

**IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF PENNSYLVANIA**

<b>EDWARD HALEY,</b>	:	
<b>Plaintiff,</b>	:	<b>CIVIL ACTION</b>
<b>v.</b>	:	
	:	
<b>JO ANNE BARNHART,</b>	:	
<b>Commissioner of Social Security,</b>	:	<b>No. 02-1868</b>
<b>Defendant.</b>	:	

**ORDER**

**AND NOW**, this 20<sup>th</sup> day of **August, 2003**, it is hereby **ORDERED** that:

The Court’s Memorandum and Order of August 11, 2003 is amended as follows:

1. On page one, line six, the sentence should read: “On April 5, 2002, Mr. Haley commenced the instant action pursuant to 42 U.S.C. § 1383(c)(3) to review the final decision of the Defendant Commissioner of Social Security (“Commissioner”) denying his claims for DIB and SSI.”
2. On page two, footnote one, the footnote should read: “A.R.” refers to the Administrative Record.” Similarly, all references throughout to the Administrative Record should read “A.R.”

An Amended Memorandum and Order incorporating the above changes is attached hereto.

**BY THE COURT:**

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**Berle M. Schiller, J.**

**IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF PENNSYLVANIA**

<b>EDWARD HALEY,</b>	:	
<b>Plaintiff,</b>	:	<b>CIVIL ACTION</b>
<b>v.</b>	:	
	:	
<b>JO ANNE BARNHART,</b>	:	
<b>Commissioner of Social Security,</b>	:	<b>No. 02-1868</b>
<b>Defendant.</b>	:	

**AMENDED MEMORANDUM AND ORDER**

**Schiller, J.**

**August 20, 2003**

On June 10, 1999, Plaintiff Edward A. Haley filed applications for Disability Insurance Benefits (“DIB”) and Supplemental Security Income (“SSI”), alleging that he had been disabled due to asthma since May 9, 1999. The Social Security Administration (“SSA”) denied the application initially on October 16, 1999 and again upon reconsideration on December 6, 1999. On June 26, 2000, following an administrative hearing on May 31, 2000, an Administrative Law Judge (“ALJ”) found that Plaintiff was not disabled. On April 5, 2002, Mr. Haley commenced the instant action pursuant to 42 U.S.C. § 1383(c)(3) to review the final decision of the Defendant Commissioner of Social Security (“Commissioner”) denying his claims for DIB and SSI. The Magistrate Judge to whom this matter was referred concluded that the ALJ had not sufficiently developed the factual record such that little was known about the causes of Plaintiff’s asthma. Accordingly, the Magistrate recommended that Plaintiff’s case be remanded to permit further exploration of potential causes of asthma such as smoking and allergens. Presently before this Court are the parties’ cross-motions for summary judgment. For the reasons set forth below, I adopt the recommendation of the Magistrate in part, grant Plaintiff’s motion, and deny Defendant’s motion.

## I. BACKGROUND

At the time of the administrative hearing, Mr. Haley was forty-three years old and had an eleventh grade education. (A.R at 40, 19.)<sup>1</sup> Although currently unemployed, he has worked as a custodian and a bus driver. (*Id.* at 64, 72, 213.) On August 3, 1997, Mr. Haley was hospitalized for three nights and ultimately diagnosed with “acute exacerbation of asthma” and “acute bronchitis.” (*Id.* at 81.) The discharge summary by Dr. Nand Ram, Mr. Haley’s attending and treating physician throughout the period relevant to the instant matter, indicated that Mr. Haley had a history of asthma and that he was taking asthma medication and using inhalers. (*Id.* at 82.) On November 21, 1997, Mr. Haley was again hospitalized for three nights for “acute exacerbation of bronchial asthma.” (*Id.* at 91.) On May 20, 1998, Mr. Haley was hospitalized for another three nights for “acute exacerbation of chronic obstructive pulmonary disease,” and his discharge summary indicated that he suffered from “chronic asthma.” (*Id.* at 102-103.) On November 17, 1998, Mr. Haley was admitted to the hospital and into Dr. Ram’s care “with the diagnosis of acute exacerbation of asthma and bronchitis.” (*Id.* at 111.) He remained hospitalized for two nights on an intense regimen of medication, inhalers and nebulizer treatment until he was “deemed stable for discharge to home.” (*Id.*) On March 2, 1999, Mr. Haley was hospitalized for three nights for “acute exacerbation of asthma” and “acute bronchitis.” (*Id.* at 117.)

An individual is considered disabled under the Social Security Act if he can demonstrate an “inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which . . . has lasted or can be expected to last for a continuous period of not less than 12 months.” 42 U.S.C. § 423(d)(2)(A) (2003). Pursuant to agency regulations, the

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<sup>1</sup> “A.R.” refers to the Administrative Record.

Commissioner evaluates each case according to a five-step process until a finding of “disabled” or “not disabled” is made. *See* 20 C.F.R. § 404.1520(a) (2003). The sequence is essentially as follows: (1) if the claimant is currently engaged in substantial gainful employment, she will be found not disabled; (2) if the claimant does not suffer from a “severe impairment,” she will be found not disabled; (3) if a severe impairment meets or equals a listed impairment in 20 C.F.R. Part 404, Subpart P, Appendix 1 (“Appendix 1”) and has lasted or is expected to last continually for at least twelve months, then the claimant will be found disabled; (4) if the severe impairment does not meet prong (3), the Commissioner considers the claimant’s residual functional capacity (“RFC”) to determine whether she can perform work she has done in the past despite the severe impairment - if she can, she will be found not disabled; and (5) if the claimant cannot perform her past work, the Commissioner will consider the claimant’s RFC, age, education and past work experience to determine whether she can perform other work which exists in the national economy. *See Schauddeck v. Comm’r. of Soc. Sec. Admin.*, 181 F.3d 429, 431-32 (3d. Cir. 1999) (*citing* 20 C.F.R. § 404.1520(b)-(f)).

The ALJ found that Mr. Haley had not engaged substantial gainful activity during the period of his alleged disability. (A.R at 12.) The ALJ also found that Mr. Haley had a “severe impairment” due to “asthma, hypertension, gastroesophageal reflux disease, and a history of substance abuse.” (*Id.*) However, the ALJ found that Mr. Haley’s asthma did not meet the criteria set forth in Listing 3.03B of Appendix 1 (“3.03B”), which “requires asthma attacks in spite of prescribed treatment and requiring physical intervention, occurring at least once every 2 months or at least six times a year,” and treats each hospitalization for control of asthma as two “attacks.” The ALJ noted that Mr. Haley had been hospitalized for asthma three times between May 1998 and March 1999, but concluded that

there did “not appear to be a medical justification for the November 1998 hospitalization.” (A.R. at 13.) Although the ALJ further found that Mr. Haley could not perform his past relevant work as a custodian or bus driver, she nevertheless concluded, relying largely on the vocational expert’s testimony, that Plaintiff was not disabled because there were a significant number of unskilled light work jobs in the regional and national economy that Plaintiff could perform. (*Id.* at 20-23.)

The Magistrate concluded that Plaintiff’s “complete medical history” was not “fully developed” by the ALJ, as required by 20 C.F.R. § 416.912(d) and that the ALJ’s conclusion was not supported by substantial evidence. (Report and Recommendation at 6.) Relying on the *Merck Manual*, the Magistrate concluded that a complete medical history of an alleged asthmatic would include his or her responses to various environmental stimuli, such as allergens and smoke. (*Id.* at 7.) The present record, he noted, does not “discus[s] what causes, or stimulates” Plaintiff’s asthma. (*Id.* at 8.) The Magistrate thus remanded for an analysis of the causes of Plaintiff’s asthma.

## **II. STANDARD OF REVIEW**

I review the Commissioner’s decision to determine whether the Commissioner applied the correct legal standards and whether the record, as a whole, contains substantial evidence to support the Commissioner’s findings of fact. *Adorno v. Shalala*, 40 F.3d 43, 46 (3d Cir. 1994); *Schwartz v. Halter*, 134 F. Supp. 2d 640, 647 (E.D. Pa. 2001). Substantial evidence is “more than a mere scintilla” but somewhat less than a preponderance of the evidence or “such evidence as a reasonable mind might accept as adequate to support a conclusion.” *Ventura v. Shalala*, 55 F.3d 900, 901 (3d Cir. 1995) (*quoting Richardson v. Perales*, 402 U.S. 389, 401 (1971)). I review de novo those portions of the Magistrate’s Report and Recommendation to which the parties have made objections.

*See* 28 U.S.C. § 636(b)(1) (2003).

### **III. DISCUSSION**

Plaintiff objects to the Magistrate’s failure to conclude that the ALJ erred by not finding him disabled at step three of the analysis under the regulations. As noted, at step three, if a severe impairment meets or equals a listed impairment in 20 C.F.R. Part 404, Subpart P, Appendix 1 and has lasted or is expected to last continually for at least twelve months, then the claimant will be found disabled without regard to age, education or work experience. *See* 20 C.F.R. 404.1520(d) (2003). Section 3.00 of Appendix 1 lists “examples of common respiratory disorders that are severe enough to prevent a person from engaging in any gainful activity.” 20 C.F.R. Part 404, Subpart P, Appendix 1, 3.00A (“3.00A”). Subsection 3.03B is unambiguous in describing asthma attacks which constitute a qualifying impairment as those occurring at least once every two months or at least six times a year, occurring in spite of prescribed treatment and requiring physician intervention. *See* 20 C.F.R. Part 404, Subpart P, Appendix 1, 3.03B. Further, “each in-patient hospitalization for longer than 24 hours for control of asthma counts as two attacks, and an evaluation period of at least 12 consecutive months must be used to determine the frequency of attacks.” *Id.*

Appendix 1 also describes the appropriate documentation for episodic exacerbations of asthma, which “should include available hospital, emergency facility and/or physician records indicating the dates of treatment; clinical and laboratory findings on presentation, such as the results of spirometry and arterial blood gas studies (ABGS); the treatment administered; the time period required for treatment; and the clinical response.” 20 C.F.R. Part 404, Subpart P, Appendix 1, 3.00C (“3.00C”). In addition, Appendix 1 states:

Attacks of asthma, episodes of bronchitis or pneumonia or hemoptysis (more than blood-streaked sputum), or respiratory failure as referred to in paragraph B of 3.03, 3.04, and 3.07, are defined as prolonged symptomatic episodes lasting one or more days and requiring intensive treatment, such as intravenous bronchodilator or antibiotic administration or prolonged inhalational bronchodilator therapy in a hospital, emergency room or equivalent setting . . . The medical evidence must also include information documenting adherence to a prescribed regimen of treatment as well as a description of physical signs. For asthma, the medical evidence should include spirometric results obtained between attacks that document the presence of baseline airflow obstruction.

*Id.*

Mr. Haley alleges that he became disabled on May 15, 1998. The record shows that during the following year, Mr. Haley was hospitalized three times for control of asthma, each time lasting well longer than 24 hours. In each case, Dr. Ram's discharge summary included the dates of treatment, clinical and/or laboratory findings on presentation, the treatment administered, the time period required for treatment, and the clinical response.

At issue, then, is the ALJ's conclusion that Plaintiff did not meet the criteria set forth in the regulatory listing because there did not "appear to be a medical justification" for the November 1998 hospitalization. The ALJ concluded that because a November 18, 1998 chest x-ray "was clear of any active cardiopulmonary disease," and Mr. Haley "denied shortness of breath and only had mild wheezing," the record did not establish that Plaintiff suffered a qualifying asthma "attack." (A.R. at 13.) The ALJ also relied on the fact that Mr. Haley did not seek medical intervention prior to going to the emergency room and the fact that he had not been hospitalized between the March 1999 hospitalization and the hearing. (*See id.*)

Dr. Ram's report, however, provides all the information necessary under 3.00C for the hospitalization to qualify as an "attack." Mr. Haley remained in the hospital for two nights,

undergoing a highly focused regimen involving steroids, inhalers and nebulizer treatment every four hours, and was only released when he was “deemed stable.” Mr. Haley’s already Herculean catalogue of treatments, which included multiple inhalers, oral medications and a breathing machine, expanded upon his release. Although the chest x-ray on November 18, 1998, was “clear of any active cardiopulmonary disease,” Dr. Ram reported that the lung exam “was significant for occasional wheezing bilaterally and decreased air entry.” (A.R. at 111.) This information was sufficient, along with Dr. Ram’s extensive reported analysis, to meet the requirement that the applicant provide a description of “physical signs” of his asthma attack.

An ALJ is not free to employ her own expertise against that of a physician who presents competent medical evidence. *Ferguson v. Schweiker*, 765 F.2d 31, 37 (3d Cir. 1985). In particular, treating physicians’ reports should be accorded great weight, especially where, as here, their opinions reflect expert judgment based on a continuing observation of the patient’s condition over a prolonged period of time.” *Rocco v. Heckler*, 826 F.2d 1348, 1350 (3d Cir. 1987); 20 C.F.R. § 404.1527(d)(2) (providing for controlling weight to treating physician’s opinion when opinion is well-supported by medical evidence and not inconsistent with other substantial evidence in the record).<sup>2</sup> Given that the report by Mr. Haley’s treating physician clearly provided all of the information required by 3.00C, the record must contain substantial countervailing evidence supporting the ALJ’s conclusion that there “does not appear to be a medical justification” for the November 1998 hospitalization and that

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<sup>2</sup> Ample record evidence supports Dr. Ram’s reported findings. When Mr. Haley was examined in August, 1999 by Defendant’s physician, Dr. Zweiback, the lung exam was again “positive for wheezing,” and Dr. Zweiback concluded that Mr. Haley “present[ed] with resting asthma.” An October 4, 1999 spirometric test reviewed by Defendant’s physician, Dr. Abdollahian, found that Mr. Haley suffered from “mild airway obstruction” and “severe chest restriction.” (A.R. at 136.) Dr. Ram’s notes from routine visits on August 22, 1998 and March 11, 1999 also report wheezing found during the physical exam. (*Id.* at 151.)

