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

DEBORAH JOHNSON,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	**No. 03-2902 MlV**
	)	
JO ANNE B. BARNHART,	)	
Commissioner of	)	
Social Security ,	)	
Defendants.	)	

REPORT AND RECOMMENDATION

Plaintiff, Deborah D. Johnson, appeals from a final decision of the Commissioner of Social Security ("Commissioner"), denying her application for a period of disability and disability insurance benefits under Title II of the Social Security Act, 42 U.S.C. §§ 401 *et seq*, and supplemental security income under Title XVI of the Social Security Act, 42 U.S.C. §§ 1381 *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 set forth below, it is recommended that the decision of the Commissioner be remanded.

PROPOSED FINDINGS OF FACT

A. Procedural History

Deborah Johnson first applied for Social Security disability

benefits on October 16, 2001 alleging that she had been unable to work as of March 20, 2001 due to a stroke, heart conditions, diabetes, carpal tunnel syndrome in both hands, cataracts, coordination problems, and depression. (R. at 14-15.) Her application was denied initially and upon reconsideration. (*Id.*) Johnson then filed a request for a hearing that was held on February 4, 2003 before Administrative Law Judge Paul Michael Stimson ("ALJ"). (R. at 342-363.) The ALJ denied Johnson's application for benefits on May 29, 2003. (R. at 11-20.) Johnson appealed to the Appeals Council of the Social Security Administration, which denied her request for review on October 1, 2003 and left the ALJ's decision as the final decision of the Commissioner of Social Security. (R. at 5-7.) Johnson filed this suit in the United States District Court on November 28, 2003 pursuant to 42 U.S.C. § 405(g), to review the Commissioner's final decision. Her suit alleges that the ALJ's decision was not supported by substantial evidence and that the ALJ applied incorrect legal standards.

B. <u>The Hearing Before the ALJ</u>

Johnson was born on November 15, 1948. (R. at 345.) At the time of the ALJ hearing she was 54 years old. (*Id.*) Johnson has sixteen years of education including a Master's Degree. (*Id.*) In 1987, Johnson began work for Schering Plough as a customer service

representative. (*Id*.) Her job was to make sure that others were paid for advertising Schering's products. (*Id*.)

During her work with Schering Plough, Johnson developed diabetes. (R. at 346.) She testified before the ALJ that she was able to control her diabetes at the time with the help of medication. (*Id*.) However, in 1996, Johnson suffered a stroke. (*Id*.) As a result, she was forced to take off work for five months. (*Id*.) After returning to work, Johnson found that the job had become very stressful. (*Id*.) She eventually had a heart attack in 1999 and was forced to undergo quintuple by-pass surgery to remove blockage from her arteries. (*Id*.) Four months after the surgery, she returned to Schering, but testified that the job gave her a lot of trouble. (R. at 347.) Consequently, she was forced to take multiple sick days and eventually she gave notice to Schering of her retirement. (*Id*.)

After leaving Schering, Johnson had a variety of other jobs which lasted for short periods of time. She worked as a full-time temporary accountant for three months. (*Id*.) Her employment as an accountant was terminated because the amount of days that she had missed work. (*Id.*) She also worked as a full-time temporary cashier for Wal-Mart for three months. (*Id*.) Johnson testified that she had to leave her post at Wal-Mart because the job was too strenuous. (*Id*.) Johnson next held a job with the Internal

Revenue Service as a tax examiner. (R. at 348) This job lasted from January to March of 2001. (*Id*.) Johnson stated that the work involved in being an accountant and a tax examiner was mainly sedentary. (*Id*.) The cashier's position however required her to stand continuously for ten hours. (R. at 90.) Johnson next obtained her real estate license and attempted to work for Crye-Leike Realtors from March until November of 2001.[1] (R. at 348.) As a commissioned agent for Crye-Leike, Johnson's duties included working with new home builders. (*Id*.) Johnson would sit at the model homes until a prospective buyer came to view the model. (*Id*.) She testified that she worked for Crye-Leike for "about four hours a day, four or less days a week" and did not make much money. (*Id*.)

