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UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

OSMIN NAHUM CALDRON, Plaintiff, v. MICHAEL J. ASTRUE, Commissioner of Social Security, Defendant.	Case No. CV 11-01678-OP MEMORANDUM OPINION AND ORDER

The Court[1] now rules as follows with respect to the two disputed issues listed in the Joint Stipulation ("JS").[2]

[1] Pursuant to 28 U.S.C. § 636(c), the parties consented to proceed before the United States Magistrate Judge in the current action. (ECF Nos. 6, 7.)

[2] As the Court advised the parties in its Case Management Order, the decision in this case is being made on the basis of the pleadings, the Administrative Record and the Joint Stipulation filed by the parties. In accordance with Rule 12(c) of the Federal Rules of Civil Procedure, the Court has determined which party is entitled to judgment under the standards set forth in 42 U.S.C. § 405(g). (ECF No. 4 at 3.)

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I.

DISPUTED ISSUES

As reflected in the Joint Stipulation, the disputed issues which Plaintiff is raising as the grounds for reversal and/or remand are as follows:

(1) Whether the Administrative Law Judge ("ALJ") should have afforded the opinion of the treating specialists controlling weight; and

(2) Whether the ALJ properly evaluated Plaintiff's subjective pain complaints.

(JS at 3.)

II.

STANDARD OF REVIEW

Under 42 U.S.C. § 405(g), this Court reviews the Commissioner's decision to determine whether the Commissioner's findings are supported by substantial evidence and whether the proper legal standards were applied. DeLorme v. Sullivan, 924 F.2d 841, 846 (9th Cir. 1991). Substantial evidence means "more than a mere scintilla" but less than a preponderance. Richardson v. Perales, 402 U.S. 389, 401, 91 S. Ct. 1420, 28 L. Ed. 2d 842 (1971); Desrosiers v. Sec'y of Health & Human Servs., 846 F.2d 573, 575-76 (9th Cir. 1988). Substantial evidence is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Richardson, 402 U.S. at 401 (citation omitted). The Court must review the record as a whole and consider adverse as well as supporting evidence. Green v. Heckler, 803 F.2d 528, 529-30 (9th Cir. 1986). Where evidence is susceptible of more than one rational interpretation, the Commissioner's decision must be upheld. Gallant v. Heckler, 753 F.2d 1450, 1452 (9th Cir. 1984).

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III.

DISCUSSION

A. **The ALJ's Findings.**

The ALJ found that Plaintiff has the severe impairments of status post-lumbar discectomy and herniated discs. (AR at 13.) The ALJ concluded that Plaintiff had the residual functional capacity ("RFC") to perform sedentary work, limited to lifting and/or carrying ten pounds occasionally; sitting six hours in an eight-hour workday; standing and/or walking two hours in an eight-hour workday with a stand/sit option; pushing, pulling, kneeling, bending, stooping, and climbing stairs occasionally; and never climbing ladders, ropes, or scaffolds. (Id. at 17.)

Relying on the testimony of the vocational expert ("VE"), the ALJ determined Plaintiff was able to perform his past relevant work as a surveillance system monitor (Dictionary of Occupational Titles ("DOT") No. 379.367-010). (AR at 21.)

B. **The ALJ Failed to Properly Evaluate the Medical Evidence in Assessing Plaintiff's RFC.**

1. **Background.**

Plaintiff was involved in two motor vehicle accidents on November 10, 2006, and again on December 20, 2006. (Id. at 94.) He initially received three months chiropractic treatment and physical therapy for his resulting neck and low back pain. (Id. at 94, 238.)

On March 9, 2007, Plaintiff underwent an MRI of the lumbar spine. The MRI revealed spondylolisthesis at L5/S1; mild to moderate disc protrusions impinging on the nerve roots at L5/S1, and at L1/L2; bilateral neuroforaminal narrowing with impingement on the L5 and L1 exiting nerve roots; and bilateral facet arthropathy. (Id. at 205.) On April 10, 2007, Plaintiff saw orthopedic spine surgeon, Daniel A. Capen, M.D., who reviewed the MRI and

indicated diagnoses of two level discopathy (based on the MRI, which showed multilevel lumbar spine disc protrusions with bilateral neural foraminal stenosis); Grade I spondylolisthesis of L5 on S1; and lumbar sprain/strain syndrome. (Id. at 205-06.) Plaintiff reported to Dr. Capen that he could only sit for about five minutes, and stand and walk for ten minutes before experiencing increased pain. (Id. at 202.) Plaintiff also reported difficulty going up and down stairs. (Id.) Examination revealed tenderness on palpation at the midline, positive sacroiliac stress test on the left, positive straight leg raising on the left, and reduced range of motion. (Id. at 203-04.) Dr. Capen initially recommended steroid injections and pain medication, and Plaintiff underwent a series of epidural injections on July 6, July 10, and August 3, 2007. (Id. at 264-69.)

On August 14, 2007, on re-examination, Dr. Capen noted that the three epidural injections had not relieved Plaintiff's pain. (Id. at 197.) At that point in time, Plaintiff "[was] still working, and is able to work." (Id.) Examination revealed range of motion that was "quite good," but some tightness, and some pain on bend and rotation. (Id. at 198.)

Plaintiff continued to work until October 9, 2007, his alleged date of onset. (Id.)

