IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

JILL CLOUTE,

Petitioner,

REPORT AND
RECOMMENDATION

v.

03-C-0737-C

JO ANNE B. BARNHART, Commissioner
of Social Security,

Respondent.

This is an appeal of an adverse decision of the Commissioner of Social Security brought pursuant to 42 U.S.C. § 405(g). Plaintiff Jill Cloute challenges the commissioner's determination that in spite of her seizure disorder, depression and post-herpetic neuralgia, Cloute is able to return to her past work as a mortgage loan closer, secretary or loan processor and therefore she is not disabled as that term is defined under sections 216(i) and 223 and of the Social Security Act, codified at 42 U.S.C. §§ 416(i), 423(d). Because I conclude that the administrative law judge who decided Cloute's claim at the hearing level failed in her decision to build an accurate and logical bridge from the evidence to her conclusion that Cloute is able to return to her past relevant work, I am recommending that this case be remanded to the commissioner. In particular, the administrative law judge made inconsistent findings concerning the severity of plaintiff's mental impairment and failed to

adequately resolve evidentiary conflicts concerning the nature, duration and frequency of Cloute's seizures.

The following facts are drawn from the administrative record.

FACTS

I. Legal and Statutory Framework

Under the Social Security Act, a disability is 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. § 1382c(a)(3)(A). A physical or mental impairment is "an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques." 42 U.S.C. § 1382c(a)(3)(C).

The commissioner has promulgated regulations setting forth the following five-step sequential inquiry to determine whether a claimant is disabled:

(1) Is the claimant currently employed?

(2) Does the claimant have a severe impairment?

(3) Does the claimant's impairment meet or equal one of the impairments listed by the SSA?

(4) Can the claimant perform his or her past work? and

(5) Is the claimant is capable of performing work in the national economy?

See 20 C.F.R. § 404.1520. The inquiry at steps four and five requires an assessment of the claimant's "residual functional capacity," which the commissioner has defined as "an assessment of an individual's ability to do sustained work-related physical and mental activities in a work setting on a regular and continuing basis." Social Security Ruling 96-8p. "A 'regular and continuing basis' means 8 hours a day, for 5 days a week, or an equivalent work schedule." *Id*.

In seeking benefits the initial burden is on the claimant to prove that a severe impairment prevents him from performing past relevant work. If he can show this, the burden shifts to the commissioner to show that plaintiff was able to perform other work in the national economy despite the severe impairment. *See Stevenson v. Chater*, 105 F.3d 1151, 1154 (7th Cir. 1997); *Brewer v. Chater*, 103 F.3d 1384, 1391 (7th Cir. 1997).

II. Medical Evidence

In March 1999, plaintiff saw her doctor for complaints of pain and a rash involving her left shoulder and arm. Plaintiff was diagnosed with herpes zoster, known commonly as shingles. Plaintiff was prescribed neurontin and vicodin. On April 30, 1999, plaintiff reported that she still had pain that varied in intensity. She was taking 1/2 a vicodin tablet twice a day which helped to "take the edge off" the pain but did not eliminate it completely.

Plaintiff was prescribed Tegretol. On May 25, 1999, plaintiff reported that her discomfort "was significantly decreased, though certainly not gone" on the medication.

At a follow-up on August 2, 1999, plaintiff reported that she still had variable pain that could be quite severe. She said she had the worst pain every 10 days or so, with the pain occurring off and on for 10-15 minute episodes. Plaintiff reported that because of the sedative effects of the Tegretol, she limited when and how far she drove and had not returned to her job as a legal clerk. Her doctor offered to try a different medication that might be less sedative but also not as effective at relieving the pain. Plaintiff stated that she was more concerned about getting the most effective pain relief than with resuming normal activity.

On September 3, 1999, plaintiff reported that she still had pain that she said averaged a 6 but sometimes flared up to a 10 on a 10-point scale. She reported feeling less drowsy but she still had not returned to work. Plaintiff's doctor increased her tegretol dosage.

On February 10, 2000, plaintiff saw nurse practitioner Barb Reineke for a physical exam. Plaintiff reported recent episodes of disorientation, difficulty speaking, memory loss, dizziness and tremors. Reineke referred plaintiff to neurologist Dr. Ivy Dreizin.

Plaintiff reported having five of these episodes during the preceding three and a half months. During one episode, plaintiff exited a department store and did not know where she was or what store she had been in. During another, she was driving with her mother and suddenly had no idea where she was. Another time, she was counting out change to pay for

her lunch at a restaurant and she could not recall how much the coins in her hand were worth. Plaintiff described these spells as lasting about two to three minutes, with her behavior returning to normal afterwards. Plaintiff told Dr. Dreizin that she did not lose consciousness and no one had told her about any rhythmic mouth movements or other automatisms associated with them. Dr. Dreizin noted that although plaintiff had lapses of attention and memory, she functioned normally in between spells, planning family meals, balancing the checkbook and running the household. Dr. Dreizin opined that plaintiff was probably experiencing complex partial seizures.

At a follow up visit on April 28, 2000, Dr. Dreizin noted that results of an MRI and EEG were both normal. Plaintiff reported having had three more seizures since her last visit. Plaintiff's husband saw one of the seizures and noticed that plaintiff got a blank look on her face; afterwards, she looked normal. Plaintiff said that after the seizure, she was tired and had blurry vision for about 90 minutes before she was completely back to normal. Dr. Dreizin reported that plaintiff's husband had seen other spells and noticed that plaintiff smacked her lips during them. Dr. Dreizin opined that even though the MRI and EEG were normal, plaintiff's spells were likely complex partial seizures. She adjusted plaintiff's medications.

On June 23, 2000, plaintiff reported still having seizures and "zone out" spells. Plaintiff described an episode in which she was talking to her daughter but suddenly could not come up with the words to answer her daughter's question. She described feeling "out

of it" on various occasions during which she is unable to talk. Dr. Dreizin questioned whether plaintiff's symptoms were being caused by a psychological condition instead of a neurologic condition. After an ambulatory EEG failed to show evidence of seizure activity, Dr. Dreizin referred plaintiff for a psychiatric evaluation. Specifically, she questioned whether the spells might be dissociative events.