At the time of the ALJ hearing on February 3, 2002, Johnson was working one day a week, and attempting to work two days a week, for Southeast College of Technology. (R. at 350.) Johnson was teaching four, hour and a half classes in one day, amounting to six hours of work per day. (*Id*.) Johnson testified that she did not have the stamina to work more hours. (R. at 351.) Her first class started at 8:00 a.m. and she would be done by noon. (R. at 350.) She testified that she would usually go home and take a nap for two

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[1] **Johnson claims that she became unable to work on March 20, 2001 in her Disability Report. This date falls in between her time as a tax examiner and her employment with Crye-Leike Realtors. (R. at 70, 348.)**

or three hours until it was time for her next class that began at 5:30 p.m. and ended at either 9:00 or 10:00. (R. at 350-51.) There were breaks in between classes, therefore; Johnson was not teaching the entire time. (*Id*.) For her services, Johnson was paid $22 per hour with no benefits and made up to $400 per month. (*Id*.)

Johnson also testified about her medical problems, symptoms, and treatment. (R. at 352-56.) Her problems originate from a stroke suffered in 1996 and a heart attack that occurred in 1999. (R. at 352.) Johnson stated that she suffered sharp chest pains. (*Id*.) At times, these pains left Johnson gasping for air, causing her shortness of breath; especially when she was lifting objects or performing any physical activity. (R. at 353.) Johnson explained that she thought that the pains were caused by her ailing heart. (*Id*.)

After a series of medical tests performed in December of 2001 and early 2002 by cardiologist Dr. Mark Wade, she learned that her chest pains were not related to her heart. (*Id*.) In fact, as Johnson explained, the pain originates from the area where her heart is connected to her chest. (*Id*.) Johnson underwent a heart catheterization on January 18, 2002 which revealed more blockages. (*Id*.) The major blockages were taken care of during the catheterization. (*Id*.)

At the time of the ALJ's hearing, Johnson had not been back to

see Dr. Wade. (R. at 354.) She testified that she had scheduled an appointment but that her TennCare authority had expired, therefore; the doctor would not see her. (*Id*.) She explained to the ALJ that she had not wilfully abstained from returning to see Dr. Wade. (*Id*.)

In response to questioning about her health, Johnson stated that her main complaint was the effect the stroke has had on her. (*Id*.) She has undergone physical therapy and other treatment but has had no success in relieving the pain. (*Id*.) Johnson testified that she has experienced pain in her left arm and her jaw. (*Id*.) Additionally, she stated that she is totally numb on her left side, "scalp to toenails."

Johnson also claimed to be suffering various other ailments. She testified that she had carpal tunnel syndrome in both hands. (R. at 355.) It is unclear, and Johnson did not know whether the numbness in her hands was related to the carpel tunnel syndrome, diabetes, or a neurological disorder. (*Id*.) Johnson claimed that her diabetes was affecting her eyes and that she had already had one eye surgery but was in need of another. (*Id*.) Johnson also stated that she was suffering from heart disease which caused her mild chest pain. (*Id*.) She testified that she takes a pill everyday for her ailment, but still suffers shortness of breath and fatigue. (R. at 356.)

The ALJ also heard testimony from Johnson about her level of fatigue and her physical capabilities on a typical day. (*Id*.) Johnson testified that five days a week she just stays at home and takes a lot of naps. (*Id*.) She prepares one simple meal a day for herself and her parents. (R. at 357.) She shops at the grocery store on Saturday for about two hours. (*Id*.) Johnson testified that she is able to manage this activity because she has a cart to lean on if she gets tired. (*Id*.) Johnson stated that she can walk for two hours, but avoids walking up and down stairs. (*Id*.) She can sit for four or five hours and does so while teaching in the classroom. She can stand for two hours continuously but no longer. (*Id*.) Finally, she can lift no more than five pounds at one time. (R. at 358.)

Johnson also told the ALJ about the medications she was taking at the time the hearing. (*Id*.) First, Johnson was taking two pills for her heart and blood pressure and a diabetic drug to regulate her insulin production. (*Id*.) She would take nitroglycerin pills only in case of an emergency. (*Id*.) Johnson also took Ibuprofen, Tylenol, and Aspirin regularly for arthritis and other pains associated with her condition. (R. at 359.). She testified that despite all her medication, she was not able to control the pain. (*Id*.) Finally, Johnson revealed that she had taken Prozac prescribed by a psychiatrist for the past four or five years due to

a decline in her mental state following her stroke. (R. at 361.)

