District Court decline to adopt my finding that the latter decision was reasonable and not egregiously mistaken, I alternatively recommend that the challenge to the Appeals Council's decision fails based on the inadequacy of Plaintiff's proffer to support a finding of "good cause." This recommendation is based on his unexplained failure to advise the ALJ at the hearing that a new MRI had just been done and on his unexplained failure to submit the Open MRI NE records until six months after they came into the possession of his attorney; as a result, the ALJ issued his decision, totally unaware of the possible existence of new evidence. See, e.g., Stepp v. Colvin, 795 F.3d 711, 725 (7th Cir. 2015) (good cause established for failure to submit new medical evidence to ALJ during time gap before decision issued based on proof that new evidence was not obtained by claimant until after hearing and there was only "relatively minor delay" of four weeks between counsel's receipt and submission to agency); Courtemanche, 2011 WL 3438858, at *13-14 (no good cause where unexplained two-month delay in submission of recent treating records); cf. Lisi v. Apfel, 111 F. Supp. 2d 103, 109 (D.R.I. 2000) (in light of unexplained failure to make timely submission of record located in physician's file but overlooked by prior counsel, good cause not shown). Thus, while there is clearly good cause for Plaintiff's failure to submit the new MRI before the hearing since it became available "less than 5 business days prior to the hearing," 20 C.F.R. § 404.970(b)(3)(iv), in light of the unexplained failure to advise the ALJ that the new MRI had just been done and of the protracted and unexplained delay that followed receipt of the new MRI, I find that Plaintiff has failed to demonstrate that a "circumstance beyond [his] control prevented [him] from informing [the ALJ] about or submitting the evidence earlier." 20 C.F.R. § 404.970(b)(3).

> "[c]lumping of the nerve roots [that] is consistent with arachnoiditis and similar to prior study." ECF No. 16-2 at 7, 27.

- "[S]evere burning" is evidenced by the notes of the nurse practitioner at the Warwick Pain Clinic at the appointment on November 4, 2016, shortly before the ALJ hearing. Tr. 852.

- "[P]ainful dysesthesia" is evidenced by Plaintiff's hearing testimony about episodes of pain he experienced "every couple of months" during which even a sheet or "an errant breeze" will hurt. Tr. 67-68.

- "[T]he need for changes in position or posture more than once every 2 hours" is evidenced by (1) the Hammond report's finding that Plaintiff's "tolerances for sitting, standing, walking, driving are all less than 1 hour before position changes are requires [sic]," Tr. 590; and (2) by Plaintiff's hearing testimony that, "I have to keep moving." Tr. 61.

Based on this analysis, Plaintiff contends that the new MRI clearly warrants remand pursuant to sentence six for an award of benefits or for further consideration.

Plaintiff's first argument – that the Appeals Council's explanation makes no sense – is unavailing in light of Mills. 244 F.3d at 5-7. In an analogous case decided under the revised regulation, the court faced the precise same challenge to an identical articulation by the Appeals Council of its reason:

> We find this evidence does not show a reasonable probability that it would change the outcome of the decision. We did not consider and exhibit this evidence.

Steven D. A. v. Comm'r of Soc. Sec., Case No. 17-cv-819-CJP, 2018 WL 3438856, at *7 (S.D. Ill. July 17, 2018). In response to the argument that the second sentence contradicts the first in that it means that the Appeals Council (improperly) did not look at the new evidence at all, the court held that these sentences are more properly interpreted as meaning that the Appeals Council did look at the new evidence to make its determination that it did not show a reasonable probability, and that the second sentence, while "admittedly not as clear as it could be[,] . . . read in context, . . . most plausibly means that the Appeals Council did not consider the additional

evidence as part of a plenary review because it denied review." Id. (emphasis supplied). This holding is consistent with the First Circuit's guidance in Mills, which makes clear that, in this Circuit, the Appeals Council's action should not be overturned simply because "its language was not perfectly apt." 244 F.3d at 7.[22]

Plaintiff's second argument aims directly at the heart of the case – whether there is a reasonable probability that the new MRI's depiction of arachnoiditis would have changed the outcome. To address the argument, it is appropriate for the Court to review the proffered new evidence together with the administrative record and to determine whether Plaintiff has sustained his burden of showing that the Appeals Council made an "egregious error." Moore, 2013 WL 812486, at *15; see Woods v. Berryhill, Civil Action No. 1:17-00452-N, 2018 WL 4934095, at *5-6 & n.9 (S.D. Ala. Oct. 11, 2018) (because it is impractical for Appeals Council to provide detailed explanation for refusal to consider new evidence, court will review whether refusal is error based on medical evidence in light of arguments of parties); Steven D. A., 2018 WL 3438856, at *7-8 (to review Appeals Council's refusal to consider new evidence based on no reasonable probability of impact on outcome, court examines evidence in context of record guided by arguments of parties).

