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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Ronda Lee Laier, Plaintiff, v. Carolyn W. Colvin, Acting Commissioner of Social Security, Defendant.	No. CV-14-02478-PHX-NVW **ORDER**

Plaintiff Ronda Lee Laier seeks review under 42 U.S.C. § 405(g) of the final decision of the Commissioner of Social Security ("the Commissioner"), which denied her disability insurance benefits and supplemental security income under sections 216(i), 223(d), and 1614(a)(3)(A) of the Social Security Act. Because the decision of the Administrative Law Judge ("ALJ") is supported by substantial evidence and is not based on legal error, the Commissioner's decision will be affirmed.

I. BACKGROUND

Plaintiff was born in October 1958, has a limited education, and is able to communicate in English. She worked as a dietary manager for a nursing home in Utah for many years before moving to Arizona to care for her ill father. In Arizona she worked as a security guard and was promoted to a supervisor position. Her employment ended in 2010. At the time of the November 2012 hearing, Plaintiff was living in a two-story house in El Mirage, Arizona, with her husband, her 12-year-old daughter, and

Plaintiff's father. Plaintiff's husband is disabled due to short-term memory loss caused by brain injury. Together, Plaintiff and her husband care for Plaintiff's father and daughter.

In May 2011, Plaintiff applied for disability insurance benefits and supplemental security income. Her amended alleged onset date of disability is September 1, 2010. On November 2, 2012, she appeared with her attorney and testified at a hearing before the ALJ in Phoenix, Arizona. A vocational expert also testified. Plaintiff's attorney explained to the ALJ that Plaintiff has moderate degenerative disc disease, which causes her some problems, but her mental impairments (*i.e.*, depression, anxiety, panic disorder) are more severe.

On February 22, 2013, the ALJ issued a decision that Plaintiff was not disabled within the meaning of the Social Security Act. The Appeals Council denied Plaintiff's request for review of the hearing decision, making the ALJ's decision the Commissioner's final decision. On November 7, 2014, Plaintiff sought review by this Court.

II. STANDARD OF REVIEW

The district court reviews only those issues raised by the party challenging the ALJ's decision. *See Lewis v. Apfel*, 236 F.3d 503, 517 n.13 (9th Cir. 2001). The court may set aside the Commissioner's disability determination only if the determination is not supported by substantial evidence or is based on legal error. *Orn v. Astrue*, 495 F.3d 625, 630 (9th Cir. 2007). Substantial evidence is more than a scintilla, less than a preponderance, and relevant evidence that a reasonable person might accept as adequate to support a conclusion considering the record as a whole. *Id.* In determining whether substantial evidence supports a decision, the court must consider the record as a whole and may not affirm simply by isolating a "specific quantum of supporting evidence." *Id.* As a general rule, "[w]here the evidence is susceptible to more than one rational interpretation, one of which supports the ALJ's decision, the ALJ's conclusion must be upheld." *Thomas v. Barnhart*, 278 F.3d 947, 954 (9th Cir. 2002) (citations omitted);

accord Molina v. Astrue, 674 F.3d 1104, 1111 (9th Cir. 2012) ("Even when the evidence is susceptible to more than one rational interpretation, we must uphold the ALJ's findings if they are supported by inferences reasonably drawn from the record.").

Harmless error principles apply in the Social Security Act context. *Molina v. Astrue*, 674 F.3d 1104, 1115 (9th Cir. 2012). An error is harmless if there remains substantial evidence supporting the ALJ's decision and the error does not affect the ultimate nondisability determination. *Id.* The claimant usually bears the burden of showing that an error is harmful. *Id.* at 1111.

III. FIVE-STEP SEQUENTIAL EVALUATION PROCESS

To determine whether a claimant is disabled for purposes of the Social Security Act, the ALJ follows a five-step process. 20 C.F.R. § 404.1520(a). The claimant bears the burden of proof on the first four steps, but the burden shifts to the Commissioner at step five. *Tackett v. Apfel*, 180 F.3d 1094, 1098 (9th Cir. 1999).

