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UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

JEFFERY DALE KIVETT,[1] Plaintiff, vs. CAROLYN W. COLVIN, Acting Commissioner of Social Security,[2] Defendant.	Case No. EDCV 13-0013-JPR MEMORANDUM OPINION AND ORDER AFFIRMING THE COMMISSIONER

I. PROCEEDINGS

Plaintiff seeks review of the Commissioner's final decision denying his application for Supplemental Security Income benefits ("SSI"). The parties consented to the jurisdiction of the undersigned U.S. Magistrate Judge pursuant to 28 U.S.C. § 636(c).

[1] The parties have spelled Plaintiff's first name at various times as "Jeffery" and "Jeffrey," and the medical records similarly use both spellings. On January 11, 2013, Plaintiff filed a Notice of Correction of Spelling of Name (Amended), clarifying that "Jeffery" is the proper spelling.

[2] On February 14, 2013, Colvin became the Acting Commissioner of Social Security. Pursuant to Federal Rule of Civil Procedure 25(d), the Court therefore substitutes Colvin for Michael J. Astrue as the proper Respondent.

This matter is before the Court on the parties' Joint Stipulation, filed August 23, 2013, which the Court has taken under submission without oral argument. For the reasons stated below, the Commissioner's decision is affirmed and this action is dismissed.

II. BACKGROUND

Plaintiff was born on November 6, 1959. (Administrative Record ("AR") 74.) He completed 10th grade but did not graduate from high school, and his ability to read and write is limited. (AR 447, 461.) He previously worked as a construction laborer. (AR 441-42, 470-72.) He has a history of drug use, and he was incarcerated from 2005 to 2009 for selling methamphetamine. (AR 452-53.) He testified at the hearing that he had not used drugs since his conviction. (AR 452.)

On February 3, 2010, Plaintiff filed applications for Social Security disability insurance benefits ("DIB") and SSI. (See AR 74-77, 84-91, 425-28.) He alleged that he had been unable to work since June 1, 1998, because of diabetes, lack of feeling in his feet, poor vision, and bleeding ulcers. (AR 74, 80, 85.) He subsequently amended the alleged disability onset date to February 3, 2010, and withdrew his request for DIB. (AR 436-37.)

After Plaintiff's applications were denied, he requested reconsideration. (AR 27.) They were again denied, after which he requested a hearing before an ALJ. (AR 30-31, 35-36.) A hearing was held on August 2, 2011, at which Plaintiff, who was represented by counsel, appeared and testified, as did a vocational expert and medical expert Dr. Samuel Landau. (AR 432-53.) In a written decision issued August 5, 2011, the ALJ

determined that Plaintiff was not disabled. (AR 11-21.) On November 6, 2012, the Appeals Council denied his request for review. (AR 3-7.) This action followed.

III. STANDARD OF REVIEW

Pursuant to 42 U.S.C. § 405(g), a district court may review the Commissioner's decision to deny benefits. The ALJ's findings and decision should be upheld if they are free of legal error and supported by substantial evidence based on the record as a whole. Id.; Richardson v. Perales, 402 U.S. 389, 401, 91 S. Ct. 1420, 1427, 28 L. Ed. 2d 842 (1971); Parra v. Astrue, 481 F.3d 742, 746 (9th Cir. 2007). Substantial evidence means such evidence as a reasonable person might accept as adequate to support a conclusion. Richardson, 402 U.S. at 401; Lingenfelter v. Astrue, 504 F.3d 1028, 1035 (9th Cir. 2007). It is more than a scintilla but less than a preponderance. Lingenfelter, 504 F.3d at 1035 (citing Robbins v. Soc. Sec. Admin., 466 F.3d 880, 882 (9th Cir. 2006)). To determine whether substantial evidence supports a finding, the reviewing court "must review the administrative record as a whole, weighing both the evidence that supports and the evidence that detracts from the Commissioner's conclusion." Reddick v. Chater, 157 F.3d 715, 720 (9th Cir. 1996). "If the evidence can reasonably support either affirming or reversing," the reviewing court "may not substitute its judgment" for that of the Commissioner. Id. at 720-21.

IV. THE EVALUATION OF DISABILITY

People are "disabled" for purposes of receiving Social Security benefits if they are unable to engage in any substantial gainful activity owing to a physical or mental impairment that is

expected to result in death or which has lasted, or is expected to last, for a continuous period of at least 12 months. 42 U.S.C. § 423(d)(1)(A); Drouin v. Sullivan, 966 F.2d 1255, 1257 (9th Cir. 1992).

A. The Five-Step Evaluation Process

The ALJ follows a five-step sequential evaluation process in assessing whether a claimant is disabled. 20 C.F.R. § 416.920(a)(4); Lester v. Chater, 81 F.3d 821, 828 n.5 (9th Cir. 1995) (as amended Apr. 9, 1996). In the first step, the Commissioner must determine whether the claimant is currently engaged in substantial gainful activity; if so, the claimant is not disabled and the claim must be denied. § 416.920(a)(4)(i). If the claimant is not engaged in substantial gainful activity, the second step requires the Commissioner to determine whether the claimant has a "severe" impairment or combination of impairments significantly limiting his ability to do basic work activities; if not, a finding of not disabled is made and the claim must be denied. § 416.920(a)(4)(ii). If the claimant has a "severe" impairment or combination of impairments, the third step requires the Commissioner to determine whether the impairment or combination of impairments meets or equals an impairment in the Listing of Impairments ("Listing") set forth at 20 C.F.R., Part 404, Subpart P, Appendix 1; if so, disability is conclusively presumed and benefits are awarded. § 416.920(a)(4)(iii). If the claimant's impairment or combination of impairments does not meet or equal an impairment in the Listing, the fourth step requires the Commissioner to determine whether the claimant has sufficient residual functional

capacity ("RFC")[3] to perform his past work; if so, the claimant is not disabled and the claim must be denied. § 416.920(a)(4)(iv). The claimant has the burden of proving that he is unable to perform past relevant work. Drouin, 966 F.2d at 1257. If the claimant meets that burden, a prima facie case of disability is established. Id. If that happens or if the claimant has no past relevant work, the Commissioner then bears the burden of establishing that the claimant is not disabled because he can perform other substantial gainful work available in the national economy. § 416.920(a)(4)(v). That determination comprises the fifth and final step in the sequential analysis. § 416.920; Lester, 81 F.3d at 828 n.5; Drouin, 966 F.2d at 1257.

B. The ALJ's Application of the Five-Step Process

At step one, the ALJ found that Plaintiff had not engaged in any substantial gainful activity since February 3, 2010. (AR 13.) At step two, she concluded that Plaintiff had severe impairments of "poorly controlled diabetes mellitus," gastritis, and esophagitis. (AR 14.) She determined that Plaintiff's hypertension, "non-obstructing right kidney stone," "right renal calculus," "tobacco dependence," and history of methamphetamine abuse were nonsevere. (Id.) The ALJ further found that Plaintiff had not established through objective evidence a medically determinable ailment of peripheral neuropathy. (Id.) At step three, she determined that his impairments did not meet or equal any of the impairments in the Listing. (Id.) At step

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[3] RFC is what a claimant can do despite existing exertional and nonexertional limitations. § 416.945; see Cooper v. Sullivan, 880 F.2d 1152, 1155 n.5 (9th Cir. 1989).

four, she found that Plaintiff retained the RFC to perform "less than a full range of light work," with certain additional limitations. (Id.) Based on the VE's testimony, the ALJ concluded that Plaintiff could not perform his past work as a construction worker as generally or actually performed. (AR 18-19.) At step five, she concluded that he was not disabled under the framework of the Medical-Vocational Guidelines, 20 C.F.R. Part 404, Subpart P, Appendix 2, and that jobs existed in significant numbers in the national economy that Plaintiff could perform. (AR 19-20.) Accordingly, the ALJ determined that Plaintiff was not disabled. (AR 20.)

