IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION

MARY B. HUGGINS, Plaintiff, vs. JO ANNE B. BARNHART, Commissioner of Social Security, Defendant.	)	No. 02-2611 MlV

REPORT AND RECOMMENDATION

The plaintiff, Mary B. Huggins, appeals from a decision of the Commissioner of Social Security ("Commissioner"), denying Huggins' application for disability, disability insurance, and supplemental security income under Titles II and XVI of the Social Security Act, 42 U.S.C. § 401 et seq. The appeal was referred to the United States Magistrate Judge for a report and recommendation pursuant to 28 U.S.C. § 636 (b)(1)(B) and (C). For the reasons given below, it is recommended that this case be remanded.

PROPOSED FINDINGS OF FACT

A. Procedural History

Huggins first applied for supplemental security income and medical insurance benefits on August 12, 1996, citing disability due to brain surgery, insulin-dependent diabetes, high blood

pressure, gall bladder surgery, colon cancer, ulcer surgery, hysterectomy, heart surgery, and irregular heartbeat. (R. at 115, 120.) Her claimed date of onset was June 29, 1996. (R. at 115.) Her Title XVI claim had a protective filing date of July 1, 1996. (R. at 9, 19.)[1] Both applications were denied initially and on reconsideration. Huggins filed a request for a hearing, which was duly held on July 2, 1997, before an Administrative Law Judge ("ALJ"). (R. at 32.) The ALJ issued an unfavorable decision on January 28, 1998. (R. at 78-85.) Huggins appealed to the Appeals Council, which vacated the ALJ's decision and remanded with instructions to hold a second hearing and to consider medical evidence submitted by Huggins after the first hearing. (R. at 106-07.)

A second hearing was held on September 21, 1999. (R. at 48.) On February 18, 2000, the ALJ again denied the claim. (R. at 25.) On June 19, 2002, the Appeals Council denied Huggins' request for review, leaving the ALJ's second decision as the final decision. (R. at 11-12.) The Appeals Council specifically noted that additional medical evidence submitted with the request for Appeals Council review did not warrant changing the ALJ's decision. (R. at

[1] The list of exhibits indicates that the form containing the protective filing date was not available for the record; however, the ALJ acknowledged this date in both written decisions.

11.) Huggins filed suit in federal district court on August 7, 2002, pursuant to 42 U.S.C. § 405(g), to review the Commissioner's final decision. Her suit alleged that the ALJ's findings from the second hearing were not based on substantial evidence and that the ALJ applied incorrect legal standards.

B. The Hearing before the ALJ

Huggins was born on August 10, 1941. At the time of the second hearing, Huggins was 58 years old. (R. at 50.) She has a high school equivalency GED, a certificate in nursing assistance, and a certification as a unit secretary.[2] (*Id.*) Her longest-held position was that of nursing technician at a hospital, a job she performed for twenty-five years, from 1965 to 1990. (R. at 124.) In this line of work, Huggins performed daily patient care including turning, feeding, and transporting patients. (R. at 52.) Her duties required standing and walking, as well as one- and two-person lifting of patients. (*Id.*)

Huggins also worked for about six years as a medical unit secretary. (R. at 51.) In this position, she recorded patient vital signs, transcribed orders from doctors' to patients' charts, and transcribed laboratory work orders to a computer. (*Id.*) She

[2] Although the hearing transcript identifies this position as "union secretary," the correct title according to the claimant's vocational history appears to be "unit clerk" or "unit secretary." (R. at 153.)

also lifted boxes of supplies weighing up to thirty pounds. (*Id.*)

Huggins' claimed date of disability onset is July 1, 1996. She was then working as a kidney dialysis technician, a job she had held for six and one half years. (R. at 124.) As a dialysis technician, she walked and stood up to ten hours per day; constantly reached and bent; lifted up to fifty pounds; and frequently lifted and carried up to twenty-five pounds. (R. at 51, 125.) She lifted patients out of beds or chairs and carried jugs of liquid, weighing thirty to forty pounds, for dialysis procedures. (R. at 51, 125.) In addition, she inserted needles into patients for dialysis treatment, charted patients' vital signs, and recorded treatment notes. (R. at 124.)

Huggins left this position because of an illness later diagnosed as bronchial asthma. (R. at 53.) She testified that, when she left her job, she was "sick and coughing, and throwing up, had lost quite a bit of weight . . . [and] couldn't work [because of] . . . coughing and wheezing." (*Id.*) She has not worked since. (R. at 50.)

Huggins briefly testified as to her daily activities. She was married at the time of the initial benefit application, but not at the time of the second hearing. (R. at 50, 115.) She resided with her grown daughter. Huggins testified that she could not read due to vision problems, (R. at 57, 63), and she occasionally walked

around the house but could not do things around the house that she used to, (R. at 59). She spent, on average, three hours daily in a reclining chair because lying prone exacerbated her cough. (R. at 55, 59.) She testified that her daughter did all the household cleaning because all cleaning products exacerbated her cough. (R. at 54.) Huggins did not testify to any difficulty washing or dressing herself. She had not driven since August of 1998, when she had an automobile accident that she attributed to her vision problems. (R. at 58.) She apparently did attend church. (*See* R. at 53.)

Huggins also testified about her medical problems and symptoms. As to her bronchial asthma, she reported using a medicated asthma inhaler twice daily every day, and on bad days treating at home with an asthma machine up to four times daily at fifteen minutes per session. (R. at 54-55.) She also managed her asthma by resting in a recliner chair during the day, (R. at 59), and by sleeping propped up on two pillows at night, (R. at 55). She stated that she was unable to sleep prone and that she would sometimes awaken in the night with severe coughing. (*Id.*) She testified to exacerbated coughing and high sensitivity to dust, odors, smoke, and perfume worn by others. (R. at 53.) She testified that all household cleaning products, including bleach, exacerbated her cough. (R. at 54.) Her coughing fits caused

extreme fatigue. (R. at 55.)

Huggins also testified to shortness of breath, which she related to both asthma and congestive heart failure. (R. at 55.) She testified that she was short of breath "most of the time," and that shortness of breath became worse when she was prone. (*Id.*) She took medication for her heart condition. (*Id.*)

Huggins next testified to fatigue and pain that she attributed in part to arthritic conditions that were undiagnosed at the time of the first hearing. (R. at 61.) During coughing spells, she reported, she had severe pain in the head and neck. (R. at 59.) She treated her symptoms with muscle relaxants. (*Id.*) Huggins testified that the could not stand a full hour without fatigue and could not sit more than two or three hours without stiffness in her hips and back. (R. at 58.)