At the first step, the ALJ determines whether the claimant is engaging in substantial gainful activity. 20 C.F.R. § 404.1520(a)(4)(i). If so, the claimant is not disabled and the inquiry ends. *Id.* At step two, the ALJ determines whether the claimant has a "severe" medically determinable physical or mental impairment. § 404.1520(a)(4)(ii). If not, the claimant is not disabled and the inquiry ends. *Id.* At step three, the ALJ considers whether the claimant's impairment or combination of impairments meets or medically equals an impairment listed in Appendix 1 to Subpart P of 20 C.F.R. Pt. 404. § 404.1520(a)(4)(iii). If so, the claimant is automatically found to be disabled. *Id.* If not, the ALJ proceeds to step four. At step four, the ALJ assesses the claimant's residual functional capacity and determines whether the claimant is still capable of performing past relevant work. § 404.1520(a)(4)(iv). If so, the claimant is not disabled and the inquiry ends. *Id.* If not, the ALJ proceeds to the fifth and final step, where she determines whether the claimant can perform any other work based on the claimant's residual functional capacity, age, education, and work experience.

§ 404.1520(a)(4)(v). If so, the claimant is not disabled. *Id.* If not, the claimant is disabled. *Id.*

At step one, the ALJ found that Plaintiff meets the insured status requirements of the Social Security Act through December 31, 2015, and that she has not engaged in substantial gainful activity since September 1, 2010, the amended onset date. At step two, the ALJ found that Plaintiff has the following severe impairments: multilevel lumbar and thoracic degenerative disc disease, hip bursitis, a dysthymic disorder, a generalized anxiety disorder, and cannabis abuse. At step three, the ALJ determined that Plaintiff does not have an impairment or combination of impairments that meets or medically equals the severity of an impairment listed in 20 C.F.R. Part 404, Subpart P, Appendix 1.

At step four, the ALJ found that Plaintiff:

> has the residual functional capacity to perform a full range of work at all exertional levels but with the following nonexertional limitations: needs to work in a job where contact with the general public or co-workers is occasional.

The ALJ further found that Plaintiff is unable to perform any past relevant work. At step five, the ALJ concluded that, considering Plaintiff's age, education, work experience, and residual functional capacity, there are jobs that exist in significant numbers in the national economy that Plaintiff can perform.

IV. ANALYSIS

A. The ALJ Did Not Err in Evaluating Plaintiff's Credibility.

In evaluating the credibility of a claimant's testimony regarding subjective pain or other symptoms, the ALJ is required to engage in a two-step analysis: (1) determine whether the claimant presented objective medical evidence of an impairment that could reasonably be expected to produce some degree of the pain or other symptoms alleged; and, if so with no evidence of malingering, (2) reject the claimant's testimony about the severity of the symptoms only by giving specific, clear, and convincing reasons for the

rejection. *Vasquez v. Astrue*, 572 F.3d 586, 591 (9th Cir. 2009). In making a credibility determination, an ALJ "may not reject a claimant's subjective complaints based solely on a lack of objective medical evidence to fully corroborate the claimant's allegations." *Bray v. Comm'r of Soc. Sec. Admin.*, 554 F.3d 1219, 1227 (9th Cir. 2009) (internal quotation marks and citation omitted). But "an ALJ may weigh inconsistencies between the claimant's testimony and his or her conduct, daily activities, and work record, among other factors." *Id.* The ALJ must make findings "sufficiently specific to permit the court to conclude that the ALJ did not arbitrarily discredit claimant's testimony." *Thomas v. Barnhart*, 278 F.3d 947, 958 (9th Cir. 2002); *accord Tommasetti v. Astrue*, 533 F.3d 1035, 1039 (9th Cir. 2008).

