

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

DALLAS ALLEN¹,

Plaintiff,

vs.

MICHAEL J. ASTRUE,
Commissioner of Social Security,

Defendant.

4:07-cv-00277-JAJ

ORDER

This matter comes before the court pursuant to briefs on the merits of Samuel Allen's applications for disability insurance benefits and supplemental security income benefits. The final decision of the Commissioner of Social Security is reversed and remanded for calculation and award of benefits.

I. PROCEDURAL BACKGROUND

Samuel Allen applied for disability benefits on March 22, 2005, alleging an inability to work since February 15, 2005 (Tr. 55-60). Allen later amended his alleged onset date to February 20, 2005 (Tr. 261). Allen's application was denied initially, and on reconsideration (Tr. 22-24; 27-30). Allen requested a hearing by an Administrative Law Judge ("ALJ") (Tr. 33). A hearing before ALJ George Gaffaney was held on April 11, 2006 (Tr. 255-81). The ALJ denied Allen's appeal in a decision dated October 18,

¹The underlying claimant and initial plaintiff in this matter, Samuel Allen, passed away on December 17, 2007. Title 42 U.S.C. § 404(d) provides that if an individual dies before any payment due him under this subchapter is completed, and there is no surviving spouse, then payment of the amount due shall be made to the child or children of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual. Dallas Allen, the son of Samuel Allen was substituted as the plaintiff in this matter on February 28, 2008 [dkt. 14].

2006 (Tr. 12-20). The Appeals Council denied Allen's request for further review on April 27, 2007 (Tr. 4-6). This action for judicial review was filed on June 20, 2007.

II. FACTUAL BACKGROUND

A. Medical History

An ultrasound of Allen's lower extremities was conducted on October 20, 2004 which found "normal femoral popliteal deep venous system" with "no DVT [] present" (Tr. 160). On October 27, 2004, Allen underwent an ankle arm index (Tr. 155-59). His doppler segmental pressures were within normal limits and doppler waveforms showed "relatively normal waveform contours and amplitudes." (Tr. 155). There was "some loss of triphasicity within the doppler signals on the left suggesting some possible mild underlying arterial insufficiency." (Tr. 155). His toe pressure in both great toes was within normal limits (Tr. 155). Following five minutes on the treadmill, Allen's ankle/arm index "dropped significantly on the left." The waveform analysis suggested the "possibility of mild underlying arterial insufficiency on the lefthand side." (Tr. 155).

Allen was hospitalized at Mercy Medical Center in Des Moines, Iowa, on November 6, 2004 following a fall (Tr. 137-51). An x-ray of his left knee showed "moderate-sized left knee joint effusion" but "no evidence of an acute fracture or dislocation." (Tr. 151). A CT scan of Allen's head was normal (Tr. 150). A chest x-ray revealed no active cardiopulmonary disease. (Tr. 149). An x-ray of Allen's cervical spine showed "no evidence of instrumentation failure or malalignment" and "no acute fractures." (Tr. 148). Allen's paraspinal soft tissue planes were intact (Tr. 148). An x-ray of his right knee found "three-compartment osteoarthritis, moderate in the medial compartment, and mild in the patellofemoral and lateral compartments." (Tr. 147). It also revealed small left knee joint effusion and ossific irregularity projecting over the superior aspect of the medial compartment (Tr. 147). Allen's history and physical state that he has

had “some lower extremity edema,” but that the “[w]orkup has been negative for DVT.” (Tr. 139). His distal pulses were 2+ and palpable throughout his upper and lower extremities (Tr. 139). Allen was strongly advised to stop smoking (Tr. 140). Allen was discharged on November 7, 2004 (Tr. 137).

Allen established care with Melinda Hubbard, PA-C on March 29, 2005 (Tr. 203-04). Allen saw Hubbard again on April 4, 2005 complaining of low back pain, worse than usual, and foot pain due to Buerger’s disease (Tr. 202). Allen reported that he was having trouble walking occasionally due to his foot pain (Tr. 202). On examination, his pedal pulses were +1/4 and he had venous stasis on his lower extremities (Tr. 202). His skin was very shiny (Tr. 202). Hubbard diagnosed Allen with lower extremity neuropathy and referred him to the podiatry department at Broadlawns Medical Center (Tr. 202).