V. RELEVANT FACTS

A. Medical Records

On January 29, 2009,[4] Plaintiff was seen at the emergency room of Oklahoma University Medical Center with complaints of abdominal pain, nausea, and "blood-tinged" vomiting. (AR 175, 181.) He was reported to have a past history of diabetes mellitus and peptic ulcer. (AR 175.) He was noted to be suffering from moderate dehydration, severe hyperglycemia, and moderate leukocytosis[5] and was admitted for observation. (AR

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[4] Plaintiff's 2009 medical records predate the amended alleged onset date of February 3, 2010; however, as these records were discussed at the hearing and in the ALJ's decision, they are detailed here. See Williams v. Astrue, 493 F. App'x 866, 868 (9th Cir. 2012) (noting that although medical opinions that predate alleged onset of disability are of limited relevance, ALJ must consider all medical-opinion evidence (quoting Carmickle v. Comm'r, Soc. Sec. Admin., 533 F.3d 1155, 1165 (9th Cir. 2008))).

[5] Leukocytosis is an abnormally large number of leukocytes, or white blood cells, and is observed in cases of acute infection, inflammation, hemorrhage, and other conditions.

177.) Plaintiff was given an MRI and treated with IV fluids, an IV antiemetic, and Zophran[6] to prevent nausea and vomiting; he also received morphine, Lantus,[7] and insulin. (AR 179-80.) On January 30, 2009, he was able to tolerate a full ADA diet,[8] and laboratory studies showed resolution of his anion gap,[9] improvement of his glucose level, and improvement of his blood-urea-nitrogen and creatinine levels. (AR 181.) A chest x-ray performed that day showed no abnormalities in Plaintiff's heart or lungs. (AR 208.) Plaintiff was discharged that day with a

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See Stedman's Medical Dictionary 991 (27th ed. 2000).

[6] Zofran is the brand name for ondansetron, used to prevent nausea and vomiting. See Ondansetron, MedlinePlus, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a601209.html (last updated Nov. 15, 2011).

[7] Lantus is the brand name for insulin glargine, a long-acting synthetic version of human insulin. See Insulin Glargine (rDNA origin) Injection, MedlinePlus, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a600027.html (last updated Feb. 15, 2012).

[8] The term "ADA diet" refers to dietary guidelines established by the American Diabetes Association, or ADA, to assist diabetics in maintaining normal blood-sugar levels. See generally Irl B. Hirsch, The Death of the "1800-Calorie ADA Diet," Clinical Diabetes, Apr. 2002, at 51-52, available at http://clinical.diabetesjournals.org/content/20/2/51.full. The ADA has clarified that each diabetic must tailor his diet to his individual needs, thus dispelling the notion that a single ADA diet accommodates all diabetics. See The "ADA Diet" Myth, Diabetes Forecast, Mar. 2011, available at http://www.diabetesforecast.org/2011/mar/the-ada-diet-myth.html. The ADA diet continues to be used as a benchmark in the treatment of diabetic patients admitted to the hospital. See Hirsch, supra, at 51-52.

[9] Anion gap is a calculation of "the difference between the sum of the measured cations and anions in the plasma or serum." Stedman's Medical Dictionary, supra, at 730. An elevated anion gap may indicate diabetic or lactic acidosis. Id.

prescription for Phenergan[10] "for persistent nausea" and orders to continue his Lantus prescription, continue checking his blood sugar, and adhere to a sliding-scale insulin regimen. (AR 182.) The discharge diagnoses included "nausea and vomiting, resolved," "abdominal pain, resolved," "hyperglycemia, resolved," "elevated Anion gap/metabolic acidosis, resolved," "uncontrolled diabetes type 2," and "leukocytosis, improved." (AR 181.)

On January 31, 2009, Plaintiff returned to the emergency room at OU Medical Center with complaints of vomiting, nausea, and abdominal pain. (AR 183.) A CT scan of Plaintiff's abdomen and pelvis revealed possible esophagitis but was otherwise normal. (AR 206.) A chest x-ray was also normal. (AR 209.) Plaintiff's extremities "exhibit[ed] normal ROM," or range of motion, and he had "[n]o lower extremity edema"; further, he had no motor or sensory deficit. (AR 184.) An electrocardiogram, or ECG, revealed sinus tachycardia but was otherwise normal. (AR 214.) Plaintiff was treated with IV fluids, Zofran, morphine, and Phenergan and released. (AR 187, 188.)

On September 3, 2009, Plaintiff was seen at the OU Medical Center emergency room with complaints of vomiting blood, black stools, nausea, chronic diarrhea, and abdominal pain. (AR 189.) Plaintiff also complained of difficulty breathing. (Id.) He was admitted, intubated, and treated with morphine, Zofran,

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[10] Phenergan is a brand name for promethazine, whose uses include relaxation and sedation, control of nausea and vomiting, and pain relief. See Promethazine, MedlinePlus, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682284.html (last updated Jan. 1, 2011).

Protonix,[11] and regular insulin. (AR 194.) A chest x-ray conducted on September 4, 2009, revealed symptoms consistent with chronic obstructive pulmonary disease. (AR 211.) A renal ultrasound conducted the same day was normal. (AR 212.) A history and physical report dated September 4, 2009, reflected past diagnoses of diabetes, peptic ulcer disease, and hypertension. (AR 197.) Plaintiff's then-current medications were reported to include Lantus, regular insulin, clonidine,[12] Reglan,[13] loperamide,[14] and loratidine.[15] (AR 197-98.) Plaintiff exhibited normal range of motion and no edema in his extremities. (AR 190.) He had no motor or sensory deficit and normal reflexes. (Id.)

On September 7, 2009, Plaintiff was discharged. (AR 200.)

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[11] Protonix is a proton pump inhibitor, or "PPI." Laura Dean, Comparing Proton Pump Inhibitors, PubMed Health (Oct. 1, 2010), http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0004954/. PPIs are medications that block gastric acid production. Id.

[12] Clonidine is used to treat high blood pressure. See Clonidine, MedlinePlus, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682243.html (last updated Oct. 1, 2010).

[13] Reglan is a brand name for metoclopramide, used to relieve heartburn, speed healing of esophageal sores and ulcers, and relieve symptoms caused by slow stomach emptying in diabetics. See Metoclopramide, MedlinePlus, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a684035.html (last updated Sept. 1, 2010).

[14] Loperamide is a nonprescription medication used to control diarrhea. See Loperamide, MedlinePlus, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682280.html (last updated Aug. 1, 2010).

[15] Loratadine is used to treat hayfever symptoms. See Loratadine, MedlinePlus, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a697038.html (last updated Oct. 1, 2010).

The discharge summary noted that Plaintiff was presumed to be suffering an upper gastrointestinal bleed at the time of admission and was therefore limited to IV ingestion and given Protonix and antiemetics. (Id.) A gastrointestinal specialist suspected Plaintiff might be suffering from esophagitis, but the attending physician chose to delay an upper endoscopy, "instead opting for conservative management while evaluating whether further bleeding was occurring." (Id.) Plaintiff was also treated for hypoglycemia and diabetic ketoacidosis. (Id.) Plaintiff was noted to have a "good" condition at the time of discharge and was instructed to continue with insulin, Protonix, Lantus, and dextrose by IV and to adhere to a diabetic diet. (Id.) A follow-up visit after two weeks was recommended. (Id.)