First, the ALJ found that Plaintiff's medically determinable impairments could reasonably be expected to cause the alleged symptoms. Second, the ALJ found Plaintiff's statements regarding the intensity, persistence, and limiting effects of the symptoms not credible to the extent they are inconsistent with the ALJ's residual functional capacity assessment.

At the ALJ hearing, Plaintiff's attorney stated that Plaintiff's mental impairments are more severe than her degenerative disc disease, which he described as moderate. The attorney said Plaintiff suffers from dysthymic disorder, major depressive disorder, generalized anxiety disorder, and the panic disorder of agoraphobia. Plaintiff has not received treatment from a mental health professional. The only mental health treatment Plaintiff has received is medication prescribed by her primary care physician, which consists of alprazolam (generic Xanax) for anxiety.[1]

[1] Plaintiff's primary care physician's notes for her first office visit on December 22, 2010, indicate that Plaintiff said Xanax had helped her chronic anxiety in the past. The physician's notes for January 7, 2011, state that Plaintiff explained her positive urine drug screen was caused by taking Xanax prescribed for her husband and that she had not been prescribed it previously.

Plaintiff testified that she is overwhelmed with anxiety for two to three hours almost every day, but her prescription medication helps. When asked about problems other than anxiety that prevent her from working, she said she feels she cannot "process quick enough," she "falls apart" when told she is not doing what she should be doing, and she gets agitated by loud noises and not understanding her daughter's homework. Plaintiff testified that being around other people makes her feel that she is being judged and causes her to panic.

Plaintiff said she left her last job in July or August 2010 because she was passing out and getting sharp pains that would radiate through her back, and she was passing out about twice a week. She also testified that when she began having pain she thought she was having a gallbladder attack, but an endoscopy and a colonoscopy did not reveal anything. When she returned to work, she was terminated because her supervisor felt she could not do the tasks she was given. She looked for other similar work, but no one was hiring at the time.

Plaintiff said she quit physical therapy after two times because the pain in her back was overwhelming. She testified that she does not drive because she is afraid of blacking out, which had happened three or four times a month since 2010. She said that she was scheduled for an appointment with a neurologist on November 8, 2012, to address her blacking out.

Plaintiff testified that the longest she can walk without stopping is 20 minutes because she gets tired. She said she can sit only 15-20 minutes before shifting positions. She said she can stand only ten minutes because standing causes her feet to swell. She also said her feet swell every day for most of the day so she must elevate her feet. She also testified that she was referred to a neurologist to determine what is causing her feet to swell.

The ALJ found that Plaintiff's credibility is diminished by the following: (1) Plaintiff has engaged in a somewhat normal level of daily activity and interaction; (2) her limited range of activities does not appear to be caused by any established impairment;

(3) Plaintiff's allegations regarding the severity of her symptoms and limitations are greater than expected in light of the objective medical record and conservative treatment; and (4) Plaintiff's hearing testimony was vague and inconsistent. The ALJ noted that Plaintiff refused mental health treatment recommended by her primary care physician and did not report her feet swelling until October 2012. The ALJ also noted that there are no medical records corroborating her alleged episodes of fainting.

Thus, the ALJ provided specific, clear, and convincing reasons supported by substantial evidence for discrediting Plaintiff's subjective symptom testimony.

B. The ALJ Did Not Err in Weighing Medical Source Opinion Evidence.

1. Legal Standard

In weighing medical source opinions in Social Security cases, the Ninth Circuit distinguishes among three types of physicians: (1) treating physicians, who actually treat the claimant; (2) examining physicians, who examine but do not treat the claimant; and (3) non-examining physicians, who neither treat nor examine the claimant. *Lester v. Chater*, 81 F.3d 821, 830 (9th Cir. 1995). The Commissioner must give weight to the treating physician's subjective judgments in addition to his clinical findings and interpretation of test results. *Id.* at 832-33. Where a treating physician's opinion is not contradicted by another physician, it may be rejected only for "clear and convincing" reasons, and where it is contradicted, it may not be rejected without "specific and legitimate reasons" supported by substantial evidence in the record. *Id.* at 830; *Orn v. Astrue*, 495 F.3d 625, 632 (9th Cir. 2007) (where there is a conflict between the opinion of a treating physician and an examining physician, the ALJ may not reject the opinion of the treating physician without setting forth specific, legitimate reasons supported by substantial evidence in the record).

