

UNPUBLISHED

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

DAVID TAPP,

Plaintiff,

vs.

JO ANNE B. BARNHART,
Commissioner of Social Security,

Defendant.

No. C01-3061-MWB

REPORT AND RECOMMENDATION

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I. INTRODUCTION

The plaintiff David H. Tapp (“Tapp”) appeals the decision by an administrative law judge (“ALJ”) denying him Title XVI supplemental security income (“SSI”) and Title II disability insurance (“DI”) benefits. Tapp argues the ALJ erred in rejecting the opinions of Tapp’s treating physician and a consultative psychologist, and in failing to make a comprehensive, individualized assessment of Tapp’s residual functional capacity. (See Doc. No. 14)

II. PROCEDURAL AND FACTUAL BACKGROUND

A. Procedural Background

On November 13, 1997, Tapp filed an application for DI benefits (R. 162-64) and SSI benefits (R. 381-85), alleging a disability onset date of April 1, 1997. The applications were denied initially on March 13, 1998 (R. 143, 145-49, 386-91¹), and on reconsideration on November 12, 1998 (R. 144, 152-56, 392-97²). Tapp requested a hearing, which was held before ALJ John P. Johnson in West Des Moines, Iowa, on November 10, 1999. Attorney Thomas A. Krause represented Tapp at the hearing. Tapp, his wife Kimberly Kay Tapp, and Vocational Expert (“VE”) Roger Marquardt testified at the hearing. (R. 66-42)

On March 1, 2000, the ALJ ruled Tapp was not entitled to benefits. (R. 9-38) The Appeals Council of the Social Security Administration denied Tapp’s request for review on June 29, 2001 (R. 5-6), making the ALJ’s decision the final decision of the Commissioner.

Tapp filed a timely Complaint in this court on July 26, 2001, seeking judicial review of the ALJ’s ruling. (Doc. No. 1) In accordance with Administrative Order #1447, dated

¹Two copies of the denial appear in the Record.

²*Id.*

September 20, 1999, this matter was referred to the undersigned United States Magistrate Judge pursuant to 28 U.S.C. § 636(b)(1)(B), for the filing of a report and recommended disposition of Tapp's claim. Tapp filed a brief supporting his claim on February 22, 2002 (Doc. No. 14). On March 29, 2002, the Commissioner filed a responsive brief (Doc. No. 15). The court now deems the matter fully submitted, and pursuant to 42 U.S.C. § 405(g), turns to a review of Tapp's claim for benefits.

B. Factual Background

1. Introductory facts and Tapp's daily activities

a. Tapp's testimony

At the time of the hearing, Tapp was 43 years old. He was 5'7" tall and weighed 175 pounds, although his normal weight is 140 to 150 pounds. (R. 71, 103) Tapp attributed his weight gain to "the insulin and the diet." (R. 103) Tapp said his weight "goes up and down," stating that at one point, he got down to 119 pounds, and at another, he was up to 193 pounds. (R. 74, 104)

Tapp completed the ninth grade in school. He had about four months of special education in tenth grade, and then his father took him out of school, saying "it's time to go work. You ain't doing yourself no good." (R. 71-72)

Tapp said he has some trouble reading and writing. (R. 72) His wife helped him fill out the vocational report, and it is her handwriting on the report. (*Id.*) Tapp lives with his wife in Mason City, Iowa, where she works as a cook at Willow Point, an assisted living center in Mason City. (R. 70, 72) Tapp's wife grosses \$900 to \$1,000 per month. (R. 72)

Tapp has no insurance and does not receive food stamps. He last worked in 1997, when he got a job through Kelly Services, working at Kraft Foods in Mason City, where he would load cups into machines. The job required him to lift 35 to 40 pound boxes every 10 to 15 minutes, and required a lot of standing. (R. 72-73, 107-108) The job ended in

October 1997, because Tapp “started getting too sick.” (R. 73) He had diarrhea, vomiting, weakness, and was “real shaky” and losing a lot of weight. (R. 73-74) He was hospitalized for about a week at the University of Iowa Hospital.

Tapp had numerous short-term, seasonal, and full-time jobs before Kelly Services. He performed janitorial services at the Cerro Gordo County Care Facility for the mentally handicapped from approximately 1995 to 1997. (*Id.*) The job required him to lift “a lot of things”; he lifted furniture, took out the garbage, mopped, swept, and waxed. He frequently had to lift more than 50 pounds. (R. 75)

Tapp worked briefly for Asplundh tree service, cutting limbs from high lines. The job required him to lift large tree branches and logs and do “[a] lot of chain saw work.” (R. 76) He worked part-time in a seasonal job at Fertile Valley, which required him to lift bags of dirt weighing from 10 to 50 pounds. (R. 76) He alternated between bagging the dirt and off-loading filled bags from a conveyor. (R. 104) He worked at J&G Poultry, an egg factory, where he would weigh the birds and pack eggs. (R. 77)

In about 1994, Tapp did seasonal work for Mid-Western Soy Bean’s elevator in Thornton. He ran the scale, weighed in semi-trucks, unloaded the grain, and issued receipts. The job required occasional lifting over 20 pounds. (R. 77, 105-106) He worked for McDowell & Sons running a backhoe, which required some lifting over 20 pounds. (R. 78-79) In about 1989 or 1990, Tapp worked for Iowa Falls Roofing doing “rubber roofing.” (R. 79) He also did hot tar roofing for Hampton Roofing. (R. 79-80) In the roofing jobs, he would have to lift “50 pounds lugs . . . [a]ll through the day,” and then “dump them in five gallon buckets and . . . hoist it up by hand.” (R. 80; see R. 106-107)

Tapp worked for Pierce Lawn Care in Chickasha, Oklahoma, as assistant manager of a cemetery. He would dig graves with a backhoe, lower the vaults, set up tents for funerals, mow the lawns, and level headstones. The job required frequent lifting over 50 pounds. (R. 80-81)

Tapp worked for County Line Engineering, cutting pieces of steel for the manufacture of hog gates, hog stalls, and hog confinements. The job involved a lot of lifting up to 50 pounds. (R. 81) He worked for L.J. Installation, installing hog confinement stalls, hog feeders, and water lines. (*Id.*) He worked for Mulfur (phonetic) Concrete, putting up forms for cement walls for hog confinements. The job involved frequent lifting over 50 pounds. (R. 82)

In about 1985, Tapp worked for Edwards Contracting, where he drove a boom truck from which another man sprayed the roadside with chemicals to control weeds. This job did not require much lifting. (R. 83)

Tapp testified he does not know if there is any kind of work he could do presently because he has constant diarrhea, muscle spasms, low blood sugar, and “nerves,” and he does not like to be around people. (R. 83-84) Tapp said he was diagnosed with diabetes “a couple years or better” before the hearing. (R. 84) He said the diabetes causes him to “lose [his] brains . . . get disoriented, eyesight goes, weakness, shakes.” (*Id.*) His insulin is finally regulated, and he reports his blood sugar levels to the doctor three times a week. (R. 84, 86) However, he still suffers from anxiety attacks, which he described as being “real shaky, nervous. Get a few muscle spasms from shaking.” (R. 84-85) His hands and body shake. He does not know what causes the shaking, but it is worse in the morning. Tapp said he had spinal meningitis when he was a child, and he takes a lot of medications, which he thought “could have something to do with [the shaking].” (R. 85)

Tapp testified he loses his balance often. He lost his balance and “fell out the front steps trying to shut the door,” resulting in a sprained ankle. (R. 86) He moved from a two-story house to a single-level house because of his problems walking up and down the stairs. In addition, he gets short-winded, and he has muscle spasms which he attributes to “shaking and tension, not being able to relax, I guess.” (*Id.*) He loses his balance when he bends or squats, and sometimes gets “a little disoriented.” (R. 111)

Tapp said he has to urinate frequently, and he has diarrhea “constantly.” (R. 87) He has embarrassing accidents four to five times a week, so he has begun wearing protective undergarments. (R. 87-88) The diarrhea is worse in the mornings. (R. 112)

Tapp has been diagnosed with cirrhosis of the liver. (R. 88) He said his liver problem is due to a history of alcohol abuse, but all his other physical problems are related to his diabetes. (R. 109)

At the time of the hearing, Tapp said he was seeing at least three different doctors for his conditions. When he reports his blood sugar, it is via a video link so he can see the doctor and the doctor can see him. (R. 89) He visits the doctor every 90 days for medication checks, a physical, and an occasional blood test. (R. 109-110) Tapp is able to test his own blood sugar, but he sometimes will forget to write down the reading, so his wife will record the reading in a log. (R. 89) Tapp takes several medications, including BuSpar, Prozac, Finamin (phonetic), folic acid, Nitroglycerine, Trazodone, Atroden (phonetic), Pancrease (phonetic), Prilosec, and an Albuterol Sulfate nebulizer. (R. 89-90) He said the Prilosec gives him a headache, nausea and diarrhea. He also takes insulin for the diabetes. (R. 90)

Tapp said he suffers from “[n]ausea sometimes, very sleepy, just run down, just don’t want to do nothing.” He does not know if these symptoms are due to his illness or side effects from medications. (R. 90)