On September 8, 2009, Plaintiff was seen by Drs. Jessica Philpott and Jeremy Moad for a gastrointestinal consult. (AR 203.) The doctors recommended a high-dose proton pump inhibitor, multiple fluid boluses,[16] and an insulin drip. (Id.) They also anticipated that Plaintiff might need an upper endoscopy to determine whether his gastrointestinal symptoms were attributable to peptic ulcer disease, esophagitis, or gastritis. (Id.)

On December 25, 2009, Plaintiff was seen at the emergency room of St. Mary Medical Center in Apple Valley for complaints of nausea, vomiting, and abdominal pain and was admitted for "diabetic vomiting." (AR 228-29.) He was noted not to be at risk for falls (AR 231), with "motor and sensory grossly intact" (AR 240). A CT scan the same day of Plaintiff's abdomen and

[16] A bolus dose indicates a relatively large quantity. Stedman's Medical Dictionary, supra, at 222.

pelvis revealed a "[t]iny hiatal hernia" and a nonobstructing kidney stone. (AR 246, 248.) On December 27, 2009, gastroenterology specialist Dr. Neera Grover examined Plaintiff and noted his "uncontrolled diabetes" but resolving symptoms. (AR 242.) On December 28, 2009, Dr. Grover performed an upper endoscopy to rule out peptic ulcer disease and gastroesophageal reflux disease. (AR 243-44.) The exam revealed "mild to moderate antral gastritis," a hiatal hernia, and "grade 2 to 3 linear erosive esophagitis." (AR 245.) Dr. Grover obtained biopsies during the exam. (Id.) She thereafter ordered that Plaintiff could "resume diet" and prescribed Protonix, Carafate,[17] and Reglan. (AR 245.) An abdominal ultrasound was normal. (AR 247.)

On December 29, 2009, Plaintiff was discharged. (AR 237.) Plaintiff was noted to be "doing better" after his consultation with Dr. Grover. (Id.) He was instructed to maintain an 1800-calorie ADA diet, continue with Protonix and his "regular other home medications," follow up with his primary-care physician in one week, and follow up with a gastrointestinal specialist in two weeks. (Id.)

On March 15, 2010, Plaintiff was seen by Michael Avila, a certified physician assistant, for complaints of "pain [in] both feet," abdominal pain with vomiting, and two weeks of diarrhea, as well as for a consultation on Plaintiff's medications. (Ex.

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[17] Carafate is a brand name for sucralfate, used to treat and prevent peptic ulcers. See Sucralfate, MedlinePlus, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a681049.html (last updated Aug. 15, 2013).

5F at 2.)[18] Plaintiff's current medications were noted to include Lantus and Neurontin. (Id.) Although Mr. Avila noted no abnormalities in Plaintiff's extremities and full range of motion, he found "gross sensory deficit" and "[bilateral] plant[a]r feet non discriminate sharp/dull." (Id.) He assessed Plaintiff as having diabetes mellitus type 2 with neuropathy in both feet. (Id.) It appears that Plaintiff was prescribed Lantus, "regular insulin," a glucometer with lancet and a 30-day supply of chemsticks, as well as gabapentin.[19] (Id.) Mr. Avila ordered testing, including a complete blood count, comprehensive metabolic panel, thyroid-stimulating hormone test, albumin/globulin ratio test, and urinalysis. (Id.) He noted that Plaintiff should monitor his fasting blood sugar, decrease his intake of carbohydrates, increase his intake of protein, and return in one month to follow up. (Id.)

On April 6, 2010, Plaintiff was seen by Dr. Damayanthi Seneviratne to follow up regarding the results of Plaintiff's bloodwork. (AR 262.) Plaintiff's current medications were noted to include Lantus and Neurontin. (Id.) Dr. Seneviratne's notes are largely illegible; however, he noted Plaintiff's complaint

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[18] Exhibit 5F does not bear an Administrative Record page number. It is located between AR 250 and AR 253.

[19] Gabapentin is a prescription medication "sometimes used to relieve the pain of diabetic neuropathy." See Gabapentin, MedlinePlus, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a694007.html (last updated July 15, 2011). The brand names for gabapentin include Neurontin (id.), which Plaintiff testified he had taken to treat peripheral neuropathy (AR 455) and prescriptions for which are reflected in the medical records (see, e.g., AR 261, 262).

that his vision was "deteriorating" and wrote "vision impaired" and "peripheral neuropathy," apparently as complications of Plaintiff's diabetes mellitus. (Id.)

On April 13, 2010, Plaintiff again was seen by Dr. Seneviratne for a complaint of high blood sugar and a general medical consult. (Ex. 5F at 1.) Plaintiff's current medications were noted to include Lantus, Neurontin, and regular insulin. (Id.) Dr. Seneviratne's assessment of Plaintiff included "uncontrolled [diabetes mellitus]" and "peripheral neuropathy." (Id.) Dr. Seneviratne's notes appear to have prescribed an increase in Plaintiff's Lantus intake and to have recommended that Plaintiff's blood sugar be checked twice daily.[20] (Id.)

On April 29, 2010, Plaintiff was seen by Dr. Seneviratne for a consultation on his medications, which were noted to include Lantus, Neurontin, and regular insulin. (AR 261.) Dr. Seneviratne appears to have noted minimally decreased tone and sensation on the part of the form for neurological assessment and to have assessed diabetes mellitus with peripheral neuropathy. (Id.) Dr. Seneviratne also appears to have noted that Plaintiff had been compliant and that his blood sugar readings "have improved"; he renewed Plaintiff's medications. (Id.) Dr. Seneviratne's last note regarding Plaintiff's peripheral neuropathy is largely illegible, but he appears to have recommended Neurontin twice daily. (Id.)

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[20] "Bid," which Dr. Seneviratne wrote, is an abbreviation of the Latin expression "bis in die," meaning twice a day. See Bid Definition, Merriam-Webster Dictionary, www.merriam-webster.com/dictionary/bid (last visited Oct. 28, 2013).

On June 6, 2010, Plaintiff was seen in the emergency room of St. Mary Regional Medical Center for complaints of nausea and vomiting. (AR 301.) Plaintiff said that he had been "working outside in the heat" when the nausea and vomiting began and that these symptoms had continued for two days. (Id.) Plaintiff was admitted with "[d]ehydration with nonketotic hyperosmolar hyperglycemia."[21] (Id.) At the time of admission, lab data showed Plaintiff's glucose to be 497[22] and his bicarbonate level to be 16.[23] (AR 306.) A "limited" chest x-ray was reported to show no abnormalities in Plaintiff's lungs or heart. (AR 305.) He was treated with IV fluids, insulin, and Protonix, and his condition "rapidly improved." (AR 303, 306-07.) Once again, he was noted not to be at risk of falling (AR 361), and he had "no

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[21] "Diabetic hyperglycemic hyperosmolar syndrome (HHS) is a complication of type 2 diabetes that involves extremely high blood sugar (glucose) levels without the presence of ketones. Ketones are byproducts of fat breakdown." Diabetic hyperglycemic hyperosmolar syndrome, MedlinePlus, http://www.nlm.nih.gov/medlineplus/ency/article/000304.htm (last updated June 12, 2012).

[22] Target blood glucose levels for people with diabetes are between 70 and 130 mg/dL before meals and below 180 mg/dL one to two hours after the start of a meal. See Prevent diabetes problems: Keep your diabetes under control, Nat'l Diabetes Information Clearinghouse (NDIC), http://diabetes.niddk.nih.gov/dm/pubs/complications_control/#numbers (last updated Aug. 8, 2013). Hyperglycemia, or high blood sugar, begins to cause symptoms when glucose values become "significantly elevated," exceeding 200 mg/dL. Hyperglycemia in diabetes, Mayo Clinic, http://www.mayoclinic.com/health/hyperglycemia/DS01168/METHOD=print (last updated June 14, 2012).