Further, an examining physician's opinion generally must be given greater weight than that of a non-examining physician. *Lester*, 81 F.3d at 830. As with a treating physician, there must be clear and convincing reasons for rejecting the uncontradicted opinion of an examining physician, and specific and legitimate reasons, supported by

substantial evidence in the record, for rejecting an examining physician's contradicted opinion. *Id.* at 830-31.

Factors that an ALJ may consider when evaluating any medical opinion include "the amount of relevant evidence that supports the opinion and the quality of the explanation provided; the consistency of the medical opinion with the record as a whole; [and] the specialty of the physician providing the opinion." *Orn*, 495 F.3d at 631. In deciding weight to give any medical opinion, the ALJ considers not only whether the source has a treating or examining relationship with the claimant, but also whether the treatment or examination is related to the alleged disability, the length of the relationship, frequency of examination, supporting evidence provided by the source, and medical specialization of the source. 20 C.F.R. § 404.1527(c). Generally, more weight is given to the opinion of a specialist about medical issues related to his area of specialty than to the opinion of a source who is not a specialist. 20 C.F.R. § 404.1527(c)(5). The ALJ may discount a physician's opinion that is based only the claimant's subjective complaints without objective evidence. *Batson v. Comm'r of Soc. Sec. Admin.*, 359 F.3d 1190, 1195 (9th Cir. 2004). The opinion of any physician, including that of a treating physician, need not be accepted "if that opinion is brief, conclusory, and inadequately supported by clinical findings." *Bray v. Comm'r of Soc. Sec. Admin.*, 554 F.3d 1219, 1228 (9th Cir. 2009).

2. Treating Primary Care Physician Mason J. Roy, M.D.

Plaintiff alleges onset of disability on September 1, 2010. Dr. Roy began treating Plaintiff on December 22, 2010, for chronic arthritis pain in her knees and hips and for chronic anxiety. He prescribed alprazolam (generic Xanax) for anxiety and nothing for pain. On January 7, 2011, Plaintiff reported pain on the right side of her lower rib cage. On January 25, 2011, Dr. Roy referred Plaintiff to a surgeon for assessment of her continued right upper abdominal pain and renewed her prescription for alprazolam. On March 7, 2011, Dr. Roy referred Plaintiff to physical therapy for lumbago (lower back pain), hip pain, and thoracic back pain, ordered hip and thoracic spine x-rays, and

prescribed carisoprodol instead of alprazolam, which Plaintiff reported was of "no help." On March 23, 2011, Dr. Roy prescribed alprazolam for anxiety and did not prescribe carisoprodol. On April 11, 2011, Dr. Roy noted that Plaintiff's anxiety was better, but she requested an increase in the number of tablets of alprazolam per day, and also that she was getting pain medications from "geriatric md but is running out of meds." Dr. Roy prescribed alprazolam for anxiety and lumbago and hydrocodone-acetaminophen for anxiety and lumbago. He also ordered blood tests and noted that Plaintiff was to have her first physical therapy session the next day. On May 9, 2011, Dr. Roy noted that Plaintiff was "feeling a little better with meds and PT."[2] He also noted that Plaintiff was applying for Social Security disability, he had completed the physical evaluation for her, and he would complete the mental evaluation next visit. He ordered refills of alprazolam and hydrocodone-acetaminophen and gave Plaintiff information regarding mental health self-referral. On June 7, 2011, Dr. Roy noted Plaintiff was "doing reasonably well on current regimen," she requested her alprazolam prescription be increased, and she decided not to go to behavioral health "due to trust issues." He ordered refills of alprazolam and hydrocodone-acetaminophen for anxiety and lumbago.