Allen was seen by Dr. Amy J. Jaeger, DPM on April 11, 2005 (Tr. 200-01). Dr. Jaeger’s examination of Allen’s lower extremities revealed that his DP and PT pulses were nonpalpable (Tr. 200). Allen had diminished dorsal pedal hair growth bilaterally (Tr. 200). Allen had “mild pitting edema +1 bilaterally with skin trophic changes bilaterally (Tr. 200). A neurological examination revealed that Allen had diminished epicritic sensation to his toes as well as his plantar met heads bilaterally (Tr. 200). Dr. Jaeger assessed Allen as having neuropathy secondary to Buerger’s disease and probable peripheral vascular disease (Tr. 200). Dr. Jaeger discussed with Allen the need for him to quit smoking, as it will only worsen his condition (Tr. 200). Dr. Jaeger’s notes state: “It is probable that his numbness as well as the decreased vascular status of his feet is caused by his Buerger’s disease and the smoking habit.” (Tr. 200). Dr. Jaeger further opined that, “It would feel better for him to have his foot elevated than in a more dependent position.” (Tr. 200).

Allen saw Hubbard again on May 3, 2005 (Tr. 199). Hubbard again encouraged Allen to quit smoking (Tr. 199). At Allen’s June 7, 2005 appointment with Hubbard,

Allen reported that the pain in his feet is “getting to the point where it is unbearable.” (Tr. 198). Hubbard’s notes state that “[t]he pain medication does seem to help with that.” (Tr. 198). Allen was advised to follow up with podiatry regarding his lower extremity pain and was encouraged to wear TED hose to help with circulation and swelling (Tr. 198). Hubbard again “strongly encouraged” Allen to quit smoking, which she advised would help with his blood pressure and vascular problems (Tr. 198). Allen followed up with Hubbard again on July 15, 2005 (Tr. 197).

On March 24, 2006, Hubbard completed an assessment of Allen, wherein she opined that Allen could lift and/or carry 10 pounds occasionally and frequently, stand and/or walk less than two hours in an eight-hour workday, sit less than six hours in an eight-hour workday, and should never climb, stoop, kneel, crouch or crawl (Tr. 248). Hubbard further opined that Allen should seldom engage in continuous reaching, handling, fingering or feeling (Tr. 248). Hubbard noted that she had been treating Allen since March 1, 2005 and that “[d]ue to his multiple medical problems I don’t see how he can work any job on a sustained basis due to pain & fatigue” (Tr. 249). Hubbard stated that, due to Allen’s history of lymphedema, osteoarthritis of his knees and Buerger’s disease, he must elevate his legs and feet throughout the day above hip level to relieve pain and swelling (Tr. 249). Hubbard opined that Allen would need to walk and stretch for 10 minutes every hour, take at least two unscheduled breaks of 15 minutes per day, and that his symptoms would “more than likely” result in absences of three or more days per month (Tr. 249).

B. Consultative Examinations

Disability Determination Services referred Allen for a mental status examination, which was conducted by Dr. Suzan B. Simmons, Ph.D., on May 9, 2005 (Tr. 187-89). During this evaluation, Allen reported that he last worked in February 2005, that he disliked his job very much, and lost his job because he felt badly one night and went home

(Tr. 187). Allen further reported that his “spirits have been better since leaving his former place of employment” as he felt no “responsibility, challenge, or feelings of accomplishment” there (Tr. 187). Dr. Simmons observed that Allen had difficulty sitting down and standing back up, which she assumed to be a result of his neck and back pain (Tr. 187). Allen reported that he is in constant pain, which he rates as a seven or eight (Tr. 187). As for his daily activities, Allen reported that he likes to spend time on the computer, that he used to do photography, and that he takes care of his mother who has early signs of Alzheimer’s, as well as cleaning, cooking, and some yard work (Tr. 188). Dr. Simmons opined that Allen’s “disability would be primarily due to his chronic pain and the effect that his chronic pain has on his depression.” (Tr. 188-89). Dr. Simmons further recommended that Allen seek assistance for pain management and that “[i]t would be important that his pain is controlled prior to him returning to any type of work environment.” (Tr. 189).