In this case, the new MRI is certainly "new" and "relates to the period on or before the hearing decision," 20 C.F.R. § 404.970(a)(5), in that, on December 1, 2016, when it was performed, Plaintiff had a lumbar spinal condition interpreted as "[c]lumping . . . consistent with

[22] A review of cases applying the revised regulation reveals that the Appeals Council has used this unfortunately confusing language in cases all over the country, at least once resulting in remand not on the merits but based on the Commissioner's poor word choice. See, e.g., West v. Berryhill, Case No. 18-cv-00091-DKW-RT, 2019 WL 362259, at *5 (D. Haw. Jan. 29, 2019) (when Appeals Council's language leaves court speculating over whether new evidence was "looked at" or "considered," remand required; "Acting Commissioner is . . . aware of terms of art in its own regulations"); Thor S. v. Berryhill, Case No. 18-cv-538-NEB-KMM, 2018 WL 7141873, at *6 (Dec. 13, 2018) (despite Appeals Council's "unclear" language, remand denied); Buckle v. Berryhill, No. 4:17-CV-3129, 2018 WL 6172491, at *3 (S.D. Tex. Nov. 26, 2018) (although Appeals Council's denial of review was "not clearly worded," this deficit is not basis for reversal).

arachnoiditis and similar to prior study," which otherwise did not appear in any record in the period in issue. ECF No. 16-2 at 7, 27. Further, with the ALJ's specific mention at Step Three of the lack of an MRI showing arachnoiditis during the relevant period, Tr. 14, it is not a stretch to find the new MRI to be potentially "material." The issue, therefore, as the Appeals Council found, is whether adding the new MRI to this record gives rise to a reasonable probability that the ALJ would have found that Plaintiff's lumbar spinal impairment met the criteria of Listing 1.04B and awarded benefits. In considering this issue, the Court must be mindful that an award of disability benefits cannot be based on a clinical finding in isolation. Rather, the Act provides that disability may be found only when such a clinical finding results in the diagnosis of an impairment[23] that is found to cause severe symptoms that impact the individual's ability to function for at least twelve months. When the new MRI is examined together with the balance of the administrative record, it is clear that Plaintiff's challenge to the Appeals Council's determination stumbles on the complete absence of such symptoms, not only the dearth of evidence of symptoms establishing the other elements of Listing 1.04B or symptoms adversely impacting the ability to function, but – more profoundly – the absence of any symptoms at all potentially related to arachnoiditis or the lumbar spine, until Plaintiff complained of lumbar spinal pain a month before the hearing.

The search for evidence of symptoms linked to arachnoiditis must begin with the August 2013 MRI, when Plaintiff was found to have "mild arachnoiditis" at L4-5. Tr. 686. This finding appears in the MRI that was ordered by the physician treating the lumbar spine in 2013, Dr. Brennan. Yet, Dr. Brennan's notes reflect no concern about this finding of arachnoiditis.

[23] It bears noting that the new MRI is not a diagnosis of arachnoiditis; it is simply a finding of a "[c]lumping . . . consistent with arachnoiditis." Listing 1.04B must be based on the diagnosis. An MRI is mentioned in the Listing as an acceptable way to confirm the diagnosis.

Rather, the 2013 record reflects a complete absence of symptoms in that, after surgery on a different part of the lumbar spine and despite this "mild arachnoiditis," the record establishes that Plaintiff made a good recovery and was able to return to work. Further, after the successful lumbar surgery on August 13, 2013, until November 4, 2016, when the nurse practitioner observed pain potentially linked to the lumbar spine, this record yields up no evidence of any symptoms linked to the lumbar spine. No treating source ordered any new lumbar imaging study or prescribed any treatment related to lumbar spinal difficulties; no treating source recorded any complaints of lumbar spinal pain or of pain potentially linked to the lumbar spine. And notwithstanding Plaintiff's argument, there is no evidence linking the lumbar spine or the pre-existing diagnosis of "mild arachnoiditis" to the symptoms that Plaintiff contends constitute evidence of the Listing criteria of "severe burning or painful dysesthesia" and the need to change position. To the contrary, the testimony that Plaintiff now points to as evidence of "dysesthesia" – his description of pain caused by an "errant breeze" – was expressly related to periodic flares every few months, consistent with the diagnosis of gout. Tr. 67-68. Similarly, Plaintiff's testimony about the need to change position was also expressly linked to these flares, which he ascribed to both gout and Lyme. Tr. 54-55. Even the reference in the report of Ms. Hammond (the non-treating physical therapist) to the need for positional changes was based on Plaintiff's subjective description of joint pain, which he told her was caused by "chronic lyme disease."[24] Tr. 588.