On November 13, 2007, Dr. Capen re-evaluated Plaintiff for surgical intervention. (Id. at 194-96.) He again noted that the three lumbar epidural steroid injections failed to adequately relieve Plaintiff of his symptoms. (Id. at 194.) Physical examination revealed tenderness to palpation over the midline, spasm, guarding, pain with range of motion testing, and positive straight leg raising on the left. (Id. at 195.) He noted that Plaintiff's injury left "dysfunction, disability and chronic pain." (Id.) He reported that therapy, medications, and all conservative treatments, including steroid injections, had failed. (Id.) He informed Plaintiff that he had the choice of "attempting to live

with the pain or undergoing surgical intervention . . ." with no guarantee of complete or even partial relief. (Id.)

After that date, Plaintiff regularly saw Dr. Capen, or others in his office, for follow-up and medication management while waiting for authorization for surgery. On December 4, 2007, physical examination found lumbar spine midline tenderness, spasm, and pain on range of motion testing. (Id. at 192.) Dr. Capen opined that Plaintiff "remains temporarily totally disabled." (Id.) In January 2008, Dr. Capen found pain and tenderness in the paralumbar region; noted that Plaintiff ambulated with an "essentially normal gait"; experienced increased pain on heel and toe walk attempts; and exhibited positive straight leg raise bilaterally. (Id. at 189.) He again opined that Plaintiff was temporarily totally disabled. (Id.) In February 2008, Dr. Capen noted ongoing spasm, tightness, tenderness, and limited range of motion of the lumbar spine. (Id. at 185-86.) In April 2008, Dr. Jarminski, filling in for Dr. Capen, found continued paralumbar muscle tenderness, guarding, limited range of motion of the lumbar spine, increased low back pain on heel/toe walk attempts, and positive bilateral straight leg raising. (Id. at 183.) In May 2008, the physician's assistant who examined Plaintiff under the direction and supervision of Dr. Capen, noted restricted range of motion of the lumbar spine, spasm, midline tenderness, positive straight leg raise bilaterally, and ambulation with an antalgic short-stepped gait. (Id. at 180.) In June 2008, Plaintiff was found to have a positive bilateral straight leg raise, continuously worse on the left side, and range of motion that is "still continuously stiff, achy and limited secondary to pain." (Id. at 177.) In July 2008, the findings were similar and Dr. Capen again stated that nothing else could be done for Plaintiff short of surgery, for which Plaintiff was still awaiting authorization. (Id. at 174.) Dr. Smith later reported that in mid-2008 Plaintiff "was declared permanent and stationary." (Id. at 238.)

As of September 9, 2008, Plaintiff was still awaiting authorization for the surgery. (Id. at 211.) On that date, Dr. Capen reiterated Plaintiff's need for authorization for surgical intervention in the form of a posterior lumbar interbody fusion at L4-5 and L5-S1. (Id. at 212.)

On September 14, 2008, Plaintiff underwent a consultative orthopedic examination, performed by orthopedic surgeon, Carlos Gonzalez, M.D.[3] (Id. at 217.) Dr. Gonzalez reviewed x-rays, apparently taken by his office, which found only mild degenerative change over L5/S1 and L4-5; there is no indication that he reviewed Plaintiff's 2007 MRI or any of Plaintiff's other medical records. (Id. at 220.) Dr. Gonzales found Plaintiff could lift and carry fifty pounds occasionally and twenty-five pounds frequently; could push and pull on a frequent basis with appropriate weight; could stand, walk, and sit without limitations; did not require an assistive ambulatory device; could bend, kneel, stoop, crawl, and crouch on a frequent basis; and could perform overhead activities. (Id. at 221.) This would constitute medium-level work. DOT, Fourth Ed. 1991, App. C.

On October 23, 2008, state agency evaluator, N.J. Rubaum, M.D., indicated that Plaintiff's primary diagnosis was low back pain. (AR at 222.) The case analysis form submitted to Dr. Rubaum references receipt of Dr. Capen's records dated April 2007 through July 2008. (Id. at 228.) The case analysis form also summarizes the findings of the "CE" (consulting examiner, Dr. Gonzalez), but fails to reflect any of the findings or conclusions from Dr. Capen's reports. (Id.) Presumably, after reviewing both Dr. Gonzalez's report and Dr. Capen's records, Dr. Rubaum completed a Physical Residual Functional Capacity Assessment, a check-box form, wherein he indicated that

[3] Plaintiff notes that Dr. Gonzalez is not board certified. (JS at 6; see also AR at 221.)

Plaintiff could lift and/or carry fifty pounds occasionally, twenty-five pounds frequently; stand and/or walk about six hours in an eight-hour workday; and could climb ramps/stairs, ladder/rope/ scaffolds, balance, stoop, kneel, crouch, and crawl frequently. (Id. at 223-26.) This would constitute medium-level work. DOT, Fourth Ed. 1991, App. C. Dr. Rubaum also opined, without explanation, that "claimant's credibility is seriously in doubt." (Id. at 227.) Moreover, Dr. Rubaum indicated that the "treating or examining source statement(s) regarding the claimant's physical capabilities" were in the file, but he also indicated that the "treating/examining source conclusions about the claimant's limitations or restrictions" were *not* significantly different from his own findings. (Id.) While this is true with respect to examining source Dr. Gonzalez's conclusions, as Dr. Rubaum's conclusions essentially mirror those of Dr. Gonzalez, it certainly is *not* true with respect to the treating source conclusions. Thus, the Court finds the record ambiguous as to whether Dr. Rubaum actually reviewed the records from Plaintiff's treating physician, Dr. Capen, prior to completing the assessment.