After slightly less than six months of treating Plaintiff as her primary care physician, Dr. Roy completed a Residual Functional Capacity Questionnaire and a Mental Capacity Assessment, both dated June 7, 2011. He identified Plaintiff's diagnosis as anxiety, depression, back pain, and hip pain, and her prognosis as fair. He identified Plaintiff's symptoms as neck pain, thoracic back pain, low back pain, and anxiety. Dr. Roy opined that Plaintiff's symptoms are severe enough to constantly interfere with the attention and concentration required to perform simple work-related tasks. He also opined that the maximum distance Plaintiff can walk is 50 feet, the maximum time Plaintiff can sit at one time is 10 minutes, and the maximum time Plaintiff can stand/walk

[2] Vibrant Care Rehabilitation records show that Plaintiff was assessed for physical therapy on April 26, 2011, was treated on April 27, 2011, and did not return after April 27, 2011.

at one time is 5 minutes. Dr. Roy further opined that in an 8-hour work day, the total amount of time Plaintiff can sit is one hour and the total amount of time she can stand/walk is one hour. He opined that Plaintiff will need to take unscheduled 15-minute breaks every 20-30 minutes. He opined that she can occasionally lift and carry less than 10 pounds, but never more, and she can do repetitive reaching, handling, or fingering 20-25% of an 8-hour workday. He further opined that Plaintiff is likely to be absent more than four times a month as a result of her impairments.

On the Mental Capacity Assessment, Dr. Roy found slight or moderate limitations in all but three areas. He opined that Plaintiff has marked limitation in her ability to maintain attention and concentration for extended periods, her ability to complete a normal workweek without interruptions from psychologically based symptoms, and her ability to set realistic goals or make plans independently of others. He also opined that Plaintiff would likely have more than four absences in an average month. For medical/clinical findings that support this assessment, Dr. Roy wrote, "Extensive medical history." Dr. Roy could not have been referring to his six-month treatment relationship with Plaintiff, but his treatment notes do not indicate that he had any knowledge of Plaintiff's past mental health history.

After June 7, 2011, Dr. Roy continued to treat Plaintiff through October 2012, primarily for lumbago, anxiety, and insomnia. On September 7, 2011, Plaintiff reported that her anxiety had improved with the increased amount of alprazolam, and she continued home exercises and physical therapy,[3] but it was not helping. Dr. Roy referred Plaintiff to an orthopedic specialist and prescribed hydrocodone-acetaminophen, alprazolam, and amitriptyline. On October 7, 2011, Dr. Roy noted that physical therapy was ongoing, and the appointment with the orthopedic specialist was scheduled for

[3] The record does not show Plaintiff received physical therapy after April 27, 2011. On November 28, 2011, when Plaintiff was first seen at the CORE Institute, she reported having recently completed 8 sessions of physical therapy with minimal improvement.

November 28, 2011. He renewed her prescription for hydrocodone-acetaminophen with refills to last for three months. On January 11, 2012, Dr. Roy noted that Plaintiff's anxiety and insomnia were worse recently due to family issues, she had an MRI completed, and she would call to schedule a follow-up appointment with the orthopedic specialist. He prescribed alprazolam, Ambien, and hydrocodone-acetaminophen with refills to last for three months.[4] On February 10, 2012, Dr. Roy saw Plaintiff again and noted that she was stable on her current medication regime and had no current complaints. On March 12, 2012, Dr. Roy noted that Plaintiff requested increased anxiety medication and she reported the orthopedic physician assistant recommended a possible ablation procedure. Plaintiff continued to see Dr. Roy monthly through October 2012 and received prescription medications for anxiety and low back pain.