Huggins testified to her insulin-dependent diabetes, which she controlled, with limited success, with oral medication and with insulin. (R. at 56.) She testified that despite treatment her blood sugar levels remained unstable. (*Id.*) She testified that low blood sugar caused her to get dizzy or black out in the evenings two to three times a week; or in the mornings when she woke with low blood sugar. (*Id.*) When her blood sugar was very low, she would consume some juice or candy to bring it back up. (*Id.*) She also took Prednisone but testified that her blood sugar

had proven difficult to regulate with medication. (R. at 57.)

Huggins testified to vision problems partially attributable to diabetes and partially attributable to cataracts. She had not testified to these conditions at the first hearing. (R. at 61.) Vision in her right eye had been declining for some time and was lost in late 1997. (R. at 57.) In 1998, Huggins underwent a right eye corneal transplant, (*id.*), but it did not correct her vision as well as doctors had hoped, (R. at 63). She had undergone two additional laser surgeries on the right eye without improvement. (R. at 62-63.) At the time of the second hearing, her right eye could not give clear vision without the assistance of her left eye. (R. at 57.) She characterized her left eye vision as "a little foggy" due to cataract, a condition that did not exist at the time of the first hearing. (*Id.*) She could identify people in a room, but not identify a person across a street. (R. at 63.) She indicated that objects "blended in" to each other, especially in bright light, although she could perceive motion. (*Id.*) She was not driving due to low vision. (R. at 58.) Her low vision also made her unable to read, although optical lens treatment for that condition was about to be attempted. (R. at 58, 63.) She testified she could not see well enough read computers and medical charts, or to insert needles into patients as she had done as a dialysis technician. (R. at 58.)

Finally, Huggins testified to stomach pain that she attributed to internal bleeding. She had been hospitalized for internal bleeding after the first ALJ hearing. (R. at 60.) She indicated that she still was passing blood but not as much blood as before the surgery. (*Id.*) She testified that her post-surgical status included pain and diarrhea, and that the only medical recommendation for those conditions was rest. (*Id.*) On bad days, her daughter stayed home with her. (R. at 59.)

In closing, Huggins acknowledged that she had taken the depression medication Zoloft in 1997, prescribed in response to interrupted sleep, but that she had discontinued it after 30 days and experienced no limitations from depression. (R. at 63-64.)

The ALJ also took hearing testimony from vocational expert Nancy Hughes. (R. at 64 et seq.) Hughes testified that Huggins' jobs in the last fifteen years - those of dialysis technician and unit clerk - were classified as "light, skilled" and "light, semi-skilled" jobs. (R. at 65.) The ALJ put to Hughes a hypothetical containing the following functional limitations: the ability to lift twenty pounds occasionally and ten pounds frequently; "no appreciable limitation" on standing, walking, or sitting; "no concentrated exposure to chemical fumes, odors, dust, humidity or poor ventilation"; and "basically . . . monocular vision only." (*Id.*)

Hughes's testimony in response to the hypothetical is not entirely clear. At first, when asked if a claimant with those limitations could return to any of Huggins' past jobs, Hughes responded, "No, sir . . ." (R. at 64.) Hughes specifically testified that, with those limitations, the position of dialysis technician would be excluded because it required visual depth perception. (R. at 65.) She then indicated, "Unit secretary would also – let me look at something, excuse me just a minute, I'm going to refer to it – as far as the unit secretary goes I believe that the monocular vision would not exclude that nor would the other limitations." (R. at 66.)

Hughes testified that Huggins could return to past relevant work as a unit clerk and also could work at two jobs that existed in significant numbers in the national economy: blood donor clerk or hospital admissions clerk. (*Id.*) She opined that Huggins had skills - knowledge of medical diagnoses codes, clerical skills, inputting data on a computer, and "putting together charts and that sort of thing," - that were transferable to the positions of hospital admissions clerk or blood bank clerk. (*Id.*)

In response to questioning from the claimant's counsel, Huggins indicated that knowledge of medical codes was "highly marketable," even in light of the Huggins' age and the fact that Huggins had last worked as a unit clerk about nine years ago. (R.

at 67.) She further testified that monocular vision would not limit the ability to perform "a sedentary clerical type job," and that the use of a computer screen for eight hours a day did not require depth perception. (R. at 68.) Finally, she acknowledged that a claimant who had to rest in a recliner chair for three hours in an eight hour period would not be able to work. (R. at 69.)

C. Longitudinal Medical History According to the Records

The medical records contain brief cardiology reports from Drs. Frank McGrew and W.L. Russo in the spring of 1991. The full longitudinal history commences two years later. Huggins treated with Lawrence Whitlock, M.D. at Peabody Health Care from December, 1993, to November, 1996; with Dr. Weiss at Internal Medicine and Cardiology from March to June of 1996; with Steven Gubin, M.D. at The Cardiology Group of Memphis on July 12, 1996; with Michael Wilons, M.D. at Memphis Lung Physicians in December, 1996, and again on July, 1997; and with Drs. Richard Dismukes, Michelle Scullock, Kunal Chaudhary, David Jennings, and Karen Hopper at Health First Medical Group from November, 1996 to October, 1997, and again from January, 1999, through May, 1999.

Huggins was admitted as an inpatient at Baptist Memorial Hospital in late 1998 for gastrointestinal bleeding. She also had two outpatient procedures: a colonoscopy at Baptist Memorial Hospital on June 3, 1998, and a mental health evaluation at

Southeast Mental Health Center in December of 2001.

No treating physicians assessed Huggins' functional capacities. She was assessed by three non-treating physicians. On October 24, 1996, examining physician Tommy Campbell, M.D. completed a physical evaluation for Tennessee Disability Determination Services. On October 29, 1996, non-treating, non-examining physician Dr. Moore completed a Residual Functional Capacity Assessment. On September 4, 1997, examining physician Samuel M. Tickle, M.D. completed a second physical evaluation for Tennessee Disability Determination Services. The record also contains a vocational assessment dated October 29, 1996.

There is evidence, without detailed records, that Huggins underwent a hysterectomy in 1973; a colon cancer resection and an ulcer surgery in 1975; a gallbladder resection in 1990; and a meningioma resection in 1994. (R. at 216.) Huggins' longitudinal medical history, as reflected in the record and for purposes of her claim, begins in March of 1991. On this date, an echocardiogram revealed "no significant defect" in the heart, (R. at 172), although slight abnormalities were found in the mitral, aortic, tricuspid, and pulmonic valves, along with a possible mitral valve prolapse, (R. at 173).