Plaintiff had a psychiatric evaluation with Dr. Barbara Calhoun on August 9, 2000. Plaintiff reported concentration problems, forgetfulness and tearfulness. Dr. Calhoun noted that plaintiff had depressive symptoms and had undergone significant life changes, including a recent separation from her husband. She noted that cognitively, plaintiff was grossly intact with no psychotic thought processes or suicidal ideation. She opined that it was difficult to determine whether plaintiff's symptoms were caused by the seizure activities, side effects of the anti-seizure medications or depression. Dr. Calhoun diagnosed plaintiff with a depressive disorder and prescribed Celexa, an anti-depressant.

Plaintiff saw Dr. Dreizin on August 18, 2000. After hearing plaintiff describe her spells again, Dr. Dreizin concluded that they were seizures as opposed to dissociative episodes. Dr. Dreizin noted that plaintiff reported a decrease in her spells since her medications were adjusted. However, two months later, Dr. Dreizin reported that plaintiff's seizures had become more frequent. Plaintiff described having "zone out" spells five or six days a week. In addition, she reported two seizures that her sister had witnessed. During one, plaintiff licked her lips, felt like everything was far from her and felt confused afterwards

for five or 10 minutes. During the second seizure, plaintiff's sister noticed that plaintiff made "weird" movements with her mouth and her body twitched. The whole spell was about 15 minutes in length, after which plaintiff slept for two hours. In addition to her spells, plaintiff complained of a general loss of cognitive function, noting that she forgot well-known recipes, left stove burners on and had a hard time balancing her checkbook. Plaintiff said she no longer had the mental ability to return to a job like her past job as a mortgage closer.

On December 27, 2000, plaintiff was evaluated by a neuropsychologist, Jerry Hasten, Ph.D. The purpose of the evaluation was to determine whether plaintiff had neurocognitive deficits associated with her seizure disorder. Hasten noted that plaintiff complained of memory problems, slowed thinking speed, distractibility, poor concentration and difficulty following conversations. Plaintiff reported that she had had these problems for six months and that they were present even when she was not having a seizure. Tests administered to plaintiff showed that her general intellectual functioning and global cognitive functioning were both average for her age and did not suggest an overall pattern of decline in her neurocognitive abilities. However, plaintiff did display some difficulty on learning and memory tests and mildly slowed expressive language abilities. Hasten noted that a combination of a residual affective disturbance and the side effects of medications could be causing the more extreme memory lapses that plaintiff reported. He diagnosed plaintiff with a mild memory disturbance.

On May 17, 2001, Barbara Reineke, a nurse practitioner, signed a residual functional capacity questionnaire regarding plaintiff. Reineke described plaintiff's symptoms as seizures, "zone out" spells, loss of cognitive function and pain. She opined that plaintiff's pain would frequently interfere with her attention and concentration and that plaintiff had a marked limitation in her ability to deal with work stress. She opined that plaintiff could stand or walk for less than two hours a day, sit about four hours per day and could never lift objects weighing less than 10 pounds. On question #16, which asked for a description of other limitations that would affect plaintiff's ability to work on a full time basis, the following comment appears: "Her seizures and 'spells' which are unpredictable prevent [plaintiff] from driving or working with any machinery. She could never work alone or supervised." AR 257. Reineke checked a box indicating that plaintiff would be absent from work more than three times a month.

On June 1, 2001, Dr. Calhoun wrote a letter to plaintiff's attorney in which she provided a summary of her treatment and diagnosis of plaintiff. Dr. Calhoun noted that she had seen plaintiff on six occasions, primarily for medication management. Dr. Calhoun noted that plaintiff had been seen briefly for psychotherapy but after two sessions plaintiff reported that she was feeling better and did not want to be seen for therapy any longer. According to Dr. Calhoun, plaintiff's chief complaints were sleep disturbance which was often secondary to her neuralgia pain and difficulty thinking or concentrating which was most likely caused by the side effects of plaintiff's anticonvulsant medications. Dr. Calhoun

found that plaintiff had no restriction in her activities of daily living or social functioning as a result of any mental impairment. She noted that plaintiff had a slight decrease in concentration which appeared to be related to her anticonvulsants. Dr. Calhoun reported that she had encouraged plaintiff to work with the Department of Vocational Rehabilitation but plaintiff did not think she could work in any structured setting because of the unpredictable nature of her neuralgia pain. Dr. Calhoun noted that from a psychiatric standpoint, plaintiff "clearly is able to work." However, she noted that Dr. Dreizen would need to comment on plaintiff's prognosis regarding her seizures.

On June 6, 2001, Dr. Dreizin completed a residual functional capacity questionnaire regarding plaintiff. Many of the sections of the form are completed in the same handwriting that appears on the form completed by Reineke, with other portions appearing to have been covered with a correction fluid. Dr. Dreizin indicated that plaintiff's symptoms consisted of lapses of attention and she described her prognosis as "fair." She indicated that questions concerning plaintiff's ability to concentrate and deal with work stress could be better answered by Dr. Calhoun and questions regarding plaintiff's physical abilities could be better answered by Reineke. Dr. Dreizin indicated that plaintiff had no exertional limitations as a result of her neurologic condition.

III. Administrative Proceedings

Plaintiff applied for disability insurance benefits on May 12, 2000, alleging that she had been disabled since February 26, 1999 from a seizure disorder and post-herpetic neuralgia. After the local disability agency denied her application initially and on reconsideration, plaintiff requested a hearing before an administrative law judge. A hearing was held on May 9, 2001, before Administrative Law Judge Dale Garwal.

At the time of the hearing, plaintiff was 47 years old. She had a high school education and past relevant work as a secretary for a convenience store, a loan processor for a bank and a mortgage loan closer for a law office. Her jobs as a secretary and a mortgage loan closer both involved significant driving.

Plaintiff testified that she stopped working in February 1999 because of her shingles. Plaintiff testified that although the rash had cleared, she still had nearly constant burning pain across her chest and down her left arm as a residual effect of the shingles. She testified that because of the pain, she was essentially unable to use her left arm or hand.

Plaintiff also testified that she was unable to work because of a seizure disorder. She testified that about three times a month, she has an episode of "mumbling and stumbling" when she has confusion and difficulty balancing and speaking. In addition, she has a more severe seizure about once a month. Plaintiff said she did not know when she last had a seizure. Plaintiff testified that she also suffers from memory problems, muscle spasms and

depression. She testified that she had less grogginess from her medications since Dr. Dreizin adjusted them in Fall 2000.