3. Treating Pain Management Physician Eric Feldman, M.D.

On February 14 and 24, 2012, Dr. Feldman, of the CORE Institute, performed bilateral L4-5 transforaminal epidural steroid injections on Plaintiff. Plaintiff was seen by a physician assistant at the CORE Institute on November 28, 2011, January 23, 2012, March 1, 2012, and April 19, 2012. It does not appear that Dr. Feldman actually examined Plaintiff before August 22, 2012.

On August 22, 2012, Dr. Feldman saw Plaintiff, ordered physical therapy, and completed a Residual Functional Capacity Questionnaire. He identified Plaintiff's diagnosis as chronic low back pain and her prognosis as fair. He identified her symptoms as low back and leg pain and fatigue. Dr. Feldman opined that Plaintiff's symptoms are severe enough to constantly interfere with the attention and concentration required to perform simple work-related tasks. He also opined that the maximum distance Plaintiff can walk is 1-2 city blocks, the maximum time Plaintiff can sit at one time is 30 minutes, and the maximum time Plaintiff can stand/walk at one time is 5-10 minutes. Dr. Feldman

[4] Medical records from the CORE Institute show that on January 23, 2012, March 1, 2012, and April 19, 2012, Plaintiff was prescribed oxycodone-acetaminophen by a physician assistant in addition to the medications prescribed by Dr. Roy.

further opined that in an 8-hour work day, the total amount of time Plaintiff can sit is 2-3 hours and the total amount of time she can stand/walk is 0-1 hour. He opined that Plaintiff will need to take unscheduled breaks of 1-2 minutes every 15 minutes. He opined that she can occasionally lift and carry up to 10 pounds, but never more, and she has no limitations in doing repetitive reaching, handling, or fingering. He further opined that Plaintiff is likely to be absent more than four times a month as a result of her impairments.

The ALJ found that the medical source statements from Drs. Roy and Feldman were not supported by their own progress notes and appeared to be based on Plaintiff's subjective statements. These are legitimate, clear, and convincing reasons, supported by substantial evidence in the record, for giving the medical source statements of Drs. Roy and Feldman little or no weight. Although the ALJ did not explicitly state that she had considered Dr. Roy's mental assessment as well as his physical assessment, she cited the exhibit numbers of both assessments, and therefore it can be assumed that she considered both exhibits that she cited. The ALJ did not explicitly state the degree of weight she gave the opinions of these treating physicians, but it is plain from the context that the ALJ gave them little or no weight.

C. The ALJ Did Not Err in Her Examination of the Vocational Expert.

An ALJ may rely on a vocational expert's testimony that is based on a hypothetical that contains all of the limitations the ALJ found credible and supported by substantial evidence in the record. *Ghanim v. Colvin*, 763 F.3d 1154, 1166 (9th Cir. 2014). "However, if an ALJ's hypothetical is based on a residual functional capacity assessment that does not include some of the claimant's limitations, the vocational expert's testimony has no evidentiary value." *Id.* (internal quotation marks and citation omitted).

For reasons previously stated, the ALJ did not err by finding Plaintiff's testimony regarding the severity of her symptoms and limitations less than fully credible or by giving little weight to the opinions of Drs. Roy and Feldman. The ALJ gave "some

weight" to the opinion of consultative examiner Ilyssa Swartout, Psy.D., regarding social functioning, and limited Plaintiff to occasional contact with the public. The ALJ was not required to pose a hypothetical to the vocational expert with limitations she did not find credible and supported by substantial evidence in the record. Giving "some weight" to Dr. Swartout's opinion did not require the ALJ to rely on a hypothetical posed to the vocational expert by Plaintiff's counsel that included Dr. Swartout's opinion of "moderate to marked" limitation in social functioning, especially when neither the opinion nor the hypothetical distinguished "moderate" from "marked" limitation.

IT IS THEREFORE ORDERED that the final decision of the Commissioner of Social Security is affirmed. The Clerk shall enter judgment accordingly and shall terminate this case.

Dated this 12th day of June, 2015.

Neil V. Wake
United States District Judge