On December 13, 1993, Huggins reported to Dr. Whitlock at Peabody Health Care with cramplike headaches in the right temporal

area. She denied blurred vision, dizziness, or syncope (fainting). (R. at 189.) Examination revealed normal heart rhythms and clear lungs. (*Id.*) Dr. Whitlock opined that the headache was secondary to hypertension and prescribed Lozol. (*Id.*)

Later that month, Huggins still had headaches. (*Id.*) Her blood sugar was "okay" at 120. (*Id.*) A CT scan of the head revealed an "abnormal . . . thickening of the skull," and on January 12, 1994, an MRI of the head identified a "small enhancing lesion" that was "thought to most likely represent a small meningiome." (R. at 196.)[3] A consultation with Dr. Whitlock revealed blood sugar of 140. (R. at 188.) Approximately ten weeks later, on March 23, 1994, Huggins presented increased blood pressure and continuing headaches. (*Id.*) Her blood sugar was 266. (*Id.*) Dr. Whitlock prescribed the blood pressure medication Adalat. (*Id.*) The following month, Huggins had increased blood sugar of 196, and Dr. Whitlock increased her Diabeta to two tablets. (*Id.*)

On July 20, 1994, Dr. Whitlock reported that Huggins' blood pressure was "doing okay" and that she denied chest pain. (R. at 188.) Due to a recent death in the immediate family he prescribed

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[3] It appears, from subsequent medical history notes, that a subsequent surgery corrected this condition. However, no detailed records are on file.

Ativan for anxiety. (*Id.*) Her blood sugar was 67. (*Id.*)

There was then a gap in treatment of more than a year, until October 11, 1995, when Huggins reported to Dr. Whitlock with complaints of "pain in her left hip, some pain in motion, some soreness in her hip, worse after she walks for a while." (R. at 187.) She was prescribed the anti-inflammatory drug Voltaren. (*Id.*) Her blood sugar on this date was 204. (*Id.*)

Huggins next treated in spring of 1996. A pulmonary function test was conducted March 28, 1996, but the results in the record are not fully legible. (R. at 167.) On April 4, 1996, Huggins presented with weakness, coughing, and heart palpitations. Her blood glucose was over 280. (R. at 166.) She was back at work. (*Id.*) An April 15 pulmonary function test revealed FVC at 107% of normal and FEV1 at 99% of normal. (R. at 169.) Huggins' coughing persisted through mid-April. (R. at 166.) On April 18, 1996, doctors planned to start the blood glucose medication Glucophage. (*Id.*)

On May 28, 1996, Huggins' blood glucose levels had risen to 200 and above. (R. at 167.) She complained of a foamy cough and wheezing on expiration. (*Id.*) She had been admitted to the emergency room four days before, although the record does not contain that admission. (*Id.*) Within the next two weeks, Huggins' blood glucose levels dropped to 160-190, but she reported light-

headedness and heart palpitations with atypical chest pain. (R. at 166.)

On June 27, 1996, Huggins' blood glucose levels were over 200 and she reported "lots [of] palpitations." (R. at 165.) A "stress test" conducted July 12, 1996, revealed "abnormally decreased uptake on stress Cardiolite images secondary to prominent liver uptake," but no ischemia and "good" stress tolerance. (R. at 171.)

Huggins returned to Dr. Whitlock on October 18, 1996, where an X-ray revealed fluid in the base of her lungs. (R. at 186.) Dr. Whitlock prescribed the diuretic Lasix, the narcotic cough suppressant Tussionex, and an increase in Adalat. (*Id.*) Her blood glucose was high at 222. (R. at 193.) Blood tests also revealed anemia, (*id.*), a low white blood cell count, (R. at 192), high blood glucose of 249, and high cholesterol, (R. at 191).

On November 1, 1996, Huggins reported heart palpitations but denied chest pain or shortness of breath (dyspnea). (R. at 186.) Dr. Whitlock reported that her blood pressure under "adequate control" with the drug Adalat. (*Id.*) She received "Relafen samples . . . for arthritis." (*Id.*) Later that month, Huggins' blood glucose tested at 133, (R. at 190), and she reported syncope (fainting spells) but denied chest pain, (R. at 186). Dr. Whitlock changed her blood pressure medication, recommended an echocardiogram and a Holter monitor, and a neurological workup if

problems persisted. (R. at 185-86.) Due to problems with her health insurance carrier, Huggins was able to complete only the echocardiogram. (R. at 185.) By November 25, 1996, Dr. Whitlock had diagnosed a mild regurgitation in the heart's mitral valve but found it "essentially asymptomatic without exertion." (*Id.*)

On December 12, 1996, at the request of Dr. Scullock of Health First Medical Group, Huggins consulted with Dr. Wilons at Memphis Lung Physicians. (R. at 202.) He noted a chronic problem with morning cough that had become more significant over the previous few months. (*Id.*) His clinical notes indicate "no history of wheeze and no marked shortness of breath." (*Id.*) Examination and X-ray revealed no acute congestion or lung infiltration. (*Id.*) Dr. Wilons did note "a mild to moderate degree of mid expiratory airflow slowing, which [was] consistent with her physical examination." (*Id.*) He recommended the inhalant medication Maxair. (R. at 203.)

Huggins returned for follow-up on July 7, 1996. (R. at 198.) Dr. Wilons noted that over the prior seven months she had shown "significant symptomatic improvement . . . until a recent exacerbation that has persisted." (*Id.*) He characterized the existing condition as "significantly severe," with "paroxysms of uncontrolled coughing." (R. at 198.) He noted a "mild degree of airflow obstruction" and "wheeze . . . with coughing but not at

rest." (*Id.*) A pulmonary function test revealed an FVC at 78% of normal and an FEV1 at 83% of normal. (R. at 200.) Dr. Wilons continued the Maxair inhaler, and added a course of steroids with increased insulin to "cover the effects of steroids on her diabetes." (R. at 198.)

On November 26, 1996, Huggins returned to Dr. Scullock with shortness of breath, dry cough, nocturnal shortness of breath, night waking with sweating, fleeting chest pain unassociated with shortness of breath or nausea, occasional palpitations, and occasional headaches. (R. at 216.) Dr. Scullock noted that Huggins was taking Adalat, Norvasc, and benazepril/Lotrel, (R. at 217), as well as Lasix and Relafen, (R. at 216.) She recommended further diagnostics to rule out "tuberculosis vs. interstitial pulmonary fibrosis vs. metastatic disease." (R. at 217.) Huggins' heart was regular and lungs clear, although some infiltration was seen via X-ray. (*Id.*) X-rays also revealed a normal heart, although within the upper limits of normal size. (R. at 224.) An echocardiogram revealed mild mitral and tricuspid valve regurgitation in the heart. (R. at 217.)

Huggins' shortness of breath persisted on December 11, 1996, arising during sweeping or vacuuming; Huggins also related a general difficulty with exertion and a persistent cough. (R. at 213.) A CAT scan of the chest had been requested, but diagnostic

personnel apparently had refused to perform a CAT scan because a preliminary chest X-ray was clear. (*Id.*) Dr. Scullock identified rales (clicking or bubbling sounds) at the base of Huggins' left lung, potentially consistent with congestive heart failure, and recommended a follow-up on the pulmonary diagnostics as well as additional diagnostics of the heart. (*Id.*) She noted that Huggins' diabetic condition could be associated with the heart condition "silent ischemia." (*Id.*)

On January 3, 1997, Huggins saw Dr. Chaudhary at the Health First Medical Group for a productive hacking cough with yellowish sputum. (R. at 212.) Dr. Chaudhary prescribed the antibiotics Biaxin and Rocephin. (*Id.*) Huggins was feeling better three days later, although she still complained of dyspnea on exertion, (R. at 211). A pulmonary function test showed Huggins' FVC and FEV1 both at 83% of normal. (R. at 201.) Dr. Chaudhary ordered an echocardiogram, (R. at 211), which revealed "moderate" mitral and tricuspid valve insufficiency, (R. at 222.) Blood tests conducted January 10, 1997, revealed low white blood cell count at 3.0, compared to a normal reference range of 5-10. (R. at 227.) Later that month, Dr. Chaudhary noted that the steroid Prednisone was seriously affecting Huggins' blood glucose levels, which had tested at highs of 300 and 580 within the previous three days. (R. at 210.) He adjusted Huggins' insulin. (*Id.*) Huggins still

complained of a dry cough, (R. at 210), but X-rays of the heart and lungs throughout the month appeared normal, (R. at 212, 221, 323).

Huggins again reported to Health First Medical Group on May 19, 1997, this time seeing Dr. Dismukes. (R. at 208.) She reported occasional chest pain, exacerbated cough at night and when lying down, dyspnea on exertion, and decreased energy. (*Id.*) Dr. Dismukes noted that her prior chart was unavailable even though she was an established patient. (R. at 208.) He suggested ruling out postnasal drip and gastrointestinal reflux. (*Id.*) He prescribed the allergy medication Allegra and gave Huggins a two-week course of Prevacid for stomach acid. (R. at 209.) An X-ray showed a normal heart but in the upper limits of the normal size range. (R. at 219.) On June 3 of 1997, Huggins reported that the medication had not helped her cough, and that it was now exacerbated when she lay on her left side. (R. at 207.) She denied shortness of breath but complained of weakness and fatigue. (*Id.*) Blood tests revealed that her white blood cell count still was low at 2.9, compared to a normal reference range of 5-10. (R. at 226.) The same test indicated a "high" rheumatoid factor of 41, compared to a normal reference of 35. (*Id.*) Dr. Dismukes ordered gastrointestinal diagnostics, recommended aspirin, and refilled prescriptions for insulin, Lasix, Norvasc, Zestril, and Relavin. (R. at 207.) Diagnostic imaging revealed a large diverticulum (a

protruding sac in the intestinal wall) as well as evidence of past surgeries, but no reflux or ulcers. (R. at 220.)

On June 6, 1997, Dr. Dismukes recommended ruling out sinus problems or chest abnormality. (R. at 206.) He ordered an X-ray of the chest and sinuses, which revealed two abnormalities: a possible soft tissue mass in the left hilum[4] and a mass in the upper abdomen. (R. at 218.) Further diagnostics were recommended to clarify these findings, but the sinuses appeared normal. (*Id.*)

On June 23, 1997, Huggins reported that the antidepressant Elavil was helping her sleep, but that Prednisone was not helping and that she still was coughing at night. (R. at 243.) Dr. Dismukes found mild heart failure, dyspnea on exertion, paroxysmal nocturnal dyspnea, and a chronic cough of indeterminate cause. (*Id.*) He noted a desire for previous diagnostic reports and referred Huggins back to Dr. Wilons, the pulmonologist.[5] (*Id.*)

Two months later, on August 25, 1997, Huggins presented with chronic fatigue and insomnia, but some improvement in her cough. (R. at 242.) Dr. Dismukes again noted a need for cardiac test results. (*Id.*) He opined that fatigue could be "an underlying

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[4] The hilum is the area where the airway, blood vessels, and nerves enter and leave the lung.

[5] It appears that Huggins did follow through on this reference sometime before October 3, 1997, (*see* R. at 241), but, if so, the results are not in the record.

element of" depression and prescribed a one-month increase of Elavil. (*Id.*) Approximately two weeks later, on October 3, 1997, Huggins reported for the first time blurred vision, growing progressively worse over the foregoing three weeks. (R. at 241.) She also reported fatigue and shortness of breath, especially with exertion, that the pulmonologist had been unable to diagnose. (*Id.*) Her chest appeared clear and her heart rhythm normal. (*Id.*) Blood tests revealed high glucose of 185 compared to a normal reference range of 60-110, and a low white blood cell count of 2.81 compared to a normal reference range of 5-10. (R. at 245.) Dr. Dismukes referred Huggins to the Vitreoretinal Foundation for vision diagnostics[6] and authorized additional CT scans of the chest and abdomen. (R. at 241.)

The pulmonary-abdominal CT scan was repeated October 7, 1997. Intravenous contrast could not be obtained, but an "exam limited to thin section imaging of the hilum as well as . . . the spleen" revealed no chest abnormality and a stable cyst in the spleen. (R. at 244.) Huggins' cough was somewhat improved but her fatigue and shortness of breath continued. (R. at 240.) She also reported and chronic reoccurring pain radiating down her chest that occasionally seemed more acute when she was walking. Dr. Dismukes started her

[6] It is unclear whether Huggins visited the Vitreoretinal Foundation; no such consultation appears on the record.

on Zoloft. (*Id.*) He wished to prescribe Serevent in place of the existing bronchial medication Maxair, but indicated difficulty in obtaining approval from Huggins' health insurer. (*Id.*)

There is then a gap in the records; only two significant medical events appear in 1998. On June 3, 1998, Huggins reported to Baptist Memorial Hospital for a routine check for previously-treated colon cancer. (R. at 259, 271.) Diagnostics revealed extensive diverticulitis, (R. at 264, 271), and two polyps were removed for biopsy, (R. at 258).[7] On December 29, 1998, Huggins was admitted to Baptist Memorial Hospital for "gastrointestinal bleeding, diverticulum" complicated by diabetes and hypertension. (R. at 249.) She presented with tachycardia (fast heartbeat) but a regular heart rate without palpitations. (R. at 253.) Her blood glucose fluctuated between 216, (R. at 275), and 317, (R. at 254). She denied pulmonary symptoms. (R. at 276.) A colonoscopy and a small bowel endoscopy were performed, (R. at 250), and she was discharged on a normal diet and on all pre-admission medications except aspirin, (R. at 252).