Plaintiff testified that because of her seizures, she does not drive, does very little cooking and tries not to go anywhere alone. She testified that she had converted her one-car garage into a one-room suite including furniture, a microwave and a small refrigerator. Plaintiff testified that she lived in that part of the house because it was a controlled environment and it reduced her anxiety. Plaintiff's daily routine included preparing light meals, performing light housekeeping, watching television, and doing paint by numbers or crossword puzzles. Plaintiff testified that she read but she had a hard time concentrating.

IV. ALJ's Decision

On October 30, 2001, Administrative Law Judge Marsha Stroup issued a decision denying plaintiff's claim. ALJ Stroup noted that the case had been assigned to her because the ALJ who had conducted the hearing was not available to issue the decision. ALJ Stroup noted that she had thoroughly reviewed the evidence of record and found that a second hearing was not required to adjudicate the case.

In her decision, the ALJ followed the Commissioner's sequential evaluation process. After concluding that plaintiff had not engaged in any substantial gainful activity after her alleged onset date, the ALJ found at step two that plaintiff suffered from severe impairments, namely, a depressive disorder, seizure disorder, shingles, tremor and anxiety. However, she

found at step three that none of plaintiff's impairments, either singly or in combination, met or equaled any section in the listed impairments. In assessing the severity of plaintiff's mental impairment, the ALJ considered the objective evidence, including the reports from Dr. Calhoun and Hasten. Applying the commissioner's procedure for evaluating mental impairments, *see* 20 C.F.R. § 404.1520a, the ALJ found that plaintiff had no restrictions in her activities of daily living; mild limitations in her social functioning; slight restrictions in her ability to concentrate and attend as a result of side effects of her medications; and no episodes of decompensation. (In order to satisfy the criteria of a listed mental impairment, plaintiff had to have "marked" limitations in at least two of the categories.)

The ALJ proceeded to evaluate plaintiff's residual functional capacity. She concluded that in spite of her impairments, plaintiff retained the ability to perform work activity at the light exertional level (jobs involving substantial sitting, walking or standing and lifting up to 20 pounds) that did not require her to climb, balance or work at heights or around hazardous machinery. In reaching this conclusion, the ALJ considered plaintiff's testimony regarding her limitations but found that it was not entirely credible. With respect to plaintiff's complaints of constant pain in her left arm and shoulder, the ALJ found that the absence of intensive medical treatment, hospitalizations, emergency room visits or intensive pain-treatment measures such as injections or a pain clinic was inconsistent with the disabling level of pain alleged by plaintiff. In addition, the ALJ noted that the medical

evidence contained records that indicated that plaintiff's pain was controlled with Tegretol and plaintiff had not been medically restricted from working.

The ALJ found plaintiff's complaints of disabling depressive symptoms to be inconsistent with Dr. Calhoun's report in which she indicated that although plaintiff had some symptoms of depression, they were not severe enough to warrant a diagnosis of major depression or to prevent plaintiff from working. In addition, the ALJ noted that plaintiff had declined psychotherapy after two sessions.

The ALJ also noted plaintiff's complaints of memory and concentration problems related to her seizures, as well as the reports from plaintiff's husband and daughter. The ALJ contrasted plaintiff's testimony with the objective medical evidence, which showed no brain abnormalities, and the testing administered by Halsten, which found little decline in plaintiff's neurocognitive functioning. The ALJ noted that plaintiff's doctors had opined that plaintiff's reports of memory and concentration problems could be a side effect of her anti-convulsant medications. However, the ALJ concluded that plaintiff's cognitive deficits were only mild, noting that "the claimant's neurologist and neuropsychologist opined that the claimant's learning and memory difficulties are mild and do not significantly impact on her daily functioning." AR 22. She also noted again that Dr. Calhoun had indicated that plaintiff was able to work. The ALJ also noted that apart from not driving or going places alone, plaintiff performed "full and effective" activities of daily living, including self-care, meal-planning, light cooking and housecleaning, paying bills, reading, putting jigsaw puzzles

together, visiting with her daughter, attending medical appointments and talking on the phone. The ALJ concluded that plaintiff's ability to perform these activities "negatively impact on her allegations of a totally disabling condition." AR 21.

The ALJ also considered the residual functional capacity assessments from Reinecke and Dr. Dreizin. She found that Reinecke's opinion was entitled to little weight because of significant inconsistencies between the RFC form and the record, including Reinecke's lack of a regular treatment relationship with plaintiff, the absence of objective evidence to support the limitations identified by Reinecke, and the reports from Dr. Calhoun which suggested lesser mental limitations than those identified by Reinecke. In addition, the ALJ noted that the credibility of the form was questionable because it was completed in the same handwriting as that used on the form allegedly completed by Dr. Dreizin and the answers to some questions did not make sense.

The ALJ found the form allegedly completed by Dr. Dreizin to be suspect for many of the same reasons. The ALJ noted the similar handwriting and the fact that someone had used a "white-out" product to alter or remove some of the answers. She also noted that Dr. Dreizin had deferred on many questions to Reineke and had qualified some answers by writing "per patient." In addition, the ALJ found Dr. Dreizin's opinion that plaintiff's prognosis was "fair" to be inconsistent with her treatment notes wherein she indicated that plaintiff functioned normally in between spells and that there was nothing that plaintiff had become unable to do since the spells started. The ALJ also noted that plaintiff's EEG and

MRI were normal and that Dr. Dreizin's treatment notes indicated that plaintiff's spells had improved with medication. Overall, the ALJ found that "the record provides that while the claimant does experience intermittent 'spells' or transient ischemic attacks, she was found to function normally with little or no limitations by a neurologist, psychiatrist, and neuropsychologist." AR 23.

In reaching her conclusion that plaintiff retained the ability to perform light work despite her limitations, the ALJ noted that the state agency medical consultants who evaluated the evidence had concluded that plaintiff could perform work at any exertional level. However, the ALJ determined that these opinions had not accounted for plaintiff's testimony or newly-submitted medical evidence that showed that plaintiff was "slightly more limited than previously determined." Accordingly, the ALJ declined to adopt the state agency consultant's opinions that plaintiff had no exertional limitations.