[23] The normal blood bicarbonate range is 23-29 mEq/L (milliequivalent per liter). CO2 blood test, MedlinePlus, http://www.nlm.nih.gov/medlineplus/ency/article/003469.htm (last updated Apr. 29, 2012). Lower than normal levels of bicarbonate can be a sign of ketoacidosis, among other ailments. Id.

focal deficit" with "fairly well preserved" "[m]otor tone" (AR 366).

On June 7, 2010, Plaintiff's anticipated discharge was delayed by his resumed nausea and vomiting. (AR 301.) Because Plaintiff "was noted to have several episodes of coffee-ground emesis"[24] following admission, a consultation with a gastrointestinal specialist was ordered. (AR 308.) An upper endoscopy showed evidence of acute gastritis, a Mallory-Weiss tear,[25] a possible benign gastric polyp, and a hiatal hernia. (AR 301, 311, 323.) The Mallory-Weiss tear was treated with injections of epinephrine, which was noted to effectively address bleeding in the area. (AR 312.) Lab tests confirmed that the probable polyp was benign. (AR 313.)

On June 8, 2010, Plaintiff was noted to have "developed a low-grade fever" overnight. (AR 321.) He was also noted to have continued nausea, vomiting, and diarrhea. (Id.) Plaintiff was to be tested for a bacterial infection, undergo an abdominal ultrasound "to rule out gallstones," undergo an abdominal CT scan "to rule out obstruction," and be tested to confirm the levels of

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[24] "Hematemesis is the vomiting of blood, which may be obviously red or have an appearance similar to coffee grounds." See H. Kenneth Walker, W. Dallas Hall & J. Willis Hurst, Clinical Methods: The History, Physical, and Laboratory Examinations 439 (3d ed. 1990), available at http://www.ncbi.nlm.nih.gov/books/NBK411/.

[25] A Mallory-Weiss tear is a tear in the mucus membrane of the lower esophagus or upper stomach near where the organs join. See Mallory-Weiss tear, MedlinePlus, http://www.nlm.nih.gov/medlineplus/ency/article/000269.htm (last updated Nov. 11, 2010). Such tears "are usually caused by forceful or long-term vomiting or coughing." Id.

amylase and lipase in his blood. (AR 321-22.) He had no cyanosis of the extremities.[26] (AR 371.) His prognosis was reported to be "guarded." (AR 322.)

The same day, a CT scan of Plaintiff's abdomen and pelvis showed evidence of subsegmental atelectasis,[27] a "small hiatal hernia," and "[a] 2 mm, nonobstructing stone" in Plaintiff's right kidney. (AR 333.) Plaintiff's other visible organs appeared normal. (Id.) A "limited" abdominal ultrasound also was reported to be normal. (AR 336.)

On June 9, 2010, Plaintiff was reported to be in sinus rhythm, tolerating clear liquids, and not having any nausea or vomiting. (AR 382.) An imaging report dated June 10, 2010, showed that Plaintiff's "lungs and pleura are clear" and his "heart and mediastinum are normal." (AR 332.)

Plaintiff was discharged on June 11, 2010. Discharge notes reflect that he was treated with PPIs and Carafate. (AR 301.) He was advised to avoid alcohol and nonsteroidal anti-inflammatory drugs,[28] limit his diet to 1800 calories a day, and follow up within a week with his primary-care physician. (AR

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[26] Cyanosis is a discoloration of the skin arising from poor circulation. See Skin discoloration - bluish, MedlinePlus, http://www.nlm.nih.gov/medlineplus/ency/article/003215.htm (last updated Apr. 21, 2013).

[27] Subsegmental atelectasis is partial collapse of the lung. Stedman's Medical Dictionary, supra, at 160.

[28] Nonsteroidal anti-inflammatory drugs, or NSAIDs, relieve pain by blocking the production of pain-signaling molecules. See Laura Dean, Comparing NSAIDs, PubMed Clinical Q&A (May 1, 2011), http://www.ncbi.nlm.nih.gov/books/NBK45590/. Common NSAIDs include aspirin and ibuprofen. Id.

301-02.)

On June 15, 2010, Plaintiff was seen by Dr. Seneviratne. (AR 275.) Plaintiff was noted to have been admitted to St. Mary Medical Center on June 6, 2010, and to be complaining of fatigue, headache, and weakness. (Id.) This record is largely illegible but reflects further notes regarding Plaintiff's endoscopy and diabetes. (Id.)

On October 10, 2010, Plaintiff was seen by a certified physician assistant for a consultation regarding his medications. (AR 349.) He was noted to have diabetes mellitus and "neuropathy lower legs." (Id.) The remainder of the examining provider's notes are largely illegible.

On November 10, 2010, Plaintiff was seen by Dr. Seneviratne for complaints of fatigue and stomach pain. (AR 350.) His notes appear to state that Plaintiff's feet were cold to the touch and that he experienced decreased sensation. (Id.) The notes appear further to state that Plaintiff suffers from diabetes mellitus, "not controlled," and peripheral neuropathy. (Id.) Plaintiff was instructed to check his blood sugar twice daily and provide the readings, and he was referred to a podiatrist. (Id.)

On March 6, 2011, Plaintiff was seen in the emergency room of St. Mary Regional Medical Center for complaints of nausea, vomiting, and abdominal pain lasting two days. (AR 281.) He was found to have "a very elevated glucose of 345," "a bicarb of 14," "a high anion gap metabolic acidosis," and leukocytosis and was admitted for diabetic ketoacidosis. (Id.) His chart notes additional "[d]iagnoses" of nausea, vomiting, and "right renal calculus." (Id.) Plaintiff was noted to have undergone a CT

scan of his abdomen and pelvis and a chest x-ray. (AR 408.) Plaintiff "responded well to IV fluids," insulin, and Levaquin[29] and was discharged on March 9, 2011, at which point he tolerated solid food and had stable vital signs. (AR 281.) Plaintiff was instructed to adhere to a "low fat, low salt, ADA 2000 kilocalorie per day diet" and to meet with his primary-care physician within two weeks. (Id.) Once again, Plaintiff was noted to have no cyanosis of the extremities. (AR 407.)

On March 15, 2011, Plaintiff was seen by Dr. Seneviratne for complaints of stomach pain and inability to control his blood sugar, problems that reportedly had lasted three to four weeks. (AR 351.) Dr. Seneviratne's notes are largely illegible but appear to pertain to Plaintiff's blood sugar and abdominal issues. No mention of peripheral neuropathy is evident. (Id.)

On April 27, 2011, Plaintiff was seen by Dr. Seneviratne for complaints of black toes lasting 10 days, feeling of numbness lasting 20 days, and "really high" blood sugar lasting 20 days. (AR 352.) Dr. Seneviratne's notes are largely illegible, but he appears to have noted swelling in Plaintiff's lower extremities, and his assessment reflects at least a suspicion of "cellulitis" and a prescription. (Id.)

On May 4, 2011, Plaintiff was seen by Dr. Seneviratne to consult regarding his medications and to address paperwork. (AR 354.) Dr. Seneviratne noted "bilateral [decreased] sensation of

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[29] Levaquin is the brand name for the antibiotic levofloxacin. See Levofloxacin, MedlinePlus, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a697040.html (last updated Sept. 15, 2013).

both feet" and peripheral neuropathy. (Id.) The same day, Dr. Seneviratne handwrote the following on a prescription pad:

> To whom it may concern
> Mr. Kivett has uncontrolled Diabetes Mellitus
> His blood sugars are Very High and we are working on him to control his Diabetes
> Thanks
> [Signature]

(AR 279.)