Tapp thinks he could lift 10 pounds regularly, but not 20 pounds. He can stand for about half an hour if he has to, but if he stands for very long, his legs get numb and he gets “wobbly.” He said, “It’s like my feet want to go to sleep and I start stumbling. And for some reason I always go to the right, I walk to the right.” (R. 91) Tapp can walk the two blocks from his house to the park, and then he sits for awhile before walking the two blocks back to his house. He is uncomfortable sitting due to backaches, anxiety and nervousness. Riding for very long in a car also makes his back hurt. (R. 92) He can only sit for about

half an hour before he has to change positions. (R. 111) He has problems with dizziness when he looks upward, such as when he reaches above his head to change a lightbulb. (R. 92-93)

Tapp has muscle spasms, numbness and tingling in his hands, and knots in the palms of his hands. The problems are worse with his right hand than with his left. (R. 93) He also occasionally has numbness and tingling in his arms. Tapp said the frequency of his hand/arm problems varies, stating, "If I pick something up or, or move my hand wrong. My knuckles crack a lot." (R. 94) Tapp does not think he could perform a job that required a lot of manual work with his hands because his hands cramp up when he uses them a lot. (R. 95)

Tapp testified he has a lot of memory problems. "[T]here's times when I can't remember what I had for supper the night before. I find myself going to the kitchen and standing there and not knowing what. And my wife will ask me what I'm doing in there. I don't know. I have to go, go, go back and sit down and think about it." (*Id.*) Tapp used to have an ATM card but he had to get rid of it because he would forget how much he had withdrawn, and sometimes he would forget how to use the ATM machine. (*Id.*) Tapp said his long-term memory is somewhat better than his short-term memory. He occasionally forgets to take his medication, and his wife helps him remember. (R. 96) Tapp occasionally will forget to bathe, or to change his socks. He wears special orthopedic shoes because of his leg. He said the doctor told him not to wear cowboy boots, and never to go barefooted because of the diabetes. "It takes a long time for a sore to heal on me." (R. 100)

Tapp said he used to have an alcohol problem, and he has been through treatment two or three times. He last had a drink about a year before the hearing. His wife does not allow alcohol in the house. However, in April 1998, when Tapp received notice that his claim for benefits had been denied on reconsideration, he "grabbed a check blank, got some

beer and went and got me a motel room, and left all my medications and stuff at home. And the next thing I remember there were two police cars there and a highway patrol and my wife.” (R. 97, 116) He has not done any drinking since then. (R. 116)

Tapp usually rises about 6:00 a.m., so he can watch the news, although he has trouble remembering what he saw and sometimes has trouble understanding. (R. 97, 114) He usually goes to bed between 6:00 p.m. and 7:00 p.m. because after he takes his evening medications, he gets sleepy. He will sleep well for four to five hours, but he has problems with involuntary body movements; he said his arms and legs “jump all over.” (R. 97-98)

Tapp occasionally has bowel movements while he is sleeping. The problem started after his Trazodone dosage was increased. He has also vomited while he sleeping. (R. 98) Because he takes sleeping medications, Tapp will not awaken sufficiently to care for himself when he vomits or has an accident, and his wife wakes him so he can clean himself up. (*Id.*, R. 113)

Tapp stated he has quit reading the newspaper because he “lost interest in it,” and he prefers to watch the news on television. He rarely makes his own meals, and does “[a] little bit” of the housework, but his wife does most of the outside chores. He will occasionally take the garbage out, or drag broken limbs out to the street. He enjoys taking his dogs outside, and he will sit on the steps and watch the dogs. (R. 99, 100, 118) Tapp has no hobbies or outside interests, stating he will “just pretty much stay at home.” (R. 100) He and his wife used to go out to dinner, and Tapp used to like to go shopping, hunting and fishing. He no longer engages in those activities. (R. 100-101) There are many days when Tapp never leaves his house. He does not visit people other than his mother and his sister. He stated his former friends no longer visit him because he will not allow them to drink at his house. (R. 101) Tapp and his wife used to go camping, but he cannot tolerate the heat, which makes him break out in hives. (R. 118)

The Iowa Department of Transportation revoked Tapp's driver's license because of his illnesses and medications. One of Tapp's doctors told Tapp he should not be driving,³ and he was having problems driving before he lost his license. He would drive in the wrong lane, or stop at a stop sign and wait, as if for a light to change. He ran red lights and got lost. He had an accident in a parking lot in 1997, but he does not remember the details. (R. 102-103)

Tapp testified he receives some assistance from the State in paying for his medications. His mental health treatment is on a sliding scale; he pays \$7.75 per visit. (R. 110)

Tapp does not have difficulty getting along with his mother and sister. He does not know his neighbors, and tends to keep to himself. If he goes into a grocery store or other places with a lot of people, he gets nervous, anxious and tired. When he goes to the grocery store with his wife, he stays in the car while she shops. (R. 115) Tapp has trouble dealing with stress and pressure. He put in Caller I.D. so he can screen his calls and avoid talking with bill collectors. (R. 116)

Tapp said although he suffers from asthma, he smokes anywhere from a half pack to a pack-and-a-half daily, depending "on how stressed out I get." (R. 117)

b. Kimberly Kay Tapp's testimony

Kimberly Tapp ("Kimberly") is Tapp's wife; they were married May 21, 1990. In the spring of 1997, Kimberly was working full-time at the IOOF Home, a nursing home in Mason City. She then went to work at Willow Point Assisted Living Program in Mason

³On March 30, 1999, J.A. Jackson, M.D. wrote a letter to the Department of Transportation, in which he stated Tapp had "a serious mental impairment which places him at risk of injuring himself or others while behind the wheel. It is my professional opinion that his license should be revoked. It is unlikely that his illness will become better over time and may in fact become worse." (R. 366)

City, which she said is less stressful than the nursing home. Also, at the nursing home, it was more difficult for her to take time off when Tapp needed to go to the doctor or was ill. (R. 122-123)

Kimberly has observed her husband's problems with diarrhea and frequent urination. She stated he has accidents during the night "once or twice a week and he doesn't realize it." He also vomits during the night, once or twice a week. She said they have to "get up in the middle of the night and change sheets, clean him up[.]" (R. 124, 130) The nocturnal vomiting occurs more if Tapp consumes milk products before he goes to bed. (R. 130) Kimberly said Tapp's diarrhea has not improved since his diabetes was diagnosed and he began receiving treatment; however, he has regained some of the weight he lost. (R. 131)

Kimberly said Tapp has problems concentrating, completing tasks, and remembering things. She has to check with him during the day to be sure he remembers to take his medication and eat his meals. She helps him record his blood sugar because if Tapp does it himself, he sometimes transposes the numbers. (R. 125-26)

Every day, Kimberly sets out food or makes sure there are leftovers Tapp can heat in the microwave for his lunch. Each week, she sorts his pills in a container with compartments labeled for each day. She fixes dinner in the evening, after she returns from work. (R. 126)

Kimberly confirmed Tapp's description of his driving problems prior to the revocation of his license. She said sometimes he would get in the car and forget where he was going, or he would get into the wrong lane, and "[i]t was sometimes scary[.]" (R. 126-27)

Kimberly agreed that Tapp has not been drinking since the November 1998 incident, after he found out his application for benefits had been denied. She said alcohol is not allowed in their house. In addition, Kimberly handles all the money, and she said Tapp never has more than a couple of dollars at a time, so he would not have money to buy alcohol. (R. 127-28)

Kimberly said she and Tapp are renting the house where they have been living for five or six months. She said Tapp does not visit much with their neighbors, nor does he socialize much. He occasionally will go for a ride in the car with a friend, but he mainly stays at home. She has seen him stay in the house for as long as seven days without leaving or talking to anyone but her. (R. 128) Tapp does not like to be around large groups of people. Even when he visits his mother, he only wants to stay for a few minutes because he gets uncomfortable sitting for very long. (R. 129)

Kimberly does not think there is any type of full-time job Tapp could do. She said Tapp's memory is not good, and physically, he lacks the strength and capability to stand for a long period of time, lift things, or hold objects in his hands. She said Tapp frequently says he "would love to go back to work," but she does not "think his body could handle it." (*Id.*)

2. Vocational expert's testimony

VE Roger Marquardt testified at the hearing. He reviewed all the exhibits of record and listened to the testimony of Tapp and Kimberly. The VE offered a chart illustrating Tapp's past work activity, which he prepared in reliance upon the exhibits of record and Tapp's testimony regarding his past work experience. The chart was admitted into evidence at the hearing and appears in the Record at page 233. (R. 134, 233)

The ALJ asked the VE the following hypothetical question:

My assumption is that we have an individual who is 43 years old, he was 41 years old as of the alleged onset date of disability, and he's a male. He has a limited education and past relevant work as you've indicated in exhibit 19E, and he has the following impairments. He has insulin dependent diabetes mellitus secondary to pancreatic atrophy, pancreatic insufficiency secondary to chronic alcoholism, cirrhosis of the liver, degenerative changes of the cervical spine, history of Wernicke's encephalopathy, history of sensory neuropathy of the arms and legs, chronic obstructive pulmonary disease with

bronchitis, and depression with a history of a major depressive disorder. As a result of a combination [of] those impairments and medication or other treatment prescribed for those impairments he has the residual functional capacity as follows. He cannot lift more than [sic] 20 pounds, routinely lift 10 pounds, with no standing of more than [sic] 30 to 60 minutes at a time, and no walking of more than [sic] three to four blocks at a time. With walking and standing of at least two out of eight hours of a day. With no repetitive stooping, squatting, kneeling, crawling, or climbing. This individual should not be exposed to more than [sic] moderate levels of humidity, heat, or cold. And he should not work at unprotected heights. He is able to do only simple routine repetitive work which does not involve the use of independent judgment for decision making and does not require close attention to detail. He should have no more than [sic] occasional contact with the public. He does require occasional supervision. He should not work at more than [sic] a regular pace, and that's using three speeds of pace from fast, regular and slow. Would this individual be able to perform any job he previously worked at either as he performed it or as it is generally performed within the national economy, and if so, would you please specify which job?