On March 23, 2009, Plaintiff was seen by orthopedic surgeon Michael Smith, M.D. (Id. at 237.) Dr. Smith reviewed the 2007 MRI and diagnosed chronic, symptomatic, post-traumatic injury of the lumbar spine, with lower lumbar musculotendino-ligamentous involvement; right and left posterior joint damage; and multilevel disc protrusions. (Id. at 242.) Based on his examination, he noted objective findings of tenderness to palpation, reduced range of motion of the lumbosacral spine, and positive straight leg raising in the seated and supine positions. (Id. a 239-42.)

On April 3, 2009, Plaintiff obtained another MRI. (Id. at 258.)

On April 8, 2009, Plaintiff was seen by neurosurgeon Ian Armstrong, M.D. (Id. at 271-73.) Dr. Armstrong reviewed the new MRI and found evidence of an L5/S1 disc protrusion and extrusion. (Id. at 271.) He also

found evidence of a disc protrusion at the L4-L5 level. (Id.) He diagnosed herniating lumbar discs at L4-5 and L5/S1, and to a lesser degree at L3-4; and lumbar radiculopathy in both lower extremities. (Id. at 272.) He recommended lumbar discectomy at the L4-5 and L5-S1 levels. (Id.)

On May 6, 2009, Plaintiff again saw Dr. Smith. (Id. at 258.) Dr. Smith reviewed the updated MRI and Dr. Armstrong's report, and noted the recommendation for lumbar disc surgery. (Id.)

On May 26, 2009, Dr. Armstrong performed lumbar surgery. (Id. at 274-76.) During surgery, he found that Plaintiff "had a very large free fragment of herniated disc at L5-S1, central to right-sided described as a massive free fragment, disrupted disc, collapsed disc." (Id. at 274.) He found "facet arthropathy bilaterally and lateral recess stenosis contributing to the patient's problems." (Id.) Additionally, there was "collapse in the up-down direction of the disc space," and at L4-L5 "there was some facet arthropathy left-sided, affecting the ligament and left-sided subligamentous herniation, approximately 5 mm." (Id.)

On June 5, 2009, post-surgery, Plaintiff again saw Dr. Smith who reported that Plaintiff "had mild pain and was using a walker." (Id. at 258.) On September 9, 2009, he was followed-up by Dr. Armstrong, "was doing well," and medication was prescribed. (Id.) On October 9, 2009, he again saw Dr. Smith, who noted "some residual pain." (Id.) At that time, Dr. Smith diagnosed "chronic, symptomatic, posttraumatic injury of the lumbar spine (status post surgery)." (Id. at 261.) He concluded that the residuals continued because of the nature of the original accident, the condition was permanent, and Plaintiff would have continuing problems in the future. (Id.) He stated that Plaintiff would require a modification in his activities of daily living and employment, and should avoid strenuous lifting, carrying, pushing and pulling, repetitive or prolonged bending and twisting; he should limit squatting, stair

climbing, and sitting for extended periods. (Id.). He further noted that Plaintiff "even has trouble with extended periods of walking and standing." (Id.)

On February 16, 2010, Dr. Smith completed a Lumbar Spine Impairment Questionnaire. (Id. at 279-84.) He opined that Plaintiff can lift and or carry ten pounds occasionally; sit no more than two hours out of an eight-hour workday; stand and/or walk no more than one hour per eight-hour workday; would need to get up and move around every hour for ten to fifteen minutes; never push, pull, bend, stoop, kneel, or work at heights. (Id. at 281-84.) He also opined that Plaintiff would miss work more than three times per month due to his impairments. (Id. at 283.)

2. Legal Standard.

It is well-established in the Ninth Circuit that a treating physician's opinions are entitled to special weight, because a treating physician is employed to cure and has a greater opportunity to know and observe the patient as an individual. McAllister v. Sullivan, 888 F.2d 599, 602 (9th Cir. 1989). "The treating physician's opinion is not, however, necessarily conclusive as to either a physical condition or the ultimate issue of disability." Magallanes v. Bowen, 881 F.2d 747, 751 (9th Cir. 1989). The weight given a treating physician's opinion depends on whether it is supported by sufficient medical data and is consistent with other evidence in the record. See 20 C.F.R. § 404.1527(d)(2). If the treating physician's opinion is uncontroverted by another doctor, it may be rejected only for "clear and convincing" reasons. Lester v. Chater, 81 F.3d 821, 830 (9th Cir. 1995); Baxter v. Sullivan, 923 F.2d 1391, 1396 (9th Cir. 1991). Where the treating physician's opinion is controverted, it may be rejected only if the ALJ makes findings setting forth specific and legitimate reasons that are based on the substantial evidence of record. Thomas v. Barnhart, 278 F.3d 947, 957 (9th Cir. 2002); Magallanes, 881 F.2d at 751; Winans v. Bowen, 853 F.2d 643, 647 (9th Cir. 1987).

Contrary opinions of examining and non-examining physicians may "serve as additional specific and legitimate reasons" for rejecting the opinions of treating and examining physicians. Tonapetyan v. Halter, 242 F.3d 1144, 1149 (9th Cir. 2001).

In Orn v. Astrue, 495 F.3d 625 (9th Cir. 2007), the Ninth Circuit reiterated and expounded upon its position regarding the ALJ's acceptance of the opinion of an examining physician over that of a treating physician. "When an examining physician relies on the same clinical findings as a treating physician, but differs only in his or her conclusions, the conclusions of the examining physician are not "'substantial evidence.'" Orn, 495 F.3d at 632; Murray v. Heckler, 722 F.2d 499, 501-02 (9th Cir. 1983). "By contrast, when an examining physician provides 'independent clinical findings that differ from the findings of the treating physician' such findings are 'substantial evidence.'" Orn, 495 F.3d at 632; Miller v. Heckler, 770 F.2d 845, 849 (9th Cir. 1985). Independent clinical findings can be either (1) diagnoses that differ from those offered by another physician and that are supported by substantial evidence, see Allen v. Heckler, 749 F.2d 577, 579 (9th Cir. 1985), or (2) findings based on objective medical tests that the treating physician has not himself considered, see Andrews v. Shalala, 53 F.3d 1035, 1041 (9th Cir. 1995).

If a treating physician's opinion is not giving controlling weight because it is not well supported or because it is inconsistent with other substantial evidence in the record, the ALJ is instructed by 20 C.F.R. section 404.1527(d)(2) to consider the factors listed in section 404.1527(d)(2)-(6) in determining what weight to accord the opinion of the treating physician. Those factors include the "[l]ength of the treatment relationship and the frequency of examination" by the treating physician; and the "nature and extent of the treatment relationship" between the patient and the treating physician. 20 C.F.R. 404.1527(d)(2)(i)-(ii). Other factors include the supportablility of the

opinion, consistency with the record as a whole, the specialization of the physician, and the extent to which the physician is familiar with disability programs and evidentiary requirements. Id. § 404.1527(d)(3)-(6). Even when contradicted by an opinion of an examining physician that constitutes substantial evidence, the treating physician's opinion is "still entitled to deference." Soc. Sec. Ruling 96-2p; Orn, 495 F.3d at 632-33. "In many cases, a treating source's medical opinion will be entitled to the greatest weight and should be adopted, even if it does not meet the test for controlling weight." Soc. Sec. Ruling 96-2p; Orn, 495 F.3d at 633. .

3. Analysis.

Plaintiff contends that the ALJ should have afforded greater weight to the opinions of Plaintiff's treating specialists, Drs. Capen and Smith ("Treating Physicians"). (JS at 3-9.) Plaintiff claims the ALJ rejected these opinions and instead credited the opinions of the consultative examining doctor, Dr. Gonzalez, who examined Plaintiff on September 14, 2008, but did not review any of Plaintiff's medical records, and the state agency doctor, Dr. Rubaum, who Plaintiff claims only reviewed the record up to October 2008[4] ("Examining Physicians"). (Id. at 9.) Plaintiff further contends that the ALJ wrongly stated that Plaintiff's MRIs failed to show any significant abnormalities. (Id.) Finally, he states that because the ALJ found that the fact of Plaintiff's May 2009 back surgery "suggests that [his] symptoms were genuine," and also that Plaintiff's May 2009 surgery was "generally successful in relieving the symptoms," at the very least the ALJ should have found Plaintiff disabled for a closed period from the date of his December 2006

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[4] As previously noted, this Court finds the evidence ambiguous as to whether Dr. Rubaum actually reviewed anything other than Dr. Gonzalez's September 2008 report and conclusions. (See Discussion supra Part III.B.1.)

accident until a reasonable time after his May 2009 surgery. (Id.)

The ALJ stated that she gave "greater weight" to the opinions of the Examining Physicians over the opinions of the Treating Physicians for the following reasons: (1) although the Treating Physicians' treatment notes did not reflect "drastic deterioration," their assessment of Plaintiff's RFC grew more restrictive over time; thus, their assessed limitations were out of proportion with their objective findings; (2) the opinions of the Treating Physicians regarding whether Plaintiff is disabled, or unable to work, are reserved to the Commissioner; thus, Dr. Capen's statement that Plaintiff was "temporarily totally disabled" was not entitled to controlling weight; and (3) the opinions of the Treating Physicians "contrast sharply" with other evidence of record, rendering them less persuasive. (AR at 19-20.)

a. The Examining Physicians' Opinions Do Not Constitute Substantial Evidence and Were Not Entitled to Significant Weight

Preliminarily, the Court finds that the ALJ erred in assigning significant weight to the opinions of the Examining Physicians, one-time examiners at least one of whom apparently did not even review Plaintiff's medical records.[5] In fact, even if Dr. Rubaum was provided with Dr. Capen's notes, he appears to

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[5] Dr. Gonzalez arguably should have been provided with Plaintiff's medical records. See 20 C.F.R. §§ 404.1517, 416.917 ("If we arrange for [a consultative] examination or test . . . [w]e will also give the examiner any necessary background information about your condition."). Moreover, there is some authority providing that when examining physicians fail to review a plaintiff's records, their opinions do not constitute substantial evidence that could justify rejecting the opinions of treating physicians. See, e.g., Bayliss v. Barnhart, 427 F.3d 1211, 1217 (9th Cir. 2005) (affirming the ALJ's rejection of psychological assessments by doctors who did not review objective medical data or reports from treating physicians or counselors).

have relied solely on the same evidence as Dr. Gonzalez in making his RFC assessment – i.e., Dr. Gonzalez's x-rays and examination.