Plaintiff was admitted to St. Mary Medical Center on July 19, 2011. (AR 423.) On July 21, 2011, Plaintiff was discharged with prescriptions for Protonix, lisinopril,[30] and ciprofloxacin.[31] (AR 422.) Plaintiff was instructed to maintain a salt-restricted diet and to follow up with a physician within a week. (Id.)

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[30] Lisinopril is used to treat high blood pressure. See Lisinopril, MedlinePlus, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a692051.html (last updated Sept. 15, 2012).

[31] Ciprofloxacin is used to treat or prevent certain bacterial infections. See Ciprofloxacin, MedlinePlus, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a688016.html (last updated Sept. 15, 2013).

B. Assessments of State Medical Consultants

On April 22, 2010, medical consultant Dr. J. Hartman, an ophthalmologist,[32] completed a Physical Residual Functional Capacity Assessment of Plaintiff. (AR 253-57.) The evaluation reflects primary diagnoses of esophagitis, gastritis, and diabetes mellitus. (AR 253.) Dr. Hartman indicated that Plaintiff could occasionally lift and/or carry 20 pounds, frequently lift and/or carry 10 pounds, stand and/or walk for a total of about six hours in an eight-hour workday, and sit for about six hours in an eight-hour workday. (AR 254.) He noted that these restrictions "are due to abdominal pain and poorly controlled diabetes." (Id.) Dr. Hartman found that Plaintiff had not established any other limitations. (See AR 254-56.) He noted that Plaintiff's file did not include statements from Plaintiff's treating or examining medical professionals regarding his physical capacities. (AR 257.)

Also on April 22, 2010, Dr. Hartman approved a Case Analysis based on medical evidence then in Plaintiff's file, including records of Plaintiff's admission to OU Medical Center on January 29, 2009, for complaints of nausea and vomiting; Plaintiff's treatment in the OU Medical Center emergency room on January 31, 2009, for persistent abdominal pain and vomiting; Plaintiff's admission to the OU Medical Center on September 5, 2009, for

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[32] Dr. Hartman's electronic signature includes a medical specialty code of 28, indicating ophthalmology. (AR 257); see Program Operations Manual System (POMS) DI 26510.089, U.S. Soc. Sec. Admin. (Oct. 25, 2011), https://secure.ssa.gov/poms.nsf/lnx/0426510090; POMS DI 26510.090, U.S. Soc. Sec. Admin. (Aug. 29, 2012), https://secure.ssa.gov/poms.nsf/lnx/0426510090.

complaints of vomiting of blood and history of peptic ulcer disease; Plaintiff's gastrointestinal consultation on September 8, 2009; and Plaintiff's admission to St. Mary Medical Center on December 25, 2009, for complaints of abdominal pain, vomiting, and nausea. (Id.) The Case Analysis confirmed that Plaintiff's diabetes was "not well controlled" but found "no evidence of complications or organ damage." (Id.) The Case Analysis further noted that Plaintiff's "gastritis, esophagitis, and history of ulcer disease have not resulted in malnutrition or significant anemia." (Id.) Accordingly, Plaintiff was found to "retain[] the RFC for light work." (Id.)

On August 26, 2010, medical consultant Dr. G. Taylor-Holmes, a specialist in internal medicine, performed a Case Analysis. (AR 276.) Dr. Taylor-Holmes noted Dr. Hartman's prior Case Analysis and findings and reviewed additional records received from Dr. Seneviratne's clinic. (Id.) Dr. Taylor-Holmes noted "DM w/ peripheral neuropathy" based on Plaintiff's April 29, 2010, consultation with Dr. Seneviratne. (Id.) Dr. Taylor-Holmes affirmed Dr. Hartman's finding that Plaintiff retained the RFC for light work. (Id.)

C. Hearing Testimony

At the August 2, 2011 hearing before the ALJ, Plaintiff testified that he completed 10th grade but left high school during his 11th-grade year. (AR 447.) Plaintiff stated that he completed his high-school coursework through the special-education program because of his poor literacy. (Id.) Plaintiff testified that he had been able to maintain employment despite his limited literacy. (AR 461-62.) He stated that he received

help with job applications from his nephew or "whoever's around." (AR 461.) He was able to bathe and dress himself without assistance and prepare meals for himself. (AR 449-50.) Plaintiff did not have a driver's license at the time of the hearing because it was suspended for reasons unrelated to his alleged impairments, he had not sought to renew his license, and his inability legally to drive had not prevented him from maintaining employment. (AR 450-51.)

Plaintiff stated that he was convicted of selling methamphetamine and incarcerated from 2005 until November 2009. (AR 452-53.) He testified that he had not used the drug since 2005. (Id.) He did not work while incarcerated because of his health issues – specifically, his poorly controlled diabetes, stomach problems, and fatigue. (AR 454.) Plaintiff testified that while incarcerated, he took medication to treat his stomach, control vomiting, and treat fatigue. (AR 455.) He testified that he also took Neurontin for the pain in his feet. (Id.) Plaintiff also confirmed that he has been taking blood-pressure medication "all along"; it is unclear from the transcript when such medication first was prescribed. (AR 456.)

Plaintiff testified that he previously worked as a laborer. (AR 442.) He stated that he began working for a company that pours cement forms while living in a halfway house following his incarceration. (AR 453-54.) He testified that he was terminated after about a month when he lost consciousness because of an imbalance in blood sugar. (AR 441.) He confirmed that he had looked for a variety of work since his release from prison, including gardening and carpentry work. (AR 454.)

Plaintiff stated that his peripheral neuropathy caused him to be unable to feel his feet, which he testified are "just numb all the time," extending to his knees. (AR 456.) He stated that he also suffered from buzzing, tingling, and sharp pains in his feet and lower legs. (AR 456-57.) When asked how the problem with his feet affected his ability to work, Plaintiff stated that "I can't feel my feet to walk half the time" and confirmed that he had stumbled "a couple of times." (AR 457.) Plaintiff testified that he had never used a cane or walker, although when asked whether he had ever used "[a]ny other device to assist you walking," Plaintiff stated, "I guess I have a couple of times because . . . every now and then it's so numb that . . . I stumble." (Id.)

Plaintiff testified that his diabetes interfered with his ability to work by causing bouts of nausea every three to four days and uncontrolled vomiting approximately every three months, requiring a visit to the hospital. (AR 457-58.) Plaintiff stated that he was often able to stifle uncontrolled vomiting by regulating his blood sugar. (AR 458.) Plaintiff further testified that he suffered from near-constant fatigue that required him to lie down once or twice a day. (AR 459-60.)

Dr. Samuel Landau, a physician board-certified in both internal medicine and cardiovascular disease, appeared at the hearing as a medical expert. (AR 435.) Dr. Landau testified that Plaintiff's medically determinable impairments included "poorly controlled diabetes mellitus," gastritis, esophagitis, and right renal calculus. (AR 462.) He stated that Plaintiff's ailments did not meet a Listing. (AR 464.) Dr. Landau noted

that although Plaintiff testified to hospitalization approximately every three months, the record reflected less frequent hospitalization. (Id.)

Dr. Landau opined that Plaintiff's diabetes would impose some limitations upon his capacity to work. He testified that Plaintiff would be able to stand, walk, or sit for six hours each in an eight-hour day and would require breaks every two hours. (AR 466.) He stated that Plaintiff could lift and carry 25 pounds frequently and 50 pounds occasionally. (Id.) He testified that Plaintiff could climb stairs but not ladders and should not work at heights or in situations requiring him to balance. (Id.) He stated that Plaintiff should work in a temperature-controlled environment. (Id.)