C. Johnson's Medical History According to the Records

The medical records contain various reports, statements, and letters from Johnson's doctor of internal medicine, Timothy Klein, cardiologist Mark R. Wade, and optometrist Mollie B. Glenn along with the assessments of state agency medical consultants. Johnson discovered in or about 1994 that she was a non-insulin-dependent diabetic. Johnson's medical condition worsened on April 21, 1996 when she was admitted to Methodist Hospital with a lacunar stroke on the right internal capsule which resulted in left sided paresthesia. (R. at 147-48.) Johnson was discharged from the hospital on April 28, 1996 after a series of tests were conducted to determine the damage caused by the stroke. (R. at 149-61.)

Johnson's medical records are devoid of any medical attention until November 4, 1997 when she visited Dr. Klein in his office. (R. at 213.) At that time Johnson was suffering from hypertension, non-insulin-dependent diabetes, stage I-II obesity, small vessel cerebrovascular disease, insomnia, and microproteinuria. (*Id*.) It was noted in Klein's report that Johnson was present for an evaluation regarding her diabetes and blood sugar. (*Id*.) Dr. Klein ordered a follow-up evaluation because of his concern that Johnson was noncompliant with her diet and was not checking her blood sugar levels regularly. (*Id*.) Johnson did not return to Klein's office

until March 19, 1998, at which time she complained of achiness in her left scapular region, dizziness and weakness. (R. at 209.) She was given blood sugar charts to monitor her sugar levels until the time of her return. (*Id*.) On May 29, 1998, Klein had a telephone conversation with plastic surgeon Karen Quigley who was scheduled to perform a blepharoplasty on Johnson. (R. at 208). Quigley reported that Johnson's blood pressure was 180/108 and that her blood sugar was greater than 350. (*Id*.) The blepharoplasty was subsequently cancelled.

According to Dr. Klein, Johnson's condition continued to decline over the next several months. After an office visit on October 13, 1998, Klein reported that Johnson had been noncompliant with her diet, that she continued to smoke, and her weight continued to climb. (R. at 216.) At this time, Johnson continued to have paresthesias on her left side due to her previous cerebrovascular accident. (*Id*.) In a follow-up visit on November 18, 1998, Johnson complained of joint aches and pain in her neck and back, and throbbing sensations in her upper and lower extremities. (R. at 200.) Johnson told Dr. Klein that she had been missing a lot of work and that she was unable to exercise or walk because she had stopped taking her pain medication. (*Id*.)

Johnson's next visit to Klein's office was not until July, 2, 1999. During the interim, Johnson had suffered from acute

myocardial infarction and underwent coronary artery bypass grafting. (R. at 197.) On this visit, Klein determined that Johnson was in need of a cardiologist and that Johnson needed to change medication to control her blood pressure. (*Id*.) On two subsequent visits to Klein's office in July and August, Klein again stated that there was continued elevation of blood pressure and blood sugars. (R. at 193, 195.) On September 29, 1999, Johnson visited Klein complaining of dizziness and fatigue. (R. at 191.) Dr. Klein determined again that Johnson was noncompliant with her diet, exercise, and diabetic management. (*Id*.) Also at this time, Johnson was ordered to switch medications from Paxil to Prozac to combat her increased depression. (*Id*.) On December 14, 1999, Johnson visited Klein complaining of a severe headache. (R. at 189.) She had concerns that it may be related to the stroke she suffered in 1996. (*Id*.) Her blood pressure was 190/110 and Dr. Klein sent her to the emergency room at Methodist Hospital. (*Id*.) Johnson's last recorded visit to Dr. Klein was on April 16, 2001. (R. at 186.) Klein's report indicates that Johnson has stopped taking Prozac and is doing well. (R. at 187.)

As a part of its investigation into Johnson's alleged disability, the Department of Human Services presented Dr. Klein with a Chest Pain Questionnaire. (R. at 278.) In a response dated December 26, 2001, Klein stated that Johnson did not complain of

chest pain and that she currently had no anginal symptoms despite having coronary disease. (*Id*.)

Other records indicate that Johnson was experiencing chest pain. A emergency room record dated October 16, 2001, from Methodist Hospital shows that Johnson was having chest wall pain, specifically in the region below her left breast. (R. at 252.) In a follow-up visit to Peabody Family Care, nurse practitioner Jamie Covington stated that Johnson was suffering from chest wall pain, hypertension, and coronary artery disease. (R. at 240.)

The medical records also indicate that Johnson has had problems with her vision. A postoperative report from Saint Francis hospital indicates that Johnson underwent cataract surgery on her right eye on February 25, 2000. (R. at 166.) The surgery record states that Johnson's vision impairment was resolved. (*Id*.) In response to the Department of Human Services request for information, optometrist Mollie Glenn stated, "[b]ased on our records the patient does not have a visual disability or impairment that would limit any work related activities." (R. at 170.)

In addition to her family practitioners, Johnson was also treated by a cardiologist. Dr. Mark Wade performed a thalium stress test to evaluate Johnson's coronary circulation and an echocardiogram to evaluate her left ventricular function. (R. at 289.) These tests revealed that there was a reversible defect in

the anterior wall of the heart suggestive of ischemia. (R. at 290.) The stress test was abnormal and revealed that Johnson suffered no chest pain with exercise. (*Id*.) The echocardiogram revealed no cardiac chamber dilatation or hypertrophy. (*Id*.) As a result of these tests, Dr. Wade determined that a cardiac catheterization was necessary. On January 18, 2002, Johnson underwent a left heart catheterization, a left cineventriculography, and a selective coronary cineangiography. (R. at 299.) After these procedures, Johnson was informed that there was diffuse disease of the coronary artery and total distal occlusion of the left internal mammary artery graft to the left anterior descending artery, and a marked vessel coronary artery disease. (R. at 300-04.) Dr. Wade opined that these problems could be managed with medication. (*Id*.)

In addition to the assessments and records from treating physicians, the record reflects that Johnson was assessed by non-treating medical consultants from the Tennessee Disability Determination Services. In a consultative examination dated December 21, 2001, Dr. Paul J. Katz determined that Johnson was not having any anginal type symptoms at that time and her biggest problem seemed to be the numbness of her left side. (R. at 274.) Dr. Katz stated that based on his evaluation, Johnson's walking might be limited to between 4 and 6 hours a day. (*Id*.) He also stated that Johnson's ability to lift objects was unaffected and

that sedentary activities probably would not be affected. (*Id*.)

On January 3, 2002, a non-treating, non-examining state agency medical consultant completed a residual functional capacity assessment and opined, without the benefit of statements from treating sources, that Johnson 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 280.) The medical consultant indicated that Johnson experienced no postural, manipulative, visual, communicative, or environmental limitations. (R. at 281-83.)

The record also reflects a consultative examination performed at the request of the ALJ after the hearing of the ALJ. On March 6, 2003, Johnson was examined by Dr. Barry Siegel. The examination revealed that Johnson's vision in her left eye was 20/200, her fingers had full range of motion, she walked with a slight limp, and that she was able to fully squat and arise while holding on to something. (R. at 330.) Dr. Siegel stated that he felt that Johnson could occasionally lift and carry about 20 pounds but probably not for 1/3 of a work day. (R. at 331.) He also opined that Johnson was unable to frequently lift and carry objects. (*Id*.) He also believed that she could stand and walk for at least two hours in a work day and sit for six hours in a work day. (*Id*.)

Finally, Siegel felt that other physical limitations, especially manipulation, were possible due the problems of pain and numbness in Johnson's hands. (*Id.*)

D. <u>The ALJ's Decision</u>

Using the five-step disability analysis,[2] the ALJ in this case found, as the first step in the evaluation, that Johnson had not engaged in any substantial gainful activity since her claimed onset date of March 20, 2001. (R. at 15.) Substantial gainful activity involves doing significant physical or mental activities. 20 C.F.R. §§ 404.1572 and 416.972. The ALJ found that because Johnson worked only one day a week for a limited amount of time and she only

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[2] **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 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).**

earned $22.00 an hour, she was not engaged any substantial gainful activity. (R. at 15.)

At the second step in the analysis, the ALJ found Johnson's impairments, including her type II diabetes mellitus with peripheral neuropathies, coronary artery bypass grafting, hypertensive heart disease, systolic heart murmer of undetermined etiology, history of cerebrovascular accident with mild left extremity residual paresis, and depression, were "severe" conditions based on the requirements listed in 20 C.F.R. §§ 404.1520(b) and 416.920(b). (R. at 16.)

At the third step, the ALJ found that although Johnson's impairments were severe, Johnson did not have an impairment or combination of impairments that would meet or medically equal the level of severity described for any impairment listed in 20 C.F.R. Part 404, Subpart P, Appendix 1. (*Id.*)

At the fourth step in the analysis, the ALJ determined that Johnson retained the residual functional capacity for sedentary work. (R. at 19.) In making this assessment, the ALJ gave significant weight to the medical examination performed by Dr. Barry Siegel and fully adopted Dr. Siegel's analysis of Johnson's limitations. (*Id.*) The ALJ also considered the State agency physician's report which concluded that Johnson was capable of performing "medium work". (*Id.*)

In addition to the medical evidence that was available, the ALJ also considered the credibility of Johnson concerning the severity of her symptoms and the extent of her limitations. (R. at 16.) During the ALJ hearing, Johnson testified that she had very sharp chest pains, however; the medical records indicate only two episodes of chest pain on October 16, 2001 and June 17, 2002. (R. at 16-17.) A physical exam taken on October 16, 2001 revealed no more than chest tenderness. (R. at 17.) Also a report from Dr. Timothy Klein from November 2001 shows no complaint of chest pain or no anginal symptoms. (*Id*.)

Johnson also testified that her main problems were residuals from her stroke and heart attack, but the medical evidence shows that Johnson suffered multiple medical problems including high blood pressure, high blood sugar, non-insulin dependent diabetes mellitus, cerebrovascular disease and carpal tunnel syndrome. (R. at 16.) The ALJ noted in his decision that Johnson had admittedly failed to comply with her diet or take the proper medication which eventually led to her problems with high blood pressure and high blood sugar. (R. at 17.)

The ALJ also questioned Johnson's credibility regarding problems with her vision. Johnson testified that her diabetes was affecting her vision, however; an opthamology evaluation taken on November 20, 2001 revealed that Johnson had no visual impairment

which would limit any work related activities. (R. at 18.)

Additionally, Johnson testified that she could sit for four hours, stand for two hours and occasionally lift five pounds. (R. at 16.) According to Dr. Siegel's exam, Johnson was able to stand at least two hours, sit at least six hours and occasionally lift and carry twenty pounds but not more than 1/3 of the day. (R. at 18.) Johnson also avowed that she was severely fatigued because of her heart problems. (R. at 16.) The record does not indicate that Johnson suffers from severe problems with fatigue nor has any doctor suggested that Johnson lie down during the day due to fatigue. (R. at 18.)

Finally, Johnson testified that she took Prozac to cope with her depression. (R. at 16.) The ALJ pointed out that no doctor had ever referred Johnson to a mental health specialist. (R. at 18.) Johnson had never required any hospital emergency room or in-patient care for her mental problems, nor did she seek help from a specialist on her own. (*Id*.)

It was also the opinion of the ALJ that Johnson was capable of daily and social functioning. (*Id*.) Johnson's testimony establishes that she is able to handle personal matters such as grooming and shopping. (*Id*.) The record also indicates that Johnson "retains the capacity to interact appropriately and communicate effectively with others." (*Id*.) This finding was

premised on the fact that Johnson continued to be employed in a social setting as a teacher. (*Id*.)