Dr. Gonzalez talked to Plaintiff about the history of his condition, took some x-rays, and performed his own examinations: orthopedic, cervical range of motion, upper extremity range of motion, thoracolumbar range of motion, lower extremity range of motion, and neurological – the same tests performed by Plaintiff's Treating Physicians. However, despite being informed by Plaintiff that he had a long history of pain and was a candidate for surgical decompression, and that more conservative treatments had provided only temporary pain relief, and despite finding that Plaintiff's examination was significant for decreased range of motion of his thoracolumbar spine, as well as severe tenderness on palpation, and severe low back pain when performing a Spurling test (used to test bilateral upper extremity radiculopathy), Dr. Gonzalez nevertheless concluded that Plaintiff could lift and carry twenty-five pounds frequently, and fifty pounds occasionally, could stand, walk and sit without limitation, and could bend, kneel, stoop, crawl, and crouch on a frequent basis. Although Dr. Gonzalez's tests and clinical findings virtually mirrored those of the Treating Physicians, his conclusions, and those of Dr. Rubaum, were different from the conclusions of the Treating Physicians. Accordingly, the conclusions of the Examining Physicians are not considered "substantial evidence," and the ALJ's reliance on them was error Orn, 495 F.3d at 632.

Moreover, given the record as a whole, together with the fact that the Examining Physicians did not review Plaintiff's medical records, the Court finds the Examining Physicians' conclusions incongruous and not based on substantial evidence of record. This seems particularly true here where the Treating Physician's records and opinions span from early in 2007 until well over a year past the one-time evaluations of the Examining Physicians, and

well past Plaintiff's May 26, 2009, surgery. In fact, no consulting examination was ever conducted after the surgery. Thus, the post-surgical examinations of Plaintiff's treating doctors are uncontradicted.

As a result, the Examining Physicians' opinions cannot be the basis for rejecting the opinions of the Treating Physicians, which, therefore, must be considered uncontradicted. As a result, the ALJ could only reject those opinions on the basis of clear and convincing reasons supported by substantial evidence. Smolen v. Chater, 80 F.3d 1273, 1285 (9th Cir. 1996). As discussed below, the Court finds that the reasons given by the ALJ for rejecting the opinions of the Treating Physicians are vague and conclusory at best, and unsupported by any evidence.

b. The Reasons Given for Rejecting the Opinions of the Treating Physicians Were Not Clear and Convincing.

With regard to Plaintiff's limitations, in late 2007, Dr. Capen found Plaintiff to be "temporarily totally disabled" and a candidate for lumbar disc surgery. (AR at 189, 192.) Sometime in mid-2008, Plaintiff was found to be "permanent and stationary." (Id. at 238.) On October 9, 2009, post-surgery, Dr. Smith opined that surgery had been unsuccessful at returning Plaintiff to performing his normal daily activities, and he would require modification of his activities of daily living and employment. (Id. at 261.) Dr. Smith stated that Plaintiff should avoid strenuous lifting, carrying, pushing and pulling, repetitive or prolonged bending and twisting; and should limit squatting, stair climbing, walking, standing, and sitting for extended periods. (Id.) On February 16, 2010, post-surgery, Dr. Smith opined that Plaintiff could only sit two hours in an eight-hour day and stand for one hour; could lift only ten pounds occasionally; would suffer frequent limitations in concentration, persistence, and pace due to his pain; and would miss work up to three times per month due to his impairments. (Id. at 282.)

The ALJ stated that although the Treating Physicians' assessment of Plaintiff's RFC grew more restrictive over time, their notes did not reflect "drastic deterioration"[6] and, therefore, their assessed limitations appear "out of [pro]portion with the objective findings and the claimant's physical examination results." (Id. at 20.) The ALJ also found that their opinions contrasted sharply with other evidence of record, rendering them less persuasive.

In support of her reasoning, the ALJ first refers to the fact that the March 9, 2007, MRI "showed only mild degenerative disc changes and a mild to moderate disc protrusion." (Id.) She then notes: "Likewise, although there was moderate narrowing of the right neural foramina at the L5-S1 level, the claimant's lumbosacral spine had mild face arthropathy with moderate arthropathy, mild canal narrowing and compression and mild endplate changes." (Id.) These vague and conclusory statements, merely parroting the MRI results, fail to provide any support for the ALJ's general proposition. Indeed, the Treating Physicians recommended surgery based in part on this MRI.

In fact, it appears that the ALJ is rejecting the Treating Physicians' findings by substituting her own medical conclusions for those of the physicians. It is inappropriate for the ALJ to do so, particularly where the ALJ did not even seek the testimony of a medical expert. Tacket v. Apfel, 180 F.3d 1094, 1102-03 (9th Cir. 1999) (finding it inappropriate for an ALJ to substitute his own medical judgment for that of a treating physician); see also Day v. Weinberger, 522 F.2d 1154, 1156 (9th Cir. 1975) (noting that hearing examiner

[6] No authority is cited by the ALJ or by the Commissioner to support the proposition that a "drastic deterioration" in a plaintiff's condition is a necessary condition for an RFC to become more restrictive over time.

was not a qualified medical expert).

Moreover, the Court is not convinced that the RFCs of the Treating Physicians even changed over time. During his treatment of Plaintiff, which spanned from early 2007 to August 2008, Dr. Capen repeatedly mentioned that surgery was Plaintiff's only remaining recourse for pain relief. (AR at 174, 177, 179-80, 183, 186 ("There is not any other treatment that I would recommend that would have a likelihood of providing this gentleman with any improvement in his condition."), 189, 192, 195, 215.) In December 2007 and January 2008, Dr. Capen referred to Plaintiff as "totally temporarily disabled."[7] (Id. at 189, 192.) Sometime in mid-2008 Plaintiff's condition was determined to be permanent and stationary. (Id. at 238.) In March 2009, Dr. Smith noted that there was a reasonable medical probability that Plaintiff would require lumbar epidural blocks and/or disc surgery in the future (id. at 242), and in May 2009, Plaintiff underwent the disc surgery. In October 2009, Dr. Smith noted that Plaintiff's residual symptoms would continue, that his condition "is permanent and [he] will have continuing problems in the future" necessitating a modification of the activities of daily living and employment. (Id. at 261.) He opined that Plaintiff should avoid strenuous lifting, carrying, pushing and pulling, repetitive or prolonged bending and twisting, squatting, stair climbing, sitting for extended periods, and walking and standing for extended periods.

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[7] In the workmen's compensation arena, "temporarily totally disabled" generally refers to an employee who has been temporarily disabled by an industrial injury, and connotes an inability to earn income in the open labor market during the period of recovery. Herrera v. Workmen's Comp. App. Bd., 71 Cal. 2d 254, 427 (1969); see also Rissetto v. Plumbers & Steamfitters Local 343, 94 F.3d 597, 605 (9th Cir. 1996) ("[An employee] is considered temporarily *totally* disabled if he is unable to earn any income during the period when he is recovering from the effects of the injury.") (citation omitted).

(Id.) None of these opinions differ that greatly from Dr. Smith's 2010 RFC assessment, wherein he more specifically opined that Plaintiff could only sit two hours in an eight-hour day and stand for one hour; could lift only ten pounds occasionally; would suffer frequent limitations in concentration, persistence, and pace due to his pain; and would miss work up to three times per month due to his impairments. (Id. at 282.) Thus, the ALJ's finding that the Treating Physicians' RFCs became more restrictive over time is not supported in the record.

Elsewhere in her decision, in support of her conclusions that the Treating Physicians' RFC assessments "contrast sharply" with other evidence of record, and in conjunction with her discussion discounting Plaintiff's credibility, the ALJ references the following:

- "Despite presenting to Dr. Capen with pain and tenderness . . . and positive straight leg raising, the claimant ambulated with an essentially normal gait with normal tendon reflexes at the knees and ankles." (AR at 18 (citation omitted));
- On March 23, 2009, Dr. Smith found normal muscle tone in the thoracic, lumbar and buttock areas; range of motion in the spine with respect to right bending, left bending, right rotation and left rotation at 100% secondary to only mild pain, upon extension it was 50% secondary to moderate pain; tandem gait, heel gait, and tiptoe gait were normal; there was no increased pain when claimant changed positions; and standing did not cause increased pain (id. (citation omitted));
- On October 9, 2009, Dr. Smith reported normal range of motion in the claimant's lumbosacral spine with no lower extremity weakness, and he had a normal tandem gait, tiptoe gait, and heel gait; sensation was normal from the waist to the toes; there was no

increased pain in the supine or prone positions; hip stability, flexion, rotation, abduction and extension were all normal; and straight leg raising was within normal limits[8] (id. (citation omitted);

- Despite reports of severe tenderness on palpation during the consultative examination, Plaintiff's range of motion was normal, and he had negative straight leg raising bilaterally; motor strength, reflexes and sensation were intact; there were no neurological deficits; he had a normal gait and stance (id. at 18 (citation omitted));
- Dr. Smith's February 16, 2010, opinion "somewhat contradicts" his October 2009 report in which he observed normal range of motion and no lower extremity weakness, and no spasms found, only reported by Plaintiff;
- Dr. Smith "twice reported negative straight leg raising: once before the claimant's back surgery and once after the surgery" (id. at 20 (citations omitted)); and
- Following surgery, Plaintiff reported only mild weakness and a restricted range of motion only on extension (id. (citation

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[8] Whether the straight leg raising results were "within normal limits" on this date is ambiguous at best. Test results show that Plaintiff was able to raise his legs between 50 and 60 degrees (AR at 261); in March 2009 he was able to raise them between 30 and 40 degrees (id. at 241). There is a notation "N" in the pain column for the straight leg raising assessment that could mean either "normal or no increase in the symptom if present before the examination." (AR at 259, 261.) As there was pain present before the examination (it was rated "moderate" in March 2009), it is quite possible that this is a positive, not a negative, straight leg raising result. Regardless, it is not clear that the results on October 2010 were "within normal limits."

omitted)).

Once again, these examples reflect the ALJ's substitution of her own medical opinion in place of the doctors. These examples also reflect the ALJ's "cherry picking," leaps of logic, and distortion of the language and findings from Plaintiff's medical records, seemingly in order to support a denial of benefits. See Saffon v. Wells Fargo & Co. Long Term Disability Plan, 522 F.3d 863, 872-73 (9th Cir. 2008) (administrator of benefit plan did not meet its duty in deciding whether to grant or deny benefits by taking various of the claimant's doctors' statements out of context or otherwise distorting them in an apparent effort to support a denial of benefits).

For instance, the ALJ does not explain why someone with positive straight leg raising should not have "normal muscle tone" or gait, or should have lower extremity weakness or increased pain on changing positions or standing. Noting only in passing that the results had not been consistent, the ALJ mentions that Dr. Smith[9] twice reported negative straight leg raising (AR at 20);[10] she fails to mention that the Treating Physicians together reported positive straight leg raising at almost every examination on at least seven occasions (April 2007, November 2007, January 2008, April 2008, May 2008, June 2008, and March 2009) (id. at 177, 180, 183, 189, 195, 204, 241). She states that Dr. Smith's October 2009 opinion is inconsistent with his February 2010 assessment because in 2009, he observed normal range of motion and no lower extremity weakness, and no spasms found, only reported by Plaintiff.

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[9] In fact, the pre-surgical report the ALJ refers to was made by Dr. Armstrong, not Dr. Smith. (AR at 271-72.)

[10] The straight leg raise is a test of the low back that stretches the nerve root. The Merck Manual of Diagnosis and Therapy, 1490 (17th Ed. 1999). A negative result indicates no pain (and thus no nerve involvement) upon this type of movement. Id.

(Id. at 20.) However, Dr. Smith's October 2009 assessment *also* reflected that Plaintiff presented with residual pain, there was no *increased* pain with changing positions or sitting, no *increased* pain in the supine or prone position, he still had mild tenderness to palpation, mild pain on flexion and extension, and an ambiguous straight leg raising result.[11] As a result of his examination, Dr. Smith concluded that Plaintiff should avoid strenuous lifting, carrying, pushing and pulling, repetitive or prolonged bending and twisting; and should limit squatting, stair climbing, walking, standing, and sitting for extended periods. (Id. at 257-62.) Nothing in this October 2009 assessment appears inconsistent with Dr. Smith's 2010 RFC assessment more specifically limiting Plaintiff's lifting, carrying, pushing, pulling, bending, stooping, kneeling, squatting, climbing, walking, standing, and sitting. The ALJ simply ignores the Treating Physicians' negative findings, which do not "contrast sharply" with their assessed limitations, but which apparently *do* "contrast sharply" with her seemingly desired conclusion.

Moreover, the ALJ apparently rejects the Treating Physicians' opinions because the records following Plaintiff's May 2009 surgery suggest some improvement. As such, she improperly conflates Plaintiff's pre- and post-surgical symptoms, arriving at an RFC that, if anything, tends to reflect Plaintiff's post-surgical status only in the month or two following surgery. This is perhaps most vividly reflected in her statement that "[Plaintiff] did undergo back surgery for the alleged impairment which certainly suggests the symptoms were genuine. While that fact would normally weigh in the claimant's favor, it is offset by the fact that the record reflects that the surgery was generally successful in relieving the symptoms." (Id. at 19.) This makes no logical sense in the context of determining whether Plaintiff was at any

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[11] See supra note 8.

point disabled from October 2007 forward – in fact, it would seem to imply that any claimant who finally undergoes surgery or treatment for a long-term problem that is then relieved by that surgery or treatment could not be found disabled prior to that surgery. In short, the ALJ's statement totally negates any possible pre-surgical impairment based solely on the premise of some later short-term surgical success. It also totally ignores the opinions of the Treating Physicians that Plaintiff was disabled – temporarily or otherwise – for any period of time either before or after his surgery. Nor is there any substantial support for the ALJ's statement that Plaintiff's surgery was "generally successful." Dr. Smith's treatment notes continue for almost six months after the surgery and seem to reflect that any improvement in Plaintiff's condition was short-lived. This is consistent with Plaintiff's testimony at the hearing that surgery did not help his condition and that, in fact, Dr. Smith was now recommending he undergo a second surgery – fusion on the lower back. (Id. at 63.) In short, the record on any post-surgery improvement is too ambiguous and undeveloped to constitute a clear and convincing reason for rejecting the Treating Physicians' pre- and post-surgical opinions regarding Plaintiff's limitations.

The Court finds that the ALJ improperly gave little weight to the opinions of the Treating Physicians, whose opinions were neither cursory nor inconsistent with the record. In fact, the inconsistent opinions are those of the Examining Physicians who had either no medical records to review, or at best a limited subset.

Based on the foregoing, the Court finds that the ALJ's decision is not supported by substantial evidence and is arguably contrary to the evidence of record. Thus, the Court finds that this matter must be reversed and remanded for further proceedings to address these issues.

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C. **The ALJ Failed to Properly Evaluate Plaintiff's Credibility.**

1. **Legal Standard.**

An ALJ's assessment of pain severity and claimant credibility is entitled to "great weight." Weetman v. Sullivan, 877 F.2d 20, 22 (9th Cir. 1989); Nyman v. Heckler, 779 F.2d 528, 531 (9th Cir. 1986). When, as here, an ALJ's disbelief of a claimant's testimony is a critical factor in a decision to deny benefits, the ALJ must make explicit credibility findings. Rashad v. Sullivan, 903 F.2d 1229, 1231 (9th Cir. 1990); Lewin v. Schweiker, 654 F.2d 631, 635 (9th Cir. 1981); see also Albalos v. Sullivan, 907 F.2d 871, 874 (9th Cir. 1990) (an implicit finding that claimant was not credible is insufficient).

Under the "Cotton test," where the claimant has produced objective medical evidence of an impairment which could reasonably be expected to produce some degree of pain and/or other symptoms, and the record is devoid of any affirmative evidence of malingering, the ALJ may reject the claimant's testimony regarding the severity of the claimant's pain and/or other symptoms only if the ALJ makes specific findings stating clear and convincing reasons for doing so. See Cotton v. Bowen, 799 F.2d 1403, 1407 (9th Cir. 1986); see also Smolen, 80 F.3d at 1281; Dodrill v. Shalala, 12 F.3d 915, 918 (9th Cir. 1993); Bunnell v. Sullivan, 947 F.2d 341, 343 (9th Cir. 1991). The ALJ must set forth "findings sufficiently specific to permit the court to conclude that the ALJ did not arbitrarily discredit claimant's testimony." Thomas, 278 F.3d at 958; Rollins v. Massanari, 261 F.3d 853, 856-57 (9th Cir. 2001); Bunnell, 947 F.2d at 345.

To determine whether a claimant's testimony regarding the severity of his symptoms is credible, the ALJ may consider the following evidence: (1) ordinary techniques of credibility evaluation, such as the claimant's reputation for lying, prior inconsistent statements concerning the symptoms, and other testimony by the claimant that appears less than candid; (2) unexplained or

inadequately explained failure to seek treatment or to follow a prescribed course of treatment; (3) the claimant's daily activities; and (4) testimony from physicians and third parties concerning the nature, severity, and effect of the claimant's symptoms. Thomas, 278 F.3d at 958-59; see also Smolen, 80 F.3d at 1284.

2. Analysis.

In addition to the his pain problems, Plaintiff complained of mental health issues (based on his foul mood and stress), and alleged that he is unable to work in part due to headaches; hip pain; atrophy in his foot; and leg, foot, and ankle pain.[12] (AR at 16.)

In determining Plaintiff's RFC, the ALJ made an adverse credibility ruling regarding Plaintiff's pain symptoms based almost exclusively on the same factors she used for rejecting the Treating Physicians' opinions, i.e., that his subjective symptoms were inconsistent with the medical evidence of record. (Id. at 13, 16-19.) For the same reasons that the Court found the ALJ's reasoning to be without support to reject the Treating Physicians' opinions as discussed above, it finds the ALJ's credibility determination to be equally faulty.

Moreover, as previously discussed, to the extent the ALJ based her

[12] The Commissioner argues that the ALJ properly rejected Plaintiff's mental impairments because he had never been treated for mental health issues; that Plaintiff did not complain that his alleged mental impairments affected his activities of daily living; that Plaintiff never complained of the numerous other physical ailments to his Treating Physicians; and that Plaintiff was never treated for the additional alleged physical impairments. (JS at 26-27.) The Court agrees that the ALJ properly rejected Plaintiff's complaints of mental health issues and additional physical impairments, as unsupported by the record. (AR at 16.) His allegations that he has difficulty sleeping because of his pain does find some record support, but there is no indication it affected his ability to work. (See, e,g., id. at 237, 257.)

credibility determination on her argument that although the fact of Plaintiff's back surgery lent support to the fact that his symptoms were genuine, this was "offset" by the fact that the "surgery was generally successful in relieving the symptoms," this reasoning improperly conflates Plaintiff's pre- and post-surgical symptomology and is not a clear or convincing reason for discounting Plaintiff's credibility.

Accordingly, the ALJ's credibility determination does not meet the clear and convincing evidence standard, and it appears to this Court that the ALJ arbitrarily discredited Plaintiff's testimony.

D. Conclusion.

Based on the foregoing, the Court finds that the ALJ committed legal error because she did not provide clear and convincing reasons for rejecting the opinions of the Treating Physicians or for rejecting Plaintiff's subjective pain testimony.

E. This Case Should Be Remanded for Further Administrative Proceedings.

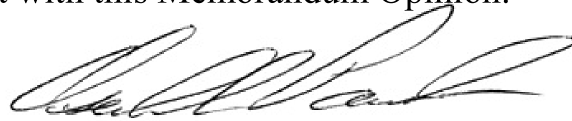
The law is well established that remand for further proceedings is appropriate where additional proceedings could remedy defects in the Commissioner's decision. Kail v. Heckler, 722 F.2d 1496, 1497 (9th Cir. 1984). Remand for payment of benefits is appropriate where no useful purpose would be served by further administrative proceedings, Kornock v. Harris, 648 F.2d 525, 527 (9th Cir. 1980); where the record has been fully developed, Hoffman v. Heckler, 785 F.2d 1423, 1425 (9th Cir. 1986); or where remand would unnecessarily delay the receipt of benefits, Bilby v. Schweiker, 762 F.2d 716, 719 (9th Cir. 1985).

Although an extremely close call, the Court concludes that further administrative proceedings might serve a useful purpose and remedy the administrative defects discussed above.

IV.

ORDER

Pursuant to sentence four of 42 U.S.C. § 405(g), IT IS HEREBY ORDERED THAT Judgment be entered reversing the decision of the Commissioner of Social Security and remanding this matter for further administrative proceedings consistent with this Memorandum Opinion.



Dated: November 14, 2011

HONORABLE OSWALD PARADA
United States Magistrate Judge