As of January 15, 1999, Huggins was recovering well from her surgery but still reporting weakness and fatigue. (R. at 278.) She also indicated neck pain. (*Id.*) Dr. Karen Hopper of Health First

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[7] The findings are expressed in diagnostic codes: T67000, M76800, M82110, M82100, T67400, M72040 and appear benign. (R. at 273).

Medical Group prescribed Darvocet for the neck pain and iron for the weakness. (*Id.*) Huggins reported to Dr. Hopper for follow-up on March 11, 1999, with neck pain, asthma, and leg cramps, but no side effects from medication. (R. at 279.) Dr. Hopper ordered blood tests and continued Robaxin for neck pain, Lasix, Prevacid, Norvasc, Humulin, Azmacort, Zestril, Albuterol, and aspirin. (*Id.*)

Huggins' blurred vision, chronic fatigue, chronic cough, shortness of breath, and wheezing all persisted on May 10, 1999. (R. at 280.) She noted chest pain after exertion that occurred with shortness of breath and lightheadedness. (*Id.*) She also intermittently was passing blood on a daily basis. (*Id.*) Dr. Hopper ordered blood work, which revealed high Hemoglobin A1C of 9.1% compared to a 4.3%-6.1% normal reference range, (R. at 282), low iron saturation of 8% compared to a 20-50% normal reference range, and a slightly low white blood cell count of 4.9 compared to a 5-10 reference range, (R. at 283). Huggins was taking Darvocet for neck pain about once a week, as well as iron, Lasix, Prevacid, Norvasc, Humulin, Glyburide, Azmacort, Albuterol, Zestril, and Robaxin. (R. at 281.)

The final medical records are those submitted to the Appeals Council when the Appeals Council declined review of the ALJ's second denial. On December 17, 2001, Huggins presented to Southeast Mental Health Center for a routine outpatient evaluation.

(R. at 287-288.) She indicated a depressed mood that had continued for about a year and fluctuated according to her health conditions. (R. at 288.) She reported feelings of helplessness and hopelessness but denied suicidal or homicidal ideations. (R. at 292.) She received Zoloft, which she already was taking, and the anti-anxiety drug Lorazepam. (R. at 294; *see also* R. at 290 (indicating Zoloft at time of admission).) At a follow-up one month later, Huggins reported tearfulness, withdrawal, loss of enjoyment of life, frequent anxiety, and other symptoms. (R. at 297.) She attributed these to her health problems and her inability to work, along with her lack of success at obtaining disability benefits. (*Id.*) She reported difficulty sleeping and that Zoloft was losing its effectiveness. (*Id.*) The examining psychiatrist diagnosed Axis I: mood disorder related to general medical condition; Axis III: diabetes, hypertension, chronic heart failure, asthma, and poor vision; Axis IV: problems with primary support group and social environment; and stable Global Assessment of Functioning (GAF) of 55 over the previous six months. (R. at 299.) He indicated no abnormal thought content or memory problems; "fair" abstract reasoning, insight, and judgment; and "average" intellectual functioning. (R. at 298-99.)

In addition to her regular treatment, Huggins was assessed by three non-treating sources. On October 24, 1996, examining but

non-treating physician Tommy Campbell, M.D., completed a physical evaluation for Tennessee Disability Determination Services. He noted that Huggins' medical history was "significant for insulin-dependent diabetes . . . hypertension, and . . . VSD repair," and for "near blindness in her right eye." (R. at 174.) He found that "in the left eye she sees 20/25 with corrective lenses" but that "[v]ision in the right eye is 20/and greater than 200 . . . She can see light and large objects only." (R. at 175.) He found a full range of motion in all extremity joints and fingers, as well as full flexion and extension in the spine. (R. at 176.) He noted that he had not seen Huggins' cardiology workups, but presented a diagnosis of probable congestive heart failure, diabetes, hypertension, status ventricular septal defect repair, and a status post-resection history of colon cancer. (*Id.*) Dr. Campbell did not express any opinion on specific functional capacities such as lifting, carrying, bending, walking, etc.

On October 29, 1996, non-treating, non-examining physician Dr. Moore completed a Residual Functional Capacity Assessment. Dr. Moore opined that Huggins could lift and carry fifty pounds occasionally and twenty-five pounds frequently; stand, walk, and sit six hours in an eight-hour workday; and had no limitations on pushing or pulling with the hands or feet. (R. at 178.) Dr. Moore indicated no postural, manipulative, communicative, or visual

limitations, although he wrote "monocular vision" in the comments area of the RFC form. (R. at 179-181.) Finally, Dr. Moore indicated that Huggins should "avoid concentrated exposure" to fumes, odors, dusts, gases, poor ventilation, etc. (R. at 181.)

On September 4, 1997, examining but non-treating physician Samuel M. Tickle, M.D., completed an RFC for Tennessee Disability Determination Services. He indicated "no history of any heart disease other than the ventricular [surgical repair]." (R. at 231.) As to Huggins' vision, he reported that "right eye can count fingers, left and both eyes 20/50. Corrected vision right eye 20/200, left eye 20/25, both eyes 20/25." (*Id.*) He observed several times, while taking Huggins' history, a "dry unproductive cough." (R. at 232.) His examination of the lungs revealed minimal snoring on forced expiration, otherwise good quality without wheezing. (*Id.*) His examination of Huggins' joints revealed a full range of motion in the spine, but some crepitation (crackling and popping) in the arms and legs "on full range of motion over the knees." (*Id.*) Dr. Tickle diagnosed surgical repair of a ventricle septal defect; childhood rheumatic fever; hypertensive vascular disease that was controlled; insulin dependent diabetes; and chronic bronchitis. (*Id.*)

Dr. Tickle opined that Huggins' hypertension and chronic bronchitis limited her to lifting and carrying up to twenty pounds

occasionally and ten pounds frequently; that Huggins could stand or walk one hour of an eight-hour workday; that she had no limitation on sitting; and that she occasionally could climb, balance, stoop, crouch, kneel, and crawl.[8] (R. at 235.) Dr. Tickle's only other limitation was environmental: a restriction on exposure to chemicals, dust, fumes, and humidity. (R. at 236.) He indicated that his findings were normally expected from the type and severity of such a diagnosis, that they were supported by objective findings, and that they were based primarily on the claimant's subjective complaints. (*Id.*)

Finally, the record contains a vocational assessment dated October 29, 1996. Substantively, it indicates only that Huggins's past relevant work in the positions of dialysis technician and nurse assistant do not require working with fumes, odors, dust, gas, etc. (R. at 138.) The form has no comments regarding transferable skills or Huggins' ability to do work other than past relevant work; these sections are blank. (R. at 138-39.)