(R. 134-35) The VE responded that the hypothetical "claimant could not perform past relevant work under the restrictions of this first hypothetical[.]" (R. 135)

The ALJ asked the VE to state which specific limitations on work activity would preclude the hypothetical claimant from performing past relevant work. The VE replied, "The weight restriction eliminates any of the claimant's past work. In addition, the restriction concerning doing no more than [sic] simple routine duties with – that do not require close attention to detail." (R. 136)

The VE stated further that the hypothetical claimant would not have any skills acquired from past relevant work that would be transferable to other work. The VE based this opinion on the hypothetical claimant's "[i]nability to exceed work that requires more

then [sic] simple routine repetitive tasks.” (*Id.*) The claimant would be unable to perform the full, and/or a wide, range of unskilled work activity. (*Id.*)

Nevertheless, the VE opined unskilled jobs exist that the hypothetical claimant could perform. As examples, the VE cited garment sorter or classifier, with 50,000-plus jobs available nationwide and 400 in Iowa; shipping and receiving clerk, with 30,000 jobs nationwide and 300 in Iowa; and produce sorter, with 200,000 jobs nationwide and at least 600 in Iowa. All of these are light duty jobs “as normally performed.” (R. 136-37)

The ALJ asked a second hypothetical question, as follows:

My next hypothetical would be an individual of the same age, sex, education, and past relevant work, and impairments as previously specified. And this individual could not lift more than 10 pounds. This individual could not stand more than [sic] a half hour at a time or sit for more than [sic] a half hour at a time with walking of no more than [sic] two blocks at a time. With no repetitive squatting, climbing, or pushing, or pulling. This individual should perform no work requiring repetitive gripping or continuous use of the hands [INAUDIBLE] sensation with no repetitive work with the arms overhead. This individual should not be exposed to excessive heat, humidity, or cold, or more than [sic] moderate levels of dust, fumes or smoke. He should not work at unprotected heights. He must have access to rest room facilities. He is able to do only simple routine repetitive work which does not require constant close attention to detail or use of independent judgement for decision making. He should have no more than [sic] occasional contact with the public. He does require occasional supervision. He should not work at more than [sic] a regular pace and should not work at more than [sic] a mild level of stress. I assume this individual could not return to past relevant work, transfer of acquired work skills, or perform the full and/or wide range of unskilled work activity, would that be correct?

(R. 137-38) The VE agreed, and in addition opined there would be no unskilled jobs the hypothetical claimant could perform. (R. 138) The VE noted his opinion was based on the

hypothetical claimant's combination of limitations, including the maximum lifting restriction, inability to stand and walk for any significant period of time, inability to tolerate anything more than occasional contact with the public, and restrictions on use of the arms and hands. (*Id.*)

Tapp's attorney posed a third hypothetical question to the VE, assuming the same age, education, past relevant work, and impairments, but adding the following limitations:

That the lifting is occasionally – limited to occasionally lifting 20 pounds, frequently lifting 10 pounds. Stand and walk 30 to 60 minutes at a time for approximately two hours total out of an eight hour work day. That the claimant would have problems remembering all but the most simple locations and work like procedures. Instructions would have to be very short and simple. . . . He may have problems maintaining attention and concentration for extended periods. He should be able to sustain an ordinary routine without special supervision and make simple work related decisions. Unfortunately, he apparently has a very poor memory. Instructions and directions may have to be repeated several times throughout the day. He would be able to interact appropriately with the general public and get along with co-workers and supervisors. He would have problems responding appropriately to changes in the work setting. Pace will be slow, judgment will be poor, and [he] would only be able to handle money with the assistance of his wife. Given those limitations, would the claimant be capable of performing any of his past relevant work?

(R. 139) The VE responded that the claimant would not be able to perform past relevant work, nor would he have any transferable skills. (R. 139-40) Further, if the claimant's slow pace were "interpreted as less than a competitive pace to perform simple routine unskilled tasks then it would eliminate unskilled employment." (R. 140)

Tapp's attorney revised the hypothetical further, to include the following limitations:

Physically limited again to, to 20 pounds occasionally, 10 pounds frequently. Stand or walk 30 to 60 minutes for a total of approximately two hours out of an eight [hour] work day.

And if we take what Dr. Jackson, Dr. Jackson's letter of May 4th, 1999, "Mr. Tapp is unable to maintain regular attendance and be punctual within customary tolerances due to gross memory deficits. Ability to maintain attention and concentration is limited to only minutes. He would not be able to complete a normal work day or work week without interruptions due to his psychiatric problems. His ability to perform at a consistent pace is highly doubtful. Ability to work in coordination with supervisors, co-workers, and the general public is unlikely to be tact [sic] due to his poor memory. Ability to handle stress is poor.["] Would there – would the claimant be capable of performing any of his past relevant work?

(R. 140) The VE responded that he would not, nor would the hypothetical claimant have any transferable skills, or be able to perform any type of work. (*Id.*) The VE explained the limitations that would preclude the performance of unskilled work are the inability to perform at a competitive, consistent pace; the inability to complete a normal work day and/or work week; and the memory deficits. (R. 141)

3. *Tapp's medical history*

The record indicates Tapp began having intermittent numbness in the fingers of his left hand sometime in mid-1995, together with stiffness and pain in his neck and upper back. (See R. 255-56, 259) A chest X-ray taken November 1, 1995, was normal (R. 259), and a cervical spine X-ray indicated some narrowing of C3-C4 and C5-C6 disk spaces. He was diagnosed with multi-level degenerative changes of the cervical spine. (R. 263) Tapp cancelled further testing due to financial reasons, and did not see a doctor again for eight months.

On July 16, 1996, Tapp went to the emergency room because he was spitting up blood. He reported a history of smoking and alcohol abuse, and said he had consumed eight beers and a burrito before he started spitting up blood. Tapp was admitted to the hospital

and treated conservatively with IV fluids and Zantac. He was discharged two days later with instructions to stop smoking and drinking. He was given prescriptions for Prozac and two asthma inhalers. (R. 234-28)

Tapp next saw a doctor on December 23, 1996, complaining of pain in the right side of his chest. He said he had been lifting a television when he felt a snap on the right side of his chest. He was diagnosed with musculoskeletal pain, and told to use heat, take Ibuprofen, and avoid heavy lifting for seven to ten days. (R. 254)

Tapp began seeing doctors frequently in February 1997. He first saw John H. Brinkman, M.D., on February 7, 1997, complaining of panic attacks, which Tapp said had been occurring since he quit working about one year earlier. Dr. Brinkman diagnosed Tapp with mild to moderate anxiety depression, and ordered a number of diagnostic tests. (R. 253-54) A chest X-ray was normal (R. 262), but Tapp's liver enzymes were abnormal. An ultrasound showed no abnormalities of Tapp's liver, and only borderline thickening of his gallbladder wall. (R. 261) Tapp was advised that his elevated liver enzymes could be due to alcohol use, although Tapp stated he had stopped drinking four months earlier. (R. 250, 251) Dr. Brinkman gave Tapp a prescription for Paxil and recommended counseling, but Tapp was "reluctant." (R. 250) Tapp saw Dr. Brinkman for follow-up on February 25, 1997, reporting his appetite was fair and he experienced occasional nausea after eating. The doctor increased Tapp's dosage of Paxil, and ordered a repeat of Tapp's liver function studies. When Tapp appeared for his next follow-up visit on March 25, 1997, he reported that he had consumed two beers the previous day. (R. 246) Dr. Brinkman again advised Tapp not to drink alcohol. He renewed Tapp's Paxil prescription and scheduled a follow-up in two months. (*Id.*)

Tapp apparently had returned to work by this time because he contracted either the flu or an upper respiratory infection in April 1997, and Dr. Brinkman's office notes indicate Tapp was to be off work until April 28, 1997. (R. 243, 245) A physician's assistant for Dr.