As the Commissioner contends, and the Court's review confirms, the first (and only) medical notation potentially linking any symptom to the lumbar spine appears in the notes from

[24] Further, as the Commissioner correctly points out, neither Plaintiff's subjective statements nor the appropriately discounted Hammond report amounts to a competent medical finding.

the nurse practitioner's examination on November 4, 2016, shortly before the ALJ hearing and less than six months before the ALJ's decision. Tr. 852-56. Significantly, this record, which notes that the "pain may be radicular pain from lumbar spine," Tr. 855, contains no suggestion that the other Listing criterion – the need frequently to change position – was coexisting with this symptom of pain.

Based on the foregoing, it is clear that the arachnoiditis finding in the new MRI is not evidence that gives rise to the reasonable probability that it would change the outcome of this case; therefore, a sentence six remand pursuant to 42 U.S.C. § 405(g) is not appropriate because of the utter dearth of evidence that this clinical finding reflects an impairment that resulted in any symptoms that materially impacted Plaintiff's ability to function during the period in issue. Evangelista, 826 F. 2d at 140 (to demonstrate "materiality" for a sentence six remand, claimant must show earlier decision "might reasonably have been different" had evidence been considered). For the period until November 2016, there is no reasonable probability that the new MRI would change the outcome, not only because there is no medical evidence linking arachnoiditis to the Listing criteria of "severe burning or painful dysesthesia" and to the need for changes in position or to any functional limitations, but also, more importantly, because there is no evidence linking arachnoiditis or the lumbar spine to any symptoms at all. And if, despite the finding that it was similar to the "mild arachnoiditis" seen in 2013, the 2016 finding of arachnoiditis ultimately is linked to a more serious manifestation based on the symptom of burning pain that began in November 2016, there is no reasonable probability that the new evidence would change the outcome because the essential twelve-month durational requirement cannot be satisfied.[25] Beugli v. Colvin, No. 6:12-CV-01327-JO, 2013 WL 5671322, at *6-7 (D.

[25] The Court observes that Plaintiff's spinal impairments have consistently responded so well to surgery that they have not impaired function for twelve months. For example, during the period in issue, Plaintiff reported cervical

Or. Oct 1, 2013) (post-decision evidence permitting inference of new impairments in early onset by time of decision properly rejected based on durational requirement); Everngam, 2009 WL 948654, at *4 (intermittent clinical signs will not suffice).

At bottom, Plaintiff has failed to show that the Appeals Council committed an egregious error or made a serious mistake in determining that it was not reasonably probable that the new MRI would change the outcome of this case. The record, as amplified by the new MRI, still has no medical opinion, diagnosis, or other clinical finding by any medical professional competent to interpret the new MRI in the context of this record that Plaintiff's arachnoiditis met or equaled the demanding and stringent criteria of Listing 1.04B at any time during the relevant period. See Sullivan, 493 U.S. at 531 (claimant must present medical findings equal in severity to all criteria for listed impairment). Nor, in light of the dearth of evidence of any lumbar spinal symptoms persisting for a sufficient durational period, does it amount to evidence of functional limitations that would reasonably have changed the outcome of the case. Medina, 2018 WL 4466024, at *3. For these reasons and based on the foregoing analysis, I do not recommend a sentence six remand either for an award of benefits or for further consideration. Rather, mindful of the deference due to the Appeals Council's determinations, I find that the Commissioner's decision rests on the "entirely reasonable" determination of the Appeals Council that the new evidence does not show a reasonable probability that it would change the outcome of the decision. See Mills, 244 F.3d at 7. I recommend that it be affirmed.

---

pain in May 2015 and had successful surgery to correct the problem in September 2015, a period of less than six months. Similarly, the 2013 records reflect that Plaintiff injured his back in early 2013 and was in successful recovery from surgery and back to work by the end of 2013, a period of well less than twelve months. Thus, it would be entirely speculative to posit that the as-yet-undiagnosed lumbar spinal condition first observed in November 2016 would not resolve in less than twelve months.

V. Conclusion

Based on the foregoing analysis, I recommend that Plaintiff's Motion for Judgment Reversing and/or Remanding the Decision of the Acting Commissioner (ECF No. 16) be DENIED and Defendant's Motion for an Order Affirming the Decision of the Commissioner (ECF No. 18) be GRANTED.

Any objection to this report and recommendation must be specific and must be served and filed with the Clerk of the Court within fourteen (14) days after its service on the objecting party. See Fed. R. Civ. P. 72(b)(2); DRI LR Cv 72(d). Failure to file specific objections in a timely manner constitutes waiver of the right to review by the district judge and the right to appeal the Court's decision. See United States v. Lugo Guerrero, 524 F.3d 5, 14 (1st Cir. 2008); Park Motor Mart, Inc. v. Ford Motor Co., 616 F.2d 603, 605 (1st Cir. 1980).

/s/ Patricia A. Sullivan
PATRICIA A. SULLIVAN
United States Magistrate Judge
February 13, 2019