Mr. Haley did not suffer an asthma attack in connection with that hospitalization.

There is negligible evidence in the record, however, to support the ALJ's conclusion as to the November 1998 hospitalization. First, the ALJ improperly made speculative inferences from medical reports. *See Smith v. Califano*, 637 F.2d 968, 972 (3d Cir. 1981). There is no stated medical basis in the record for concluding that the absence of evidence of "active cardiopulmonary disease" from a chest x-ray suggests that Mr. Haley did not suffer an asthma attack on November 17, 1998, particularly in light of the presence of other signs that Dr. Ram regarded as demonstrative of an exacerbation of asthma. Second, the ALJ improperly ignored record evidence that undermined her conclusion. *See Stewart v. Secretary of H.E.W.*, 714 F.2d 287, 290 (3d Cir. 1983) (holding that ALJ must consider all evidence and give some reason for discounting evidence she rejects). A complete summation of Dr. Ram's discharge summary would have reflected the fact that the document stated, "the patient denied shortness of breath, *but took shallow breaths.*" (A.R. at 110.) The ALJ's summation reported merely that Mr. Haley denied shortness of breath. Finally, the remaining record evidence relied upon by the ALJ in reaching her conclusion carries little weight in the analysis under the regulations. Neither the fact that Mr. Haley did not seek medical intervention prior to going to the emergency room nor the fact that Mr. Haley had not been hospitalized between the March 1999 hospitalization and the hearing have any bearing on whether Mr. Haley actually suffered an asthma attack on November 17, 1998.

The ALJ's refusal to accept the November 1998 hospitalization as an "attack" was the only stated reason that Mr. Haley's impairment did not meet or equal the impairment listed in 3.03B. I therefore conclude that there is not substantial support in the record for the ALJ's determination that Mr. Haley did not demonstrate that his impairments met or equaled the objective criteria set forth

in listing 3.03B.

This conclusion, of course, is tantamount to a finding that Mr. Haley is disabled under the Social Security Act. The Commissioner has already found that Mr. Haley is not currently engaged in substantial gainful employment and suffers a severe impairment. The record evidence clearly establishes that Mr. Haley's asthma severe meets a listed impairment in 20 C.F.R. Part 404, Subpart P, Appendix 1 and has lasted for at least twelve months. Under the regulations, Mr. Haley's asthma attacks occurred six times in one year, in spite of extensive prescribed treatment and required physician intervention. Accordingly, summary judgment for the Plaintiff is appropriate and remand for a further exploration of the facts, as recommended by the Magistrate, is unnecessary. I approve and adopt the Magistrate's Report and Recommendation in part, such that the Defendant's Motion for Summary Judgment is denied and the matter is remanded solely for a calculation of benefits. An appropriate Order follows.

**IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF PENNSYLVANIA**

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<b>Plaintiff,</b>	:	<b>CIVIL ACTION</b>
<b>v.</b>	:	
	:	
<b>JO ANNE BARNHART,</b>	:	
<b>Commissioner of Social Security,</b>	:	<b>No. 02-1868</b>
<b>Defendant.</b>	:	

**AMENDED ORDER**

AND NOW, this 20<sup>th</sup> day of August, 2003, upon consideration of cross-motions for summary judgment, the responses thereto, the Report and Recommendation of United States Magistrate Judge Arnold C. Rapoport, and the objections thereto, and for the reasons set forth above, it is hereby **ORDERED** that:

1. The Report and Recommendation (Document No. 15) is **APPROVED IN PART and REJECTED IN PART**, as set forth in the accompanying Memorandum.
2. Plaintiff's Motion for Summary Judgment (Document No. 11) is **GRANTED**.
3. Defendant's Motion for Summary Judgment (Document No. 12) is **DENIED**.
4. The matter is **REMANDED** to the Commissioner for an award of benefits.

**BY THE COURT:**

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**Berle M. Schiller, J.**