Brinkman gave Tapp a prescription for Zithromax Z-Pack on April 18, 1997 (R. 245), but Dr. Brinkman noted on April 25, 1997, that Tapp had not filled the prescription. (R. 243)

On May 6, 1997, Tapp went to the doctor complaining that he had been lifting a tire three days earlier at work, and had felt a snapping or popping in his neck and upper back. He reported back pain with any movement of his neck or arms, occasional tingling in both hands, and intermittent shooting pains down his right arm.⁴ (R. 241-42) An X-ray indicated mild bone loss in his thoracic spine. An X-ray of his cervical spine indicated little change from the previous exam; narrowing at the C4-5 and C5-6 cervical vertebral levels was noted. (R. 260)

In addition to the back and neck pain, Tapp also reported he had lost 15 pounds, possibly due to depression. Dr. Brinkman continued Tapp's Paxil prescription and scheduled a follow-up in one week. (R. 242) When he returned for the follow-up visit on May 15, 1997, Tapp reported he was throwing up and was still losing weight, although Tapp's wife said he was eating well. Dr. Brinkman referred Tapp to the University of Iowa Hospital for a malabsorption workup. (R. 240)

Tapp saw Chris Goerdt, MD. at the University of Iowa Hospital on July 14, 1997. Tapp presented with a history of nausea, vomiting and diarrhea for three months; liver lesions; exertional chest pain; alcohol and tobacco abuse; and a 32-pound weight loss. A CT scan revealed multiple lesions in Tapp's liver with moderate enlargement of the liver. A chest X-ray was negative. Tapp underwent a treadmill examination which revealed chest tightness occurring at 10 seconds into stage 3, and no EKG changes. Tapp was scheduled

⁴Doctor's notes indicate Tapp had a history of degenerative arthritis of the neck. Although the record indicates Tapp had degenerative changes of the cervical spine and some narrowing of cervical disk spaces (see R. 263), this is the first reference in the record to degenerative arthritis in Tapp's neck. (R. 242)

for a gastroenterology consultation. Various tests were ordered, and Tapp was given a prescription for nitroglycerin to use as needed. (R. 272-73)

Tapp saw Kenneth Hubel, M.D. on July 16, 1997, for a gastroenterology consultation. Tapp reported having three to eight bowel movements a day, accompanied by crampy abdominal pain. He became nauseous and began vomiting anywhere from five to 90 minutes after eating. Tapp said he had a good appetite but vomited after nearly every meal. He reported losing 35 pounds over the previous five months. Tapp said he had smoked one to two packs a day for 25 years, and he drank a 12-pack of beer daily for 15 years. Dr. Hubel noted Tapp's past medical history was significant for depression; jaundice in 1985, secondary to alcoholic hepatitis; and meningitis. He scheduled lab tests and a follow-up exam. (R. 275-76)

Tapp returned to see Dr. Hubel on July 25, 1997, for follow-up. The doctor found a few linear erosions in Tapp's esophagus, and some scattered small erosions in his duodenal bulb. He took biopsies from the distal and proximal duodenum. Tapp received prescriptions for Cisapride and Prilosec, and a sigmoidoscopy was scheduled for July 28, 1997, with a possible small bowel X-ray. (R. 278-79) Tapp returned for a follow-up with Dr. Azade Yedidag on August 12, 1997, to review the results of his lab work and biopsies. Lab studies were negative for hepatitis A, B and C, and stool studies were normal. Colon biopsies revealed mild nonspecific changes; duodenal biopsies indicated nonspecific duodenitis with erosion; and stomach biopsies revealed chronic gastritis with moderate activity and H-pylori organisms present. Ultrasound of Tapp's gallbladder and pancreas were normal. (R. 280) Dr. Yedidag prescribed Flagyl, Amoxicillin, and Pepto-Bismol for H-pylori infection. Tapp's prescriptions for Prilosec and Cisapride were continued, and the doctor recommended Metamucil for the diarrhea. Tapp was advised to stop consuming alcohol. (*Id.*) A liver CT scan was scheduled for August 25, 1997, but nothing appears in the record to indicate whether the CT scan was performed.

On October 20, 1997, Tapp was admitted to the University of Iowa Hospital with diagnoses of volume depletion with altered mental status and mild ketoacidosis⁵; cirrhosis of the liver; chronic weight loss; chronic diarrhea; history of alcohol and tobacco abuse; previous *Helicobacter pylori*⁶ positive, status post eradication therapy. He was found to have some small low-attenuation lesions throughout his liver, but no other abnormalities. Tapp reported a one-month history of intermittent weakness and dizziness, especially when standing; unsteady gait, and a sensation of staggering while walking. He also complained of increased memory problems, and Tapp's wife reported he had difficulty remembering events and times. Tapp's chronic diarrhea had recurred, with as many as 15 bowel movements each day. Tapp reported having a poor appetite and poor sleep, sometimes not sleeping for one to two days at a time. He also experienced chills and cold sweats. Tapp said he had consumed two beers several days earlier, and he was cutting back on tobacco. Dr. Gerdt admitted Tapp for further testing and evaluation, noting Tapp's increasing mental status changes were worrisome. He advised Tapp to refrain completely from alcohol and tobacco. (R. 284-86)

Tapp saw Michael D. Voigt, M.D., for follow-up on October 26, 1997. Dr. Voigt noted Tapp was tense, very emaciated, and alert and oriented only to person (*i.e.*, not to place or time). Reflexes were absent at Tapp's knees and ankles, and he had loss of vibration and position sensation in both hands and feet up to his wrists and ankles. Tapp had

⁵"Acidosis" is defined as "a pathologic condition resulting from accumulation of acid or depletion of the alkaline reserve (bicarbonate content) in the blood and body tissues, and characterized by an increase in hydrogen ion concentration (decrease in pH)." *Dorland's Illustrated Medical Dictionary*, 17 (27th ed. 1988). "Ketoacidosis" is "acidosis accompanied by the accumulation of ketone bodies (ketosis) in the body tissues and fluids, as in diabetic acidosis." *Id.* at 876. Ketosis is "a complication of diabetes mellitus and starvation." *Id.* at 877.

⁶*Helicobacter pylori* (*H. pylori*) are a corkscrew-shaped bacteria that live in the stomach and are a leading cause of peptic ulcers and stomach infections. See "H. pylori: Beyond Stomach Ulcers" (Apr. 20, 2001), at www.MayoClinic.com.

marked loss of pain and light touch sensation in his feet above the mid-calf, and in his hands to above the wrists. Dr. Voigt diagnosed Wernicke's encephalopathy, Korsakoff's syndrome⁷, and alcoholic dementia. Tapp was treated with thiamine, Haldol, and insulin for his diabetes. Dr. Voigt noted Tapp might require 24-hour health care supervision if his amnesia and disorientation continued. Tapp made a verbal commitment to return to AA and pursue abstinence from alcohol, and to begin the application process to receive disability benefits. As to the latter, Dr. Voigt noted, "Given his extensive neurologic deficits, [Tapp] may be a good candidate for this form of assistance. As stated . . . he may require extensive health care support." (R. 289-92)

Tapp was feeling much better at his follow-up visit with Dr. Goerdts on November 3, 1997. He had more energy, and his wife reported he was no longer sleeping all day. Tapp denied any diarrhea, nausea, vomiting, or abdominal pain, and reported only minimal problems with his memory. He had gained 17 pounds since October 24, 1997. Tapp complained of increased depression and sleep disturbance, worsening of back pain, and increased heartburn. Dr. Goerdts told Tapp to continue taking multivitamins, Thiamine and Folic acid; continue to abstain from alcohol and attend AA meetings; continue on insulin; restart Paxil; and continue taking Maalox for gastroesophageal reflux disease. (R. 294-95)

Tapp was to schedule a follow-up exam with Dr. Goerdts in one month, but on this record, it appears he next saw a treating physician (as opposed to an evaluating physician for purposes of his disability application) on March 31, 1998, when he saw Bradley Britigan, M.D., for follow-up of his numerous symptoms. (R. 327-32) Prior to seeing Dr. Britigan, Tapp was seen by several physicians for evaluations in connection with his application for Iowa disability benefits and Social Security benefits. The first of these was Steven Gordon, Psy.D., on December 5, 1997, who performed a psychological assessment of Tapp in

⁷See Appendix A, note 2, for definitions.

connection with his disability application. Dr. Gordon noted Tapp was polite and cooperative and appeared to do his best on various tests that were administered. Tapp had problems with information that was presented verbally or visually, and exhibited short-term memory problems. (R. 296-98)

Tapp described a typical day to Dr. Gordon, stating he is able to do the cooking, cleaning, and laundry, but he has trouble dealing with money. Tapp usually gets up with his wife, has coffee, his wife administers Tapp's medications, they watch the news, eat breakfast, and then Tapp "has to go to bed because he has an upset stomach and diarrhea. He'll lay in bed from 9:00 a.m. until noon." (R. 197-98) He then "will vacuum, take out the garbage, let the dogs out, and do dishes. His wife will leave him a menu for what he can eat for lunch. For enjoyment he likes to watch movies, read, and go for walks." (R. 198)

Dr. Gordon opined Tapp

would have problems remembering all but the most simple locations and work-like procedures. Instructions would have to be very short and simple. He may have problems maintaining attention and concentration for extended periods. He should be able to sustain an ordinary routine without special supervision and make simple work-related decisions. . . . [H]e apparently has a very poor memory and instructions and directions may have to be repeated several times throughout the day. He should be able to interact appropriately with the general public and to get along with co-workers and supervisors. He will likely have problems responding appropriately to changes in the work setting. Pace will be slow. Judgment will be poor. He should be able to handle cash benefits at this time since he has the assistance of his wife.