The ALJ then considered whether, in light of her residual functional capacity for light work involving no work around heights or machinery, plaintiff was able to return to her past relevant work as a mortgage loan closer, secretary or loan processor. The ALJ found that plaintiff could return to any of these jobs because the jobs as she performed them were at the light or sedentary exertional levels, which was consistent with plaintiff's residual functional capacity. Accordingly, the ALJ ended the sequential analysis and denied plaintiff's application at step four.

ANALYSIS

I. Standard of Review

Under 42 U.S.C. § 405(g), the Commissioner's findings are conclusive if they are supported by "substantial evidence." *See Stevenson v. Chater*, 105 F.3d 1151, 1153 (7th Cir. 1997); *Brewer v. Chater*, 103 F.3d 1384, 1390 (7th Cir. 1997). "Substantial evidence is more than a mere scintilla. It is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Stevenson*, 105 F.3d at 1153 (quoting *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938), as quoted in *Richardson v. Perales*, 402 U.S. 389, 401 (1971)) (other citations omitted). A standard this low could allow for different supportable conclusions in a given claimant's case. That being so, this court cannot in its review reconsider facts, reweigh the evidence, decide questions of credibility, or otherwise substitute its own judgment for that of the ALJ regarding what the outcome should be. *See Brewer*, 103 F.3d at 1390 (citations omitted); *Kapusta v. Sullivan*, 900 F.2d 94, 96 (7th Cir. 1990).

Although the ALJ's reasonable resolution of evidentiary inconsistencies is not subject to review, *see Brewer*, 103 F.3d at 1390, and the ALJ's written opinion need not evaluate every piece of testimony and evidence submitted, the ALJ "must at least minimally discuss a claimant's evidence that contradicts the Commissioner's position." *Godbey v. Apfel*, 238 F.3d 803, 808 (7th Cir. 2001). The ALJ's opinion must adequately articulate how the evidence was weighed so that this court may trace the path of his or her reasoning. *Id*. For

example, ignoring an entire line of evidence would fail this standard. *Diaz v. Chater*, 55 F.3d 300, 307 (7th Cir. 1995). However, as with any fact finder, the ALJ is entitled to choose between competing opinions. *Luna v. Shalala*, 22 F.3d 687, 690 (7th Cir. 1994). Most importantly, "the ALJ must build an accurate and logical bridge from the evidence to his conclusion." *Clifford v. Apfel*, 227 F.3d 863, 872 (7th Cir. 2000). In addition, the court reviews the ALJ's decision to ensure that no errors of law occurred. *Dixon v. Massanari*, 270 F.3d 1171, 1176 (7th Cir. 2001).

II. ALJ's Failure to Hold Another Hearing

Plaintiff first contends that ALJ Stroup erred as a matter of law by failing to conduct another hearing when the case was reassigned from Judge Garwal. Plaintiff relies on Section I-2-840 from the Social Security Administration's Hearing, Appeals and Litigation Law Manual (HALLEX), which provides as follows:

> When an Administrative Law Judge (ALJ) who conducted a hearing in a case is not available to issue the decision because of death, retirement, resignation, prolonged leave of 30 or more days, etc., the Hearing Office Chief ALJ will reassign the case to another ALJ. The ALJ to whom the case is reassigned will review the record and determine whether or not another hearing is required to issue a decision. The ALJ's review will include all of the evidence of record, including the cassette recording of the hearing.
>
> 1. If the ALJ is prepared to issue a fully favorable decision, another hearing would not be necessary.
>
> 2. If the ALJ is prepared to issue a less than fully favorable decision, another hearing may be necessary. For example, another hearing would be necessary if relevant vocational expert opinion was not obtained at

> the hearing, or the claimant alleges disabling pain, and the ALJ believes the claimant's credibility and demeanor could be a significant factor in deciding the case.
>
> If the ALJ holds a new hearing, the ALJ will consider all pertinent documentary evidence admitted into the record at the prior hearing, the oral testimony at the prior hearing, and the evidence and testimony adduced at the new hearing.

HALLEX I-2-8-40, see http://www.ssa.gov/OP_Home/hallex/I-02/I-2-8-40.html (SSA' s web site).

Plaintiff argues that credibility was a significant factor in her case because if the ALJ had credited her testimony regarding her pain, she would have had to have found plaintiff disabled. Plaintiff contends that the ALJ was not entitled to find her testimony not fully credible without holding a new hearing and observing plaintiff testify. Alternatively, plaintiff contends the second ALJ should have held a new hearing for the purpose of obtaining vocational expert testimony concerning the effect of plaintiff's nonexertional limitations on her ability to work.

As an initial matter, I note that although the Seventh Circuit has held that an interpretive ruling is binding on the Social Security Administration, *Lauer v. Bowen*, 818 F.2d 636, 640, n. 8 (7th Cir. 1987), it has not addressed whether an ALJ's failure to follow a provision of HALLEX is reversible error. The two circuits that have addressed the issue have reached different outcomes. The Ninth Circuit has concluded that HALLEX is purely an internal manual to guide the Office of Hearings and Appeals staff and does not have any legal force. *Moore v. Apfel*, 216 F.3d 864, 869 (9th Cir. 2000). The Fifth Circuit has held

that although HALLEX "does not carry the authority of law," the failure of the agency to follow its own procedures is reversible error where that failure results in prejudice to an individual. *Newton v. Apfel*, 209 F.3d 448, 459 (5th Cir. 2000).

The parties have not addressed these cases. The commissioner has not argued that HALLEX is not binding; instead, she maintains that the ALJ reasonably concluded in this case that another hearing was not necessary.

Even assuming that some provisions of HALLEX may have regulatory teeth, I am not persuaded that Section I-2-4-80 is one of those provisions. Section I-2-4-80 cites cases where credibility is an issue or vocational expert testimony is needed merely as examples of when a new hearing "may" be necessary. The provision's language suggests that it is aimed primarily at ensuring that the second ALJ has enough evidence upon which to render a decision as opposed to imposing any mandatory requirements on the ALJ. Notably, it vests a substantial amount of discretion with the new ALJ to determine whether or not another hearing is necessary to decide the case. In light of that discretion, it is difficult to conclude that the provision creates any enforceable right for social security claimants.

Moreover, finding the existence of such a right is not necessary to protect claimants. An ALJ who erroneously decides to forego another hearing prejudices the claimant by making findings that are not supported by substantial evidence. The ordinary mechanism of judicial review under 42 U.S.C. § 405(g) is adequate to cure that prejudice. For example, this court would find substantial evidentiary support lacking (and therefore that the ALJ had erred in

failing to hold another hearing) had ALJ Stroup rested her credibility determination on subjective considerations such as plaintiff's demeanor while testifying.