D. The ALJ's Decision

Using the five-step disability analysis,[9] the ALJ in this case

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[8] Dr. Tickle's entries for crouching and crawling are unclear.

[9] Entitlement to Social Security benefits is determined by a five-step sequential analysis set forth in the Social Security Regulations. 20 C.F.R. §§ 404.1520, 416.920. First, the claimant must not be engaged in substantial gainful activity for

found, as the first step in the evaluation, that Huggins had not engaged in any substantial gainful activity since her claimed onset date of June 29, 1996. (R. at 20.) At the second step in the analysis, the ALJ found that Huggins' insulin-dependent diabetes, bronchitis, hypertension, status post-surgical ventricle septal defect, and monocular vision all were "severe" conditions within the regulatory definition. (R. at 21.)

At the third step, the ALJ found that although Huggins' impairments were severe, Huggins did not have an impairment or combination of impairments that would meet or equal the level of severity described for any listed impairment set out in 20 C.F.R. Part 404, Subpart P, Appendix 1. (R. at 21.) In reaching this conclusion, the ALJ relied upon the opinions of the DDS medical consultants. (R. at 20.) The ALJ also examined the claimant's

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a period of not less than twelve months. 20 C.F.R. § 404.1520(c). Second, a finding must be made that the claimant suffers from a severe impairment. *Id.* Third, the ALJ determines whether the impairment meets or equals the severity criteria set forth in the Listing of Impairments contained in the Social Security Regulations. 20 C.F.R. §§ 404.1520(d), 404.1525, 404.1526. If the impairment satisfies the criteria for a listed impairment, the claimant is considered to be disabled. If the claimant's impairment does not meet or equal a listed impairment, the ALJ must undertake the fourth step in the analysis and determine whether the claimant has the residual functional capacity to return to any past relevant work. 20 C.F.R. § 404.1520(e). If the ALJ finds the claimant unable to perform past relevant work, then, at the fifth step, the ALJ must discuss whether the claimant can perform other work which exists in significant numbers in the national economy. 20 C.F.R. § 404.1520(f).

subjective complaints according to the seven-factor test set forth by 20 C.F.R. § 404.1529 and 416.929, (R. at 22), but found the claimant only partly credible, (R. at 23). In support of his decision to discredit Huggins' testimony, the ALJ found that for the previous two years Huggins had been seen primarily for gastrointestinal bleeding; that Huggins' shortness of breath limitations were not substantiated by the medical evidence; and that Huggins had reported chronic neck pain when "physical examinations revealed only mild tenderness" in the shoulder. (R. at 23.)

At the fourth step in the analysis, the ALJ determined that Huggins retained the residual functional capacity to perform "past relevant work as a unit clerk or blood donor clerk."[10] (R. at 23-24.) The ALJ found Huggins capable of lifting twenty pounds occasionally and ten pounds frequently, and capable of standing, walking, and sitting for six hours of an eight-hour workday. (R. at 23.) He found that environmental limitations "preclude[d] concentrated exposure to fumes, odors, dusts, gases, and poorly ventilated areas." (R. at 23.) He also found "visual limitations that result in monocular vision." (*Id.*) To reach his conclusions

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[10] **There is no evidence that Huggins ever worked as a blood donor clerk; this job was proffered by the vocational expert as other work that Huggins might be capable of performing. (R. at 66.)**

as to the exertional limitations, the ALJ relied in part on the report of DDS physician Dr. Tickle, but partially discredited Dr. Tickle's findings on the basis that they were inconsistent with the longitudinal medical record. (*Id.*) To reach his conclusions as to Huggins' environmental limitations, the ALJ relied on the findings of the state agency medical consultant. (*Id.*) To reach his conclusions as to Huggins' visual acuity, the ALJ "gave considerable weight" to the report of Dr. Tickle, finding 20/200 visual acuity in Huggins' right eye. (*Id.*) The ALJ did not cite or quote any specific longitudinal treating source records in this fourth step. It also appears the ALJ did not weigh any of Huggins' testimony or subjective claims at this fourth step.

Because the ALJ found environmental limitations, the ALJ solicited testimony from vocational expert Nancy Hughes. (R. at 23; 64 et seq.) He adopted Hughes's opinion that Huggins could return to past relevant work as a unit clerk. (R. at 24.) Because the ALJ found that Huggins could perform her past relevant work, the ALJ did not make a finding as to whether Huggins could perform other work existing in significant numbers in the national economy. (*Id.*)

PROPOSED CONCLUSIONS OF LAW

Huggins challenges the ALJ's determination at Step Four that she was able to perform light work and able to return to her past

relevant work as a unit secretary. She argues that the ALJ's findings were not based on substantial record evidence. She also argues that the ALJ failed to properly apply the Sixth Circuit's pain standard and discounted the claimant's credibility without adequate support from the record. (Pl.'s Brief at 1.) Finally, Huggins submits that a "sentence six" remand is required for consideration of the new medical evidence that was submitted with her appeal of the second ALJ decision.

A. Standard of Review

Judicial review of the Commissioner's decision is limited to whether there is substantial evidence to support the decision, and whether the Commissioner used the proper legal criteria in making the decision. 42 U.S.C. § 405(g); *Barker v. Shalala*, 40 F.3d 789, 794 (6th Cir. 1994); *Abbott v. Sullivan*, 905 F.2d 918, 922 (6th Cir. 1990). Substantial evidence is more than a scintilla of evidence but less than a preponderance and is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Kirk v. Sec'y of Health and Human Servs.*, 667 F.2d 524, 535 (6th Cir. 1981) (quoting *Richardson v. Perales*, 402 U.S. 389, 401 (1971)).

In determining whether substantial evidence exists, the reviewing court must examine the evidence in the record taken as a whole and must take into account whatever in the record fairly

detracts from its weight. *Abbott*, 905 F.2d at 923. If substantial evidence is found to support the Commissioner's decision, however, the court must affirm that decision and "may not even inquire whether the record could support a decision the other way." *Barker*, 40 F.3d at 794 (quoting *Smith v. Sec'y of Health and Human Servs.*, 893 F.2d 106, 108 (6th Cir. 1989)). Similarly, the court may not try the case *de novo*, resolve conflicts in the evidence, or decide questions of credibility. *Cutlip v. Sec'y of Health and Human Servs.*, 25 F.3d 284, 286 (6th Cir. 1994).

B. <u>Weight Given to Medical Reports and Records</u>

Huggins argues that the ALJ erred in rejecting the only RFC on record from an examining physician and instead finding her functional capacity midway between that proposed by the examining physician and that proposed by the non-treating, non-examining physician, i.e., that instead of resolving a conflict in the evidence the ALJ improperly substituted his own judgment for that of the medical sources. (Pl.'s Brief at 12, 15.) She argues that the ALJ erred in adopting only those portions of the examining physician's report that cast her functional capacity in a favorable light. (Pl.'s Reply Brief at 3.)

Huggins first challenges the ALJ's determination that Huggins could walk or stand for six hours of an eight-hour workday, which was critical to the ALJ's determination that she could perform past

relevant work in the light duty category. "Even though the weight lifted in a particular light job may be very little, a job is in [the light work] category when it requires a good deal of walking or standing--the primary difference between sedentary and most light jobs." SSR 83-10, 1983-1991 Soc. Sec. Rep. Serv. 24, 1983 WL 31251 (S.S.A. 1983); 20 C.F.R. 404.1567(b).

Huggins asserts that the ALJ improperly weighed the medical evidence as to this limitation. Huggins testified that she could stand for only one hour or less. (R. at 58.) This concurred with the assessment of Dr. Tickle, the only examining physician who produced an RFC. (R. at 235.) Dr. Tickle's assessment, which was completed on September 4, 1997, (R. at 230), conflicts with an RFC produced a year earlier by one Dr. Moore, a non-treating, non-examining physician. Moore opined that Huggins could stand or walk up to six hours of an eight-hour workday. (R. at 178.) The Commissioner, relying on *Walters v. Comm'r of Social Security*, 127 F.3d 525, 530 (6th Cir. 1997), argues that Dr. Tickle's findings may be discredited because they are unsupported by detailed, clinical, diagnostic evidence. (*Id.* at 13.) The Commissioner further argues that Dr. Tickle's RFC, even if it was given controlling weight, supports a finding that Huggins can perform "a reduced range of light work." (Mem. in Supp. of the Comm'r's Decision at 12.)

The opinions of treating physicians generally are entitled to greater weight than those of non-examining physicians. *Farris v. Sec'y of Health and Human Servs.*, 773 F.2d 85, 90 (6th Cir. 1985); 20 C.F.R. § 404.1527(d). Similarly, between an examining and a non-examining physician, the examining physician's opinion usually merits greater weight. *See* 20 C.F.R. § 404.1527(d)(1); *Kinsella v. Schweiker*, 708 F.2d 1058, 1060 (6th Cir. 1983) (Swygert, J., dissenting.)

In this case the ALJ discredited the report of the examining physician, Dr. Tickle, declaring it "inconsistent with the claimant's overall clinical picture" insofar as it reflected inability to "perform sustained work activity at any exertional level." (R. at 23.) The ALJ did not, however, list any specific clinical evidence inconsistent with Dr. Tickle's assessment. In addition, the ALJ gave "considerable weight" to Dr. Tickle's evaluation of Huggins's visual limitations. (*Id.*) Accepting one part of a medical report and rejecting another, without identifying the contrary evidence that justifies the rejection, calls into question the basis for the rejection. *See Howard v. Comm'r of Soc. Sec.*, 276 F.3d 235, 240 (6th Cir. 2002).

In addition, it is submitted that Dr. Moore's earlier RFC does not provide substantial contrary evidence. First, the ALJ cited no clinical evidence to bolster Dr. Moore's findings. Substantial

evidence does not arise from the "isolated remarks of one or two medical reports." *Miracle v. Celebrezze*, 351 F.2d 361, 373 (6th Cir. 1965). In addition, Dr. Moore's RFC was nearly three years old by the time of the second hearing. In the interim, not only did Dr. Tickle opine that Huggins could not walk or stand for more than one hour, but the longitudinal records show that Huggins had tested positive for rheumatoid factor, (R. at 226), had received arthritis medication, (R. at 186), had repeatedly sought treatment for increasing fatigue and weakness, (R. at 207, 241-42, 278), and had reported chest pain when walking, (R. at 240).

Accordingly, it is submitted that the ALJ's decision to discredit Dr. Tickle's report and find that Huggins was capable of standing or walking for up to six hours in an eight-hour workday was not based on substantial evidence.

C. <u>The Pain Standard and the ALJ's Credibility Determination</u>

Huggins next argues that the ALJ improperly applied the Sixth Circuit's pain standard and improperly found her testimony lacking in credibility. The pain standard argument is not fully developed, and it is submitted that in any event it would not be dispositive.

While there evidence relating to pain, it is submitted that Huggins' functional limitations would arise from a combination of symptoms including shortness of breath, fatigue, coughing, and vision problems in addition to pain. This factual posture does not

call for the "pain standard" test, which primarily is used to determine whether pain alone constitutes a functional limitation. *See, e.g., King v. Heckler*, 742 F.2d 968, 975 (6th Cir. 1984) (finding disability where the claimant testified to "severe and constant back pain, resulting from two laminectomies and degenerative disc disease" and there was a lack of conflicting medical evidence); *Felisky v. Bowen*, 35 F.3d 1027, 1038-42 (6th Cir. 1994) (accepting as credible claimant's complaints of back pain in light of medical evidence showing inflammation of bones, tenderness in muscles, and degenerative joint disease).

As to credibility, an ALJ's determination is given great deference because the fact finder has the unique opportunity to observe and evaluate the witness. *Walters,* 127 F.3d at 531; *Kirk*, 667 F.2d at 538. However, the ALJ's credibility determination must be supported by substantial evidence. *See, e.g., Walters,* 127 F.3d at 531*; McGuire v. Comm'r of Social Sec.*, 1999 U.S. App. LEXIS 5915, *17 (6th Cir. 1999) (unpublished).

In this case, the ALJ discredited Huggins' testimony based on three findings of inconsistency: 1) that for the two years preceding the hearing Huggins had been seen primarily for gastrointestinal bleeding; 2) that Huggins' claimed limitations due to shortness of breath were not substantiated by the medical evidence; and 3) that Huggins had reported chronic neck pain when

"physical examinations revealed only mild tenderness." (R. at 23.) Huggins argues that these are not supported by substantial evidence and also that the ALJ should have favorably considered Huggins' strong work history. (Pl.'s Brief at 18.) The Commissioner responds that the ALJ's determination should receive deference because the ALJ cited specific reasons for his findings.[11] (Mem. in Supp. of the Comm'r's Decision at 10-11.)

It is submitted that the ALJ's determinations of inconsistency in this case are not supported by substantial evidence. First, the record is replete with non-gastrointestinal complaints between 1997 and 1999. Huggins presented with shortness of breath, cough, fatigue, and weakness, inter alia, on January 3, 9, 10, and 16 of 1997; on May 19, 1997; on June 3, 6, and 23 of 1997; on August 25, 1997; and on October 3, 7, and 15 of 1997. While it is true that the records from 1998 are limited, those that do exist clearly note ongoing diabetes and hypertension, as well as a plethora of medications related to non-gastrointestinal conditions.[12] (*See* R.

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[11] The Commissioner also argues that the ALJ's credibility determinations should receive deference because of gaps in Huggins' medical treatment record. (Mem. in Supp. of the Comm'r's Decision at 10.) However, it is submitted that review should be limited to the actual stated grounds for the ALJ's credibility determination.

[12] The lack of 1998 records may well be due to something other than a failure to seek treatment. There is repeated evidence of difficulty in persuading the claimant's medical insurance carrier to pay for diagnostic tests, (*see, e.g.,* R. at

at 249, 252.) Huggins's shortness of breath is again consistently documented in Health First medical records in January, March, and May of 1999, along with chronic fatigue, chronic cough, wheezing, asthma, diabetes, and hypertension. No diagnostic findings during this period undermine Huggins' shortness of breath claims. To the contrary, a blood test in May of 1999 showed low iron and low white blood cells, which reasonably could give rise to easy fatigue. (R. at 283.) Finally, there is no substantial inconsistency between Huggins' neck pain and Dr. Hopper's examination notes. The pain apparently was significant enough that Dr. Hopper prescribed Darvocet, a narcotic painkiller. (R. at 278-79.) The record contains no X-ray or other diagnostic test that is inconsistent with the claim of neck pain at this time. For the foregoing reasons, it is submitted that the ALJ's determinations as to record inconsistencies were not supported by substantial evidence; and, accordingly, that they did not provide an adequate basis for discrediting Huggins' testimony.

D. Vocational Expert's Testimony

Finally, Huggins asserts that the vocational expert's testimony was based on a hypothetical that did not fairly reflect

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185, 240), and there is an entry reflecting that medical records were lost or misplaced at Health First, (R. at 208), after which at least one physician complained about an absence of prior workups, (R. at 243).

Huggins' exertional limitations. (*See* Pl.'s Reply Brief at 6.) A vocational expert's testimony provides substantial evidence of ability to perform work only when the testimony is responsive to a hypothetical question that accurately portrays a claimant's impairments. *Howard,* 276 F.3d at 239 (quoting *Varley v. Sec'y of Health & Human Servs.*, 820 F.2d 777, 779 (6th Cir. 1987)). In this case, the ALJ posted the following hypothetical:

> [An] individual of Miss Huggins[']s age, education, and work background who is limited to lifting 20 pounds occasionally and ten pounds frequently, with no appreciable limitation on sitting, standing, or walking, but who is further limited to no exposure – no concentrated exposure to chemical fumes, odors, dust, humidity or poor ventilation and who basically has monocular vision only, could such an individual return to any of [Huggins'] past work?

(R. at 65.)

It is submitted that the hypothetical is flawed in several respects. First, as discussed above, there was not substantial evidence for the ALJ's determination that Huggins was free from limitations on walking and standing. Second, the hypothetical does not account for problems with near visual acuity. Huggins testified at the hearing that she could not see well enough to read, insert a syringe needle, or do close work. (R. at 57-58, 63.) No medical evidence undermines this claim. The record clearly establishes that Huggins' right eye was extremely poor: limited in 1996 to "light and large objects only," (R. at 175),

and measured at 20/200 in 1997, (R. at 231). Huggins testified that, since those examinations, she had acquired left eye fogginess from a cataract. (R. at 57, 61.) There is no clinical basis for discrediting this testimony. No record evidence indicates that Huggins was able to read at the time of the second hearing. Given the condition of the right eye, any additional loss of left eye vision reasonably could give rise to an inability to read. The ALJ, however, failed to include near visual limitations in the hypothetical or to pose an alternate scenario that included such a limitation. Finally, the ALJ should have included in the hypothetical the diagnoses of insulin-dependent diabetes, bronchitis, hypertension, and status post-surgical ventricle septal defect. According to the ALJ's own findings, these were severe conditions that existed on the claimed date of onset. A hypothetical is not an accurate portrayal of a claimant's condition when it fails to include the claimant's diagnoses as well as the claimant's functional limitations. ***Howard,*** **276 F.3d at 241. Accordingly, it is submitted that the vocational expert's testimony was given in response to an incomplete hypothetical and therefore is not substantial evidence of Huggins' ability to return to past relevant work.**

Huggins' second argument is based on the requirement that "[w]hen a VE . . . provides evidence about the requirements of a

job or occupation, the adjudicator has an affirmative responsibility to ask about any possible conflict between that . . . evidence and information provided in the DOT." SSR 00-4p, Dec. 4, 2000, 2000 WL 1898704 (S.S.A. 2000). In this case, the DOT listing for a unit clerk, DOT number 245.362-014, requires near visual acuity for one-third to two-thirds of the workday. Because the ALJ only inquired about monocular vision and not near acuity, it is not clear whether the vocational expert's testimony actually conflicted with the DOT listing. However, as discussed, the hypothetical posed to the vocational expert was incomplete and this alone vitiates the value of that testimony.

CONCLUSION

For the foregoing reasons, it is submitted that this case should be remanded. Because remand is recommended on the basis of the ALJ's decision, the court does not reach the issue of whether additional medical treatment in December of 2002 justifies a "sentence six" remand.

Respectfully submitted this 1st day of July, 2003.

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DIANE K. VESCOVO
UNITED STATES MAGISTRATE JUDGE