(R. 298) Dr. Gordon's final diagnosis was that Tapp suffers from alcohol dependence in early partial remission, and alcohol-induced persisting dementia. (*Id.*)

On January 5, 1998, Tapp saw Dr. Sant Hayreh for a neurological consultation due to numbness in his arms and hands, and weakness in his legs and feet. Dr. Hayreh diagnosed sensory polyneuropathy resulting from a combination of chronic alcohol abuse and diabetes; poor memory secondary to chronic alcohol abuse and depression; and musculoskeletal neck and back pain with no evidence of radiculopathy. (R. 299-302)

M. Jane Bibber, Ph.D. perform a Psychiatric Review Technique (R. 303-11) and a Mental Residual Functional Capacity Assessment (R. 312-16) of Tapp on January 19, 1998. Dr. Bibber found Tapp to have alcohol-induced persisting dementia and alcohol dependence in recent remission. She noted Tapp had slight restriction in the activities of daily living, no difficulties in maintaining social functioning, and frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner, both in a work setting and elsewhere. Dr. Bibber concluded Tapp would be moderately limited in his ability to: (1) remember locations and work-like procedures; (2) understand and remember very short and simple instructions; (3) carry out very short and simple instructions; (4) maintain attention and concentration for extended periods; (5) perform activities within a schedule; (6) maintain regular attendance; (7) be punctual within customary tolerances; (8) sustain an ordinary routine without special supervision; (9) work in coordination with or proximity to others without being distracted by them; (10) complete a normal workday and workweek without interruptions from psychologically based symptoms; (11) perform at a consistent pace without an unreasonable number and length of rest periods; (12) interact appropriately with the general public; (13) respond appropriately to changes in the work setting; (14) travel in unfamiliar places or use public transportation; and (15) set realistic goals or make plans independently of others.

Dr. Bibber found Tapp would be markedly limited in his ability to understand and remember detailed instructions, and to carry out detailed instructions. She found Tapp did not have any significant limitation in his ability to: (1) make simple work-related decisions;

(2) ask simple questions or request assistance; (3) accept instructions and respond appropriately to criticism from supervisors; (4) get along with coworkers or peers without distracting them or exhibiting behavioral extremes; (5) maintain socially appropriate behavior; (6) adhere to basic standards of neatness and cleanliness; and (7) be aware of normal hazards and take appropriate precautions. (R. 312-16)

Dr. Bibber noted Tapp had improved somewhat since he stopped consuming alcohol and started complying with his medication and vitamin regimen. She opined Tapp could perform very simple tasks with occasional supervision during the work day. The doctor concluded, "Given very short and simple instructions, [Tapp] can understand, remember, and carry out these instructions with occasional supervision during the work day and especially when changes in the routine occur; and he can sustain adequate concentration in a moderately placed, low-stress work place; moreover, in such a work setting he can interact appropriately with supervisors and co-workers." (R. 315)

Jan Hunter, D.O., performed a Residual Functional Capacity Assessment of Tapp on March 11, 1998. (R. 317-22) Dr. Hunter found Tapp could occasionally lift and/or carry 20 pounds; frequently lift and/or carry 10 pounds; stand and/or walk for a total of at least two hours in an eight-hour work day; sit for a total of six hours in an eight-hour work day; push and/or pull without limitation; and climb, balance, stoop, kneel, crouch and crawl with occasional limitations. She found Tapp had no manipulative, visual, communicative, or environmental limitations. (*Id.*)

Dr. Hunter prepared an Iowa Disability Determination Services Medical Consultant Review Summary (R. 323-24), in which she noted Tapp has a "medically determinable impairment which would be expected to limit his functioning[;] however, given his improvement, he would be capable of some type of work activity, as outlined on RFC." (R. 324) Dr. Hunter also noted Tapp "is credible to the degree in which he does have a history of problems, and he does continue to experience some problems related to his multiple

medical conditions,” although Tapp’s consistent treatment over the previous year “has improved his condition.” (*Id.*)

As noted above, Tapp resumed regular medical treatment with a visit to Dr. Britigan on March 31, 1998. Tapp was upset because he had been denied Social Security benefits. He stated he was still unable to return to work. Tapp reported increasing tremors, cold legs, variable appetite without bowel problems, and a reluctance to leave his house. Dr. Britigan referred Tapp to physical therapy for an evaluation of his ability to handle daily living activities. He increased Tapp’s Paxil dosage, started him on Ativan for agoraphobia/anxiety, and advised him to stop smoking due to the presence of wheezing on pulmonary exam. (R. 327-32)

On April 1, 1998, Dr. Nitin Chandramouli wrote a letter to Tapp explaining that Tapp’s liver enzyme tests were again elevated. Tapp had stated he was drinking again, but not to excess. Dr. Chandramouli advised Tapp to stop drinking alcohol altogether and decrease his Paxil dosage. (R. 333) Tapp saw Dr. Chandramouli for follow-up on May 21, 1998. Tapp’s appetite was better, his diarrhea had resolved, and he was gaining weight. Tapp complained that his depression was worse and the doctor noted Tapp was visibly upset regarding a pending appeal from the denial of Social Security benefits. Dr. Chandramouli encouraged Tapp to abstain completely from alcohol. He maintained Tapp’s current regimens of insulin, thiamine and folic acid. He referred Tapp to a psychiatrist for evaluation and further treatment. And he noted Tapp eventually would be started on Zyban to assist him in stopping smoking. (R. 338-39)

Tapp saw J.A. Jackson, M.D., on July 1, 1998, for a psychiatric intake exam. Dr. Jackson found Tapp to have normal psychomotor activity, fair insight and judgment, low impulsivity and adequate frustration tolerance. He noted Tapp’s memory showed gross deficits in recent and intermediate modes. Tapp’s abstraction and concentration were poor, and his intelligence was in the low average range. Dr. Jackson diagnosed Tapp as having

alcohol induced persisting dementia, depressive disorder, alcohol dependence in remission, insulin-dependent diabetes mellitus, hypertension, and chronic medical problems. He assessed Tapp as having a Global Assessment of Functioning (“GAF”)⁸ of 38, indicating Tapp had major impairment in several areas.⁹ (R. 343) The doctor increased Tapp’s Paxil dosage and scheduled a follow-up exam.

Tapp called Dr. Jackson on August 5, 1998, complaining that he was not feeling better despite the increased Paxil dosage. Dr. Jackson called in another prescription for Paxil and a prescription for Klonopin. (R. 363) Tapp saw Dr. Jackson again on August 12, 1998, at which time the doctor found Tapp to have a GAF of 42, which is not significantly improved from the prior GAF of 38.¹⁰ He prescribed Buspar, Prozac, and Trazodone, and scheduled a follow-up exam in six weeks.

Tapp saw Febe Wallace, M.D., at the University of Iowa Hospitals and Clinics for a routine physical exam on August 17, 1998. Tapp reported his diabetes was fairly well controlled, his appetite was better, and he had started to gain weight. Tapp still was smoking one and one-half to two packs per day, and occasionally drinking four beers per day. He complained of intermittent muscle spasms in his left leg, especially the calf, occurring with activity. Dr. Wallace ordered lab tests to monitor Tapp’s pancreatic atrophy and insufficiency, platelet count, hemoglobin, and electrolyte panels. Dr. Wallace instructed Tapp to continue taking folic acid and thiamine, and advised him to stop drinking alcohol, noting it was unclear whether Tapp would do so. (R. 369-70)

After cancelling two appointments with Dr. Jackson on September 23 and 25, 1998, Tapp saw Dr. Jackson again on September 30, 1998. Tapp continued to complain of anxiety

⁸See Appendix, note 3.

⁹*Id.*

¹⁰*See id.*

and depression. Dr. Jackson increased Tapp's Buspar, Prozac and Trazodone dosages, and told him to return for follow-up in three months.

On November 16, 1998, Tapp saw a doctor at the Mental Health Center of North Iowa, requesting a referral to the Liberty Square residential care facility. Tapp was very upset after being denied Social Security benefits, and had been drinking over the weekend. (R. 354) Tapp followed up with Dr. Jackson on December 23, 1998, when he continued to complain of anxiety. Tapp admitted he was still drinking on occasion. Dr. Jackson assessed Tapp as having a GAF of 42, and increased his Trazodone. He diagnosed Tapp with major depression, and told him to follow up in three months. (R. 352)

Tapp was Dr. Wallace for a follow-up on February 15, 1999. He reported the onset of increasing bloating after meals and watery diarrhea, primarily in the morning. He denied he was drinking, but said he continued to smoke two packs per day. He also said his depression was "bad." Dr. Wallace was concerned that Tapp was still drinking, despite his denial. The doctor increased Tapp's insulin dosage, counseled Tapp to quit smoking, and ordered further blood work to check for evidence of alcohol consumption and follow-up on Tapp's overall condition. Tapp was told to follow up in three months. (R. 374)

Tapp saw Dr. Jackson again on February 26, 1999, and requested a prescription for Wellbutrin as a stop-smoking aid. Tapp was given a prescription for Wellbutrin; no other changes were made to his medications. (R. 351) Tapp failed to show up for his next appointment, on March 16, 1999. (R. 350)

On April 19, 1999, a nurse from Iowa City called the Mental Health Center of North Iowa looking for Tapp. The nurse reported Tapp had been having problems at home, and had gone on a drinking binge. The nurse was concerned that she could not locate Tapp. (R. 349)

On May 4, 1999, Dr. Jackson wrote an opinion letter to Tapp's attorney regarding Tapp's condition. In the letter, Dr. Jackson opined:

Mr. Tapp is unable to maintain regular attendance and be punctual within customary tolerances due to his gross memory deficits. His ability to maintain concentration and attention is limited to only minutes. He would not be able to complete a normal work day or work week without interruptions due to his psychiatric problems. His ability to perform at a consistent pace is highly doubtful. His ability to work in coordination with supervisors, coworkers and the general public is unlikely to be intact due to his poor memory. His ability to handle stress is poor. These symptoms have been severe on the order of several years at this point in time. Mr. Tapp is generally compliant with medications as his wife makes sure that he takes them. Typically, cancelled appointments are followed by rescheduled appointments within a short period of time. I have no indication that he is obtaining medication from more than one source. He is drinking alcohol to excess in my opinion. This has a negative effect on his medication regimes and worsens his memory deficits. Liberty Square is a residential care facility. Given his wife's involvement, I do not believe it is appropriate at this point in time. Mr. Tapp's current GAF is approximately 35. I do believe his GAF over the last year would be consistent with a claim for disability.