In any case, even if this court assumes Section I-2-8-40 created a duty, I find that the ALJ did not violate it. Contrary to plaintiff's reading of the provision, I do not read it as mandating a new hearing any time the ALJ is not prepared to accept fully the claimant's allegations. Rather, the provision indicates that it is important to hold a new hearing when the claimant's credibility *and* demeanor is likely to be a significant factor. In this case, however, the ALJ did not make any findings concerning plaintiff's demeanor but rested her credibility determination on inconsistencies between plaintiff's statements and the objective medical evidence and other evidence in the record. The evidence upon which the ALJ relied was available from the existing record and the transcript from the first hearing. Accordingly, there was no need for the ALJ to hold a new hearing.

III. Residual Functional Capacity

A. Mental Impairment

Plaintiff argues that the ALJ failed to consider her mental impairments when she concluded that plaintiff could return to her past relevant work as a mortgage loan closer, secretary or loan processor as she performed those jobs. Plaintiff points out that the ALJ found that she suffered from two severe impairments, depression and anxiety, yet included

no mental limitations in her residual functional capacity assessment.[1] Plaintiff argues that this omission was significant because her past relevant jobs were skilled or semi-skilled jobs involving the performance of activities requiring higher mental functioning. Because the ALJ never explained why plaintiff could return to her past relevant work in spite of her severe mental impairments, plaintiff argues, remand is required.

I agree. Under the commissioner's regulations, an impairment is "severe" if it "significantly limits your physical or mental ability to do basic work activities," 20 C.F.R. § 404.1520(c), and thus an impairment is "not severe" if "it does not significantly limit your physical or mental ability to do basic work activities." 20 C.F.R. § 404.1521(a). Basic work activities include, among other things: understanding, carrying out, and remembering simple instructions; using judgment; responding appropriately to supervision, co-workers, and usual work situations; and dealing with changes in a routine work setting. 20 C.F.R. § 404.1521(b).

The commissioner has a regulation that sets out a special procedure that must be followed when there is evidence of a possible mental impairment. Pursuant to the regulation, the commissioner must: 1) evaluate the "pertinent symptoms, signs, and laboratory findings" to determine whether the claimant has a medically determinable mental impairment; 2) specify the symptoms, signs and findings that substantiate the presence of

[1] The basis for the ALJ's finding that plaintiff suffers from anxiety is unclear from her decision or the record.

the impairment; 3) rate the degree of functional limitation resulting from the impairments in four broad areas considered essential to work; and 4) determine the severity of the impairment based upon the ratings. 20 C.F.R. § 404.1520a(b)-(d). The commissioner rates the degree of the functional limitations resulting from a mental impairment "based on the extent to which [the] impairment(s) interferes with [the plaintiff's] ability to function independently, appropriately, effectively, and on a sustained basis." 20 C.F.R. § 404.1520a(c)(2). Relevant factors to be considered in this analysis include the quality and level of the plaintiff's overall functional performance, any episodic limitations, the amount of supervision or assistance the plaintiff requires, and the settings in which the plaintiff is able to function. *Id*.

There are four broad functional areas in which the commissioner rates the degree of functional limitation: activities of daily living; social functioning; concentration, persistence, or pace; and episodes of decompensation. 20 C.F.R. § 404.1520a(c)(3); *Nelson v. Apfel*, 210 F.3d 799, 802 (7th Cir. 2000). The degree of limitation in the first three functional areas --- activities of daily living; social functioning; and concentration, persistence, or pace --- is rated on a five-point scale: none, mild, moderate, marked and extreme. 20 C.F.R. § 404.1520a(c)(4). The degree of limitation in the fourth functional area--episodes of decompensation--is rated on a different four-point scale: none, one or two, three, four or more. *Id*. The last point on each of these scales represents a degree of limitation that is incompatible with the ability to do any gainful activity. *Id*. On the other hand, if the degree

of limitation in the first three functional areas is "none" or "mild," and "none" in the fourth area, the commissioner will "generally conclude that [the] impairment is not severe, unless the evidence otherwise indicates that there is more than a minimal limitation in [the plaintiff's] ability to do basic work activities." 20 C.F.R. § 404.1520a(d)(1). The regulations provide that if the commissioner finds that the claimant has a severe impairment that neither meets nor is equivalent in severity to any listing, "we then review your residual functional capacity and the physical and mental demands of the work you have done in the past. If you can still do this kind of work, we will find that you are not disabled." 20 C.F.R. § 404.1520(e).

The ALJ in this case rated plaintiff's functional loss as "none" in the first functional area; "mild" in the second functional area; "slight" in the third functional area; and "none" in the fourth area. Assuming that the ALJ's use of the term "slight" in the third functional area equates with "mild," the ALJ's rating of plaintiff's functional loss would suggest that plaintiff's mental impairment was not severe. Nonetheless, the ALJ found that plaintiff "has a severe mental impairment that does not meet and is not equivalent in severity to any listed impairment." However, in spite of finding that plaintiff's mental impairments were severe, the ALJ did not identify any mental limitations in her residual functional capacity assessment or review the mental demands of plaintiff's past work.

To determine that a claimant is unable to return to her former work, the administrative law judge must compare the demands of that work with the claimant's

existing abilities. *Strittmatter v. Schweiker*, 729 F.2d 507, 509 (7th Cir. 1985). In performing this comparison, the ALJ must not use "generic" terms such as "sedentary" or "light" to describe plaintiff's past jobs but must look specifically at the functional requirements of the particular type of work that the plaintiff used to perform. *Id*. Evaluation of whether a claimant can perform her past work "requires careful consideration of the interaction of the limiting effects of the person's impairment(s) and the physical and mental demands of his or her [past relevant work]." SSR 82-62. "[F]or a claim involving a mental/emotional impairment, care must be taken to obtain a precise description of the particular job duties which are likely to produce tension and anxiety, e.g., speed, precision, complexity of tasks, independent judgments, working with other people, etc., in order to determine if the claimant's mental impairment is compatible with the performance of such work." *Id*.

When considering whether plaintiff could return to any of her past jobs, the ALJ wrote:

> The claimant's past relevant work included jobs as a mortgage loan closer, secretary and loan processor were performed at the light and sedentary exertional levels. The exertional and non-exertional requirements of these jobs, as the claimant performed them, are consistent with the claimant's residual functional capacity as determined by the undersigned in the text of this decision. Therefore, the undersigned finds that the claimant retains the capacity to perform her past relevant work as a mortgage loan closer, secretary or loan processor as she performed these jobs.

AR 24. This paragraph of the ALJ's decision does not provide assurance that the ALJ engaged in the necessary analysis with respect to the mental requirements of plaintiff's past

work. Although the ALJ noted that she had considered the "non-exertional" requirements of plaintiff's past jobs, it appears that she was referring to the limitations on plaintiff's ability to climb, balance or work around heights or machinery as opposed to any mental limitations.

The commissioner argues that "[p]lainly the ALJ considered the impact of plaintiff's depression and mental condition on her ability to work and reasonably concluded that it did not preclude her from performing the semi-skilled to skilled nonexertional requirements of her past jobs as a loan processor, secretary or mortgage closer." Br. in Opp., dkt. #7, at 22. The commissioner points out that the ALJ discussed Dr. Calhoun's conclusion that plaintiff was "clearly able to work" in spite of her slight decrease in concentration and plaintiff's various daily activities, which included mental tasks such as balancing her checkbook and doing paint by numbers and jigsaw puzzles. While I agree that the ALJ's decision demonstrates that she considered the extent to which plaintiff's mental impairment would prevent her from performing *all* work activity, the decision falls short of assuring that she carefully considered whether plaintiff's concentration deficits would prevent her from performing her *past jobs*. According to plaintiff's testimony and forms she completed in connection with her disability application, all of her past jobs involved the performance of somewhat complex mental tasks requiring a high degree of precision, including accounting, managing personnel files and preparing, reviewing and processing loan documents. Although the ALJ referred repeatedly to Dr. Calhoun's opinion that plaintiff was "able to work," Dr. Calhoun gave no indication that she meant mentally-demanding jobs like plaintiff had

performed in the past. Similarly, balancing the checkbook or putting together a jigsaw puzzle at one's leisure would not demand the same precision or ability to work under pressure as plaintiff's past jobs demanded. Notably, the ALJ did not mention Dr. Dreizin's office note of October 2000, wherein she wrote that plaintiff "knows that she cannot do anything like [her old job arranging mortgages] any more" and was having "a much harder time doing things that used to be simple for her, such as balancing her checkbook." AR 187.

It is possible that the ALJ thought plaintiff's mental limitations so slight as to have essentially no effect on her ability to perform the mental demands of work. Indeed, that is the tenor of the ALJ's decision, sounding in her repeated references to Dr. Calhoun's statement that plaintiff was "able to work" and to Dr. Dreizin's notation in March 2000 that there was "nothing that [plaintiff] has become unable to do since these spells started." However, a finding that plaintiff's mental limitations were *de minimis* is inconsistent with the ALJ's finding that plaintiff's mental impairment was "severe." Because the evidence in the record could support either conclusion, it would be unfair to plaintiff for this court to assume the ALJ erred in concluding that plaintiff had a severe mental impairment. Furthermore, even if the ALJ had found plaintiff's mental impairment to be "not severe," under the commissioner's rulings she was required to consider any limitations imposed by that impairment when analyzing whether plaintiff was able to return to her past work. *See* 96-8p ("While a 'not severe' impairment(s) standing alone may not significantly limit an

individual's ability to do basic work activities, it may --- when considered with limitations or restrictions due to other impairments --- be critical to the outcome of a claim").

In sum, internal inconsistencies and gaps in the ALJ's decision prevent this court from determining the extent to which the ALJ found plaintiff to be limited by her mental impairments, and in turn, from determining whether there is substantial evidence to support her conclusion that plaintiff can return to her past relevant work. Furthermore, by ending her analysis at step four and failing to obtain vocational evidence to show that there are other jobs in the economy that plaintiff could perform despite her impairments, the ALJ failed to establish an alternate basis for finding that plaintiff is not disabled. Accordingly, this case should be remanded to the commissioner for further findings concerning the severity of plaintiff's mental impairments and their affect on plaintiff's ability to perform her past work, and, if necessary, further development of the record.

For the sake of completeness, I note that substantial evidence supports the ALJ's evaluation of plaintiff's mental impairment insofar as she rejected plaintiff's contention that her depressive symptoms were so severe as to prevent her from performing any work. As the ALJ noted, plaintiff's allegations of suicidal thoughts, crying spells and lack of ambition were not supported by the report from her treating psychiatrist, Dr. Calhoun, who reported that plaintiff had only some depressive symptoms and that she had declined psychotherapy after two sessions because she felt better. The ALJ also noted that Dr. Calhoun had opined that plaintiff was "clearly able to work" from a psychiatric standpoint and that she had

encouraged plaintiff to seek vocational services. Faced with this conflict in the evidence, it was not improper for the ALJ to question the credibility of plaintiff's allegations of totally disabling depressive symptoms.

B. Seizures

Plaintiff also contends that the ALJ failed to adequately consider the effect that plaintiff's seizures would have on her ability to work. First, plaintiff contends the ALJ improperly rejected the residual functional capacity questionnaire from her treating neurologist, Dr. Dreizin. The ALJ rejected Dr. Dreizin's report because she found it to be internally inconsistent, inconsistent with the record as a whole and of questionable credibility. Speaking to this last point, the ALJ noted that some of the handwriting on the form appeared to be the same as that on the form completed by Reineke, some of the answers had been altered or removed with white liquid eraser product, some of the answers were qualified with the remark "per patient," and Dr. Dreizin had deferred several answers to other health professionals.

Plaintiff argues that many of the inconsistencies noted by the ALJ do not exist, but most of her arguments are beside the point. Even accepting plaintiff's argument that the alterations on the form make Dr. Dreizin's opinion more credible than had she simply signed off on a pre-completed form, there is little in Dr. Dreizin's form that is helpful to plaintiff. As the ALJ noted, Dr. Dreizin deferred to Reineke concerning plaintiff's physical limitations.

In fact, Dr. Dreizin wrote "no neurologic limitations" in the margin next to the questions concerning plaintiff's physical limitations. With respect to the mental limitations endorsed on the form, Dr. Dreizin noted that they were "per patient;" in addition, she noted that Dr. Calhoun would be better able to address that issue.

In fact, in spite of her vigorous defense of Dr. Dreizin's report, the only finding to which plaintiff points as supporting her claim is the answer to question 15l, which asked how often plaintiff was likely to miss work as a result of her impairments or treatment. Plaintiff asserts that Dr. Dreizin checked the box indicating "more than three times a month." However, whether Dr. Dreizin so opined is not clear from the form. It appears from the photocopy in the record that Dr. Dreizin may have deferred to Reineke on that question and attempted to cross out a check mark that had already been placed in the box. In light of Dr. Dreizin's deference to other health care providers concerning plaintiff's functional limitations and the indications that the form had already been completed before it was presented to Dr. Dreizin, it was not unreasonable for the ALJ to resolve the ambiguous response to question 15l against plaintiff.

Second, plaintiff argues that the ALJ "ignored" questionnaires from plaintiff's husband and daughter, who reported that plaintiff's seizures last between a few minutes to an hour, occur at different times during the day and cause plaintiff to feel fatigued and leave her in a "trance." The ALJ mentioned these reports in her decision, but never made any specific finding regarding their credibility or evidentiary weight. The ALJ found that the

only work-related limitations resulting from plaintiff's seizures were an inability to climb, balance and work around heights or hazardous machinery, none of which were requirements of plaintiff's past relevant jobs.

The commissioner argues that the ALJ implicitly rejected the questionnaires when she found that "while the claimant does experience intermittent 'spells' or transient ischemic attacks, she was found to function normally with little or no limitations by a neurologist, psychiatrist, and neuropsychologist." The commissioner argues that this finding is supported by substantial evidence in the record. However, the evidence on which the ALJ relied for her conclusion that plaintiff functioned "normally" addressed only plaintiff's ability to function *between* seizures. The ALJ relied on Dr. Calhoun's conclusion that plaintiff had only slight limitations in concentration and was able to work, but Dr. Calhoun addressed only plaintiff's depressive symptoms; Dr. Calhoun expressly deferred to Dr. Dreizin regarding plaintiff's seizures. Similarly, Hasten's conclusion that plaintiff had only mild memory dysfunction and no decline in her cognitive abilities addressed plaintiff's baseline functioning and did not evaluate her ability to function during or immediately after a seizure. The ALJ also focused on Dr. Dreizin's notes from her first visit with plaintiff wherein she noted that plaintiff functioned normally between spells and there was "nothing that [plaintiff] has become unable to do since these spells started." Again, however, those comments referred to plaintiff's functioning when she was not having a seizure. The same goes for the unimpressive objective evidence and plaintiff's panoply of daily activities.

In spite of finding that plaintiff had intermittent spells or seizures, nowhere in her decision does the ALJ make any finding concerning the nature, frequency or duration of those attacks. The record contains widely varying descriptions of plaintiff's "spells" or seizures, some of which suggest that they are only brief annoyances, others which suggest that they are incapacitating events. For example, plaintiff initially told Dr. Dreizin that her spells were about three minutes in duration, involved no rhythmic mouth movements or automatisms and afterwards she felt normal. However, the next month, plaintiff reported that she had had fatigue and blurred vision for 60-90 minutes after one particular seizure and that her husband had noticed her smacking her lips during a seizure. In May 2000, plaintiff's husband and daughter completed their questionnaires on which they reported that during a seizure plaintiff had uncontrolled twitching of her head and arms, could not speak, smacked her lips and swallowed repeatedly and looked as if she was in a trance. They reported that plaintiff had two seizures per week that lasted between a few minutes to an hour. In June 2000, plaintiff described having seizures as well as less severe spells that she described as "zone out spells" during which she could hear things going on around her but could not speak. In August, she told Dr. Dreizin that she had had three spells in July: during one, she felt detached from what was going on around her; during another, she was very tired. In October, she reported that she had been having "zone out" spells five or six days a week and had had two complex seizures; one seizure lasted 15 minutes and afterwards plaintiff slept for about two hours. In December, plaintiff told Hasten that she had had two

"zone out" spells that month. She also said she had "sporadic" seizures that ranged in duration from 2 to 20 minutes and involved automatisms, difficulty speaking and occasional jerking motions of her upper extremities. Plaintiff reported that her post-seizure phase lasted no more than 30 minutes and felt like she was "coming out of a deep sleep."

At the administrative hearing, plaintiff testified that she had about one severe seizure and about three less severe spells per month during which she "mumbled and stumbled." Plaintiff did not know when she had had her last seizure. Plaintiff was not asked to describe her seizures, their duration or her condition after a seizure.

The only of these descriptions that the ALJ mentioned were the questionnaires from plaintiff's husband and daughter. It is unclear from the ALJ's decision whether she credited that evidence and found that plaintiff was able to return to her past relevant work *in spite* of having twice-weekly seizures lasting up to one hour, or whether she found plaintiff's husband's and daughter's descriptions of plaintiff's seizures to be incredible. If the former, then it is difficult to comprehend how the ALJ could have found plaintiff able to perform any full time job, much less jobs requiring the performance of complex mental tasks. And if the latter, then how often does plaintiff have a seizure, what is it like, and how long does it last? The ALJ did not answer these questions in her decision. Depending on the answers, plaintiff could be more limited in her ability to perform basic work activities than the ALJ found.

That said, I must note that I share the ALJ's obvious skepticism about plaintiff's claim of disabling seizures. In addition to the absence of any objective abnormalities that might

confirm the existence of the seizures or explain their cause, the seemingly ever-changing descriptions of plaintiff's "spells" or seizures cast an unfavorable light on the credibility of her claim. Furthermore, even if plaintiff may have had more severe seizures in the past, her testimony that she now has only one severe seizure per month suggests that they might now be under better control. It is also worth noting that Dr. Dreizin did not endorse any exertional or mental limitations on the residual functional capacity form.

If the seizures were the only issue before the court, this evidence might be enough to persuade me to recommend affirming the ALJ's decision. However, because I am already recommending that this case be remanded for further findings concerning the mental impairment, I think it is better to ask the commissioner to also make a specific finding concerning the nature, duration, and frequency of the seizures. As noted above, there is evidence that suggests that the actual seizures themselves are severe enough and occur frequently enough to limit plaintiff's ability to work to a greater extent than merely being unable to work around heights or machinery. The evidence upon which the ALJ relied does not refute this evidence because that evidence relates only to plaintiff's functioning when she is not having a seizure. Accordingly, the ALJ's decision fails to bridge a logical and accurate bridge from the evidence to her conclusion.

Plaintiff also contends that the ALJ failed to consider her testimony that Dr. Dreizin had instructed her not to drive a motor vehicle. Plaintiff argues that this limitation would prevent her from returning to her past jobs as a secretary and mortgage loan closer as she

performed them because her tasks at those jobs included driving to various locations. The commissioner appears to concede that substantial evidence in the record supports a driving limitation and that the ALJ erred in failing to include it in her residual functional capacity assessment. However, the commissioner contends that this error was harmless because the ALJ also found that plaintiff could return to her past relevant work as a loan processor, which did not require driving.

If the district judge agrees with either of my previous recommendations to remand this case to the commissioner for additional findings, then on remand the ALJ should also consider the effect of plaintiff's alleged driving limitation on her ability to perform her past relevant work or other jobs. However, if the judge disagrees with my recommendations, then remand is not necessary with respect to the driving issue. I agree with the commissioner that the error was harmless insofar as one of the past relevant jobs that the ALJ identified did not require plaintiff to operate a motor vehicle.

C. Arm and Shoulder Pain

Plaintiff argues the ALJ should have found her unable to perform any job because of her post-herpetic neuralgia pain in her left arm and shoulder. She contends that the ALJ's conclusion that her subjective complaints of pain were not entirely credible is not supported by substantial evidence. I disagree.

The ALJ found plaintiff's complaints of disabling left shoulder and arm pain to be inconsistent with plaintiff's treatment history, which showed no frequent or intensive medical treatment, hospitalizations, emergency room visits, injections, a pain clinic or other methods commonly used to alleviate pain as severe as that alleged by plaintiff. In addition, the ALJ noted reports in the record that indicated that plaintiff's pain was controlled with Tegretol. Although plaintiff argues that the ALJ attributed too much weight to these reports and ignored other remarks that indicated that plaintiff still had pain on Tegretol, overall the record supports the ALJ's conclusion that Tegretol provided substantial if not complete pain relief to plaintiff. The ALJ could reasonably conclude from the record that if plaintiff's pain was more severe, her doctors would have recommended a different medication or more intensive pain treatment measures. Plaintiff herself told Dr. Dreizin that it was only on"rare occasions" that her pain was unbearable on the Tegretol. This evidence reasonably supports the ALJ's conclusion that plaintiff was not totally disabled from shingles pain, as she alleged.

Plaintiff contends that even if the ALJ did not find her shingles pain to be totally disabling, there is no support in the record for her conclusion that plaintiff retains the residual functional capacity to lift up to 20 pounds. However, it was plaintiff's burden to produce evidence showing she was disabled. The only evidence that plaintiff produced to support a lesser lifting restriction was the residual functional capacity assessment from Reineke. However, the ALJ rejected that report, finding among other deficiencies that it was not supported by any objective evidence and that Reineke had not treated plaintiff for her

herpes zoster. Plaintiff wages numerous attacks on the reasons cited by the ALJ for her conclusion that Reineke's report was entitled to little weight, but none of them are persuasive. The record supports the ALJ's conclusions regarding the lack of any treatment relationship between plaintiff and Reineke and the absence of objective findings by Reineke to support the limitations she endorsed on the residual functional capacity assessment form. Those were accurate and adequate reasons for the ALJ to reject the findings on Reinke's report. *See* 20 C.F.R. § 404.1527(d) (explaining factors ALJ should consider when assessing weight to give medical opinions, including length of treatment relationship, supportability of opinion and consistency with other evidence in record).

The ALJ noted that the state agency physicians had opined that plaintiff had no lifting restrictions. However, the ALJ reduced that exertional capacity and limited plaintiff to lifting 20 pounds on the basis of her testimony at the hearing. Contrary to plaintiff's contention, there was nothing improper or inconsistent about the ALJ finding plaintiff to be incredible insofar as she alleged that she was completely disabled but credible insofar as she had pain that limited her to some degree. Plaintiff's suggestion that she is incapable of lifting 20 pounds is not supported by any evidence in the record apart from evidence that the ALJ reasonably determined was not credible. Accordingly, the ALJ's assessment of plaintiff's lifting ability is supported by substantial evidence.

D. Other Alleged Limitations

Finally, plaintiff asserts that the ALJ failed to account for plaintiff's stuttering, muscle spasms or headaches in her residual functional capacity assessment. It is true that the ALJ did not mention plaintiff's complaints of stuttering, muscle spasms or headaches. However, it is well-settled that the ALJ is not required to discuss every piece of evidence in the record. *Herron v. Shalala*, 19 F.3d 329, 333 (7th Cir. 1994). Plaintiff did not testify that any of these symptoms prevented her from working and there is no evidence that she sought medical attention for any of these symptoms. In fact, when asked whether her stuttering and muscle spasms were side effects of her medications or part of her seizure disorder, plaintiff said "no." Accordingly, the ALJ could reasonably conclude either that plaintiff's complaints were not related to her medically-determinable impairments or that they were not severe enough to affect plaintiff's ability to perform basic work activities.

IV. Conclusion

In sum, although substantial evidence supports the ALJ's conclusion that plaintiff's complaints of totally incapacitating impairments were not entirely credible, she failed to build an accurate and logical bridge from the evidence to her conclusion that plaintiff retained the functional ability to return to her past skilled and semi-skilled jobs as a mortgage loan closer, loan processor or secretary. Accordingly, I recommend that this case be remanded to the commissioner so that she can resolve the inconsistencies and gaps in the

ALJ's decision that I have identified in this report. In particular, the commissioner should clarify the extent to which plaintiff's mental impairments and seizures affect her ability to perform her past relevant work, and, if necessary, obtain vocational expert testimony to determine whether there are other jobs in the national economy that plaintiff is able to perform despite her impairments.

REPORT

Pursuant to 28U.S.C. § 636(b)(1)(B), I respectfully recommend that the decision of the Commissioner denying plaintiff Jill Cloute's application for disability insurance benefits be REVERSED AND REMANDED pursuant to sentence four of 42 U.S.C. § 405(g).

Dated this 25th day of June, 2004.

BY THE COURT:

STEPHEN L. CROCKER
Magistrate Judge