At the final step in the evaluation, the ALJ opined that based on Johnson's residual functional capacity, she was able to perform past relevant work as generally performed in the national economy. (R. at 19.) The ALJ based his conclusion on Johnson's ability to perform her current job as a teacher and her descriptions of her past work as a realtor associate, tax examiner, travel agent, and customer service representative. (*Id.*) The ALJ stated that at these past jobs, Johnson was not required to perform tasks that are precluded by her existing functional capacity. (*Id*.)

PROPOSED CONCLUSIONS OF LAW

On appeal, Johnson contends that the Commissioner's decision should be reversed because the ALJ improperly determined that Johnson's cardiovascular condition was not equal to or the medical equivalent of the requirements set forth in 20 C.F.R. Pt. 404, Subpt. P, App. 1, 4.02, 4.03, or 4.04; the opinion of the ALJ did not set forth the correct examination results of Dr. Barry Siegel, upon which the ALJ relied significantly in forming his opinion; the ALJ erroneously found Johnson's activities as a realtor associate, tax examiner, travel agent, and customer service representative to be past relevant work; and the ALJ's findings were not supported by substantial evidence.

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 & 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 & 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 & Human*

***Servs.*, 25 F.3d 284, 286 (6th Cir. 1994).**

B. Consideration of Social Security Listing of Impairments

Johnson first contends that the Commissioner's decision should be remanded because the ALJ committed legal error at step three of the sequential evaluation by finding that Johnson's condition did not meet the requirements of an applicable medical listing of impairment. In particular, Johnson argues that the ALJ improperly determined that her cardiovascular condition was not equal to or the medical equivalent of the impairments listed in 20 C.F.R. Pt. 404, Subpt. P, App. 1, 4.02, 4.03, or 4.04.

A claimant is considered disabled per se if the listings criteria are met for a particular impairment. 20 C.F.R. § 404.1520(d); *Gambill v. Bowen*, 823 F.2d 1009, 1011 (6th Cir. 1987). The claimant has the burden of establishing that she meets a listed impairment. 20 C.F.R. § 404.1525(d). The Commissioner claims that Johnson's condition does not meet the threshold requirement of Listing 4.02, i.e., chronic heart failure, and therefore Johnson does not suffer from a disability per se. The record establishes, and the ALJ agreed, that Johnson suffers from hypertensive cardiovascular disease. (R. at 16.) The regulation which covers hypertensive cardiovascular disease, 20 C.F.R. Pt. 404, Subpt. P, App. 1, 4.03, states: "Evaluate under 4.02 or 4.04, or under the criteria for the affected body system." Thus to demonstrate that a

person suffering from hypertensive cardiovascular disease is disabled per se, the regulations require an evaluation under part 4.02, which covers chronic heart failure, or an evaluation under part 4.04 for ischemic heart disease.

According to the regulations, chronic heart failure can manifest itself in either of two ways. 20 C.F.R. Pt. 404, Subpt. P, App. § 4.00E.1.b. First, chronic heart failure can exist when there is pulmonary or systemic congestion, or both. (*Id*.) Second, the condition can exist if there are symptoms of limited cardiac output, such as weakness, fatigue, or intolerance of physical activity. (*Id.*) The Commissioner correctly determined that Johnson's symptoms do not include pulmonary or systemic congestion. Indeed, Johnson concedes in her reply brief that any evidence of pulmonary and systemic congestion is slight. (Pl's Reply Brief at 2.) The Commissioner, however, failed to address whether Johnson suffered from limited cardiac output.

The medical records and the lay testimony before the ALJ are replete with evidence concerning Johnson's limited cardiac output, including weakness, fatigue, and intolerance for physical activity. It appears that Johnson would have met the threshold requirement under listing 4.02, i.e., chronic heart failure, had the ALJ properly applied 20 C.F.R. Pt. 404, Subpt. P, App. 1 § 4.00E.1.b. This finding would allow the Commissioner to move forward under

4.02 to determine if Johnson was in fact disabled per se.

The Commissioner also takes the position that Johnson does not satisfy the requirements of Listing 4.04 either. As previously stated, hypertensive cardiovascular disease can also be evaluated under Listing 4.04, i.e., ischemic heart disease. The Commissioner contends that Johnson did not report chest discomfort associated with myocardial ischemia as required by Listing 4.04. The regulations state that:

> **Discomfort of myocardial ischemic origin (angina pectoris) is discomfort that is *precipitated by effort* and/or emotion and *promptly relieved by sublingual nitroglycerin*, other rapidly acting nitrates, or rest. Typically the discomfort is located in the chest (usually substernal) and described as crushing, squeezing, burning, aching, or oppressive. Sharp, sticking, or cramping discomfort is considered less common or atypical.**

20 C.F.R. Pt. 404, Subpt. P, App. 1 § 4.00E 3.a. (emphasis added). The Commissioner contends Johnson's repeated complaints of occasional "sharp" pain are not consistent with the requirements for ischemic heart disease in Listing 4.04. However, the Commissioner's reliance on Johnson's choice of terminology is misplaced. Although Johnson described her chest pain as sharp on several occasions, the Commissioner failed to reveal in her brief the context from which these descriptions originate. During the ALJ hearing, Johnson testified that if she twists or turns, or bends in a certain way, she gets a sharp enough pain that it takes

her breath away so that she is limited in her movement. (R. at 352.) Johnson also said that when experiencing the pain she has to grab her side and gasp for air because the pain is so strong. (R. at 353.) This type of pain, if not crushing, squeezing, burning, aching or oppressive, is certainly of the type contemplated by the regulations. Furthermore, the record does reflect that Johnson takes nitroglycerin for her heart in order to promptly relieve her pain.

Additionally, Johnson points out that in order to establish the requirements for ischemic heart disease, it is not necessary for her to show that she suffered chest discomfort. Johnson directs the court's attention to § 4.00E.3.d. which states: "[i]f there is documented evidence of silent ischemia or restricted activity to prevent chest discomfort, this information must be considered along with all available evidence to determine if an equivalence decision is appropriate." The record reflects that Johnson's activities were restricted in order to prevent chest discomfort. The Commissioner's brief does not address this issue and instead relies heavily on the fact that Johnson did not use the correct terminology in describing her chest discomfort.

The ALJ's analysis of the third step of the sequential evaluation concerning the applicable impairment listing was limited to one sentence:

> **Although the claimant's impairments are severe, they are not severe enough to meet or medically equal one of the impairments listed in Appendix 1, Subpart P, Regulations No. 4.**

(R. at 16.) Based on the ALJ's conclusary finding, it is impossible to determine if the ALJ performed the proper evaluation required under 20 C.F.R. Pt. 404, Subpt. P, App. 1, 4.02, 4.03, or 4.04. It is therefore submitted that the decision of the Commissioner be remanded in order to properly evaluate Johnson's condition under 20 C.F.R. Pt. 404, Subpt. P, App. 1 § 4.00E.1.b in conjunction with Listing 4.02 and under 4.04.

C. <u>Dr. Barry Siegel's Findings</u>

Johnson also argues that the Commissioner's decision should be remanded because the ALJ misinterpreted the language contained in the medical assessment of Dr. Barry Siegel. Johnson claims that Dr. Siegel's assessment contains greater physical restrictions than those stated in the opinion of the ALJ. The Commissioner acknowledges in her brief that the ALJ did misunderstand Siegel's assessment, but contends that this misunderstanding amounts to a harmless error and has no effect on the final decision in this case. Although the ALJ's misunderstanding may be harmless error, the fact remains that the ALJ admittedly placed significant weight on Dr. Siegel's examination. Accordingly, this case should be remanded with instructions to re-evaluate Johnson's physical

limitations based on the correct interpretation of Dr. Siegel's report.

RECOMMENDATION

After an exhaustive review of the record, this court recommends that the Johnson's application for benefits be remanded to the Commissioner for further consideration of step three in the disability evaluation and for reconsideration of Dr. Siegel's report. Because this court finds that the ALJ committed legal errors at step three in the disability evaluation, it is not necessary to consider Johnson's argument regarding her residual functional capacity or her ability to perform past relevant work. On remand, the Commissioner should also consider relevant evidence that has come into existence subsequent to the hearing of the ALJ.

Respectfully submitted this 29th day of September, 2004.

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DIANE K. VESCOVO
UNITED STATES MAGISTRATE JUDGE