(R. 367) In a follow-up letter dated May 21, 1999 (R. 368), Dr. Jackson stated:

I do not believe that abstinence from alcohol would improve Mr. Tapp's condition to the point that []he would be capable of competitive employment. This is largely due to the fact that his is an irreversible neurologic condition secondary to chronic alcohol use where a patient is not able to incorporate new information into their memories. In other words, the patient would not be able to learn new tasks or necessarily find his way to a place of employment on a daily basis without prompting.

On this record, it appears Tapp next saw a doctor on June 3, 1999, when he saw Stephen Holbrook, Psy.D., at the Mental Health Center of North Iowa. Tapp, accompanied by his wife, appeared for an evaluation and follow-up of his depression and other problems. The doctor stressed the need for Tapp's home life to have as much routine as possible, and

discussed memory aids to use at home. Tapp's wife reported she laid out Tapp's medications and called him several times daily to remind him to take his medications. Tapp complained of continued anxiety, stating he felt agitated and anxious at home due to noise from outside. He and his wife planned to move to a quieter neighborhood. Dr. Holbrook stressed to Tapp and his wife that Tapp's memory problems are irreversible and Tapp needs to find coping mechanisms. He referred Tapp to the Community Support Program, and told Tapp to follow up with him in a few weeks. (R. 379)

Dr. Holbrook saw Tapp again on August 12, 1999. Tapp and his wife had moved to a quieter neighborhood, and Tapp had improved somewhat due to the move. He reported he was less anxious and agitated at home, and had an appropriate affect and upbeat mood. Tapp reported significant memory problems, stating he was unable to manage his medication regime without assistance. He had been abstaining from alcohol, and felt his psychotropic medications were decreasing his anxiety and jitteriness. Tapp stated he only left home with his wife, or to walk to the park by himself twice a week. Dr. Holbrook told Tapp to return for follow-up in six to eight weeks. (R. 378)

When Tapp returned to see Dr. Holbrook on September 17, 1999, he continued to report significant short-term memory problems, often getting confused as to the date and day of the week. He was not having any significant problems with anxiety, but was staying at home most of the time. Tapp declined intensive community support or involvement with the RENEW Center, and Dr. Holbrook told Tapp to return for follow-up in six to eight weeks.

4. *The ALJ's conclusion*

The ALJ found Tapp had not engaged in substantial gainful activity since April 1, 1997, his claimed disability onset date. (R. 37, ¶ 2) The ALJ further found:

The medical evidence establishes that [Tapp] has the following impairments: insulin-dependent diabetes mellitus Type II secondary to pancreatic atrophy, pancreatic insufficiency

secondary to chronic alcoholism, cirrhosis of the liver, degenerative changes of the cervical spine, a history of Wernicke's encephalopathy, a history of sensory polyneuropathy of the arms and legs, chronic obstructive pulmonary disease with bronchitis, and depression with a history of major depressive disorder, which impairments are severe, but that [Tapp] does not have an impairment or combination of impairments listed in, or medically equal to one listed in Appendix 1, Subpart P, Regulations No. 4.

(R. 37, ¶ 3)

The ALJ found the allegations of Tapp and his wife that Tapp is incapable of all work to be "less than fully credible." (R. 37, ¶ 4) He found Tapp to have the following residual functional capacity:

to perform the physical exertional and non-exertional requirements of work with the following limitations: can lift no more than 20 pounds occasionally and 10 pounds frequently, can stand for no more than 30 to 60 minutes at a time, and can walk no more than three to four blocks at a time, and can walk and/or stand at least two hours out of an eight hour workday. Further, he can do no repetitive stooping, squatting, kneeling, crawling, or climbing, and can tolerate no more than moderate exposure to heat, humidity, and cold. He must avoid working at heights, can do only simple, routine, repetitive work; can do no work requiring use of independent judgment or requiring close attention to detail, can have no more than occasional contact with the public and requires occasional supervision, can do no work at greater than a regular pace, and can tolerate only a mild level of stress. (Citation omitted.)

(R. 37, ¶ 5)

Although finding Tapp is unable to return to any of his past relevant work (R. 38, ¶ 6), and also that Tapp lacks "any acquired work skills which are transferable to the skilled or semi-skilled work functions of other work" (R. 38, ¶ 9), the ALJ nevertheless found a significant number of unskilled jobs exist in the national economy that Tapp can perform,

citing examples of garment sorter/classifier, shipping and/or receiving weigher, and produce sorter. (R. 38, ¶ 10).

The ALJ based his decision that Tapp retains the residual functional capacity, age, education, and work experience to perform certain light-duty, unskilled jobs on the VE's response to the ALJ's first hypothetical question. (See R. 36, 136-37) Finding jobs exist in significant numbers in the national economy that Tapp could perform, the ALJ held Tapp was not disabled at any time through the date of his decision. (R. 36, 38 ¶ 11)

Noting that the abuse of alcohol and other drugs may not form a substantial basis for a finding of disability, the ALJ found Tapp's alcohol abuse to be "a material factor in this case." (R. 14) In his review of Tapp's medical history, the ALJ noted numerous occasions where Tapp's physicians advised him to quit drinking alcohol altogether, but Tapp would appear at a subsequent appointment and report he had consumed some alcohol. Laboratory tests, in particular liver enzyme elevation, confirmed that Tapp had been consuming alcohol from time to time. The ALJ noted Tapp reported to his doctors his opinion that some of his physical and mental problems were due to past alcohol abuse.

The ALJ also found Tapp's activities of daily living belied Tapp's claim that he was totally disabled. Tapp prepared meals, went shopping, and did some housework. In addition, Tapp had injured himself at work one month following his alleged disability onset date. The ALJ concluded "[t]he weight of the evidence shows that [Tapp] participated in activities of daily living which were inconsistent with an allegation of disability as a whole, and even if he were impaired, this was due in material part to his continuing alcohol abuse." (R. 30) Also impugning Tapp's credibility, in the ALJ's opinion, was his "misreporting" of the amount of weight loss he had sustained during a five-month period. (See R. 31)

The ALJ recognized that according to Dr. Jackson, complete abstinence from alcohol was not likely to improve Tapp's condition to a point that he would be capable of competitive employment, "largely due to the fact that [Tapp has] an irreversible neurologic

condition secondary to chronic alcohol abuse where [Tapp is] unable to incorporate new information into his memory.” (R. 27-28) However, the ALJ found Dr. Jackson’s opinion that Tapp was limited in most areas and would remain so limited “would apply only if alcohol is included in the picture,” explaining:

However, deducting out alcohol results in a residual functional capacity which generally appears to be compatible with gainful employment. In this instance, the claimant’s alcoholism is a contributing factor material to a determination that the claimant is disabled, and based upon the existing law, can no longer form a basis for a finding of disability.

(R. 31-32) The ALJ set forth a detailed rationale for his finding that Tapp’s continued consumption of alcohol, even in lesser amounts, was a substantial contributing basis for his limitations, citing evidence in the record that during the periods when Tapp abstained from consuming alcohol, both his physical and mental capacity improved markedly. (R. 32-33) The ALJ found it “quite significant” that Tapp was able to check and regulate his blood sugar levels, and found Tapp’s “level of functioning . . . tends to gainsay the allegation that his cognitive function is so impaired as to preclude all gainful work.” (R. 33)

The ALJ concluded it was “clear that [Tapp] did not stop drinking when he said he did,” noting Tapp historically had been less than forthcoming in admitting the extent of his drinking. (R. 33-34) The ALJ concluded:

From this record it is hard to verify that [Tapp] has ever quit drinking. Since [Tapp’s] impairment is specifically affected and worsened by his alcoholism, the fact that he did not quit drinking as he alleged shows that his impairments are indeed materially affected by his continued drinking.

(R. 34)

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

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

To determine whether a claimant has a disability within the meaning of the Social Security Act, the Commissioner follows a five-step process outlined in the regulations. 20 C.F.R. §§ 404.1520 & 416.920; see *Kelley*, 133 F.3d at 587-88 (citing *Ingram v. Chater*, 107 F.3d 598, 600 (8th Cir. 1997)). First, the Commissioner must determine whether the claimant is currently engaged in substantial gainful activity. Second, he looks to see whether the claimant labors under a severe impairment; *i.e.*, “one that significantly limits the claimant’s physical or mental ability to perform basic work activities.” *Kelley*, 133 F.3d at 587-88. Third, if the claimant does have such an impairment, then the Commissioner must decide whether this impairment meets or equals one of the presumptively disabling impairments listed in the regulations. If the impairment does qualify as a presumptively disabling one, then the claimant is considered disabled, regardless of age, education, or work experience. Fourth, the Commissioner must examine whether the claimant retains the residual functional capacity to perform past relevant work.

Finally, if the claimant demonstrates the inability to perform past relevant work, then the burden shifts to the Commissioner to prove there are other jobs in the national economy that the claimant can perform, given the claimant’s impairments and vocational factors such as age, education and work experience. *Id.*; *Hunt v. Heckler*, 748 F.2d 478, 479-80 (8th

Cir. 1984) (“[O]nce the claimant has shown a disability that prevents him from returning to his previous line of work, the burden shifts to the ALJ to show that there is other work in the national economy that he could perform.”) (citing *Baugus v. Secretary of Health & Human Serv.*, 717 F.2d 443, 445-46 (8th Cir. 1983); *Nettles v. Schweiker*, 714 F.2d 833, 835-36 (8th Cir. 1983); *O’Leary v. Schweiker*, 710 F.2d 1334, 1337 (8th Cir. 1983)).

Step five requires that the Commissioner bear the burden on two particular matters:

In our circuit it is well settled law that once a claimant demonstrates that he or she is unable to do past relevant work, the burden of proof shifts to the Commissioner to prove, first that the claimant retains the residual functional capacity to do other kinds of work, and, second that other work exists in substantial numbers in the national economy that the claimant is able to do. *McCoy v. Schweiker*, 683 F.2d 1138, 1146-47 (8th Cir. 1982) (*en banc*); *O’Leary v. Schweiker*, 710 F.2d 1334, 1338 (8th Cir. 1983).

Nevland v. Apfel, 204 F.3d 853, 857 (8th Cir. 2000) (emphasis added) accord *Weiler*, 179 F.3d at 1110 (analyzing the fifth-step determination in terms of (1) whether there was sufficient medical evidence to support the ALJ's residual functional capacity determination and (2) whether there was sufficient evidence to support the ALJ's conclusion that there were a significant number of jobs in the economy that the claimant could perform with that residual functional capacity); *Fenton v. Apfel*, 149 F.3d 907, 910 (8th Cir. 1998) (describing “the Secretary’s two-fold burden” at step five to be, first, to prove the claimant has the residual functional capacity to do other kinds of work, and second, to demonstrate that jobs are available in the national economy that are realistically suited to the claimant's qualifications and capabilities).

Governing precedent in the Eighth Circuit requires this court to affirm the ALJ's findings if they are supported by substantial evidence in the record as a whole. *Weiler v. Apfel*, 179 F.3d 1107, 1109 (8th Cir. 1999) (citing *Pierce v. Apfel*, 173 F.3d 704, 706 (8th Cir. 1999)); *Kelley v. Callahan*, 133 F.3d 583, 587 (8th Cir. 1998) (citing *Matthews v.*

Bowen, 879 F.2d 422, 423-24 (8th Cir. 1989)); 42 U.S.C. § 405(g) (“The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive. . . .”). Under this standard, substantial evidence means something “less than a preponderance” of the evidence, *Kelley*, 133 F.3d at 587, but “more than a mere scintilla,” *Richardson v. Perales*, 402 U.S. 389, 401, 91 S. Ct. 1420, 1427, 28 L. Ed. 2d 842 (1971); accord *Ellison v. Sullivan*, 921 F.2d 816, 818 (8th Cir. 1990). Substantial evidence is “relevant evidence which a reasonable mind would accept as adequate to support the [ALJ’s] conclusion.” *Weiler*, 179 F.3d at 1109 (again citing *Pierce*, 173 F.3d at 706); *Perales*, 402 U.S. at 401, 91 S. Ct. at 1427; accord *Gowell v. Apfel*, 242 F.3d 793, 796 (8th Cir. 2001) (citing *Craig v. Apfel*, 212 F.3d 433, 436 (8th Cir. 2000)); *Hutton v. Apfel*, 175 F.3d 651, 654 (8th Cir. 1999); *Woolf v. Shalala*, 3 F.3d 1210, 1213 (8th Cir. 1993); *Ellison*, 91 F.2d at 818.

Moreover, substantial evidence “on the record as a whole” requires consideration of the record in its entirety, taking into account “‘whatever in the record fairly detracts from’” the weight of the ALJ’s decision. *Willcuts v. Apfel*, 143 F.3d 1134, 1136 (8th Cir. 1998) (quoting *Universal Camera Corp. v. N.L.R.B.*, 340 U.S. 474, 488, 71 S. Ct. 456, 464, 95 L. Ed. 456 (1951)); accord *Gowell*, *supra*; *Hutton*, 175 F.3d at 654 (citing *Woolf*, 3 F.3d at 1213). Thus, the review must be “more than an examination of the record for the existence of substantial evidence in support of the Commissioner’s decision”; it must “also take into account whatever in the record fairly detracts from the decision.” *Kelley*, 133 F.3d at 587 (citing *Cline v. Sullivan*, 939 F.2d 560, 564 (8th Cir. 1991)).

In evaluating the evidence in an appeal of a denial of benefits, the court must apply a balancing test to assess any contradictory evidence. *Sobania v. Secretary of Health & Human Serv.*, 879 F.2d 441, 444 (8th Cir. 1989) (citing *Gavin v. Heckler*, 811 F.2d 1195, 1199 (8th Cir. 1987)). The court, however, does “not reweigh the evidence or review the factual record *de novo*.” *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996) (quoting *Naber*

v. Shalala, 22 F.3d 186, 188 (8th Cir. 1994)). Instead, if, after reviewing the evidence, the court finds it “possible to draw two inconsistent positions from the evidence and one of those positions represents the agency's findings, [the court] must affirm the [Commissioner’s] decision.” *Robinson v. Sullivan*, 956 F.2d 836, 838 (8th Cir. 1992) (citing *Cruse v. Bowen*, 867 F.2d 1183, 1184 (8th Cir. 1989)); see *Hall v. Chater*, 109 F.3d 1255, 1258 (8th Cir. 1997) (citing *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996)). This is true even in cases where the court “might have weighed the evidence differently,” *Culbertson v. Shalala*, 30 F.3d 934, 939 (8th Cir. 1994) (citing *Browning v. Sullivan*, 958 F.2d 817, 822 (8th Cir. 1992)), because the court may not reverse “the Commissioner’s decision merely because of the existence of substantial evidence supporting a different outcome.” *Spradling v. Chater*, 126 F.3d 1072, 1074 (8th Cir. 1997); accord *Pearsall v. Massanari*, 274 F.3d 1211, 1217 (8th Cir. 2001); *Gowell*, *supra*.

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

Shalala, 29 F.3d 428, 432 (8th Cir. 1994); *see also Bishop v. Sullivan*, 900 F.2d 1259, 1262 (8th Cir. 1990) (citing *Polaski v. Heckler*, 739 F.2d 1320, 1322 (8th Cir. 1984)). Under *Polaski*:

The adjudicator must give full consideration to all of the evidence presented relating to subjective complaints, including the claimant's prior work record, and observations by third parties and treating and examining physicians relating to such matters as:

- 1) the claimant's daily activities;
- 2) the duration, frequency and intensity of the pain;
- 3) precipitating and aggravating factors;
- 4) dosage, effectiveness and side effects of medication;
- 5) functional restrictions.

Polaski, 739 F.2d at 1322.

IV. ANALYSIS

In 1996, Congress amended the Social Security Act to eliminate benefits for disabilities arising from addiction to alcohol or other drugs. Pub. L. No. 104-121, 110 Stat. 847 (codified in scattered sections of 42 U.S.C.) The implementing regulations are found in 20 C.F.R. § 404.1535 (relating to disability applications) and § 416.935 (relating to SSI applications). The two sections are identical, and provide as follows:

How we will determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability.

(a) General. If we find that you are disabled and have medical evidence of your drug addiction or alcoholism, we must determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability.

(b) Process we will follow when we have medical evidence of your drug addiction or alcoholism.

- (1) The key factor we will examine in determining whether drug addiction or alcoholism is a contributing

factor material to the determination of disability is whether we would still find you disabled if you stopped using drugs or alcohol.

(2) In making this determination, we will evaluate which of your current physical and mental limitations, upon which we based our current disability determination, would remain if you stopped using drugs or alcohol and then determine whether any or all of your remaining limitations would be disabling.

(i) If we determine that your remaining limitations would not be disabling, we will find that your drug addiction or alcoholism is a contributing factor material to the determination of disability.

(ii) If we determine that your remaining limitations are disabling, you are disabled independent of your drug addiction or alcoholism and we will find that your drug addiction or alcoholism is not a contributing factor material to the determination of disability.

20 C.F.R. § 404.1535.

Thus, the regulations provide for a two-step process which the Commissioner must follow in cases where it appears drug addiction or alcoholism may have contributed to a claimant's limitations. First, the Commissioner must determine whether a claimant is disabled. If the claimant is not disabled, then no further inquiry need be made regarding the extent to which the claimant's drug addiction or alcoholism may contribute to the claimant's limitations. If the Commissioner makes a finding of disability, and there is medical evidence of the claimant's drug addiction or alcoholism, then the Commissioner must determine whether the claimant's drug addiction or alcoholism is a contributing factor material to the disability determination. *Id.* At this stage, the burden of proof is on the claimant to show alcoholism or drug addiction is not a material factor to the finding of

disability. *Estes v. Barnhart*, 275 F.3d 722, 725 (8th Cir. 2002) (citing *Mittlestedt v. Apfel*, 204 F.3d 847, 852 (8th Cir. 2000)); *Pettit v. Apfel*, 218 F.3d 901, 903 (8th Cir. 2000) (citing *Brown v. Apfel*, 192 F.3d 492, 497-98 (5th Cir. 1999)). The “key factor” in the determination “is whether the claimant would still be found disabled if he or she stopped using drugs or alcohol.” *Pettit*, 218 F.3d at 903 (citing 20 C.F.R. § 404.1535(b)(1); *Jackson, supra*).

In the present case, the ALJ made an ultimate finding that Tapp was not disabled (R. 36, 38 ¶ 11), but appears to have done so only by taking into account Tapp’s alcoholism. This puts the cart before the horse, as the first determination must be whether Tapp is disabled as he presented himself, without “deducting out alcohol” in making this determination. See *Bustamante v. Massanari*, 262 F.3d 949, 954-55 (9th Cir. 2001) (implementing regulations require finding of disability as condition precedent to finding alcoholism to be a contributing material factor; citing *Drapeau v. Massanari*, 255 F.3d 1211, 1213 (10th Cir. 2001)). Furthermore, after finding Tapp was not disabled because he retained the residual functional capacity to perform unskilled jobs, the ALJ then found Tapp’s “alcoholism is a contributing factor material to a determination that the claimant is disabled[.]” (R. 32, emphasis added) Although the ALJ attempted to present a thorough, reasoned rationale for his decision, it is not clear from the ALJ’s opinion that he clearly understood and correctly applied the sequential evaluation process for a case involving alcoholism. The court notes, however, that the regulations are somewhat difficult to apply in this case, where it is not clear the claimant has actually stopped drinking. See *Jackson v. Apfel*, 162 F.3d 533, 537 (8th Cir. 1998) (“At first blush these standards seem simple enough. We suspect, however, that they may prove difficult to apply when a claimant has not, in fact, stopped using drugs or alcohol.”)

A similar error in reasoning appears in Tapp’s argument. In Tapp’s brief, he addresses only the first prong of the two-step test. Tapp argues the ALJ erred in finding he

is not disabled by (1) rejecting the opinions of Dr. Jackson, one of Tapp's treating physicians, and of Dr. Gordon, the consultative psychologist, and (2) failing to make a comprehensive, individualized assessment of Tapp's residual functional capacity. However, even if Tapp is correct and the ALJ should have found him to be disabled, such a finding would not end the inquiry. The second prong of the test still would remain; that is, whether Tapp's alcoholism is a contributing factor material to the disability determination.

The Commissioner, on the other hand, addresses the second step first, arguing briefly that the ALJ correctly found Tapp's alcoholism to be a material contributing factor to his disability – ignoring the fact that the ALJ preliminarily found Tapp *not* to be disabled. The Commissioner goes on to address Tapp's arguments, but continues to confuse the issue by failing to address the disability determination at the outset without considering Tapp's alcoholism.

In reviewing the Commissioner's decision, the court will take "first things first," and consider whether substantial evidence exists in the record to support a finding that Tapp is not disabled. The court finds the contrary to be true. Without taking Tapp's alcoholism into consideration, this record presents a clear case of disability. The record paints a picture of a man with serious mental and physical problems that are likely to continue throughout his life. The court also disagrees with the ALJ's credibility determination. The fact that Tapp is able to complete numerous tasks of daily living does not, in the court's opinion, impugn his credibility. "[A]n SSI claimant need not prove that []he is bedridden or completely helpless to be found disabled and the fact that claimant cooks and cleans for [him]self, shops for groceries, does laundry, visits friends, attends church, and goes fishing does not in and of itself constitute substantial evidence that a claimant possesses the residual functional capacity to engage in substantial gainful activity." *Cline v. Sullivan*, 939

F.2d 560, 566 (8th Cir. 1991) (citing *Thomas v. Sullivan*, 876 F.2d 666, 669 (8th Cir. 1989)).

Although the record indicates some improvement in Tapp's condition beginning in 1998, it remains clear that Tapp suffers from gross memory deficits that are not likely to improve and which, together with ongoing physical problems, would preclude him from any type of gainful employment. The court finds the ALJ's basis for discounting Dr. Jackson's opinion to be improper (*i.e.*, the ALJ's finding that Dr. Jackson's opinion as to Tapp's limitations "would apply only if alcohol is included in the picture"). Dr. Jackson specifically stated he did *not* believe complete abstinence from alcohol would improve Tapp's condition, finding Tapp to have "an irreversible neurologic condition secondary to chronic alcohol use where a patient is not able to incorporate new information into their memories." (R. 368) This opinion of Tapp's treating physician "is accorded special deference under the social security regulations" and should be granted "'controlling weight,' provided the opinion is 'well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in [the] record.'" *Prosch v. Apfel*, 201 F.3d 1010, 1012-13 (8th Cir. 2000) (citing 20 C.F.R. § 404.1527(d)(2)). Although the ALJ must consider the record as a whole, in this case, the ALJ failed to give an adequate reason for discounting Dr. Jackson's opinion, which is well supported by evidence in the record.

Having found substantial evidence exists in the record to support a finding that Tapp is, in fact, disabled, the court turns to consideration of the second prong of the regulatory test. As noted above, the burden of proof is on Tapp to prove his alcoholism is not a material contributing factor to his disability. This requires a showing that if he abstained from alcohol, he would remain disabled. Once again, the court turns to the opinion of Tapp's treating physician, Dr. Jackson. The court agrees with the ALJ that the record indicates whenever Tapp abstained from drinking, or was drinking small amounts, his

condition improved. Nevertheless, the court finds nothing in the record to support the ALJ's ultimate conclusion that if Tapp were to abstain from drinking permanently, he would be able to sustain competitive employment. Dr. Jackson noted that Tapp's "gross memory deficits," which are expected to continue even if he abstains from alcohol, would prevent Tapp from being able to maintain regular attendance and punctuality within customary tolerances. With an attention and concentration span of "only minutes," Tapp "would not be able to complete a normal work day or work week without interruptions due to his psychiatric problems." (R. 367)

The court finds Tapp has met his burden to show that his mental limitations would continue, and would continue to be disabling, even if he stops drinking altogether. "[E]ven if long-term alcohol abuse causes a disability, alcoholism will not be found 'material' to the finding of disability if the disability remains after the claimant stops drinking." *Pettit, supra*, 218 F.3d at 904.

Finally, to address Tapp's second argument, the court also finds the ALJ improperly relied on his first hypothetical to the VE in making a finding that Tapp is not disabled. When presented with all of Tapp's limitations as supported by the record, the VE opined Tapp would be unable to sustain any type of competitive employment.

For these reasons, the court recommends the ALJ's decision be reversed.

V. CONCLUSION

Having found Tapp is entitled to benefits, the court may affirm, modify or reverse the Commissioner's decision with or without remand to the Commissioner for rehearing. 42 U.S.C. § 405(g). In this case, where the record itself "convincingly establishes disability and further hearings would merely delay receipt of benefits, an immediate order granting benefits without remand is appropriate." *Cline*, 939 F.2d at 569 (citing *Jefferey v. Secretary of H.H.S.*, 849 F.2d 1129, 1133 (8th Cir. 1988); *Beeler v. Bowen*, 833 F.2d

124, 127-28 (8th Cir. 1987)); accord *Thomas v. Apfel*, 22 F. Supp. 2d 996, 999 (S.D. Iowa 1998) (where claimant is unable to do any work in the national economy, remand to take additional evidence would only delay receipt of benefits to which claimant is entitled, warranting reversal with award of benefits). Consequently, it is recommended that the court reverse the ALJ's decision and remand this case to the Commissioner for an award of benefits in the appropriate amount.

IT IS RECOMMENDED, unless any party files objections¹¹ to the Report and Recommendation in accordance with 28 U.S.C. § 636 (b)(1)(C) and Fed. R. Civ. P. 72(b), within ten (10) days of the service of a copy of this Report and Recommendation, that judgment be entered in favor of Tapp¹² and against the Commissioner, and that this case be **reversed and remanded** to the Commissioner for the calculation and award of benefits.

IT IS SO ORDERED.

DATED this 16th day of May, 2002.

PAUL A. ZOSS
MAGISTRATE JUDGE
UNITED STATES DISTRICT COURT

¹¹Objections must specify the parts of the report and recommendation to which objections are made. Objections must specify the parts of the record, including exhibits and transcript lines, which form the basis for such objections. See Fed. R. Civ. P. 72. Failure to file timely objections may result in waiver of the right to appeal questions of fact. See *Thomas v. Arn*, 474 U.S. 140, 155, 106 S. Ct. 466, 475, 88 L. Ed. 2d 435 (1985); *Thompson v. Nix*, 897 F.2d 356 (8th Cir. 1990).

¹²If final judgment is entered for the plaintiff, the plaintiff's counsel must comply with the requirements of Local Rule 54.2(b) in connection with any application for attorney fees.