Dr. Landau confirmed that the nausea and vomiting from which Plaintiff had suffered were consistent with his poorly controlled diabetes mellitus but that Plaintiff "also has underlying digestive diseases in addition to that." (AR 467-68.)

He testified that he did not find any "objective evidence of peripheral neuropathy" in Plaintiff's medical records. (AR 466.) He believed the diagnoses of peripheral neuropathy in the record were based on symptoms alone, without objective testing. (AR 467.) Dr. Landau stated that to establish such a diagnosis, an examination must be performed to establish "abnormalities" such as "sensory abnormalities, dependent reflex changes, vibratory sense change, weakness, atrophy." (AR 466-67.) He noted that "electrodiagnostic studies" exist to confirm such a diagnosis but none had been performed on Plaintiff. (AR 467.)

Dr. Landau found no support in Plaintiff's medical record

for Plaintiff's claim that his medical impairments prevented him from maintaining full-time employment. (AR 468.) He noted that the record reflected four hospitalizations for treatment of Plaintiff's diabetes but stated, "[W]hy the diabetes control is so poor, I can't tell you." (AR 469.)

D. ALJ's Decision

In her August 5, 2011 decision, the ALJ found that Plaintiff had severe impairments of poorly controlled diabetes mellitus, gastritis, and esophagitis. (AR 14.) She found that peripheral neuropathy was not a medically determinable impairment "due to a lack of objective evidence," citing Dr. Landau's testimony. (Id.)

The ALJ determined that Plaintiff retained the RFC to perform "less than a full range of light work."[33] (Id.)

> Specifically, the claimant can lift and/or carry ten pounds frequently and twenty pounds occasionally; he can stand and/or walk six hours, sit two hours in an eight hour workday; the claimant cannot climb ladders, ropes, or scaffolds or work at unprotected heights; and the claimant must avoid concentrated exposure to extreme cold, extreme heat, and extreme weather.

(Id.) In so finding, the ALJ considered all of Plaintiff's

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[33] "Light work" involves "lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds." § 416.967(b). "Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls." Id. "To be considered capable of performing a full or wide range of light work, [a claimant] must have the ability to do substantially all of these activities." Id.

symptoms and found his "allegations not fully credible" to the extent his alleged limitations were inconsistent with both his own testimony about his activities and the medical evidence of record. (AR 15-16.)

The ALJ "assigned significant, but not great, weight" to Dr. Landau's testimony in determining Plaintiff's RFC. (AR 17.) As the ALJ noted, Dr. Landau "is board-certified in internal medicine and cardiovascular disease, he has an awareness of all the medical evidence in the record, and he understands Social Security disability programs and requirements." (Id.) The ALJ found more restricted functional limitations than those assessed by Dr. Landau, based in part upon Plaintiff's subjective complaints. (AR 18.) The ALJ also "accorded some, but not significant, weight" to the findings of the state medical consultants. (Id.) She found that "[a]dditional evidence added to the record after [their RFC] determination, including the claimant's hearing testimony, establishes the presence of more restrictive limitations" than those assessed by the medical consultants. (Id.)

The ALJ found that Plaintiff's RFC was insufficient to enable him to perform his past relevant work. (AR 18-19.) Given Plaintiff's age, education, work experience, and RFC, she found that jobs "exist[ed] in significant numbers in the national economy that the claimant can perform." (AR 19.) The ALJ therefore held that Plaintiff was not under a disability from the amended alleged onset date of February 3, 2010, through the date of her decision. (AR 20.)

VI. DISCUSSION

Plaintiff alleges that the ALJ erred in evaluating (1) the medical evidence of record, specifically, his diagnosis of peripheral neuropathy,[34] and (2) Plaintiff's credibility. (J. Stip. at 4.) Neither of these contentions warrants reversal.

A. The ALJ Properly Evaluated the Medical Evidence

Plaintiff contends that the ALJ erred in finding that Plaintiff failed to establish a severe medically determinable impairment of peripheral neuropathy. (J. Stip. at 7.) As a result, Plaintiff argues, the ALJ erred in finding that Plaintiff retained the RFC to perform less than a full range of light work. (Id.) Reversal is not warranted.

1. The ALJ did not err in finding that the medical evidence failed to establish a severe, medically determinable impairment of peripheral neuropathy

Plaintiff argues that the ALJ "failed to properly consider Plaintiff's diabetic neuropathy." (J. Stip. at 4.) Plaintiff maintains that the medical record provides objective evidence supporting a diagnosis of peripheral neuropathy and the ALJ erred in accepting Dr. Landau's testimony to the contrary. (J. Stip. at 6-7.)

a. *Applicable Law*

At step two of the sequential evaluation process, the claimant has the burden to show that he has one or more "severe" medically determinable impairments that can be expected to result

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[34] Plaintiff does not argue that the ALJ erred in finding him not disabled based on the impairments she found to be medically determinable.

in death or last for a continuous period of at least 12 months. See Bowen v. Yuckert, 482 U.S. 137, 146 n.5, 107 S. Ct. 2287, 2294 n.5, 96 L. Ed. 2d 119 (1987) (claimant bears burden at step two); Celaya v. Halter, 332 F.3d 1177, 1180 (9th Cir. 2003) (same); 20 C.F.R. §§ 416.908 (defining "physical or mental impairment"), 416.920(a)(4)(ii) (claimants will be found not disabled at step two if they "do not have a severe medically determinable physical or mental impairment that meets the duration requirement"). A medically determinable impairment must be established by signs, symptoms, or laboratory findings; it cannot be established based solely on a claimant's own statement of his symptoms. § 416.908; Ukolov v. Barnhart, 420 F.3d 1002, 1004-05 (9th Cir. 2005); SSR 96–4p, 1996 WL 374187, at *1 (July 2, 1996); see also 42 U.S.C. § 423(d)(3) ("physical or mental impairment" is one that "results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques"). A "medical sign" is "an anatomical, physiological, or psychological abnormality that can be shown by medically acceptable clinical diagnostic techniques." Ukolov, 420 F.3d at 1005 (quoting SSR 96-4p, 1996 WL 374187, at *1 n.2 (July 2, 1996) (internal quotation marks omitted)); accord 20 C.F.R. § 416.928(b).

To establish that a medically determinable impairment is "severe," moreover, the claimant must show that it "significantly limits [his] physical or mental ability to do basic work

activities."[35] § 416.920(c); accord § 416.921(a). "An impairment or combination of impairments may be found not severe only if the evidence establishes a slight abnormality that has no more than a minimal effect on an individual's ability to work." Webb v. Barnhart, 433 F.3d 683, 686 (9th Cir. 2005) (emphasis in original, internal quotation marks omitted); see also Smolen v. Chater, 80 F.3d 1273, 1290 (9th Cir. 1996) ("[T]he step-two inquiry is a de minimis screening device to dispose of groundless claims."). Applying the applicable standard of review to the requirements of step two, a court must determine whether an ALJ had substantial evidence to find that the medical evidence clearly established that the claimant did not have a medically severe impairment or combination of impairments. Webb, 433 F.3d at 687.

b. *Analysis*

Plaintiff has failed to meet his burden to present evidence of medical signs, symptoms, and laboratory findings establishing his alleged peripheral neuropathy as a medically determinable impairment. Plaintiff points to five "Progress Notes" that document consultations by Dr. Seneviratne and a physician assistant regarding Plaintiff's diabetes and related ailments, including peripheral neuropathy. (J. Stip. at 5.) Although the

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[35] "Basic work activities" include, among other things, "[p]hysical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling"; "[c]apacities for seeing, hearing, and speaking"; [u]nderstanding, carrying out, and remembering simple instructions"; using judgment; "[r]esponding appropriately to supervision, co-workers and usual work situations"; and "[d]ealing with changes in a routine work setting." 20 C.F.R. § 416.921(b); accord Yuckert, 482 U.S. at 141.

notes in each case reference peripheral neuropathy or treatment with Neurontin, none indicate the completion of any medically accepted diagnostic test to confirm the diagnosis. (See Ex. 5F at 1, 2; AR 262, 350, 354.) Rather, these records appear merely to record Plaintiff's complained-of symptoms of pain and numbness. Symptoms alone are insufficient to establish a medically determinable impairment. See Ukolov, 420 F.3d at 1005-06 (treating physician's notation of balance problems, dizziness, problems with "sustained ambulation," and increased tendency to fall did not support finding of impairment because they were based "solely" on plaintiff's own "perception or description of his problems" (internal quotation marks omitted)); 20 C.F.R. § 416.908 ("A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by your statement of symptoms."); SSR 96-4p, 1996 WL 374187, at *1 (July 2, 1996) ("[R]egardless of how many symptoms an individual alleges, or how genuine the individual's complaints appear to be, the existence of a medically determinable physical or mental impairment cannot be established in the absence of objective medical abnormalities; i.e., medical signs and laboratory findings.").