On May 19, 2005, Dr. Majed Barazanji, M.D. conducted a physical examination of Allen, again at the request of Disability Determination Services (Tr. 190-96). Allen’s orthopedic exam revealed “pitting edema of both feet and ankles and some erythema.” (Tr. 191). Dr. Barazanji’s examination of Allen’s spine showed “tenderness to palpation of cervical and lumbar spine.” (Tr. 191). Allen had decreased range of motion of his knees, cervical spine, lumbar spine, and his straight leg test was bilaterally positive at 70 degrees (Tr. 191-92). X-rays revealed disc space narrowing at L5/S1 and mild narrowing of the S1 joints (Tr. 192). Dr. Barazanji’s impressions included senile osteoporosis, degenerative disc disease of L5/S1, generalized arteriosclerosis, and degenerative joint disease on the left S1 joint (Tr. 192). Dr. Barazanji offered the following opinions as to Allen’s residual functional capacity (RFC):

Patient will have problems with stooping, climbing, kneeling and crawling.

I don't see any limitation with this patient in handling objects, seeing, hearing, speaking and traveling.

There is no problems with work environments such as dust, fumes, temperature, hazards, etc.

Standing: Can be tolerated for 10-15 minutes.

Moving about, walking: Can be done for less than one block.

Sitting: Can be tolerated for less than an hour at a time.

This individual can lift 20 pounds.

(Tr. 192).

On May 23, 2005, Dr. Sandra Davis, Ph.D., completed a Psychiatric Review Technique and a Mental Residual Functional Capacity form regarding Allen (Tr. 211-36). Dr. Davis opined that Allen suffered from a pain disorder associated with "gen. med. and psych. factors" (Tr. 217). Dr. Davis further opined that Allen was mildly limited in his activities of daily living and in maintaining social function, moderately limited in maintaining concentration, persistence, or pace, and had no episodes of decompensation (Tr. 221). Dr. Davis opined that Allen was not significantly limited in his understanding and memory or sustained concentration and persistence, except that he was moderately limited in his ability to maintain attention and concentration for extended periods and in his ability to complete a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods (Tr. 225-26). Dr. Davis opined that Allen was moderately limited in his ability to interact appropriately with the general public, but otherwise not significantly limited in terms of social interaction or adaptation (Tr. 226). Dr. Davis found no evidence that Allen was limited in his ability to respond appropriately to changes in the work setting (Tr. 226). Dr. Davis's summary states, in part: "In summary, the claimant's medically determinable impairment would be considered severe. He has some subjective difficulty sustaining concentration; he is uncomfortable in crowds.

His pace would be interrupted by frequent breaks. The medical evidence is consistent.” (Tr. 227).

On June 9, 2005, Dr. Jan Hunter, D.O. completed a Physical Residual Functional Capacity Assessment of Allen (Tr. 229-36). Dr. Hunter opined that Allen could occasionally lift 20 pounds, frequently lift 10 pounds, stand and/or walk about six hours in an eight-hour workday, sit about six hours in an eight-hour workday, and was unlimited in his ability to push and/or pull (Tr. 230). Dr. Hunter further opined that Allen should never climb ladders, rope or scaffolds, but could occasionally climb ramps/stairs, balance, stoop, kneel, crouch, and crawl (Tr. 231). Dr. Hunter found no manipulative, visual, communicative, or environmental limitations (Tr. 232-33). Dr. Hunter’s summary states, in part:

In 11/04 the claimant underwent a lower extremity Doppler study which was normal. Updated information was needed. Therefore a CE was purchased which indicates that the claimant has a long history of back and knee pain which increases with activity. However the pain does not radiate. The exam revealed some edema of the LE, some decreased ROM of the knees and spine as well as a positive bilaterally SLR at 70 degrees. X-rays were also performed of the L-spine which showed some narrowing of L5/S1. A MSS from the CE restricted the claimant to limited standing and walking as well as limited sitting and the lifting of 20#s. However the claimant’s ADLs indicate that he is still able to do housework, yard work and cooking. Therefore due to the claimant’s current level of activity his credibility has been slightly eroded and would be restricted to the attached RFC.

