UNPUBLISHED

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
CENTRAL DIVISION

MARK A. HAYES, Plaintiff, vs. JO ANNE B. BARNHART, Commissioner of Social Security, Defendant.	No. C04-3023-MWB **REPORT AND RECOMMENDATION**

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I. INTRODUCTION

The plaintiff Mark A. Hayes ("Hayes") appeals a decision by an administrative law judge ("ALJ") denying his applications for Title II disability insurance ("DI") and Title XVI supplemental security income ("SSI") benefits. Hayes claims the ALJ erred in failing to evaluate his mental condition as instructed by the Appeals Council upon remand. He further argues the ALJ performed an incomplete and insufficient credibility analysis, posed an inaccurate hypothetical question to the Vocational Expert ("VE"), and relied on a faulty analysis by the VE. (*See* Doc. Nos. 7 & 9)

II. PROCEDURAL AND FACTUAL BACKGROUND

A. Procedural Background

On September 25, 1998, Hayes protectively filed applications for DI benefits (R. 95-98) and SSI benefits (R. 416-18), alleging a disability onset date of July 25, 1998.[1] Hayes alleged he was disabled due to blurred vision, diabetes, bronchial asthma, and emphysema. (*See* R. 113) His applications were denied initially on April 6, 1999, (R. 67-70, 419-24), and upon reconsideration on July 14, 1999 (R. 73-76, 427-31).

On August 27, 1999, Hayes requested a hearing, stating, "I am disabled due to a combination of problems including being obese, pulmonary disease, asthma, and extremely limited physical ability in general including residuals of diabetes including poor vision" (R. 78) A hearing was held before ALJ Ronald D. Lahners on June 13, 2000. (R. 432-67) Hayes was represented at the hearing by attorney Terry Guinan. Hayes testified at

[1]The protective filing worksheet and the typewritten forms prepared for Hayes show an alleged disability onset date of June 5, 1998. On both applications, the date has been changed to July 25, 1998, in handwriting that appears to be Hayes's. (*See* R. 96, 416) The ALJ and the parties have operated on the basis of an alleged onset date of July 25, 1998. (*See, e.g.*, R. 436)

the hearing, as did VE Sandra Trudeau. On December 28, 2000, the ALJ ruled Hayes was not entitled to benefits. (R. 43-62)

Hayes appealed the ALJ's ruling, and on January 28, 2003, the Appeals Council of the Social Security Administration reversed the ALJ's decision and remanded the case for further consideration. (R. 87-91) The Appeals Council set forth a number of specific issues for resolution upon remand. These included (1) reassessment of the nature and severity of Hayes's mental impairments, and the functional limitations resulting therefrom; (2) further analysis of Hayes's work-related mental limitations in assessing his residual functional capacity; and (3) evaluation of Hayes's obesity on his "ability to perform routine movement and necessary physical activity within the work environment," and consideration of the combined effect of his obesity with his other impairments. (*Id.*) The Appeals Council directed the ALJ to consider specific evidence already in the record, obtain updated and supplemental evidence, and give further consideration to Hayes's claim. (*See* R. 90)

A supplemental hearing was held on April 10, 2003, before ALJ John Sandbothe. (R. 468-513) Hayes was represented at the hearing by attorney Blake Parker. Hayes testified at the hearing, as did VE Bill Asenjo. On October 30, 2003, the ALJ ruled Hayes was not entitled to benefits. (R. 13-27) Hayes again appealed, and on January 30, 2004, the Appeals Council of the Social Security Administration denied Hayes's request for review (R. 8-10), making the ALJ's decision the final decision of the Commissioner.

Hayes filed a timely Complaint in this court on March 10, 2004, seeking judicial review of the ALJ's ruling. (Doc. No. 2) In accordance with Administrative Order #1447, dated September 20, 1999, this matter was referred to the undersigned United States Magistrate Judge pursuant to 28 U.S.C. § 636(b)(1)(B), for the filing of a report and recommended disposition of Hayes's claim. Hayes filed a brief supporting his claim on

July 15, 2004. (Doc. No. 7) The Commissioner filed a responsive brief on August 13, 2004 (Doc. No. 8), and Hayes filed a reply brief on August 19, 2004 (Doc. No. 9).

The matter is now fully submitted, and pursuant to 42 U.S.C. § 405(g), the court turns to a review of Hayes's claim for benefits.

B. Factual Background

1. Compliance with remand order

Before turning to a summary of Hayes's testimony, the court notes the very first thing to occur in the second ALJ hearing was the following colloquy between the ALJ and Mr. Parker concerning the State of the record:

> ALJ: One of the questions I have is the last medical records I have are four years old.
>
> ATTY: Well, I wondered if this hearing was a little premature because I think that when it was remanded by the Appeals Council, there were certain things that needed to be done, and I can – my Claimant tells me he's not [been] sent, for instance, for any additional mental health work. He does attend North Central Iowa Mental Health Center and gets continuing therapy there, but that was not for purposes of a disability evaluation.
>
> ALJ: Well, I'm probably more inclined towards his physical problems. Has he had any kind of physical treatment over the last four years?
>
> ATTY: He has. He has continuing care at the University of Iowa Healthcare, and I think he meets the listings of impairments under the obesity standards, and I can point those out to you.
>
> ALJ: Well, I'm sure he does meet the obesity listing. Unfortunately, we don't use those anymore. . . .

(R. 470) Counsel and the ALJ discussed the status of the ALJ's receipt of additional medical records, which ultimately were included in the record. (*See* R. 3 & 4, listing exhibits received subsequent to the hearing at R. 177-182A & 275-415) A few minutes later, immediately prior to the beginning of Hayes's testimony, the ALJ advised Hayes, "I would note that the Appeals Council has returned this, as I recall, mainly because of limitations given regarding your mental State." (R. 472)

In his brief, Hayes argues the ALJ "failed to do what was required by the Appeals Council" (Doc. No. 7, at 8) because the ALJ did not obtain additional evidence regarding Hayes's mental limitations. (*See id.* at 8-9) The court notes the Appeals Council did not expressly direct the ALJ to obtain additional evidence regarding Hayes's mental impairments. Rather, the Appeals Council found the first ALJ's decision was not clear with respect to what evidence was considered, and the rationale that was used, in assessing Hayes's mental functional limitations. The Commissioner argues the ALJ did not need a new consultative examination because he could base his findings regarding Hayes's mental health on numerous additional records, including those from Hayes's treating mental health professional, that were submitted after the remand. The Commissioner argues the ALJ had sufficient evidence to evaluate whether Hayes was disabled due to mental impairments, and the ALJ fully and fairly evaluated the evidence presented. (*See* Doc. No. 8, at 10-12) In addition, the Commissioners argues the Appeals Council's failure to review the second ALJ's decision leads to a conclusion that the Appeals Council found its instructions had been followed satisfactorily.

The Appeals Council directed the ALJ to do the following, in pertinent part:

> Give consideration to the non-examining source opinion [from a State agency psychological consultant] pursuant to the provisions of 20 CFR 404.1527(f) and 416.927(f) and Social

> Security Ruling 96-6p, and explain the weight given to such opinion evidence.
>
> Obtain updated evidence concerning the claimant's impairments in order to complete the administrative record in accordance with regulatory standards concerning consultative examinations and existing medical evidence (20 CFR 404.1512-404.1513 and 416.912-416.913). The additional evidence should include, if available, treating source records with medical source statements about what the claimant can still do despite the impairments. The additional evidence may include, if warranted and available, consultative physical and/or psychological examinations with medical source statements about what the claimant can still do despite the impairments.
>
> Further evaluate the claimant's mental impairments in accordance with the special technique described in 20 CFR 404.1520a and 416.920a and document application of the technique in the decision by providing specific findings and appropriate rationale for each of the functional areas described in 20 CFR 404.1520a(c) and 416.920a(c).
>
> Give further consideration to the claimant's maximum residual functional capacity and provide appropriate rationale with specific references to evidence of record in support of the assessed limitations (20 CFR 404.1545 and 416.945 and Social Security Rulings 85-16 and 96-8p). In so doing, consider the effect, if any, of obesity on the claimant's functional abilities (Social Security Ruling 00-3p). In addition, State the claimant's mental and other limitations in terms of restrictions on specific work-related activities.

(R. 90)

The Appeals Council's instructions to the ALJ upon remand would encompass obtaining additional evidence regarding Hayes's mental limitations only to the extent necessary to provide the full and complete analysis required by the Appeals Council. (*See*

R. 88-89) The question, then, is whether the additional medical records supplied by Hayes following the remand were sufficient for purposes of meeting the Appeals Council's mandate upon remand. This question will be discussed below in the context of the court's analysis of the ALJ's decision.

2. Introductory facts and Hayes's daily activities

At the time of the hearing,[2] Hayes was forty-six years old, and unmarried. He was 6'1" tall and weighed 423 pounds. He stated his weight had never dropped below 400 pounds since the time he first applied for benefits, and he had been carrying that much weight for five or six years. (R. 473)

Hayes had a driver's license with a restriction for corrective lenses. He stated that because of his weight, he will get back and leg pain if he drives for a long time without stopping to rest. (R. 474)

Hays took some college courses in computer science, but he does not have a degree. He stated he has some problems with reading when his blood sugar fluctuates because his vision "can be kind of blurry." (*Id.*) He stated this happens "on a fairly regular basis." (*Id.*) He indicated the problem began in 1998, around the time he was diagnosed with diabetes. (R. 495)

Hayes reviewed a "relevant work summary," and stated the information contained in the document was correct with regard to the types of jobs he has had, the skill levels, and "the weight levels." (R. 474) It is not clear what document Hayes was reviewing at the time of this testimony. The record contains a Past Relevant Work Summary prepared by VE Sandra Trudeau in connection with the first hearing (R. 167), and a Past Relevant

[2]References to "the hearing" are to the second ALJ hearing held on April 10, 2003.

Work Summary prepared by VE Bill Asenjo on April 9, 2003 (R. 176). However, neither of those summaries contains any "weight levels."

Hayes also reviewed the records he had submitted regarding his medications. (*See* R. 141-58) The record indicates Hayes was taking the following medications for his physical problems:

> Atorvastatin Tablets 10 mg, one tablet daily – used to lower cholesterol and triglyceride levels in the blood. (R. 142)
>
> Salmeterol Inhaler, twice daily – used to prevent asthma. (R. 143, 146)
>
> Combivent Inhaler (Ipratropium Bromide and Albuterol) 14.7 gm, four times daily – used to treat or prevent symptoms of asthma, emphysema, chronic bronchitis, and other breathing conditions. (R. 144)
>
> Fluticasone Oral Inhaler 110 mcg, two puffs twice daily – used to treat asthma and prevent asthma attacks. (R. 145)
>
> Fluticasone Nasal Spray 0.05%, use daily – used to treat itching, nasal congestion, and sneezing due to allergy. (R. 147)
>
> Metformin Tablets 500 mg, three tablets in morning and two tablets in evening – used to treat diabetes mellitus in patients who also may or may not require insulin. (R. 148)
>
> Chlorpheniramine SR 12 mg, one tablet twice daily – used to treat or prevent symptoms of hay fever, other allergies, and colds. (R. 149)
>
> Nitroglycerin SL Tablets 0.4 mg, one tablet dissolved under tongue as needed every five minutes, up to three tablets – used to treat and prevent angina. (R. 151)
>
> Albuterol Inhaler, as needed – used to treat or prevent symptoms of asthma, emphysema, and other breathing conditions. (R. 152)
>
> Glyburide Tablets 5 mg, one tablet twice daily – used to treat diabetes mellitus. (R. 153)

> Acetaminophen 325 mg, over-the-counter medication, two tablets every four hours as needed – analgesic and antipyretic used to treat pain, headache, and fever. (R. 154)
>
> Acetaminophen with Codeine, one to two tablets every six hours as needed – analgesic used to relieve pain. (R. 155)
>
> Theophylline, Theo-Dur 200 mg & 300 mg, one 200 mg tablet and one 300 mg tablet twice daily -- used to treat symptoms of asthma, chronic bronchitis, and emphysema. (R. 156-57)
>
> Atenolol Tablets 50 mg, one tablet daily – used to treat high blood pressure and angina pectoris. (R. 158)

Hayes stated he had been started on twenty units of insulin once a day. This began the day prior to the hearing. (R. 475, 476) He stated that once his doctors figured out the correct insulin dosage for him, he would be switched to a different kind of insulin. (R. 476)

He stated the insulin was helping his eyesight but it still was not stabilized. (R. 475) According to Hayes, his eye him problems prevented from reading about three times a week, and the condition usually lasted from several hours up to most of the day. (*Id.*) To try to get his blood sugar under control, Hayes stated he could "do some walking," but he was limited in the amount he could walk because of problems with his knees and feet. He also watched his carbohydrate intake. (*Id.*)

Hayes described problems he had experienced the last couple of times he had done computer work through a temporary agency. He stated he has arthritis in his hands, and sometimes his fingers would get stiff and painful and his keyboarding would slow down or he would have to stop. He would take some kind of pain medication, usually Tylenol, and massage his fingers. He could resume working, but he would still have pain and his work would be slower. He stated he ultimately had to quit working due to his arthritis and diabetes, and their effect on his eyesight. (R. 477-78) Hayes did not believe he could do

any type of work. He noted that sitting for eight hours was very uncomfortable and caused his back and knees to hurt. (R. 478)

Hayes stated he had no source of income. He had been living with his mother, who paid all the bills. He also received food stamps. (R. 478)

Hayes stated he walks with a cane, which was prescribed about a year earlier by an orthopedist from Iowa City. The cane takes some of the weight off of his knees, and helps reduce his pain over the course of a day. He rated his knee pain at a seven or eight on a scale of ten. The pain will be rated at nine if he has to bend down to pick something up, or when he is in the act of standing up or sitting down. He takes pain medication and anti-inflammatories, which helps somewhat in relieving his pain generally, but does not remove the pain that occurs when he stands up and sits down. He noted that if he has to sit for very long at a time, his back and legs get very stiff. He opined he could walk only about half a block before his legs and knees would start to hurt, and he has back pain if he is on his feet for very long. In addition, when he walks, his heart rate goes up, he perspires a lot, and he has trouble breathing. (R. 479-80, 495)

Hayes explained that he uses an Albuterol "rescue inhaler" when he has trouble breathing or feels an asthma attack coming on. He uses the inhaler six to eight times daily. He also has a nebulizer containing Albuterol and a steroid, and he uses that four times daily. (R. 480-81) A nebulizer treatment takes about fifteen minutes. He does the treatment by himself; it does not require anyone's assistance. (R. 490) He stated he usually can control an asthma attack with inhalers, but occasionally he has to go to the emergency room. He thought the last time he had to go to the emergency room was in the middle of 2002. He went to Iowa City, and doctors increased his medications but did not hospitalize him. They also put him on antibiotics to prevent pneumonia. (489-90) Hayes

admitted he used to be a smoker, but he quit smoking on November 1, 2001, and has not smoked since that date. (R. 494)

Hayes indicated he had fairly regular pulmonary testing until about six months earlier, and he had not seen his pulmonary doctor in awhile. The last time he saw the doctor, the doctor mentioned a pulmonary rehabilitation program, but Hayes had not heard from the doctor further about that. (R. 496) Hayes did not believe his pulmonary status had changed much since 1999. (R. 497)

According to Hayes, after he has walked half a block, it will take him twenty to thirty minutes to recover before he can walk another distance. During that time, he has to sit down and rest. He stated he "possibly" could work at a job that allowed him to get up and move as needed to relieve his pain and stiffness, but he noted that in situations where he sits for awhile, then walks for awhile, then sits again, etc., he tends to perspire excessively and have perspiration dripping off of him. He also will have trouble breathing. During those recovery times, he finds it difficult to concentrate. (R. 481-82)

Hayes stated he had had a growth surgically removed from his heel and since the surgery, his heel had been very tender and caused him a lot of pain. He had obtained custom-made orthotics to wear in his shoes, but he still had general foot pain if he was on his feet for any length of time. He rated his foot pain at a seven or eight. To relieve the pain, he would sit down and put his feet up. He stated pain medications did not relieve the pain in his feet. (R. 482-83)

Hayes stated his current physician was Robert Freele, an internist in the University of Iowa's Family Care Clinic. Hayes saw Dr. Freele at least four to six times a year. He noted he had no insurance, so he was unable to see a doctor closer to his home town of Fort Dodge. (R. 483) He stated Dr. Freele had been treating him for his ankle, knee, and lower back pain for two or three years. According to Hayes, the doctor prescribed the

nonsteroidal anti-inflammatory medication Salsalate, and acetaminophen. He indicated that more recently, his orthopedist from Iowa City had prescribed the analgesic Tramadol. According to Hayes, doctors have told him he has arthritis, and that his excessive weight is a likely cause of his pain. (R. 495)

Hayes indicated he also went to the Mental Health Center, where he received treatment for depression and social anxiety disorder. Hayes stated his depression manifested itself "in a basic hopelessness. Just the feelings of stress and life just isn't worth living sometimes." (R. 484) He has had suicidal thoughts but has not actually attempted suicide. He indicated he was taking medication that had been prescribed by a doctor at the Mental Health Center. He received counseling from a therapist, and medical management from a psychiatrist. (*Id.*)

Hayes stated his social anxiety occurs in situations when he has to be around strangers or a lot of people. He feels anxious, uncomfortable, and shaky; his heart rate increases; and he perspires. He stated the condition causes him problems when he has to go to Iowa City to see his doctors, but he takes his medication and tries to "deal with it." (R. 484-85) He has less trouble, but still some, dealing with only two or three people if he does not know them. He agreed he has to interact with people on occasions, such as a bank teller, and he can manage those interactions relatively well, although sometimes he has difficulty. (R. 498) He indicated he "always had a pretty good relation[] with employers." (*Id.*)

According to Hayes, the psychiatrist tried different medications to treat his depression and anxiety, including Zoloft, which helped his symptoms but caused him to have stomach problems. At the time of the hearing, he was taking Effexor and Wellbutrin (R. 485-86) As far as side effects from those medications, Hayes stated he seems to sleep

more, he is tired a lot, and he has decreased sexual desire. He sometimes has trouble concentrating, and he thought the medications made his thinking less sharp. (R. 486)

The ALJ noted Hayes's mental health records mention schizoid symptoms. Hayes stated he was not hearing voices, but he imagined that people were talking about him. (R. 496)

Hayes stated he went through a sleep apnea study and he has a CPAP machine that helps him sleep. However, he stated he cannot always use the machine due to his sinus problems. (*Id.*) Even though the CPAP helps him sleep better, he still has to get up to urinate frequently. He stated he drinks a lot of water during the day due to his diabetes. He stated he does not feel refreshed after a night's sleep and he usually sleeps for a short time during the day. (R. 486-87) Hayes believes his depression causes him to sleep during the day because it provides a "means of escape" when he doesn't have to "deal with anything." (R. 487) He also stated some of his pain medication and the antidepressants make him tired. (*Id.*)

Hayes also is being treated for hypertension, and his blood pressure still is not as low as his doctor would like it to be. The doctor gave him a blood pressure cuff so he can monitor his blood pressure at home. He takes his blood pressure twice a day and keeps track of it on a chart. He stated his blood pressure has "gone from 160 normally to in the 140s," and his doctor would "like to see it around 120." (R. 488) His medication had been changed the morning of the hearing, and he was scheduled for a blood test to make sure the new medication was not going to have a detrimental effect on his kidneys. (R. 488-89)

Hayes has not taken a treadmill test because doctors told him he is too heavy for the treadmill. Cardiologists have given him a stress test with chemicals, and according to Hayes, his testing has shown "some heart disease." (R. 489) He stated the doctors

"weren't real specific," but they put him on "an extended-release nitroglycerin drug . . . to increase oxygen to the heart." (*Id.*) He stated he gets chest pains about once a month, and he takes the nitroglycerin for that. He indicated he used to get chest pains more often until the doctors started him "on this other medicine, which is sort of a sustained-release nitroglycerin." (R. 497) He stated any kind of exertion or exercise brings on his chest pain, and sometimes stress also will cause him to have chest pain. (*Id.*)

Hayes stated that on an average day, he gets up and tries to eat breakfast before he takes his medications. He estimated he takes seventeen pills in the morning. About every two days, he goes to his sister's house and watches her nine-year-old son until the boy leaves for school, and then after school until his sister comes home. He stated he does not do anything in terms of caring for his nephew; he is "just there . . . in case anything should arise." (R. 490) He occasionally will fix the boy lunch or supper, but he stated the boy usually just entertains himself. Hayes stated he is alone in his sister's house for most of the day, and being there and being with his nephew does not cause him any anxiety. (R. 490-91) He sometimes naps at his sister's house during the day. (R. 491) He usually returns to his mother's house in the evening, but sometimes he spends the night at his sister's house if she is working again the next day, because he would have to be there early the next day anyway. (*Id.*)

Hayes takes care of his own laundry, does the grocery shopping, and occasionally cooks for himself, but he stated someone else usually does his cooking. His mother has a housekeeper who comes in twice a week, and his sister does her own house cleaning. (*Id.*)

Hayes stated it is "awfully hard on his knees to get down on [his] hands and knees," so it would be hard for him to crawl. (R. 492) He does not squat well. He can bend at the waist, but not very far because of his size. He believed he would have difficulty in a

job that required bending. He guessed he could lift up to seventy-five pounds occasionally, but could not carry that much weight very far, and he could not lift that much weight regularly. (*Id.*)

Hayes's attorney noted some of Hayes's previous jobs were performed at the sedentary level and some at the medium level. Hayes explained that on the medium level jobs, he occasionally had to do light lifting. In doing inventory, he might have to look into packages or lift them out of the way to see what was behind them, but he stated lifting was not the biggest part of the job. He indicated he was on his feet quite a bit, and occasionally he would have to climb onto a pallet or rack. He did not believe he could do that job anymore. (R. 493)

Hayes stated his depression causes him problems with concentrating for any length of time because his "mind tends to wander." (*Id.*) He used to be good at doing paperwork but he now finds it daunting. He stated he needed assistance even to fill out his Social Security paperwork. (R. 494)

Hayes indicated his weight had increased four to five years earlier, and before then, it was closer to 350 or 375. He speculated he gained weight because he became depressed after losing a job, and also he began eating better after he moved in with his mother. (R. 494) Hayes acknowledged that he was still able to work when he weighed as much as 350 pounds. (R. 499)

Hayes stated he entertains himself by reading "all kinds of things." He has no hobbies or activities, and does not belong to any kinds of groups, social organizations, or a church. Besides his mother, sister, and nephew, he sometimes interacts occasionally with neighbors in the apartment complex. He does not go visit them, but will run into them occasionally. (R. 498-99)

3. Hayes's medical history

For purposes of considering Hayes's claim, the court has separated its summary of his medical history into physical and mental problems.

a. Hayes's physical complaints

Since August 1998, Hayes has been seen for ongoing medical management of diabetes mellitus; chronic shortness of breath, asthma, and sleep apnea; intermittent chest pain; fluctuations in vision; foot problems; dental problems; and knee and hip pain. As the following chronological summary reflects, it appears the majority of Hayes's problems are due in large part to, or at least are exacerbated greatly by, his morbid obesity.

On August 6, 1998, Hayes went to the emergency room complaining of increased thirst and urinary frequency. He stated he could not sleep due to his need to urinate so frequently. He reported perspiring excessively, and stated he was using an over-the-counter asthma inhaler. Testing revealed that Hayes had diabetes mellitus. The ER doctor prescribed Micronase, and advised Hayes to follow up with his family doctor the next day. (R. 183-88) James W. Rathke, M.D. confirmed the diagnosis through additional testing. He prescribed ongoing treatment with Glyburide and Glucophage. (R. 190-93)

On December 18, 1998, Hayes was visiting his brother in Omaha, Nebraska, when he developed an increasing dry cough, wheezing, and shortness of breath. Hayes went to the ER, where he received nebulizer treatments. A chest X-ray revealed "diffuse bilateral interstitial prominence consistent with an acute atypical pneumonia." (R. 195) After two or three nebulizer treatments in the ER, Hayes was still short of breath and requiring supplemental oxygen, so he was admitted to the hospital's pulmonary unit for further treatment. He was given I.V. antibiotics and steroids, inhaled bronchodilators, and supplemental oxygen. He made "very slow progress," and finally was converted to oral medications on December 20, 1998. He was discharged on December 21, 1998, with

diagnoses of acute bronchoreactive disease, atypical pneumonia, respiratory distress secondary to the other illnesses, and diabetes mellitus. His medications at the time of discharge were antibiotics and steroids, Combivent and Azmacort inhalers, a cough syrup, and his two diabetes medications. He was instructed to follow up with his family doctor in ten to fourteen days. (R. 194-206)

Hayes was seen for follow-up cardiopulmonary testing on January 4, 1999. (R. 207-12) Testing indicated he had "a moderate obstructive lung defect," with confirmed airway obstruction. He had a positive response to bronchodilator treatment. (R. 209) Records indicate Hayes was smoking one to two packs of cigarettes a day as of January 1999. (R. 208)

On January 28, 1999, Hayes was seen by Michael G. Kienzle, M.D. in the Cardiology Clinic at the University of Iowa Hospitals and Clinics, for evaluation of chronic anginal chest pain. (R. 239-41) Dr. Kienzle noted Hayes's "obesity precludes most routine diagnostic tests and excludes all but medical therapy as an intervention." (R. 240) The doctor suggested Hayes use sublingual nitroglycerin as needed, and he recommended Hayes start "presumptive antianginal therapy, perhaps starting with a once-daily preparation of diltiazem," and one aspirin daily (*Id.*) He noted Hayes could not take beta blockers due to his bronchospasm. He also noted Hayes's asthma medications could play a role in causing his symptoms. (*Id.*)

Dr. Kienzle found Hayes was not a candidate for angiography, angioplasty, or open-heart surgery due to his weight. He opined that if Hayes's symptoms did not improve, he might have to undergo invasive testing to obtain a definitive diagnosis. The doctor recommended Hayes receive additional consultation for his asthma and perhaps his diabetes, and he had a social services counselor meet with Hayes to discuss ways he could obtain assistance through a medical indigent program. (*Id.*)

On March 6, 1999, Hayes was admitted into the hospital "with complaints of increasing shortness of breath, cough, chest tightness, and wheezing." (R. 217-23, 275-93) He was treated with "Beta 2 agonists, anticholinergics, intravenous steroids, and empiric intravenous antibiotics." (R. 217) He improved gradually and was switched to oral steroids and metered-dose inhalers. He was discharged with instructions to follow-up in one week. Discharge notes indicate he would be scheduled for an outpatient sleep study. (*Id.*) At a follow-up appointment on March 17, 1999, Hayes reported feeling better. He was told to continue his current medications, which included Glucophage, Glyburide, Prednisone, Theophylline, Atenolol, Combivent inhaler, Serevent inhaler, Vanceril inhaler, and Primatine mist inhaler. (R. 224-25)

Hayes was examined on March 19, 1999, by Joseph Latella, D.O. at the request of Disability Determination Services ("DDS"). (R. 213-16) Dr. Latella's report notes Hayes had worked last as a "temp" in the computer field. Hayes claimed he was disabled as a result of asthma and his eyesight. He was still smoking one pack of cigarettes daily, in spite of his asthma. Dr. Latella noted Hayes's asthma was being treated with oral Prednisone which was "playing havoc with his diabetes." (R. 214) Dr. Latella diagnosed Hayes with "Chronic asthma, uncontrolled due to obesity and chronic smoking; Exogenous obesity; Diabetes mellitus type II, non-insulin dependent;" and hypertension due to his obesity and diabetes. (*Id.*) He found the following with regard to Hayes's work-related capacity:

> He cannot work in any dusty or moldy environment. He can see, write and understand the English language. He can transfer objects in either hand, cannot crawl, squat or bend with any repetitiveness. He can walk short distances only due to the obesity and asthma. His extremities have a normal range of motion with reflexes 4/4 and no loss of sensory or

> motor functions. No signs of any diabetic retinopathy or neuropathy.

(*Id.*)

Hayes was evaluated in the Pulmonary Clinic at the University of Iowa Hospitals and Clinics on March 25, 1999. (R. 233-38) He weighed 424 pounds, his blood pressure was 164/86, and his pulse was 123. He exhibited some wheezing and diminished breath sounds. George N. Bedell, M.D. opined that the dosage of Theophylline Hayes was taking was "subtherapeutic." (R. 234) He increased Hayes's dosage of Serevent to two puffs twice daily, and increased his long-acting Theophylline to 500 mg. twice daily. He continued the following medications: Combivent, three puffs four times daily; Vanceril double-strength inhaler, three puffs twice daily; Volmax (an albuterol tablet), 4 mg. twice daily; and "prednisone taper." (*Id.*) The doctor scheduled Hayes for a sleep study to check for sleep apnea, and arranged for him to be seen by Ophthalmology in regard to diabetes-related eye problems. Dr. Bedell noted Hayes was "anxious to stop smoking," so he prescribed Zyban 150 mg. daily for one week; then Hayes was to stop smoking and start using nicotine patches, 21 mg. for the first two weeks, then 14 mg. for two weeks, then 7 mg. for two weeks. (R. 234-35) He scheduled a follow-up appointment in one month. (R. 235)

Lawrence Staples, M.D. completed a Residual Physical Functional Capacity Assessment of Hayes on April 1, 1999. (R. 245-54) He found Hayes could lift twenty pounds occasionally and ten pounds frequently; stand and/or walk for a total of at least two hours in an eight-hour workday; sit for a total of about six hours in an eight-hour workday; and push and/or pull without limitation. He found Hayes to have no postural, manipulative, visual, or communicative limitations. He opined Hayes should avoid concentrated exposure to fumes, odors, dusts, gases, and poor ventilation, but he otherwise

had no environmental limitations. Dr. Staples found Hayes's diabetes was improved on medication. He found Hayes to have "a moderate obstructive lung defect." (R. 254) He also found Hayes's credibility was eroded by his continued smoking despite his asthma and use of inhalers. (*Id.*) Dennis A. Weis, M.D. reviewed Dr. Staples's findings on June 22, 1999, and affirmed his RFC. Dr. Weis noted Hayes's diagnosis of sleep apnea and use of a CPAP did not modify the RFC. (R. 245)

Hayes was seen by Ophthalmology in Iowa City on April 29, 1999. He complained of problems with reading due to fluctuations in his vision. He reported he had not smoked in the previous week. Doctors found no diabetic retinopathy. They opined his symptomatic vision problems could be due to fluctuations in his blood sugar. He received a prescription for bifocals to assist him in reading, and he was advised to follow up in one year to check for possible diabetic retinopathy. (R. 228-29)

Hayes underwent a sleep study on April 28 and 29, 1999. (R. 230-32) The study revealed "significant obstructive sleep apnea with snoring." (R. 230) Doctors recommended a CPAP trial, aggressive weight loss using appropriate diet and exercise, and avoidance of all tobacco products, central nervous system depressants, and alcohol. (*Id.*) He was prescribed a CPAP and instructed on its use, with follow-up scheduled for one month. (R. 231)

Hayes saw Dr. Bedell for follow-up of his pulmonary problems on May 5, 1999. (R. 226-27) The doctor's report indicates Hayes "was in the hospital at the first of the month for five days because of a flare up of his asthma," but no records of this hospitalization appear in the record. Dr. Bedell indicates Hayes "was treated with antibiotics, intravenous steroids and a nebulizer"; insulin for his diabetes; and increased dosages of prednisone (to 40 mg. daily) and his glyburide (two times daily). He noted Hayes was not smoking and was using a nebulizer every four hours. (R. 226) The doctor

was anxious to get Hayes off the prednisone due to undesirable side effects, so he prescribed a tapered dosage, reduced by 10 mg. every five days, and cessation after twenty days. He scheduled a follow-up exam in three months. (R. 227)

Hayes had an intake exam at the Family Care Center at Iowa City on June 24, 1999. Notes indicate Hayes was having difficulty getting approval for a CPAP machine through the State. Notes also indicate Hayes was not checking his blood sugars regularly. Hayes reported that he had cut his smoking down to one pack every three days. On examination, doctors noted decreased heart tones and decreased breath sounds, no edema in his lower extremities, and no synovitis of his hands. Hayes was instructed to continue his dosages of Glyburide and Metformin; continue using Nicoderm patches and Zyban to stop smoking; and continue using his inhalers. (R. 344-45)

Hayes had repeat pulmonary function testing on July 21, 1999 (R. 270), and then he saw Dr. Bedell for a follow-up exam on July 23, 1999. (R. 346-47) He reported his asthma condition was unchanged. He sometimes had more breathing difficulty on humid days. He had not obtained a CPAP yet because he could not afford one. He had lost about twenty pounds, which Hayes attributed to an abscessed tooth that prevented him from eating very well. He stated dental care was not covered under his insurance so he was unable to get all of his cavities filled. He reported problems keeping his blood sugar down, but stated it was usually under 200. He had completed his course of prednisone and was no longer taking the steroid. Dr. Bedell noted Hayes's greatest need was continued weight loss, and he encouraged Hayes to lose another twenty pounds over the next six months. (*Id.*)

On September 23, 1999, Hayes saw orthopedist Charles Saltzman, M.D. regarding an induction cyst on his left heel. (R. 248-50) Although the cyst was somewhat painful and caused hm to limp a bit, it was not causing a problem for Hayes in his daily activities.

Dr. Saltzman gave Hayes some inserts for his shoes, and he scheduled surgery to remove the mass, which was performed on November 10, 1999. (R. 354) Hayes's incision healed nicely. On December 9, 1999, Hayes's sutures were removed, and Dr. Saltzman advised Hayes he could begin walking on his heel "as tolerated." (R. 355-56) Fifteen months later, Hayes had "no complaints" and his incision was healed. Dr. Saltzman gave him new shoe inserts. (R. 367)

Hayes had a chest X-ray on November 9, 1999, likely in preparation for his heel surgery. The X-ray shows development of a soft tissue lesion in his left lower lobe which the radiologist opined was "highly suspicious for primary bronchogenic carcinoma or metastatic focus." (R. 351) The X-ray also showed a second questionable lesion in the same lobe. The radiologist recommended Hayes have a CT scan for further evaluation. (*Id.*)

On November 11, 1999, Hayes was seen in the General Medicine Clinic of the Family Care Center in Iowa City, for follow-up of numerous medical problems. (R. 352-53) Hayes reported his asthma had been under good control generally, but had been somewhat worse for the past few days due to cold, dry air. He reportedly obtained good relief from his inhalers and nebulizers. He still did not have money to get a CPAP for his apnea. Hayes stated his blood sugar had been "running in the upper 200's." (R. 352) He had lost twenty pounds due to some tooth problems but had gained back the weight quickly. He wanted to continue using Zyban and wanted to try nicotine patches again, noting he had decreased his smoking down to a half pack per day. Doctors continued his Zyban, and noted they would try to get Hayes a CPAP machine. They increased his metformin dosage to three times daily. (*Id.*)

Hayes was seen in Iowa City on January 27, 2000, for follow-up of his obstructive sleep apnea. He had obtained a CPAP but reported trouble sleeping with it, stating it was

difficult to use when he slept on his side. He stated he did not exercise. His weight was 402 pounds and blood pressure was 158/60. Dr. Bedell advised Hayes to try to use the CPAP every night, and he asked the sleep lab to give Hayes suggestions to help him make better use of the machine. The doctor also advised Hayes to eat less and begin exercising, starting slowly with a goal of working up to walking one mile per day. (R. 357-58)

Hayes was seen for follow-up of his diabetes and sleep apnea on March 2, 2000. Hayes's blood sugar still was not under good control. He stated he was not complying well with a diabetic diet, and his blood sugars frequently were in the mid to high 200's. He was still smoking about half a pack of cigarettes a day, and he reported coughing and wheezing frequently. He stated his nose was usually stopped up and he could not breathe through his nose. He was using the CPAP most of the time but still had difficulties adjusting to it. He had intermittent, brief chest pain related to stress, but he stated the pain usually resolved in a few seconds, before he had a chance to take a nitroglycerin pill. The doctor increased Hayes's metformin dosage, started him on Entex LA and Flonase, and ordered a number of lab tests. (R. 359-60)

Hayes returned to the clinic on May 18, 2000, for follow-up. He reported his blood sugars were ranging from 120-250, usually around 150-170s. He had completed some diabetic education and dietary consultation. He stated he was trying to watch his diet but he had not lost any weight; in fact, his weight was up slightly. He reported smoking one pack of cigarettes daily. He stated his nasal symptoms had improved with the Flonase, but he still had a chronically runny nose. The doctor continued his diabetic medications without change; started him on Lipitor for cholesterol control; increased his atenolol and told him to have his blood pressure checked regularly, write down the results, and bring them to his next follow-up visit; and told him to continue using his CPAP and inhalers. (R. 361-62)

Hayes was seen in the Pulmonary Clinic on August 16, 2000, for follow-up of his bronchial asthma and sleep apnea. (R. 363-64) He stated he had not used the CPAP recently. He had lost two pounds and was at 400 pounds. Dr. Bedell noted Hayes "appear[ed] to be on the right program." (R. 364) He recommended Hayes lose weight by cutting his caloric intake. (*Id.*)

Hayes returned for follow-up on October 19, 2000. (R. 365-66) He stated his blood sugars had been in the upper 100's and lower 200's. He not "not been compliant with exercise, or dietary modifications." (R. 365) He continued to have shortness of breath on exertion, but had not had recent chest pain. He was smoking half a pack per day, on average. His blood pressure was 145/76, and doctors advised him to reduce his salt intake and increase his atenolol dosage. They again discussed the importance of dietary control and scheduled him for another diabetes education class. They advised him that if he had not lost weight and begun to exercise, it was likely he would have to add either a third oral medication or insulin to his regimen. (*Id.*)

Hayes was seen for follow-up on January 11, 2001. (R. 368-69) He had lost five pounds, attended diabetes education class, and been more compliant with his dietary recommendations. He stated he had not been able to exercise much. His blood sugars had been in the upper 100's, an he was doing well with his COPD, reporting some nasal drainage but no increased shortness of breath or cough. Because Hayes reported a willingness to try to lose more weight and to exercise, doctors continued him on metformin and glyburide and did not add insulin or a third medication. They started him on benazepril four times daily due to albumin in his urine, and ordered a check of his potassium level in two weeks. His sleep apnea was doing well, and he was directed to continue using his inhalers and follow up with the Pulmonary Clinic. His Lipitor dosage remained unchanged. (*Id.*)

Hayes returned to the Pulmonary Clinic for follow-up on April 11, 2001. (R. 372-73) He reported that his asthma was doing well but he complained of sinus problems, and he stated he had an appointment with Otolaryngology later that day. Hayes stated he was walking a bit for exercise, watching his diet, and trying to get his blood sugars down. He was checking his blood sugar four times daily, and stated it usually ran around 100 to 130, which was a significant improvement over his prior reports. He reported some vision problems, especially when his blood sugar fluctuated. He complained of continued urinary frequency and urgency, and recent onset of diarrhea four to five times daily. He reportedly was living with his mother, who was in poor health, and he stated he did all the laundry, shopping, and errands. Hayes's weight was down to 389 pounds, and his blood pressure was 144/68. The doctor found Hayes's bronchial asthma to be "under good control with his present medical program." He prescribed refills for Hayes's medications and told him to return for follow-up in six months. (*Id.*)

Hayes had five teeth extracted in the Oral Surgery Clinic in Iowa City on April 12, 2001, incident to findings of "multiple non-restorable teeth secondary to gross caries and malposed impacted wisdom teeth." (R. 370-71, 379-80) A biopsy of a lesion associated with one tooth apparently was negative because the administrative record includes no further records relating to problems with Hayes's teeth.

Hayes was seen for follow-up in the Diabetes Clinic in Iowa City on April 12, 2001. (R. 274-76) His blood sugar control had improved since his January visit. He was checking his blood sugar more often. His level was seldom higher than 200, and those occasions were "usually explained by dietary indiscretion." (R. 374) Since he was first diagnosed with diabetes, he had lost around forty pounds by watching his diet, but he reported that his ability to exercise remained limited due to shortness of breath on exertion, and by back pain. He was still smoking one-half pack of cigarettes daily. The doctor

reduced Hayes's Glucophage from 1500 to 1000 mg twice daily. He was advised to take one baby aspirin daily, and to quit using tobacco altogether. His cholesterol levels were noted to be "excellent" on the Lipitor. (*Id.*)

The same day, Hayes also was seen in the General Medicine Clinic for follow-up. Doctor's notes indicate Hayes's Otolaryngology exam revealed nasal polyps. Otherwise, his examination was unremarkable. His current medications were continued, and he was advised to continue losing weight and get more exercise. Doctors suggested he might benefit from adding a humidifier to his CPAP machine. (R. 377-78)

On April 17, 2001, Hayes underwent an endoscopic procedure to biopsy his nasal polyp. (R. 381) The court has not located a biopsy report in the record, but notes from a visit to the Allergy/Immunology Clinic in December 2001, indicate Hayes was diagnosed with inflammatory polyposis as a result of the biopsy. (*See* R. 399)

On July 18, 2001, Hayes was seen in the General Medicine Clinic for follow-up of his multiple medical problems. (R. 382-83) He had no new complaints. He stated his blood sugar was highly variable, with ranges from 80 to 220, and he was testing it once daily. He "also stated that he was not trying very hard to lose weight despite his morbid obesity and his having a hard time staying away from fatty foods." (R. 382) He was smoking about a pack a day. He was taking Tylenol, four tablets four times daily, with little relief of his back and knee pain. The doctor opined Hayes's heavy weight was a cause of his back and knee problems, but Hayes stated he had been unable to lose much weight in recent months. He stated he was scheduled for a CT scan of his sinuses the next day. Doctors counseled Hayes about diet and weight loss, and continued his diabetic medications for the time being. He was told to stop taking Tylenol, and they prescribed salsalate for his pain. They opined losing weight likely would improve his pain. They advised Hayes to stop taking his metformin for two days in connection with his receipt of

radiocontrast dye for the CT scan. Hayes was directed to measure his blood pressure before his next appointment, and they opined he might need to increase the dosage of his blood pressure medication at a future date. His asthma was stable. (R. 383)

On July 19, 2001, Hayes underwent a CT scan of his sinuses which indicated severe sinus disease with lobulation in his left maxillary sinus and possible polyps in his sinus and nose; mild to moderate ethmoid sinus disease; moderate right maxillary sinus disease; and moderate sphenoid sinus disease. (*See* R. 384) He was referred to the Allergy and Immunology Clinic for further evaluation. (*See* R. 399)

Hayes was seen in the Family Care Center in Iowa City on October 24, 2001. He reported an increase in his nasal congestion and upper respiratory symptoms, including pain during walking. He was back to smoking one pack per week, but stated he was trying to cut down. He was having frequent episodes of chest pain, and reported taking nitroglycerin three or four times during the previous month. He complained of back and knee pain, with minimal help from the salsalate he was taking. He reported sleeping better and stated he had no concentration problems, but he had a low energy level and was tired throughout the day. (R. 385) A chest X-ray revealed "modest hyperinflation in both lungs." (R. 387) The doctors started Hayes on antibiotics and a steroid taper for twelve days, and albuterol nebulizers four times daily for two days. He was advised to lose weight and to get a flu vaccination at his next visit. (R. 386)

Hayes was seen for follow-up in the Pulmonary Clinic on October 25, 2001. He reported a worsening cough and shortness of breath over the past month. He could only walk about fifty feet before having to rest, whereas previously he had been able to walk a few blocks before resting. The doctor noted Hayes "appear[ed] to be in a COPD exacerbation." (R. 389) The doctor prolonged Hayes's course of prednisone for one month. He told Hayes to stop using Azmacort and started him on Flovent. He was

directed to continue using his Serevent and albuterol inhalers, and he received a flu shot. He was advised to quit smoking and the doctor started him on a ten-week nicotine patch treatment. (R. 388-91)

On November 14, 2001, Hayes was seen for follow-up in the Pulmonary Clinic. After two weeks on the "prednisone burst," Hayes stated he felt 80% better and he was coughing only occasionally. He still had some wheezing. He stated he was still smoking. A chest X-ray done on November 8, 2001, showed his lungs were clear. He was still having "bouts of retrosternal chest pain" during both exercise and rest. He reported using six nitroglycerin pills during the previous two weeks. Doctors told Hayes to finish his course of prednisone as directed. They suggested he discontinue using nebulizers altogether and switch to using only a Combivent inhaler and a Flovent inhaler. He again was warned about the anticipated consequences if he continued to smoke, and doctors noted he was "reluctant to seek help." He was referred back to the Cardiology service for further evaluation in light of his increased nitroglycerin use. (R. 392-95)

Hayes was seen in the Family Care Center on December 7, 2001, for follow-up of his shortness of breath. He reported significant improvement after his prednisone treatment, but still complained of shortness of breath with minimal exercise and occasionally at rest. He stated his shortness of breath was worse than it had been just a few months earlier. His blood sugars had increased during his steroid treatment. He also complained of knee pain, worse on the left than the right, that caused him difficulty in climbing up stairs. At this appointment, Hayes stated he had "quit smoking for the last month with the use of Nicoderm patch." He still complained of social anxiety. Doctors did not change Hayes's diabetes medications, but noted he might need insulin at some point. He was encouraged to lose weight, and was referred to Orthopedics for evaluation of his knee pain and instability. (R. 396-98)

Hayes was seen for follow-up on December 6, 2001, in the Allergy and Immunology Clinic. He reported no evidence of sinusitis and a marked decrease in his rhinitis and congestion over the past two months. He attributed the improvement to cessation of smoking, use of Flonase, and a change in his CPAP mask from nasal pillows to an oral nasal mask. He was encouraged to continue abstaining from smoking. He was instructed on sinus irrigation and told to do this twice daily. (R. 399-401)

Hayes was seen in the Orthopedics service on February 14, 2002, in connection with complaints of left knee and left hip pain. (R. 408-12) He stated his knee pain had been progressing for a little over two years. The pain was worse with activity and weight-bearing, and improved with inactivity and lying down. He described the pain as sharp in quality, and stated it increased with mobility or movement of the knee. The pain occurred right at his kneecap. His hip pain usually was in the groin area. He occasionally used Tylenol without much relief. He stated his general health was poor, and somewhat worse than it was a year previously. (*Id.*) However, he stated he had quit smoking recently after smoking one pack of cigarettes daily for twenty-seven years.

Hayes stated he had begun having difficulty with some of his daily activities as a result of pain. He reported "a lot" of limitation in the following areas: moderate activities, climbing one flight of stairs, bending, kneeling, stooping, walking more than a mile, and walking one block. He also reported "a little" limitation in his ability to lift and carry groceries. He stated that due to his physical health, he had cut down on the amount of time spent on work or other activities most of the time; he had accomplished less than he would like most of the time; he was limited in the kinds of work and other activities he could pursue; and he experienced interference with social activities. He reported severe difficulty descending stairs; an inability to climb stairs or carry heavy loads; severe trouble

rising from a chair, bending to the floor, putting on his shoes and socks, and doing yard work; moderate trouble vacuuming; and mild trouble doing laundry. (R. 408-09)

Upon examination, his knee showed no tendon or ligament laxity. Motion caused Hayes mild discomfort. "Palpation over the patella and motion of the patella reveal[ed] a grinding and increased the pain significantly." (R. 410) Hip flexion, extension, internal and external rotation, and other movement revealed "mild pain in the groin aspect of the hip area." (*Id.*) The doctor diagnosed Hayes with osteoarthrosis, primary, left knee. He prescribed Ultram for pain relief, and advised Hayes to be active on days when he was feeling less pain, and "to back off when he feels more pain." (*Id.*)

Hayes was seen on February 13, 2002, in the Iowa Heart Care Center with complaints of "two types of chest discomfort. (R. 402-04) One is a substernal pressure and tightness that occasionally radiates to the left shoulder," occurring both upon exertion and at rest, with episodes lasting two minutes or less and usually resolving before he could take nitroglycerin. He obtained relief on the occasions when he had to take nitroglycerin, and usually took only one pill. (R. 402) "The other pain occurs in the left sternal border and goes straight to his back. He describes this pain as a sharp stabbing pain," occurring with hard exertion and resolving with rest. (*Id.*) Hayes stated that since his asthma symptoms had improved, his anginal symptoms also had diminished, and he was having symptoms once every one to two weeks. He reported that he had quit smoking about two months earlier. (*Id.*)

Upon examination, Hayes was noted to be in mild respiratory distress, but his lungs evidenced no wheezes or crackles. His heart had a regular rhythm and normal rate, with no murmurs. His extremities evidenced some bilateral pitting edema, but he had good peripheral pulses. Doctors recommended he continue on his current medications, and continue with "aggressive control of his risk factors, including blood pressure, diabetes,

and hyperlipidemia." (R. 403) They noted Hayes's obesity would be "a major factor in his long-term health," and they recommended he be considered for bariatric surgery. (*Id.*)

Hayes returned to the Pulmonary Care Clinic for follow-up on February 19, 2002. (R. 405-07) During his examination, doctors "walked him down the office hallway. With 1-1/2 laps exertion his pulse rate rose from 94 at rest to 105 with exertion. His pulse oximetry rose from 93% at rest to 94%. He was noted to be profoundly diaphoretic at the end of exertion although he stopped secondary to some knee pain." (R. 405) Doctors assessed Hayes's COPD as stable, noting he still suffered from "significant baseline symptoms that are marginally worse over the last 2 months." (R. 406) They noted Hayes had "shown remarkable compliance with his new medication regimen[.]" (*Id.*) They reinitiated him on a Flovent inhaler, started him on one aspirin daily, and scheduled him for a nuclear medicine stress test preliminary to making a decision on pulmonary rehabilitation. (*Id.*)

Hayes underwent a stress test on March 28, 2002, that demonstrated "decreased uptake in the inferoapical region of moderate size and degree on stress images[,] . . . predominantly reversible on rest images." (R. 413) The radiologist's impression was "adenosine induced ischemia in the inferoapical region." (*Id.*) The results were reviewed with Hayes at a follow-up appointment in the Pulmonary Care Clinic on March 29, 2002. Hayes "demonstrate[d] reactive but stable chronic obstructive pulmonary disease with remarkable improvement in his FEV1 [at 57% predicted] since starting Flovent." (R. 312) He was referred to Cardiology to evaluate "the appropriateness of pulmonary rehabilitation which is likely to benefit his dyspnea." (R. 313) He was encouraged to keep a Sleep Clinic appointment scheduled for June 2002. (*Id.*)

Hayes saw Dr. Ajayi for follow-up of his depression on May 10, 2002. He had no complaints, reported sleeping much better, and stated his mood had been stable. He was

directed to continue taking Zoloft "to prevent recurrence of depression," and Trazodone as needed for sleep. (R. 299)

Hayes was seen in the Heart Care Center on June 5, 2002, "for angina pectoris, stable and improved." (R. 314) Hayes stated his chest pain had not been occurring as frequently. He reported profuse sweating, with or without the chest pain. The doctor assessed Hayes's angina as somewhat improved and stable. He noted that Hayes's morbid obesity "would make coronary angiography, interventional therapy, and surgery more difficult and of higher risk." (*Id.*) He recommended continued medical management, and started Hayes on a long-acting nitrate to see if it might decrease the frequency and severity of his stable angina. (*Id.*)

Hayes was seen for follow-up in the Allergy-Immunology Clinic on June 6, 2002. He tested mildly positive for grass and weed allergies. Doctors started him on Allegra and directed him to continue using Flonase, Combivent and Albuterol, but suggested he try backing off the inhalers. They encouraged him to use nasal saline once or twice daily. They noted Hayes had stopped smoking in November 2001. (R. 316-37)

Hayes returned to the Family Care Center for follow-up on July 31, 2002. (R. 318-21) He reported his blood sugar was in the 200's. He complained of a foot ulcer on his right foot. He also complained of "hunger pains" with some reflux and indigestion, improved with eating; and a history of diarrhea for several years, recently worsening and more consistent. (R. 318) In their assessment, doctors noted Hayes was "obviously not compliant" with his diabetic diet, but they noted his depression could influence his increased diet. They ordered a Diabetic Foot Clinic consult, and noted they would consider putting Hayes on insulin at his next visit. Hayes was encouraged again to lose weight. For his diarrhea, doctors prescribed Famotidine, and ordered a Helicobacter pylori test. They noted he was taking Ultram for his osteoarthritis, and they reduced his

Zoloft dosage because of the interaction of Ultram with Zoloft, noting his diarrhea might improve with the reduced dosage. (R. 319)

Hayes was seen in the Pulmonary Clinic for follow-up on September 26, 2002. He reported using the Combivent inhaler six to eight times daily to recover from shortness of breath, and two to three times at night. He was still using his CPAP, but had missed his appointment in the Sleep Clinic. He had gained weight over the past six months, and his current weight was 431 pounds. He stated his chest pain intensity had improved and he was using sublingual nitroglycerin only three or four times a month. Doctors noted the following assessment and plan:

> 1) Chronic obstructive pulmonary disease. I believe Mr. Hayes demonstrates stability in his chronic obstructive pulmonary disease. I think his excessive use of Combivent inhaler arises from undue dyspnea due to his obesity and severe deconditioning apart from his chronic obstructive pulmonary disease. I therefore think that he will benefit from pulmonary rehab. He is on State papers and will have to undergo pulmonary rehab here at the University as a boarder. He has agreed to do this. I have also recommended an annual flu shot as the flu season is fast approaching.
> 2) Obstructive sleep apnea. I think given his continued weight gain and some residual symptoms of sleep apnea . . . he would benefit from a visit to the Sleep Clinic and I have recommended him to follow up with the Sleep Clinic.
> 3) Obesity. The predominant theme to all of his symptoms is his morbid obesity I think he will benefit from a visit to the Bariatric Services. He had received some paperwork that he is required to fill [out] to attend the Bariatric Services. I reminded him again and he has . . . agreed to fill them [out] and visit with the Bariatric surgeons.

(R. 322-23)

Hayes was seen for general medical follow-up on October 23, 2002. (R. 325-28) He reported blood sugars fluctuating from 160 to 300, despite medication, but it was noted he was not compliant with his diet. He complained of a worsening growth on his left heel. His blood pressure was elevated moderately at 152/71, and his dosage of benazepril was increased to 10 mg. daily. His diarrhea had improved with reduction in the Zoloft. Doctors prescribed an orthotic shoe insert and referred Hayes to the Foot Clinic for follow-up. (R. 325-26)

Hayes was seen in the Diabetic Foot Clinic on November 12, 2002, "for evaluation of ulceration of the plantar aspect of his left heel." (R. 329) X-rays of Hayes's left foot were normal. Doctors placed Hayes in a DH boot to try to relieve pressure on his left heel. (R. 329-33, 414) On December 10, 2002, Hayes returned for follow-up. (R. 334-35) He stated the boot had helped "maybe 20%," and he was still having pain. He was directed to continue using the DH boot, and doctors also prescribed "an orthotic with a drill and fill of shoe and relief area over this painful area." (R. 335) They stated they had nothing more to offer him, and opined the problem resulted largely from his obesity. They referred him to the Gastric Banding General Surgery Clinic. (*Id.*)

Hayes was seen for general medical follow-up on February 12, 2003. (R. 336-37) He reported being off cigarettes for more than a year, and stated he recently had quit drinking caffeine "due to thoughts of improving his mood." (R. 336) His shortness of breath continued, and was worse in cold weather. He noted his diarrhea had recurred since he went back on Zoloft. He reported continued joint pain, mostly in his knees, but also in his shoulder and hands. He was taking Ultram and acetaminophen for the pain. (*Id.*) Blood tests revealed abnormal liver enzymes, but no evidence of hepatitis B or C and no evidence of excessive iron or copper in his liver. Doctors opined he could have excessive fat deposits in his liver, and noted he probably should have a liver ultrasound at

some point. Hemoglobin testing, which indicated how his blood sugars had behaved over the past few months, was markedly abnormal, and doctors noted Hayes would begin insulin therapy at his next appointment. They advised Hayes that in the meantime, it was crucial for him to reduce his fat and carbohydrate intake as much as possible. (R. 338) Doctors increased his Ultram and Salsalate dosages, and noted he could continue using Tylenol up to 1000 mg. three times daily for pain. They advised him to discontinue the Zoloft once again due to recurrence of diarrhea, and replace it with Effexor. They continued his other medications without change. (R. 337)

Hayes returned for general medical follow-up in the Internal Medicine Clinic on March 26, 2003. He was scheduled to start insulin after instruction, with close monitoring of his blood sugar for several weeks and dosage adjustments as indicated. Doctors hoped to discontinue some of Hayes's oral medications when he was stabilized on the insulin. They continued Hayes's medications, except as discussed in the next section with regard to his antidepressants. Doctors noted that due to Hayes's lower extremity edema, an echocardiogram to evaluate right heart failure and pulmonary hypertension might be indicated, but they also noted Hayes's obesity could be a limiting factor in performing the study. They planned to consider using Lasix for symptomatic relief in the future. (R. 340-42)

Hayes was seen again on April 23, 2003, for a recheck of his blood sugars and blood pressure. He stated his blood sugars were running between 147 and 300 or more. Doctors increased his insulin and directed Hayes to "continue to eat regular meals to avoid hypoglycemia." They also prescribed benazepril for his hypertension. (R. 343)

b. Hayes's mental complaints

The first notation in the record of Hayes's mental complaints is a psychological assessment conducted on June 7, 1999, by Dan L. Rogers, Ph.D. (R. 242-44) The assessment was performed at the request of DDS. Dr. Rogers found Hayes was "experiencing long-term depression of moderate degree," and he opined Hayes's personality style "would make him encounter difficulty in forming and maintaining close interpersonal relationships." (R. 244) He diagnosed Hayes with Dysthymia and Schizoid personality, and assessed his Global Assessment of Functioning (GAF) at 60, indicating "moderate symptoms (*e.g.*, flat affect and circumstantial speech, occasional panic attacks) or moderate difficulty in social, occupational, or school functioning (*e.g.*, few friends, conflicts with peers or co-workers)." American Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders (4th ed. 1994) ("DSM-IV"), at 32. With regard to Hayes's work-related mental capacity, Dr. Rogers found as follows:

> He is able to remember and understand instructions, procedures, and locations, but his physical problems and his personality style would make it difficult for him to maintain an adequate pace. His attention and concentration wane at times in such a manner that there would be interference with his carrying out instructions. He is able to interact appropriately with supervisors, coworkers, and the public, except that his relationships would not be very close. His judgment is fair to good and he should be able to respond appropriately to changes in the work place a majority of the time.

(R. 244)

During an intake examination at the Family Care Center in Iowa City, one of Hayes's diagnoses of record was "depression." (R. 344) Doctors at the Clinic started Hayes on Paxil 20 mg. daily, with instructions for follow-up in three months. (*Id.*)

John C. Garfield, Ph.D. completed a Psychiatric Review Technique on June 29, 1999. (R. 255-63) He found the records indicated Hayes had suffered from "long term

depression (Dysthymia) of moderate degree," but he found no evidence of treatment for the disorder. Dr. Garfield found Hayes suffered from both depression/dysthymia and personality disorder consisting of "[s]eclusiveness or autistic thinking." (R. 258, 260) He opined Hayes would have a slight degree of limitation in his ability to perform daily activities and maintain social functioning, and frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner, in work settings or elsewhere. He found Hayes had never had episodes of deterioration or decompensation. (R. 262)

In his review summary, Dr. Garfield indicated he had found "only a single reference to depressive symptoms in the medical evidence of record." (R. 264) He noted Hayes had not been reviewed mentally "at the initial level," but had added an allegation of depression to his physical complaints. He found no evidence that Hayes had ever been diagnosed with or treated for a depressive condition, although he noted Dr. Rogers had found Hayes "to be chronically depressed to a moderate degree, largely over his enormous bulk . . . and his inability to find work." (*Id.*) The doctor found Hayes's mental impairments did not meet or equal the Listing requirements, and Hayes would be "capable of engaging in at least routine unskilled competitive employment, judged from purely psychological perspective." (*Id.*) He also found "[t]he medical evidence, with it's [sic] very scant reference to any mental disorder, is internally consistent and claimant is considered a credible informant." (*Id.*)

In a related Mental Residual Functional Capacity Assessment (R. 266-69), Dr. Garfield found Hayes would have moderate limitations in the ability to understand, remember, and carry out detailed instructions; maintain attention and concentration for extended periods; complete a normal workday and work week without interruptions from psychologically-based symptoms; and perform at a consistent pace without an unreasonable

number and length of rest periods. He found no other significant limitations in Hayes's work-related mental abilities. (*Id.*)

At a general medical follow-up on November 11, 1999, Hayes told doctors he did not believe Paxil was helping his depression and he wanted to stop taking it. The doctors agreed he could discontinue taking Paxil. (R. 352)

Hayes underwent a psychiatric evaluation by Richard Ajayi, M.D. on March 15, 2001, upon referral from a social worker. (R. 309-11) Hayes reported feeling depressed for about three and one-half years. A nurse at the Diabetes Clinic in Iowa City had suggested he consider treatment for depression. Hayes reported symptoms of insomnia, anorexia [sic], poor concentration, anhedonia, sporadic suicidal ideation without plan or history of attempts, lack of energy, decreased libido, sporadic anxiety, feelings of helplessness and hopelessness, and being "overwhelmed with negative feelings." (R. 309) He stated he also was depressed about being turned down for Social Security benefits.

Hayes described himself as shy, socially anxious, afraid of strangers and new situations, and avoidant of places that would expose him to other people. He denied ever having a panic attack in a social setting. He noted he had taken Paxil for a few months previously, but he did not believe it helped him any. (*Id.*) Dr. Ajayi noted Hayes was "withdrawn with a noticeable psychomotor retardation." (R. 310) His attention, concentration, and long- and short-term memory were good. His mood was depressed and his affect was constricted.

The doctor diagnosed Hayes with "Major Depressive Disorder, Single Episode, Moderate . . . Rule out Social Phobia"; and "Personality Disorder, NOS . . . mainly with avoidant traits." (*Id.*) He started Hayes on a trial of Prozac, and he prescribed Trazodone for Hayes to take as needed to sleep. (R. 310-11)

Hayes was seen for follow-up of his depression by counselor Kyle McCard on May 22, 2001. Hayes showed moderate progress, and stated he felt "a lot better" since he began taking the Prozac. He stated he sometimes went to the park or the library, and he read books. Mr. McCard assessed Hayes's GAF at 55, indicating moderate symptoms (*see* DSM-IV at 32). Hayes agreed to continue taking his medication, and to "follow through with getting out and doing a few things." (R. 308)

Hayes saw Dr. Ajayi for follow-up of depression on June 19, 2001. He had not noticed any significant change despite an increase in his Prozac dosage, and he continued to be isolative. He stated he felt "socially inept and inadequate," and he often was uncomfortable around people. He had low self-esteem and viewed himself as not as good as his peers. The doctor noted Hayes's affect was bland and his mood was depressed. He gave Hayes a video about social anxiety disorder to watch. Prozac was discontinued as ineffective, and he was started on Zoloft. (R. 307)

Hayes saw Dr. Ajayi on July 24, 2001, for follow-up of his depression. He reported some improvement on the Zoloft, but not as much as he wanted, and he stated he was "still depressed, moody and down." (R. 306) He had been neglecting his physical health, and had not complied with physicians' directives to walk regularly to lose weight. He claimed he had "no appreciation for life." (*Id.*) Dr. Ajayi noted Hayes was malodorous and disheveled," his mood was depressed, and his affect was "restricted in range." (*Id.*) The doctor increased Hayes's Zoloft dosage and encouraged him to comply with his doctors' orders. (*Id.*)

Hayes returned to see Dr. Ajayi for follow-up on August 24, 2001. He reported feeling somewhat better. He stated he had quit smoking three weeks earlier and had experienced an increase in his appetite as a result. He was being more compliant with his doctors' orders, and his attitude and outlook were more positive. Dr. Ajayi noted Hayes's

affect was "constricted but reactive," his mood was "even," and he was somewhat better groomed. He was told to continue his current Zoloft dosage and follow up in six to eight weeks. (R. 305)

When Hayes saw Dr. Ajayi again on October 5, 2001, he stated he was "more 'mellow' on Zoloft but still socially anxious and avoidant of crowds." (R. 304) The doctor noted Hayes was wheezing loudly and appeared to be in physical distress. His mood was "somewhat euthymic," and his affect was constricted. The doctor increased Hayes's Zoloft dosage again, and encouraged hm to see his family doctor for a possible upper respiratory tract infection. (*Id.*)

Hayes saw Dr. Ajayi again on November 6, 2001. He stated he was remaining abstinent from cigarettes and he was receiving treatment for his COPD. He stated his mood had improved and he was sleeping better, but he continued to avoid social interactions due to overwhelming anxiety. The doctor noted Hayes's mood was "somewhat euthymic," and his affect was "expressive and of good range." The doctor increased his Zoloft dosage. (R. 303)

Hayes missed a scheduled appointment with Dr. Ajayi on December 4, 2001. (R. 302)

Hayes saw Dr. Ajayi for follow-up of his depression on February 22, 2002. He reported feeling less "down in the dump[s]," but still experiencing some social anxiety. He was pleased that he had quit smoking. His grooming was better. Dr. Ajayi noted Hayes's depression was in remission and his social phobia was improved. He prescribed continued Zoloft. (R. 300)

At a general medical follow-up appointment on July 31, 2002, doctors noted the following: "[Hayes] also complains of worsening agoraphobia and depression. He has less energy and more appetite. His sleep is disrupted on a daily basis. He chooses not to leave

his house due to anxiety in public situations, and had a difficult time getting to the clinic at all." (R. 318) Doctors noted Hayes's depression could be affecting his ability to comply with his diabetic diet. They reduced Hayes's Zoloft dosage because they noted Zoloft's interaction with Ultram, which Hayes was taking for his osteoarthritis, could be causing his diarrhea. They added Wellbutrin to his medication regimen. (R. 319)

Hayes cancelled his appointment with Dr. Ajayi that was scheduled for August 23, 2002, "due to illness." (R. 298) On September 10, 2002, he saw Lee Berryhill, M.D. for follow-up of his depression. He reported continued nervousness in public and stated he did not go out much. He stated his mood was fair. He scheduled a counseling appointment with Kyle McCard. (R. 297)

At his next general medical follow-up appointment on November 12, 2002, Hayes reported his diarrhea had improved with a reduction in the Zoloft. Doctors planned to taper him off Zoloft and increase the Wellbutrin. (R. 326)

After missing a November 15, 2002, appointment (R. 296), Hayes saw Dr. Berryhill for follow-up of his depression on January 2, 2003. He reported feeling more anxious since discontinuing Zoloft. The doctor told him to continue taking 300 mg. daily of Wellbutrin, and he added 50 mg. of Zoloft, which he did not believe would cause Hayes's intestinal problems to return. (R. 295)

At a general medical follow-up on February 12, 2003, Hayes reported his diarrhea had returned with resumption of the Zoloft. Doctors recommended he discontinue the Zoloft again, and they prescribed Effexor. (R. 337)

Hayes saw Dr. Berryhill again on February 27, 2003. He had few complaints. He reported slight improvement from replacing the Zoloft with Effexor. He stated he would be placed on insulin and taken off oral tablets for his diabetes. The doctor increased Hayes's Effexor dosage to 75 mg. daily. (R. 294)

At his general medical follow-up appointment on March 26, 2003, Hayes reported some continued anxiety, which doctors opined could be due to the Wellbutrin. They increased his Effexor dosage and tapered down his Wellbutrin. They noted he should monitor his blood pressure carefully to determine if the Effexor was exacerbating his hypertension.

4. Vocational expert's testimony

The ALJ asked VE Bill Asenjo to consider the following hypothetical question:

> This would be currently a 46-year-old male, 12th grade education plus, past relevant work as noted in [Exhibit] 18E. He has been diagnosed with obesity, asthma/COPD, currently insulin-dependent diabetes mellitus, high blood pressure, dysthymia. He has also indicated anxiety and arthritis of the lower extremities, but we don't have medical records to back that up yet. . . . Eye problems. Again, we don't have medical records for that yet.
>
> I would limit this person [to] lifting 20 pounds occasionally, ten pounds frequently, stand or walk 30 minutes at a time, no more than two hours total during the day – the workday. He cannot do any bending, stooping, squatting, kneeling, crawling or climbing. Cannot tolerate extremes of heat, cold, dust, smoke or fumes. He would be limited to no close attention to detail, only occasional contact with the public, only occasional contact with coworkers or supervisors, no more than a regular pace.

(R. 500-01) The ALJ stated the hypothetical individual's arthritis would not impact his hand and finger dexterity.

With those limitations, the VE stated the individual could not return to any of Hayes's past work, but there would be other jobs he could perform. These would include eyeglass frame polisher, which is a sedentary, unskilled job; surveillance system monitor,

which is sedentary and unskilled, but depending on the circumstances might require close attention to detail; and lamp shade assembler, which is sedentary and unskilled. (R. 501-02)

The ALJ posed a second hypothetical question to the VE, as follows:

> This has all the same limitations as the first hypothetical limitation. However, I would add he needs a cane. He would require two or more unscheduled breaks per day, lasting 15 minutes for his use of his nebulizer. He would require a slow pace, for up to one-third of the day. He would have blurred vision, lasting several hours, two to three – well, let's make it at least once a week.

(R. 502-03) The VE stated the individual would be precluded for all work due to "the need for unscheduled breaks, and also the slower pace one-third of the day and the issue of blurred vision." (R. 503)

Hayes's attorney asked the VE to consider the ALJ's first hypothetical, but add to it that the individual would have problems with concentration that would interfere with carrying out instructions. As to how these additional limitations would affect the VE's opinion regarding the individual's ability to work, the VE stated, "That also would depend on the particular occupation. Some require less attention to detail than others, and the issue of following directions, simple directions, occasionally repeated, may be part of the job description." (R. 504-05)

The ALJ agreed that if the individual could not concentrate for one-third of the day, "that would preclude work." (R. 505)

With regard to the job of eyeglass frame polisher, the VE indicated there were "[a]pproximately 148,000 such jobs in the United States. Roughly 600 in the Iowa job market." (R. 501) Upon questioning by Hayes's attorney, the VE acknowledged this number was from conversations with the Iowa Workforce Development staff, and the VE

could not point to any document suggesting there were as many as 500 of those jobs in the State. The same would be true for the numbers of available jobs the VE listed for lamp shade assembler; i.e., 500,000 nationwide and 500 hundred in Iowa; and the surveillance system monitor, 166,000 nationwide and 400 in Iowa. (R. 502, 506) The VE was not aware of the source of the statistics he had received.

Hayes's attorney[3] then interposed an objection on the basis that the VE's testimony failed to meet the *Daubert* standards, arguing counsel had "no idea that [the VE] wasn't relying on statistical evidence of the statistics that he's citing." (R. 506) Counsel asked that his objection precede the VE's testimony. (*Id.*)

The ALJ reopened the record on July 8, 2003, for the purpose of admitting numerous additional medical records, as well as correspondence from Hayes's attorney. (*See* R. 507-13)

5. The ALJ's decision

The ALJ found Hayes was not disabled because he retained the residual functional capacity to perform jobs that exist in significant numbers in the national economy. (R. 16, 27) He found Hayes to have severe impairments including "diabetes mellitus, asthma/chronic obstructive pulmonary disease, obesity, hypertension, dysthymia, angina, sleep apnea, sinus polyps, and chronic knee and back pain," but he found none of those impairments satisfied the Listing requirements. (R. 17)

The ALJ found Hayes's subjective complaints regarding his limitations were not credible due to "numerous inconsistencies." (R. 26, ¶ 4) In support of this finding, the ALJ noted Hayes required "very few hospitalizations which were of short duration."

[3]The transcript erroneously indicates this objection was made by the ALJ. (*See* R. 506)

(R. 23-24) He also noted Hayes repeatedly was warned to lose weight and quit smoking, and "[w]hen he finally did quit smoking in October 2001, some of his symptoms improved." (R. 24) He found Hayes was noncompliant with his diabetes mellitus regiment, not checking his blood sugars as frequently as advised, and failing to take his medications on one occasion. (*Id.*) He further found, "Mr. Hayes has been repeatedly admonished that his excessive weight and continued smoking have exacerbated all of his conditions, yet he has not lost weight. There does not appear to be a medical reason why the claimant is unable to lose weight." (*Id.*) The ALJ found Hayes had not complained of debilitating side effects from his medications that would prevent him from working; he was able to help his sister with child care; and he was "independent in his activities of daily living." (*Id.*)

The ALJ specifically found Hayes's complaints regarding blurred vision were not credible. He noted the ophthalmology report from Iowa City "showed good visual acuity," and fluctuations in his vision were "felt to be due to changes in blood sugar levels." (*Id.*) The ALJ concluded, "Clearly, Mr. Hayes'[s] diabetes could be managed better if he were compliant with medical directives. He does not monitor his blood sugars as he has been directed to. There has been no indication of diabetic neuropathy." (*Id.*; citations to exhibits omitted.)

The ALJ found Hayes to have the following residual physical functional capacity:

> The credible evidence of record shows that the claimant is capable of [occasionally] lifting 20 pounds and frequently lifting 10 pounds. He can stand or walk for 30 minutes at a time for a total of 2 hours out of an 8 hour day. He can sit for a total of six hours out of an 8 hour day. The claimant should do no bending, stooping, squatting, kneeling, crawling or climbing. He should not be exposed to extremes of heat, cold, dust, smoke or fumes. The claimant is able to do work that

> does not require close attention to detail and would have only occasional contact with the public, coworkers or supervisors. He can work at no more than a regular pace.

(R. 24)

The ALJ agreed with the VE's analysis that someone with these limitations could not return to Hayes's past relevant work, and would have no transferable skills. (R. 24-25) However, based on the VE's response to the ALJ's first hypothetical question, the ALJ found Hayes could perform unskilled jobs that exist in significant numbers in the national economy, including eye glass frame polisher, surveillance system monitor, and lamp shade assembler. (R. 25)

The ALJ's opinion did not contain an evaluation of Hayes's obesity on his "ability to perform routine movement and necessary physical activity within the work environment," or consideration of the combined effect of his obesity with his other impairments, as required by the Appeals Council's order upon remand. (R. 89)

Because Hayes has raised the issue of how the ALJ evaluated his mental functional capacity, the court will review the ALJ's findings regarding Hayes's mental limitations in some detail. The ALJ explained the procedure he utilized as follows:

> In evaluating the claimant's mental impairments, the undersigned has utilized the psychiatric review techniques as described in the revised regulations at 20 CFR 404.1520a and 416.920a. Application of the technique reflects the claimant's severe impairment of dysthymia which corresponds to section 12.04 of the Listing of Impairments. As a result of the claimant's mental impairments, he has mild restriction of activities of daily living, mild difficulties in social functioning, moderate difficulties maintaining concentration, persistence, or pace, and has had no repeated episodes of decompensation, each of extended duration. The evidence does not establish the presence of the "C" criteria. . . .

(*Id.*)

The ALJ summarized Hayes's testimony regarding his mental condition as follows:

> In describing his mental condition, the claimant indicated he feels hopeless, stressed and as if life is not worth living. Mr. Hayes has not attempted suicide but has thoughts concerning it. He takes medication for these problems. The claimant experiences anxiety in situations where he has to be around people. His symptoms include discomfort, anxiousness, shakiness and his heart rate going up. Mr. Hayes receives medications from Iowa City also. He was on Zoloft but was unable to tolerate it. He was switched to a different medication and has tried Effexor and Wellbutrin. The claimant complained of side effects, including stomach problems. He sleeps a lot more and is tired a lot. He has experienced sexual side effects resulting in loss of interest in sex. Sometimes he has difficulty concentrating, but he is not sure if it is from the medication.

(R. 18)

The ALJ summarized the medical evidence relating to Hayes's mental capacity as follows:

> [A]t the request of the Disability Determination Services, Mr. Hayes was referred to Dan L. Rogers, Ph.D., licensed clinical psychologist, who evaluated Mr. Hayes on June 7, 1999. Dr. Rogers indicated that present observations and the claimant's history suggested that the claimant was experiencing long term depression of moderate degree. Mr. Hayes also seemed to have a personality style that would make him encounter difficulty in formulating and maintaining close interpersonal relationships. However, the claimant would be able to remember and understand instructions, procedures, and locations but his physical problems and personality style would make it difficult for him to maintain an adequate pace. His attention and concentration wane at times in such a manner that

> there would be interference with carrying out instructions. He is able to interact appropriately with supervisors, coworkers and the public, except that his relationships would not be very close. His judgment is fair to good and he should be able to respond appropriately to changes in the workplace the majority of the time. Dr. Rogers noted, "his last job was as a data entry worker and it ended one year ago. [Hayes] was not clear about why he is unable to get another job; it seemed to be related to his weight and his health, but he seemed reluctant to admit that." Dr. Rogers assessed a generalized assessed functioning [sic] (GAF) of 60. (Citation omitted.)
>
> . . .
>
> The claimant was referred for psychiatric evaluation which was conducted on March 15, 2001 by Richard Ajayi, M.D. Major depressive disorder, single episode, moderate, was diagnosed as well as rule out social phobia, personality disorder NOS, mainly with avoidant traits. The claimant requested a trial of an antidepressant. Mr. Hayes underwent individual counseling sessions approximately monthly from May through November of 2001. The claimant failed appointments in December and February. It was noted on February 22, 2002, that overall, there seemed to be some improvement in the claimant's condition. By May 10, 2002 his depression was found to be in full remission and his social phobia was improved. Mr. Hayes continued to be seen but again, failed an appointment in November of 2002.

(R. 20-21) The ALJ noted that as of March 256, 2003, Hayes was taking Wellbutrin, and he "appeared stable on Effexor." (R. 23)

In finding Hayes to be "capable of work," the ALJ noted his depression was managed medically, he had a GAF of 60, he had "not been hospitalized for mental health problems," and he "failed to attend many counseling sessions." (R. 24) The ALJ noted that in his initial hypothetical question to the VE, he included a diagnosis of dysthymia,

and the VE found the hypothetical individual could perform unskilled jobs even including that diagnosis. (R. 25) Although the VE indicated, in response to questioning by Hayes's attorney, that the hypothetical individual could not work if he had concentration problems for up to one-third of the day that interfered with his ability to carry out instructions, the ALJ found those limitations were not supported by the record. (*Id.*)

III. DISABILITY DETERMINATIONS, THE BURDEN OF PROOF, AND THE SUBSTANTIAL EVIDENCE STANDARD

A. Disability Determinations and the Burden of Proof

Section 423(d) of the Social Security Act defines a disability as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." 42 U.S.C. § 423(d)(1)(A); 20 C.F.R. § 404.1505. A claimant has a disability when the claimant is "not only unable to do his previous work but cannot, considering his age, education and work experience, engage in any other kind of substantial gainful work which exists . . . in significant numbers either in the region where such individual lives or in several regions of the country." 42 U.S.C. § 432(d)(2)(A).

To determine whether a claimant has a disability within the meaning of the Social Security Act, the Commissioner follows a five-step sequential evaluation process outlined in the regulations. 20 C.F.R. §§ 404.1520 & 416.920; *Dixon v. Barnhart*, 353 F.3d 602, 605 (8th Cir. 2003); *Kelley v. Callahan*, 133 F.3d 583, 587-88 (8th Cir. 1998) (citing *Ingram v. Chater*, 107 F.3d 598, 600 (8th Cir. 1997)). First, the Commissioner will consider a claimant's work activity. If the claimant is engaged in substantial gainful activity, then the claimant is not disabled. 20 C.F.R. § 404.1520(4)(i).

Second, if the claimant is not engaged in substantial gainful activity, the Commissioner looks to see "whether the claimant has a severe impairment that significantly limits the claimant's physical or mental ability to perform basic work activities." *Dixon*, 353 F.3d at 605; *accord Lewis v. Barnhart*, 353 F.3d 642, 645 (8th Cir. 2003). The United States Supreme Court has explained:

> The ability to do basic work activities is defined as "the abilities and aptitudes necessary to do most jobs." . . . Such abilities and aptitudes include "[p]hysical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling"; "[c]apacities for seeing, hearing, and speaking"; "[u]nderstanding, carrying out and remembering simple instructions"; "[u]se of judgment"; "[r]esponding appropriately to supervision, co-workers, and usual work situations"; and "[d]ealing with changes in a routine work setting."

Bowen v. Yuckert, 482 U.S. 137, 140-42, 107 S. Ct. 2287, 2291, 96 L. Ed. 2d 119 (1987) (citing 20 C.F.R. §§ 404.1521(b), 416.921(b)).

Third, if the claimant has a severe impairment, then the Commissioner will consider the medical severity of the impairment. If the impairment meets or equals one of the presumptively disabling impairments listed in the regulations, then the claimant is considered disabled, regardless of age, education, or work experience. 20 C.F.R. § 404.1520; *Kelley*, 133 F.3d at 588.

Fourth, if the claimant's impairment is severe, but it does not meet or equal one of the presumptively disabling impairments, then the Commissioner will assess the claimant's residual functional capacity ("RFC") to determine the claimant's "ability to meet the physical, mental, sensory, and other requirements" of the claimant's past relevant work. 20 C.F.R. §§ 404.1520(4)(iv); 404.1545(4); *see Lewis*, 353 F.3d at 645-46 ("RFC is a medical question defined wholly in terms of the claimant's physical ability to perform

exertional tasks or, in other words, 'what the claimant can still do' despite his or her physical or mental limitations.") (citing *Bradshaw v. Heckler*, 810 F.2d 786, 790 (8th Cir. 1987); 20 C.F.R. § 404.1520(e) (1986)); *Dixon*, *supra*. The claimant is responsible for providing evidence the Commissioner will use to make a finding as to the claimant's RFC, but the Commissioner is responsible for developing the claimant's "complete medical history, including arranging for a consultative examination(s) if necessary, and making every reasonable effort to help [the claimant] get medical reports from [the claimant's] own medical sources." 20 C.F.R. § 404.1545(3). The Commissioner also will consider certain non-medical evidence and other evidence listed in the regulations. *See id.* If a claimant retains the RFC to perform past relevant work, then the claimant is not disabled. 20 C.F.R. § 404.1520(4)(iv).

Fifth, if the claimant's RFC as determined in step four will not allow the claimant to perform past relevant work, then the burden shifts to the Commissioner "to prove that there is other work that [the claimant] can do, given [the claimant's] RFC [as determined at step four], age, education, and work experience." Clarification of Rules Involving Residual Functional Capacity Assessments, etc., 68 Fed. Reg. 51,153, 51,155 (Aug. 26, 2003). The Commissioner must prove not only that the claimant's RFC will allow the claimant to make an adjustment to other work, but also that the other work exists in significant numbers in the national economy. *Id.*; 20 C.F.R. § 404.1520(4)(v); *Dixon, supra*; *Pearsall v. Massanari*, 274 F.3d 1211, 1217 (8th Cir. 2001) ("[I]f the claimant cannot perform the past work, the burden then shifts to the Commissioner to prove that there are other jobs in the national economy that the claimant can perform.") (citing *Cox v. Apfel*, 160 F.3d 1203, 1206 (8th Cir. 1998)); *Nevland v. Apfel*, 204 F.3d 853, 857 (8th Cir. 2000). If the claimant can make an adjustment to other work that exists in significant numbers in the national economy, then the Commissioner will find the claimant is not

disabled. If the claimant cannot make an adjustment to other work, then the Commissioner will find the claimant is disabled. 20 C.F.R. § 404.1520(r)(v).

B. The Substantial Evidence Standard

The court reviews an ALJ's decision to determine whether the ALJ applied the correct legal standards, and whether the factual findings are supported by substantial evidence on the record as a whole. *Hensley v. Barnhart*, 352 F.3d 353, 355 (8th Cir. 2003); *Banks v. Massanari*, 258 F.3d 820, 823 (8th Cir. 2001) (citing *Lowe v. Apfel*, 226 F.3d 969, 971 (8th Cir. 2000)); *Berger v. Apfel*, 200 F.3d 1157, 1161 (8th Cir. 2000) (citing 42 U.S.C. § 405(g); *Richardson v. Perales*, 402 U.S. 389, 401, 91 S. Ct. 1420, 28 L. Ed. 2d 842 (1971)). This review is deferential; the court must affirm the ALJ's factual findings if they are supported by substantial evidence on the record as a whole. *Id.* (citing *Estes v. Barnhart*, 275 F.3d 722, 724 (8th Cir. 2002); *Krogmeier v. Barnhart*, 294 F.3d 1019, 1022 (8th Cir. 2002) (citing *Prosch v. Apfel*, 201 F.3d 1010, 1012 (8th Cir. 2000)); *Kelley v. Callahan*, 133 F.3d 583, 587 (8th Cir. 1998) (citing *Matthews v. Bowen*, 879 F.2d 422, 423-24 (8th Cir. 1989)); 42 U.S.C. § 405(g) ("The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive. . . ."). Under this standard, "[s]ubstantial evidence is less than a preponderance but is enough that a reasonable mind would find it adequate to support the Commissioner's conclusion." *Krogmeier, id.*; *Weiler v. Apfel*, 179 F.3d 1107, 1109 (8th Cir. 1999) (citing *Pierce v. Apfel*, 173 F.3d 704, 706 (8th Cir. 1999)); *accord Gowell v. Apfel*, 242 F.3d 793, 796 (8th Cir. 2001) (citing *Craig v. Apfel*, 212 F.3d 433, 436 (8th Cir. 2000)); *Hutton v. Apfel*, 175 F.3d 651, 654 (8th Cir. 1999); *Woolf v. Shalala*, 3 F.3d 1210, 1213 (8th Cir. 1993).

Moreover, substantial evidence "on the record as a whole" requires consideration of the record in its entirety, taking into account both "evidence that detracts from the Commissioner's decision as well as evidence that supports it." *Krogmeier*, 294 F.3d at 1022 (citing *Craig*, 212 F.3d at 436); *Willcuts v. Apfel*, 143 F.3d 1134, 1136 (8th Cir. 1998) (quoting *Universal Camera Corp. v. N.L.R.B.*, 340 U.S. 474, 488, 71 S. Ct. 456, 464, 95 L. Ed. 456 (1951)); *Gowell*, 242 F.3d at 796; *Hutton*, 175 F.3d at 654 (citing *Woolf*, 3 F.3d at 1213); *Kelley*, 133 F.3d at 587 (citing *Cline v. Sullivan*, 939 F.2d 560, 564 (8th Cir. 1991)). The court must "search the record for evidence contradicting the [Commissioner's] decision and give that evidence appropriate weight when determining whether the overall evidence in support is substantial." *Baldwin v. Barnhart*, 349 F.3d 549, 555 (8th Cir. 2003) (also citing *Cline*, *supra*).

In evaluating the evidence in an appeal of a denial of benefits, the court must apply a balancing test to assess any contradictory evidence. *Sobania v. Secretary of Health & Human Serv.*, 879 F.2d 441, 444 (8th Cir. 1989) (citing *Steadman v. S.E.C.*, 450 U.S. 91, 99, 101 S. Ct. 999, 1006, 67 L. Ed. 2d 69 (1981)). The court, however, does not "reweigh the evidence presented to the ALJ," *Baldwin*, 349 F.3d at 555 (citing *Bates v. Chater*, 54 F.3d 529, 532 (8th Cir. 1995)), or "review the factual record *de novo*." *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996) (citing *Naber v. Shalala*, 22 F.3d 186, 188 (8th Cir. 1994)). Instead, if, after reviewing the evidence, the court finds it "possible to draw two inconsistent positions from the evidence and one of those positions represents the agency's findings, [the court] must affirm the [Commissioner's] decision." *Id.* (quoting *Robinson v. Sullivan*, 956 F.2d 836, 838 (8th Cir. 1992), and citing *Cruse v. Bowen*, 867 F.2d 1183, 1184 (8th Cir. 1989)); *accord Baldwin*, 349 F.3d at 555; *Young v. Apfel*, 221 F.3d 1065, 1068 (8th Cir. 2000). This is true even in cases where the court "might have weighed the evidence differently." *Culbertson v. Shalala*, 30 F.3d 934, 939 (8th Cir.

1994) (citing *Browning v. Sullivan*, 958 F.2d 817, 822 (8th Cir. 1992)); *accord Krogmeier,* 294 F.3d at 1022 (citing *Woolf*, 3 F.3d at 1213). The court may not reverse the Commissioner's decision "merely because substantial evidence would have supported an opposite decision." *Baldwin*, 349 F.3d at 555 (citing *Grebenick v. Chater*, 121 F.3d 1193, 1198 (8th Cir. 1997)); *Young*, 221 F.3d at 1068; *see Pearsall*, 274 F.3d at 1217; *Gowell*, 242 F.3d at 796; *Spradling v. Chater*, 126 F.3d 1072, 1074 (8th Cir. 1997).

On the issue of an ALJ's determination that a claimant's subjective complaints lack credibility, the Sixth and Seventh Circuits have held an ALJ's credibility determinations are entitled to considerable weight. *See, e.g., Young v. Secretary of H.H.S.,* 957 F.2d 386, 392 (7th Cir. 1992) (citing *Cheshier v. Bowen,* 831 F.2d 687, 690 (7th Cir. 1987)); *Gooch v. Secretary of H.H.S.,* 833 F.2d 589, 592 (6th Cir. 1987), *cert. denied*, 484 U.S. 1075, 108 S. Ct. 1050, 98 L. Ed. 2d. 1012 (1988); *Hardaway v. Secretary of H.H.S.,* 823 F.2d 922, 928 (6th Cir. 1987). Nonetheless, in the Eighth Circuit, an ALJ may not discredit a claimant's subjective allegations of pain, discomfort or other disabling limitations simply because there is a lack of objective evidence; instead, the ALJ may only discredit subjective complaints if they are inconsistent with the record as a whole. *See Hinchey v. Shalala,* 29 F.3d 428, 432 (8th Cir. 1994); *see also Bishop v. Sullivan,* 900 F.2d 1259, 1262 (8th Cir. 1990) (citing *Polaski v. Heckler,* 739 F.2d 1320, 1322 (8th Cir. 1984)). As the court explained in *Polaski v. Heckler:*

> The adjudicator must give full consideration to all of the evidence presented relating to subjective complaints, including the claimant's prior work record, and observations by third parties and treating and examining physicians relating to such matters as:
>
> 1) the claimant's daily activities;
> 2) the duration, frequency and intensity of the pain;
> 3) precipitating and aggravating factors;

4) dosage, effectiveness and side effects of medication;
5) functional restrictions.

Polaski, 739 F.2d 1320, 1322 (8th Cir. 1984). *Accord Ramirez v. Barnhart*, 292 F.3d 576, 580-81 (8th Cir. 2002).

IV. ANALYSIS

As noted previously, Hayes complains the ALJ failed to evaluate his mental condition as instructed by the Appeals Council. He specifically complains the ALJ should have obtained further evidence of his mental condition before making any decision about the degree of his mental limitations. The court finds it unnecessary to address this particular argument, or the other grounds Hayes has raised for reversal, because the court finds the ALJ failed to comply with the instructions of the Appeals Council on remand in another respect; i.e., specifically with regard to evaluating the effect of Hayes's obesity on his ability to work.

The ALJ failed to account for Hayes's obesity in arriving at his residual functional capacity, and in determining Hayes would be able to work on a full-time basis. As the Social Security Administration has recognized, "The combined effects of obesity with other impairments may be greater than might be expected without obesity. For example, someone with obesity and arthritis affecting a weight-bearing joint may have more pain and limitation than might be expected from the arthritis alone." SSR 02-1p, Question 8. Although obesity is not, itself, a listed impairment, the SSA has "instruct[ed] adjudicators to consider the effects of obesity not only under the listings but also when assessing a claim at other steps of the sequential evaluation process, including when assessing an individual's residual functional capacity." SSR 02-1p, Intro.

The SSA further recognized that obesity "may also cause or contribute to mental impairments such as depression. The effects of obesity may be subtle, such as the loss of mental clarity and slowed reactions that may result from obesity-related sleep apnea." *Id.*, Question 2.

Of particular note in the present case is the following explanation by the SSA of how obesity may be a factor in whether an individual's impairments "equal" a listed impairment:

> We will also find equivalence if an individual has multiple impairments, including obesity, no one of which meets or equals the requirements of a listing, but the combination of impairments is equivalent in severity to a listed impairment. For example, obesity affects the cardiovascular and respiratory systems because of the increased workload the additional body mass places on these systems. Obesity makes it harder for the chest and lungs to expand. This means that the respiratory system must work harder to provide needed oxygen. This in turn makes the heart work harder to pump blood to carry oxygen to the body. Because the body is working harder at rest, its ability to perform additional work is less than would otherwise be expected. Thus, we may find that the combination of a pulmonary or cardiovascular impairment and obesity has signs, symptoms, and laboratory findings that are of equal medical significance to one of the respiratory or cardiovascular listings. [Footnote omitted.]

Id., Question 7. The Ruling goes on to explain that in evaluating obesity in assessing an individual's RFC, "[o]besity can cause limitation of function," in any number of ways, some of them not immediately apparently. For example, obesity can cause sleep apnea, which "can lead to drowsiness and lack of mental clarity during the day." *Id.*, Question 8. "Obesity may also affect an individual's social functioning." *Id.*

The court finds the record in this case contains an abundance of evidence that the combination of Hayes's obesity and his other impairments affects his functioning to such a degree that he would be unable to maintain competitive employment on a day-in, day-out basis. There is ample medical evidence that Hayes suffers from ongoing shortness of breath, asthma, and allergies. These are controlled by medication to an extent that allows Hayes to go about his daily activities, but the conditions remain present to a degree that requires frequent nebulizer treatments and use of inhalers. The evidence suggests these conditions are exacerbated greatly by Hayes's obesity.

The court finds the ALJ erred in relying on the lack of record evidence that would explain why Hayes has been unable to lose weight. (*See* R. 24) In cases pre-dating the deletion of Listing 9.09 (Obesity), courts consistently recognized that "'losing weight is a task which is not equivalent to taking pills or following a prescription.'" *Reed v. Sullivan*, 988 F.2d 812, 817 (8th Cir. 1993) (quoting *Hammock v. Bowen*, 879 F.2d 498, 503-04 (9th Cir. 1989), in turn relying on *Lovelace v. Bowen*, 813 F.2d 55, 59 (5th Cir. 1987) (Fifth Circuit faulted Commissioner for finding obesity to be *per se* remediable), and *Johnson v. Sec'y of H.H.S.*, 794 F.2d 1106, 1112-13 (6th Cir. 1986) (claimant's failure to lose weight does not necessarily constitute refusal to undertake treatment)). *Cf. O'Donnell v. Barnhart*, 318 F.3d 811, 819 (8th Cir. 2003) (failure to lose weight not necessarily inconsistent with allegations of disabling pain; obesity may be due to effects of medication or inability to exercise due to pain). The court finds these cases continue to be applicable despite the deletion of obesity as a stand-alone listing. The SSA ruling makes it clear that the effect obesity has on a claimant in combination with other impairments continues to be an important consideration during the sequential evaluation process. Nothing about the deletion of obesity as a separate listing negates the difficulties faced by an obese person in losing weight and otherwise functioning in spite of the

person's weight. In the present case, there is no evidence to indicate Hayes's obesity is "reasonably remediable in the light of [his] other disabilities." *Reed*, 988 F.2d at 818-19.

The evidence indicates Hayes was intermittently compliant with his diabetic diet and blood sugar testing. At least one physician suggested his depression could be a factor in his intermittent noncompliance with his diet. The record reflects one isolated occasion when Hayes failed to take his prescribed medications. That occasion was before Hayes began receiving his prescriptions through social service programs, and he stated he had been unable to afford the medications. Except for that one occasion, there is nothing in the record to suggest Hayes failed to take all of his numerous medications as directed by his physicians. He also kept his medical appointments. He attempted to exercise for purposes of weight loss, but found it difficult or impossible due to his other impairments. Considering the evidence as a whole, the court finds it was error for the ALJ to imply that Hayes should be able to lose weight if he complied with all of his doctors' orders.

Further, the court finds credible Hayes's testimony that, as a result of his medications and his depression, he often has difficulty concentrating and must nap during the day. Those complaints are supported by the medical evidence. In the consultative psychological assessment obtained by the DDS in June 1999, Dr. Rogers indicated Hayes's "attention and concentration wane at times in such a manner that there would be interference with his carrying out instructions." (R. 244) Dr. Rogers also noted Hayes's "physical problems and his personality style would make it difficult for him to maintain an adequate pace." (*Id.*) In addition, the court finds the ALJ erred in finding Hayes "failed to attend many counseling sessions." (R. 24) The record indicates Hayes missed three counseling appointments over a period of four years, with one of those being due to illness.

Hayes's applications for benefits have been pending now for six-and-a-half years. The Court may affirm, modify, or reverse the Commissioner's decision with or without remand to Commissioner for a rehearing. 42 U.S.C. § 405(g). "Where the record overwhelmingly supports a disability finding and remand would merely delay the receipt of benefits to which plaintiff is entitled, reversal is appropriate." *Thompson v. Sullivan*, 957 F.2d 611, 614 (8th Cir. 1992). In the present case, the court finds the record does not contain substantial evidence to support the Commissioner's decision that Hayes is not disabled. On the contrary, the court finds the record contains substantial evidence to support the opposite result. The court therefore finds reversal is appropriate.

V. CONCLUSION

For the reasons discussed above, **IT IS RESPECTFULLY RECOMMENDED**, unless any party files objections[4] to the Report and Recommendation in accordance with 28 U.S.C. § 636 (b)(1)(C) and Fed. R. Civ. P. 72(b), within ten (10) days of the service of a copy of this Report and Recommendation, that the Commissioner's decision be

[4]Objections must specify the parts of the report and recommendation to which objections are made. Objections must specify the parts of the record, including exhibits and transcript lines, which form the basis for such objections. *See* Fed. R. Civ. P. 72. Failure to file timely objections may result in waiver of the right to appeal questions of fact. *See Thomas v. Arn*, 474 U.S. 140, 155, 106 S. Ct. 466, 475, 88 L. Ed. 2d 435 (1985); *Thompson v. Nix*, 897 F.2d 356 (8th Cir. 1990).

reversed, judgment be entered for the plaintiff, and this matter be remanded for calculation and award of benefits.[5]

IT IS SO ORDERED.

DATED this 19th day of January, 2005.

PAUL A. ZOSS
MAGISTRATE JUDGE
UNITED STATES DISTRICT COURT

[5]**NOTE TO PLAINTIFF'S COUNSEL:** If final judgment is entered for the plaintiff, the plaintiff's counsel must comply with the requirements of Local Rule 54.2(b) in connection with any application for attorney fees.