Diagnosis of peripheral neuropathy is "difficult" and generally requires "[a] thorough neurological examination," "extensive patient history," tests to identify the cause of the disorder, and tests to determine the extent and type of nerve damage. See Peripheral Neuropathy Fact Sheet, Nat'l Inst. of Neurological Disorders & Stroke, http://www.ninds.nih.gov/disorders/peripheralneuropathy/detail_peripheralneuropathy.htm

(last updated Sept. 19, 2012); (see also AR 466-67 (Dr. Landau noting that diagnosis requires examination to establish "abnormalities" such as "sensory abnormalities, dependent reflex changes, vibratory sense change, weakness, atrophy")). Further testing is sometimes required to determine the nature and extent of the neuropathy. See Peripheral Neuropathy Fact Sheet, supra; (see also AR 467.) Nothing in the record indicates that Dr. Seneviratne – or any other doctor – ever conducted a "thorough neurological examination" or performed any tests on Plaintiff at all, much less sufficient to diagnose peripheral neuropathy. The only even arguable medical signs in the record supporting the diagnosis are brief notations on March 15, 2010, and May 4, 2011, that Plaintiff had decreased sensation in his feet and a November 10, 2010 notation that his feet were cold. But Plaintiff's hospital records of the same general time frame belie these conclusory observations, which may well simply be notations of Plaintiff's subjective symptoms. In June 2010, the hospital noted that he was not at risk of falling, had no focal deficit, and had "fairly well preserved" motor tone. (AR 361, 366.) He also had no cyanosis of the extremities. (AR 371.) In March 2011, the hospital noted once again that he had no cyanosis of the extremities. (AR 401.) Further, Plaintiff's original diagnosis of peripheral neuropathy came from a physician assistant, not a medically acceptable source. See Molina v. Astrue, 674 F.3d 1104, 1111 (9th Cir. 2012) (physician assistants are not "[a]cceptable medical sources" (alteration in original, internal quotation marks omitted)); Thornton v. Astrue, CV-09-0138-CI, 2010 WL 1904661, at *5 (E.D. Wash. May 12, 2010)

(noting that physician assistant's opinion cannot establish medically determinable impairment (citing 20 C.F.R. § 416.913(d); SSR 06-03p, 2006 WL 2329939 (Aug. 9, 2006))).

Nor is there any other evidence in the record of a diagnosis of peripheral neuropathy based upon medically acceptable diagnostic techniques. Although Plaintiff testified that he has taken Neurontin since he was incarcerated in 2005 (AR 455; see also AR 451), the only references to peripheral neuropathy in the record are the more recent ones discussed above. Moreover, Neurontin is used to treat other ailments, including restless-legs syndrome. See Gabapentin, MedlinePlus, http://www.nlm.nih.gov/medlineplus/druginfo/meds/a694007.html (last updated July 15, 2011).

Further, to the extent the ALJ relied upon Dr. Landau's testimony that the medical record contained no objective evidence of peripheral neuropathy, that testimony was consistent with the medical record and the ALJ was entitled to rely upon it. See Thomas v. Barnhart, 278 F.3d 947, 957 (9th Cir. 2001) ("The opinions of non-treating or non-examining physicians may also serve as substantial evidence when the opinions are consistent with independent clinical findings or other evidence in the record."); Morgan v. Comm'r of Soc. Sec. Admin., 169 F.3d 595, 600 (9th Cir. 1999) ("Opinions of a nonexamining, testifying medical advisor may serve as substantial evidence when they are supported by other evidence in the record and are consistent with it" (citing Andrews v. Shalala, 53 F.3d 1035, 1041 (9th Cir. 1995))); 20 C.F.R. § 416.927(c)(4) (ALJ will generally give more weight to opinions that are "more consistent . . . with the

record as a whole"). Moreover, the ALJ could credit Dr. Landau's opinion because he testified at the hearing and was subject to cross-examination. See Andrews, 53 F.3d at 1042 (greater weight may be given to nonexamining doctors who are subject to cross-examination). Any conflict in the properly supported medical-opinion evidence was therefore the sole province of the ALJ to resolve. See id. at 1041.

Because the record does not reflect diagnosis of Plaintiff's alleged peripheral neuropathy by medically acceptable clinical and laboratory diagnostic techniques, the ALJ did not err in holding that the record lacked objective evidence sufficient to establish a medically determinable impairment of peripheral neuropathy. (AR 14); see Ukolov, 420 F.3d at 1005-06; 42 U.S.C. § 423(d)(3) ("[A] 'physical or mental impairment' is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques."); see also 20 C.F.R. § 416.928(a)-(c); Ball v. Massanari, 254 F.3d 817, 823 (9th Cir. 2001) ("[I]f the claimant's ailment does not pass step 2, . . . it is not disabling.").

2. The ALJ did not err in determining Plaintiff's RFC

Plaintiff argues that the ALJ's RFC finding was in error because it excluded limitations related to Plaintiff's peripheral neuropathy, including that he "could not stand/walk for 6 of 8 hours" and required unscheduled work breaks that would preclude full-time competitive employment. (J. Stip. at 7.)

As explained above, the ALJ did not err in holding that Plaintiff failed to establish peripheral neuropathy as a

medically determinable impairment. The lack of objective medical evidence of peripheral neuropathy excludes its consideration in the determination of Plaintiff's RFC.[36] See McLavey v. Astrue, 325 F. App'x 593, 594 (9th Cir. 2009) ("A claimant's RFC must take into account 'only limitations and restrictions attributable to medically determinable impairments.'" (citing SSR 96-8P, 1996 WL 374184 (July 2, 1996))); Allison v. Astrue, 425 F. App'x 636, 639 (9th Cir. 2011) (same); Bayliss v. Barnhart, 427 F.3d 1211, 1217 (9th Cir. 2005) ("Preparing a function-by-function analysis for medical conditions or impairments that the ALJ found neither credible nor supported by the record is unnecessary."). Accordingly, Plaintiff is not entitled to relief on this claim.

B. The ALJ Properly Evaluated Plaintiff's Credibility

Plaintiff argues that the ALJ failed to provide clear and convincing reasons for discrediting portions of Plaintiff's testimony. (J. Stip. at 11.) Plaintiff asserts that the ALJ was not permitted to discredit Plaintiff's testimony solely because it was unsupported by objective medical evidence. (Id. at 12.)