(Tr. 234).

On September 7, 2005 Allen was examined again on a consultative basis, at the request of Disability Determination Services, by Dr. Robert C. Winchell, D.O. (Tr. 206-10). Dr. Winchell noted that Allen moved about the office and exam room without difficulty and using no assistive devices (Tr. 207). Dr. Winchell’s examination revealed

no tenderness over the spinous processes in the cervical, thoracic, or lumbar areas (Tr. 207). There was no gross deformity of Allen's spine (Tr. 207). According to Dr. Winchell, Allen's peripheral circulation is "grossly intact," although there were some "brawny changes about the left leg and left foot." (Tr. 207-08). Allen's deep tendon reflexes were 0 to 1/4 at his achilles (Tr. 208). Dr. Winchell offered the following assessment:

Based upon medical records available at this time, history and physical today, I would estimate that the patient should be able to lift and carry at least 50 to 60 pounds on an occasional basis and 20 to 25 pounds more frequently in an eight hour day. I see no significant problems with standing, moving about, walking or sitting in an eight hour day. I see no significant limitation to stooping, climbing, kneeling or crawling. I see no restriction in handling objects, seeing, hearing, speaking or traveling. Within reason, I see no limitation in the work environment in terms of dust, fumes, temperature changes or other hazards. In short, I find no physical reason why this patient can not be gainfully employed should he choose to do so.

(Tr. 208).

On September 21, 2005, Dr. John May, M.D. completed a Physical Residual Capacity Assessment of Allen (Tr. 237-44). Dr. May's opinions were identical to those of Dr. Hunter (Tr. 237-44).

C. Hearing Testimony

Allen testified that he lives with his 16 year-old son and his 82 year-old mother, who had been diagnosed with Alzheimer's (Tr. 262). His source of income is his sister (Tr. 262). Allen testified that his last job was a control center operator, which he quit because he "hated it" as there was "no challenge, no sense of accomplishment" (Tr. 263). Allen also testified that he was working the graveyard shift and "it just got to my nerves." (Tr. 263). Allen testified that he never looked for another job because his feet were

hurting so bad and he was having a lot of trouble walking (Tr. 264). Allen testified that he can only drive for 20 minutes before he has to take a break and get out of his car due to his knee and neck pain (Tr. 264).

Allen testified that he is taking Oxycodone and Methadone for pain, which help, but not that much (Tr. 265). Allen testified that he was down to smoking about five cigarettes per day (Tr. 266). Allen testified that the pain in his neck sometimes spreads to his shoulder and has gotten worse since his surgery in 2002 (Tr. 266). Sitting too long makes his neck pain worse (Tr. 267). He is most comfortable sitting in a recliner with a pillow under his head (Tr. 267).

With respect to his knee pain, Allen testified that both knees hurt every day, and that the pain is made worse by walking (Tr. 267-68). Allen testified that his feet are numb, but still so sensitive that a “real mild bump and it just sends it right off the scale.” (Tr. 268). Allen testified that his legs swell up “every once in a while” and that his feet were “purplish-gray” at the time of the hearing (Tr. 268). Nothing makes his feet feel better (Tr. 268). Allen testified that he elevates his feet probably a minimum of six to eight times per day for twenty minutes or so, in his recliner (Tr. 269).

Allen testified that he has good and bad days, and on his bad days he keeps himself “stretched out” and tries not to “get too aggressive with working or anything like that.” (Tr. 271). On a good day he could maybe walk around the mall once (Tr. 271). Allen testified that he has three to four bad days per week (Tr. 271).

Allen testified that he could lift 15 or 20 pounds a few times during an average day, stand maybe 15 or 20 minutes, and can sit for 20 to 30 minutes (Tr. 271-72). Allen testified that he has trouble going down stairs due to his knees (Tr. 272).

The ALJ posed the following hypothetical scenario to the vocational expert:

The first one is to limit lifting to 20 pounds occasionally and 10 pounds frequently, stand and sit six hours each in an eight-hour workday, all the non-exertional physical limits are

occasional only except no ladder climbing. So occasional stair climbing, balance, stoop, kneel, crouch and crawl. Frequently only exposure to extremes of cold. Able to do more than simple, routine work but not complex, in other words semi-skilled work, with frequently only rather than functional capacity, could past relevant work be performed?

(Tr. 277).

The vocational expert responded that Allen could still perform his past work as a bartender and merchant patroller (Tr. 277). The ALJ then posed the following hypothetical scenario:

Second hypothetical would be the same as number one except I'd limit standing and sitting to 30 minutes at a time, then require a slight positional change. With that addition, could past relevant work be performed?

(Tr. 277).

The vocational expert responded that the 30 minute sitting and standing limitations would preclude Allen's past work as a bartender and merchant patroller, both of which were "light" jobs (Tr. 277). Under the second hypothetical, Allen would be limited to sedentary jobs (Tr. 277).

When questioned by Allen's attorney, the vocational expert testified that Allen would be precluded from performing any jobs if limited to no climbing, stooping, kneeling, crouching, crawling, occasional reaching, handling, fingering, and feeling, avoiding concentrated cold, and only occasional contact with the public (Tr. 278-79). The vocational expert further testified that taking two unscheduled breaks due to pain and concentration issues would preclude competitive employment (Tr. 279).

III. CONCLUSIONS OF LAW

A. Scope of Review

In order for the court to affirm the ALJ's findings of fact, those findings must be supported by substantial evidence appearing in the record as a whole. See Lochner v. Sullivan, 968 F.2d 725, 727 (8th Cir. 1992); Cruse v. Bowen, 867 F.2d 1183, 1184 (8th Cir. 1989). Substantial evidence is more than a mere scintilla. It means relevant evidence a reasonable mind might accept as adequate to support a conclusion. Richardson v. Perales, 402 U.S. 389, 401 (1997); Cruse, 867 F.2d at 1184; Taylor v. Bowen, 805 F.2d 329, 331 (8th Cir. 1986). The court must take into account evidence that fairly detracts from the ALJ's findings. Cruse, 867 F.2d at 1184; Hall v. Bowen, 830 F.2d 906, 911 (8th Cir. 1987). Substantial evidence requires "something less than the weight of the evidence, and the possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency's findings from being supported by substantial evidence."). Cruse, 867 F.2d at 1184 (quoting Consolo v. Fed. Mar. Comm'n, 383 U.S. 607, 620 (1966)). The court must consider the weight of the evidence appearing in the record and apply a balancing test to contradictory evidence. Gunnels v. Bowen, 867 F.2d 1121, 1124 (8th Cir. 1989); Gavin v. Heckler, 811 F.2d 1195, 1199 (8th Cir. 1987).

B. ALJ's Disability Determination

Determining whether a claimant is disabled involves a five-step evaluation. See 20 C.F.R. § 404.1520(a)-(f); Bowen v. Yuckert, 482 U.S. 137, 140 (1987).

The five steps are:

- (1) If the claimant is engaged in substantial gainful activity, disability benefits are denied.
- (2) If the claimant is not engaged in substantial gainful activity, her medical condition is evaluated to determine whether her impairment, or combination of impairments, is medically severe. If the impairment is not severe, benefits are denied.

- (3) If the impairment is severe, it is compared with the listed impairments the Secretary acknowledges as precluding substantial gainful activity. If the impairment is equivalent to one of the listed impairments, the claimant is disabled.
- (4) If there is no conclusive determination of severe impairment, then the Secretary determines whether the claimant is prevented from performing the work she performed in the past. If the claimant is able to perform her previous work, she is not disabled.
- (5) If the claimant cannot do her previous work, the Secretary must determine whether she is able to perform other work in the national economy given her age, education, and work experience.

Trenary v. Bowen, 898 F.2d 1361, 1364 n.3 (8th Cir. 1990) (citing Yuckert, 482 U.S. at 140–42); 20 C.F.R. § 404.1520(a)–(f).

“To establish a disability claim, the claimant bears the initial burden of proof to show that he is unable to perform his past relevant work.” Frankl v. Shalala, 47 F.3d 935, 937 (8th Cir. 1995) (citing Reed v. Sullivan, 988 F.2d 812, 815 (8th Cir. 1993)). If the claimant meets this burden, the burden of proof then shifts to the Commissioner to demonstrate that the claimant retains the physical residual functional capacity (RFC) to perform a significant number of other jobs in the national economy that are consistent with the claimant’s impairments and vocational factors such as age, education and work experience. Id.

Under the first step of the analysis, the ALJ found that Allen had not engaged in substantial gainful activity at any time pertinent to the decision (Tr. 14). At the second step, the ALJ determined that Allen has the following severe impairments: degenerative disc disease of the cervical and lumbar spine; obesity; osteoarthritis of the knees; Buerger’s disease of the feet; lymphedema; depression; and somatoform pain disorder (Tr.

14). At the third step, the ALJ found that Allen did not have an impairment or combination of impairments that meets or medically equals a listed impairment (Tr. 15). Proceeding to the fourth step, the ALJ determined that Allen was able to perform his past relevant work as a bartender and merchant patroller (Tr. 19). Therefore, the ALJ found that Allen was not disabled within the meaning of the Social Security Act at any time through the date of the decision (Tr. 19-20).

C. Treating Source Opinion

With respect to Hubbard's opinion, the ALJ found:

A physician's assistant gave the opinion as documented in Exhibit 15F that the claimant is disabled. The undersigned does not give much weight to this opinion because it is not consistent with the evidence in its entirety. In addition, the physician's assistant is not a treating physician whose opinion is entitled to controlling weight.

(Tr. 19).

On August 9, 2006, the Social Security Administration (SSA) issued Social Security Ruling (SSR) 06-3p, which clarified how it considers opinions from sources who are not what the agency terms "acceptable medical sources." 71 Fed. Reg. 45,593. Under SSA regulations, "acceptable medical sources" include licensed physicians, licensed or certified psychologists, licensed optometrists, licensed podiatrists, and qualified speech-language pathologists. See 20 C.F.R. §§ 404.1513(a) and 416.913(a). Only "acceptable medical sources" can provide evidence to establish the existence of a medically determinable impairment, provide medical opinions, and be considered treating sources, whose opinions may be entitled to controlling weight. See 20 C.F.R. §§ 404.1513(a), 404.1527(a)(2), 416.927(a)(2), 404.1502, 416.902, 404.1527(d), and 416.927(d).

Information from "other sources," as defined in 20 C.F.R. §404.1513(d) and 416.913(d) may be used to demonstrate the severity of the individual's impairment(s) and

how it affects an individual's ability to function. 71 Fed. Reg. 45,593 *45,594. These sources include, but are not limited to physician assistants. Id.

Information from these "other sources" cannot establish the existence of a medically determinable impairment. Instead, there must be evidence from an "acceptable medical source" for this purpose. However, information from such "other sources" may be based on special knowledge of the individual and may provide insight into the severity of the impairment(s) and how it affects the individual's ability to function.

Id.

Factors to consider in considering opinion from "other sources" include:

- How long the source has known and how frequently the source has seen the individual;
- How consistent the opinion is with other evidence;
- The degree to which the source presents relevant evidence to support an opinion;
- How well the source explains the opinion;
- Whether the source has a specialty or area of expertise related to the individual's impairment(s); and
- Any other factors that tend to support or refute the opinion.

Id. at 45,595.

Opinions from "other medical sources" may reflect the source's judgment about some of the same issues addressed in medical opinions from "acceptable medical sources," including symptoms, diagnosis and prognosis, what the individual can still do despite the impairment(s), and physical and mental restrictions.

Not every factor for weighing opinion evidence will apply in every case. The evaluation of an opinion from a medical

source who is not an “acceptable medical source” depends on the particular facts in each case. Each case must be adjudicated on its own merits based on a consideration of the probative value of the opinions and a weighing of all the evidence in that particular case.

The fact that a medical opinion is from an “acceptable medical opinion” is a factor that may justify giving that opinion greater weight than an opinion from a medical source who is not an “acceptable medical source” because, as we previously indicated in the preamble to our regulations at 65 FR 34955, dated June 1, 2000, “acceptable medical sources” “are the most qualified health care professionals.” However, depending on the particular facts in a case, and after applying the factors and weighing opinion evidence, an opinion from a medical source who is not an “acceptable medical source” may outweigh the opinion of an “acceptable medical source,” including the medical opinion of a treating source.

...

Since there is a requirement to consider all relevant evidence in an individual’s case record, the case record should reflect the consideration of opinions from medical sources who are not “acceptable medical sources” and from “non-medical sources” who have seen the claimant in their professional capacity. Although there is a distinction between what an adjudicator must consider and what the adjudicator must explain in the disability determination or decision, the adjudicator generally should explain the weight given to opinions from these “other sources,” or otherwise ensure that the discussion of the evidence in the determination or decision allows a claimant or subsequent reviewer to follow the adjudicator’s reasoning, when such opinions may have an effect on the outcome of the case.

Id. at 45,595-6.

The court's review of the record reveals that Allen established care with Hubbard in March 2005 and saw Hubbard eight times prior to her March 24, 2006 assessment. The length and frequency of Allen's treatment relationship with Hubbard weigh in favor of affording Hubbard's opinion more weight than afforded by the ALJ. Moreover, the ALJ's rationale for "not giv[ing] much weight" to Hubbard's opinion, i.e., "it is not consistent with the evidence in its entirety" is hardly a "discussion of the evidence in the determination or decision allows a claimant or subsequent reviewer to follow the adjudicator's reasoning." SSR 06-3p. Hubbard's opinion is consistent with the April 11, 2005 opinion of Dr. Jaeger, i.e.,

He does have an etiology of Buerger's disease which would bring about the discoloration of his toes as well as some numbness to his toes . . . It is probable that his numbness as well as the decreased vascular status of his feet is caused by his Buerger's disease and the smoking habit. It would feel better for him to have his foot elevated than in a more dependent position.

(Tr. 200).

Likewise, Hubbard's opinion is consistent with the May 5, 2005 opinion of Dr. Simmons that it is important that Allen's pain be controlled prior to him returning to any type of work environment, and with the May 19, 2005 opinion of Dr. Barazanji. Drs. Jaeger, Simmons, and Barazanji are "acceptable medical sources." The only inconsistent evidence in the record is the September 7, 2005 opinion of Dr. Winchell, although Dr. Winchell did note "some brawny changes about the left lower leg and left foot," as well as the opinions of Drs. Davis, Hunter, and May, none of whom actually examined Allen. 20 C.F.R. § 404.1527(d) ("Generally, we give more weight to the opinion of a source who has examined you than to the opinion of a source who has not examined you."). There is no requirement that Hubbard's opinion be consistent with the file evidence "in its entirety" in order to be afforded due weight.

A review of Dr. Winchell's report reveals that he, in connection with his examination of Allen, reviewed a podiatry clinic note dated April 5, 2005, clinic notes dated May 23, 2005 and July 11, 2005, but no other medical records or x-rays (Tr. 206). A November 2004 x-ray revealed three-compartment osteoarthritis in his right knee. Dr. Barazanji's May 2005 examination revealed pitting edema in both Allen's feet and ankles and decreased range of motion in Allen's knees, cervical spine, and lumbar spine. X-rays revealed disc space narrowing at L5/S1 and mild narrowing of the S1 joints.

The court finds that the ALJ did not have adequate reason to discount the opinions of Hubbard and Drs. Simmons, Jaeger, and Barazanji. Hubbard's opinion should have been afforded greater weight than that of Dr. Winchell, as it was the result of an established patient relationship with Allen and consistent with the other evidence in the file. Giving Hubbard's opinion the proper weight, the medical evidence in the record as a whole establishes that Allen was disabled. The ALJ's decision to the contrary was not supported by substantial evidence in the record as a whole and must be reversed. Accordingly, this matter is remanded to the Commissioner for calculation and award of benefits.

Upon the foregoing,

IT IS ORDERED that the decision of the ALJ is reversed and remanded for calculation and award of benefits. The Clerk of Court shall enter judgment accordingly.

DATED this 19th day of September, 2008.



JOHN A. JARVEY
UNITED STATES DISTRICT JUDGE
SOUTHERN DISTRICT OF IOWA