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[36] Further, even if Plaintiff had presented objective evidence of peripheral neuropathy, the ALJ properly found that Plaintiff received only routine, conservative treatment for the alleged ailment (AR 16), implying that any symptoms were adequately controlled with medication. See 20 C.F.R. § 416.929(c)(3)(iv)-(v) (ALJ may consider effectiveness of medication in evaluating severity and limiting effects of impairment); Warre v. Comm'r of Soc. Sec. Admin., 439 F.3d 1001, 1006 (9th Cir. 2006) ("Impairments that can be controlled effectively with medication are not disabling for the purpose of determining eligibility for [Social Security] benefits."). No evidence in the record supported more restrictive functional limitations than the ALJ assessed. (AR 16); cf. Lewis v. Astrue, 498 F.3d 909, 911 (9th Cir. 2007) (step-two error harmless when ALJ accounts for resulting limitations later in sequential evaluation process.)

Plaintiff disputes the ALJ's assessment that his testimony reflected "somewhat normal" daily activities. (Id. at 13.) Reversal is not warranted on these grounds.

An ALJ's assessment of pain severity and claimant credibility is entitled to "great weight." See Weetman v. Sullivan, 877 F.2d 20, 22 (9th Cir. 1989); Nyman v. Heckler, 779 F.2d 528, 531 (9th Cir. 1986). "[T]he ALJ is not required to believe every allegation of disabling pain, or else disability benefits would be available for the asking, a result plainly contrary to 42 U.S.C. § 423(d)(5)(A)." Molina, 674 F.3d at 1112. In evaluating a claimant's subjective symptom testimony, the ALJ engages in a two-step analysis. See Lingenfelter, 504 F.3d at 1035-36. "First, the ALJ must determine whether the claimant has presented objective medical evidence of an underlying impairment [that] could reasonably be expected to produce the pain or other symptoms alleged." Id. at 1036 (internal quotation marks omitted). If such objective medical evidence exists, the ALJ may not reject a claimant's testimony "simply because there is no showing that the impairment can reasonably produce the *degree* of symptom alleged." Smolen, 80 F.3d at 1282 (emphasis in original). When the ALJ finds a claimant's subjective complaints not credible, the ALJ must make specific findings that support the conclusion. See Berry v. Astrue, 622 F.3d 1228, 1234 (9th Cir. 2010). Absent affirmative evidence of malingering, those findings must provide "clear and convincing" reasons for rejecting the claimant's testimony. Lester, 81 F.3d at 834. If the ALJ's credibility finding is supported by substantial evidence in the record, the reviewing court "may not engage in

second-guessing." Thomas, 278 F.3d at 959.

Reversal is not warranted based on the ALJ's alleged failure to make proper credibility findings or properly consider Plaintiff's subjective symptoms. As discussed above, the ALJ's evaluation of the medical evidence was consistent with the record; her rejection of Plaintiff's testimony to the extent it was inconsistent with the objective evidence was therefore proper. See Carmickle v. Comm'r, Soc. Sec. Admin., 533 F.3d 1155, 1161 (9th Cir. 2008) ("Contradiction with the medical record is a sufficient basis for rejecting the claimant's subjective testimony."); Lingenfelter, 504 F.3d at 1040 (in determining credibility, ALJ may consider "whether the alleged symptoms are consistent with the medical evidence"). Although Plaintiff is correct that the ALJ was not permitted to rely on a lack of objective medical evidence "alone" to discredit Plaintiff's testimony (J. Stip. at 12), here the ALJ properly considered it as one factor in her evaluation. See Burch v. Barnhart, 400 F.3d 676, 681 (9th Cir. 2005) ("Although lack of medical evidence cannot form the sole basis for discounting pain testimony, it is a factor that the ALJ can consider in his credibility analysis."); Kennelly v. Astrue, 313 F. App'x 977, 979 (9th Cir. 2009) (ALJ may not disregard testimony "solely" because it was unsubstantiated by medical evidence but "may use the medical evidence . . . as one factor in his evaluation").

The ALJ specifically identified various inconsistencies between Plaintiff's testimony and the objective medical evidence of his ailments. She found that although Plaintiff testified that he visited the emergency room every three months (AR 457),

the medical records revealed less frequent medical interventions (AR 16). The ALJ noted that although Plaintiff testified that peripheral neuropathy affected his ability to work because it interfered with his walking, causing sharp pain, tingling, and numbness that made him stumble, Plaintiff confirmed that he did not use a cane or walker. (AR 15.) Indeed, the hospitals repeatedly found that he was not at risk of falling. (AR 231, 361.) The ALJ also noted that Plaintiff's complaints of vision problems were unsupported by the medical evidence in the record, a finding Plaintiff does not challenge. (AR 16.) Indeed, as the ALJ noted, "there is no medical source statement from an examining or treating physician that endorses the extent of Plaintiff's alleged functional limitations." (Id.) The ALJ thus properly discounted Plaintiff's statements because they either were not supported by or were contradicted by the record. Carmickle, 533 F.3d at 1161; Lingenfelter, 504 F.3d at 1040.

Moreover, as the ALJ noted, Plaintiff testified that he was able to do basic daily activities, including maintaining personal hygiene, dressing himself, and cooking. (AR 15.) She noted Plaintiff's testimony that he was able to apply for jobs with the help of his nephew and others. (Id.) During the hearing the ALJ observed that one of Plaintiff's hospitalizations occurred after he got overheated while "working outside" on a hot day, further indicating that he was not as impaired as he claimed. (AR 460.) The ALJ also noted that Plaintiff's lack of a driver's license was not due to health issues but to a suspension that Plaintiff had chosen not to remedy. (AR 15-16.) That Plaintiff's allegations of disabling functional limitations were inconsistent

with evidence in the record as to his daily activities was a valid reason for the ALJ to discount his testimony. See Molina, 674 F.3d at 1113 ("Even where [claimant's] activities suggest some difficulty functioning, they may be grounds for discrediting the claimant's testimony to the extent that they contradict claims of a totally debilitating impairment."); see also Fair v. Bowen, 885 F.2d 597, 603 (9th Cir. 1989) ("[I]f, despite his claims of pain, a claimant is able to perform household chores and other activities that involve many of the same physical tasks as a particular type of job, it would not be farfetched for an ALJ to conclude that the claimant's pain does not prevent the claimant from working.").

Finally, the ALJ properly found that Plaintiff "received only routine, conservative treatment for poorly controlled diabetes mellitus, treated gastritis, and esophagitis." (AR 16); see 20 C.F.R. § 416.929(c)(3)(iv)-(v) (ALJ may consider effectiveness of medication and nature of treatment in evaluating severity and limiting effects of impairment). Indeed, although the record reflected three hospital visits since the amended alleged onset date, in each case Plaintiff was successfully treated and discharged with medication, dietary instructions, and a recommendation that he follow up with his regular medical provider. (See AR 281, 301, 423.) His diabetes, gastrointestinal ailments, and alleged peripheral neuropathy were otherwise managed with visits to Dr. Seneviratne's clinic, where his medications were renewed or adjusted and he was encouraged to augment his diet and test his blood sugar twice daily. (See 5F at 1-2; AR 261, 352.)

Because the ALJ gave clear and convincing reasons for her credibility finding and those reasons were supported by substantial evidence, the Court "may not engage in second-guessing." Thomas, 278 F.3d at 959. Plaintiff is not entitled to reversal on this claim.

VII. CONCLUSION

Consistent with the foregoing, and pursuant to sentence four of 42 U.S.C. § 405(g),[37] IT IS ORDERED that judgment be entered AFFIRMING the decision of the Commissioner and dismissing this action with prejudice. IT IS FURTHER ORDERED that the Clerk serve copies of this Order and the Judgment on counsel for both parties.

DATED: November 8, 2013

JEAN ROSENBLUTH
U.S. Magistrate Judge

[37] This sentence provides: "The [district] court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing."