1 **WO** NOT FOR PUBLICATION
2
3
4
5 **IN THE UNITED STATES DISTRICT COURT**
6 **FOR THE DISTRICT OF ARIZONA**
7

8 G Alan Byerhoff, 9 Plaintiff, 10 v. 11 Commissioner of Social Security 12 Administration, 13 Defendant.	No. CV-16-00754-PHX-JJT **ORDER**

14 At issue is the denial of Plaintiff G. Alan Byerhoff's Applications for Disability
15 Insurance Benefits ("DIB") by the Social Security Administration ("SSA") under the
16 Social Security Act ("the Act"). Plaintiff filed a Complaint (Doc. 1) with this Court
17 seeking judicial review of that denial, and the Court now addresses Plaintiff's Opening
18 Brief (Doc. 18, "Pl.'s Br."), Defendant Social Security Administration Commissioner's
19 Opposition (Doc. 22, "Def.'s Br."), and Plaintiff's Reply (Doc. 23, "Reply"). The Court
20 has reviewed the briefs and Administrative Record (Doc. 11, R.) and now reverses the
21 final decision of the Commissioner of Social Security. (R. at 4-7.)
22 **I. BACKGROUND**
23 Plaintiff filed an application for DIB on November 30, 2011, for a period of
24 disability beginning January 2, 2011 until the date last insured (DLI) of June 30, 2011.
25 (R. at 95-96.) Plaintiff's claim was denied initially on March 28, 2012 (R. at 97-106), and
26 again on reconsideration on August 17, 2012. (R. at 109-19.) Plaintiff then testified at a
27 hearing held before an Administrative Law Judge (ALJ) on April 2, 2014. (R. at 74-94.)
28 On April 18, 2014, the ALJ issued a decision denying Plaintiff's SSI application. (R. at

Dockets.Justia.com

56-73.) On January 19, 2016, the Appeals Council denied Plaintiff's request for review of the ALJ's decision, making the ALJ's decision the final decision of the Commissioner of Social Security. (R. at 4-7.) The present appeal followed. The Court has reviewed the record, including hearing testimony and medical evidence, in its entirety and provides a summary below.

A. Medical Evidence

Plaintiff's reports of chronic neck pain radiating to his right shoulder led to an MRI of his spine in February 2010 that revealed cervical scoliotic deformity and severe spondylotic disease with severe right foraminal narrowing. (R. at 266.) While doctors also often noted depression/anxiety but not as chief complaints, Plaintiff was formally diagnosed and treated by his treating physician, Jack Poles, M.D. in January 2012, although his affect was normal at all visits. (R. at 260-359.) Similarly, Plaintiff reported headaches, but not usually as a chief concern. (R. at 260-359.) In general, Plaintiff usually followed up with Dr. Poles six weeks later than instructed, and with Jeffrey T. Bucholz, D.O. one to two months later than instructed; however, there is a gap in treatment for nine months with Dr. Poles (April 27, 2011 until January 30, 2012) and 17 months with Dr. Bucholz (January 14, 2011 until June 8, 2012). (R. at 260-359.)

On January 4, 2011, Plaintiff saw Dr. Poles, his primary care physician, due to hypertension and an increase in the amount of Vicodin required to manage his neck pain. (R. at 260.) On physical examination, Dr. Poles noted Plaintiff had "fairly good range of motion but posterior tenderness" in his neck and requested a follow up in four months. (R. at 261.)

On January 7, 2011, Plaintiff visited The Pain Center of Arizona to see Dr. Bucholz about his "severe" neck pain resulting in a "moderate" functional impairment that only interfered with some daily activities. (R. at 276, 278.) Plaintiff reported right upper extremity pain and numbness and "deep bone pain," with no relief from chiropractic adjustments. (R. at 276, 278.) Under "Psychiatric System," Dr. Bucholz noted that Plaintiff has a normal level of consciousness, memory, mood and affect, and

capacity for sustained mental activity. (R. at 277.) At this visit, Dr. Bucholz gave Plaintiff a cervical epidural steroid injection, ordering a follow up when necessary. (R. at 277-78.)

On January 14, 2011, Plaintiff returned to Dr. Bucholz with moderate neck pain. (R. at 273.) Plaintiff characterized his response to steroid injections as "fluctuating," but reported that episodes of pain are shorter and less frequent. (R. at 273.) Dr. Bucholz noted that Plaintiff's cervical radicular symptoms have "significantly improved from the previous epidural injection." (R. at 275.) At this visit, Dr. Bucholz gave Plaintiff a trigger point injection in sensitive areas of his trapezius muscle(s), ordering a follow up in one month. (R. at 274-75.)

On April 27, 2011, Plaintiff timely followed up with Dr. Poles about managing his neck pain, and reported some paresthesia in his fingertips. (R. at 263.) On physical examination, Dr. Poles noted Plaintiff's neck had good range of motion but "posterior spasm and pain." (R. at 264-65.)

While the Court reviewed the multitude of medical records for visits after the DLI, little of note was found in those records to clarify the severity of impairments in the relevant period. These records included similar fluctuating reports of and concerns about Plaintiff's neck pain, paresthesia, headaches, and depression/anxiety, with treatments as before with Drs. Pole and Bucholz. (R. at 268-72, 280-82, 290-367.)

On September 22, 2011, Plaintiff visited Dynamic Chiropractic Center due to neck pain on his left side, after having "lifted a patient." (R. at 289.) A registered nurse noted a decreased range of motion in his cervical area. (R. at 289.) Plaintiff received manipulations and electrical muscle stimulation with heat for both sides of his neck and shoulders. (R. at 289.)

On January 30, 2012 Plaintiff visited Dr. Poles for a follow up on medications and listed depression and neck pain as his chief complaints (R. at 280.) Dr. Poles diagnosed Plaintiff with "depression/anxiety" (due to stress from his father developing Parkinson's disease and moving to Plaintiff's group home) and prescribed Xanax. (R. at 280-81.)

Dr. Poles indicated on a check-box form on July 13, 2012, that Plaintiff had "moderately severe" impairments ("an impairment which seriously affects ability to function") only in reacting to work pressure, performing varied tasks, and completing a normal workday without interruptions to rest or for interruptions from psychological symptoms, adding that Plaintiff had "severe neck pain" that limited his activities and anxiety and panic attacks that "hinder his ability to function." (R. at 255-56.) He also limited Plaintiff's lifting to 10-20 pounds, standing and/or walking for at least two hours and sitting for only two hours in an eight hour workday. (R. at 257.) Dr. Poles indicated Plaintiff could use both hands "continuously" for "feeling (skin reception)." (R. at 258.)

Dr. Bucholz began to note cervical facet syndrome on August 22, 2012, treating with multiple targeted injections over a few months and a facet ablation on December 28, 2012. (R. at 292, 296, 300, 304, 314, 318, 320, 352.) An MRI was done on April 1, 2014 to compare results with the 2010 MRI and revealed progressive changes in the alignment of the cervical spine and severe cervical levorotoscoliosis with considerable neural foraminal narrowing mainly on the right side. (R. at 367.)

By 2012, Plaintiff reported being unable to lift anything over his shoulders, nor anything over 10 pounds. (R. at 232.) Plaintiff could not drive for more than five to seven miles because of neck pain and tingling in his right arm and slept in a neck brace, needing medications to help reduce muscle spasms after four to five hours of sleep. (R. at 232-33.) For treatment, Plaintiff applied dry heat/moisture and took various medications for his pain (methadone, Vicodin, oxycodone), muscle spasms, high blood pressure, and anxiety. (R. at 227, 231, 236.) In addition, Plaintiff would rest for an hour, once or twice per day due to his pain and medication side effects (dizziness, fatigue, constipation, tiredness, poor concentration, lightheadedness). (R. at 231, 236.)

Non-examining physicians reviewed Plaintiff's medical records at both the initial and reconsideration levels and found there was insufficient evidence to evaluate the spondylosis and depression/anxiety claims as there was no support for the severity of the

impairments in the objective medical record, and the DLI was too far past for Plaintiff to qualify for a consultative examination. (R. at 98-119.)

C. Hearing Testimony

1. Plaintiff's Testimony

At Plaintiff's hearing before the ALJ on April 2, 2014, Plaintiff testified as to his pain. (R. at 79-91.) Plaintiff stated that pain at the base of his neck prompted him to seek medical attention in 2007 when it was not well managed by muscle relaxers. (R. at 79.) By 2009, various narcotic medications required Plaintiff to stop driving as part of his work for his referral service for senior living, and instead provide minimal assistance at his group home until 2011, when he could no longer work at all due to pain and the effects of the medication. (R. at 80.)

After being diagnosed with cervical spondylotic disease in February 2010 by way of an MRI, Plaintiff underwent various treatments including trigger point injections, epidurals, and pain management (including Vicodin, oxycodone, Flexeril, and methadone). (R. at 83-84.) Plaintiff testified that doctors said he was not a good candidate for surgery, as his pain is caused by a degenerative bone disease, so his current treatment strategy is limited to pain management. (R. at 91.)

At the hearing, Plaintiff presented with his head tilted to the right, limited range of motion, pain at the base of his neck with headaches that radiate to his shoulder blade, and tingling in his right pointer finger. (R. at 85-86.) Plaintiff indicated these symptoms were present in 2010-11, but had worsened over time. (R. at 86.) Plaintiff testified that the headaches at the base of his neck were worse now, but did occur two to three times a week in 2011, without warning, after sitting up for 30-45 minutes. (R. at 87.) These headaches were accompanied by noise sensitivity and nausea that would require Plaintiff to lie down for up to three hours, depending on the effectiveness of his treatment with heat and pain medications. (R. at 88.) Plaintiff also testified to experiencing panic attacks about three times a week in 2011, prompted by worries about his pain and his neck not

straightening up, and eased by breathing exercises for up to an hour until he was prescribed Xanax. (R. at 88-89.)

With regard to daily activities, Plaintiff testified he is able to help his wife with chores by occasionally taking out the trash, dusting, and taking laundry to the laundry room, his condition permitting. (R. at 90.) Plaintiff's ability to drive is limited due to his neck issues and restrictions from his doctor due to his strong pain medications. (R. at 90.)

2. Vocational Expert Testimony

Gayle Tichauer, a vocational expert (VE), also testified before the ALJ at the April 2, 2014 hearing. (R. at 91-93.) The VE described Plaintiff's previous work history of community placement worker as a sedentary, skilled job and the owner of a group home as light, highly skilled work. (R. at 92.) When the ALJ asked the VE whether a hypothetical individual–one with Plaintiff's age, education, and vocational background, who could do a range of medium work, with occasional bilateral overhead reaching, avoiding unprotected heights or dangerous machinery except vehicles, without climbing ladders, ropes, or scaffolds–could perform any of Plaintiff's past work, the VE said "yes" for both of his previous jobs. (R. at 92.) In a second hypothetical posed to the VE, the ALJ asked about work availability, with the same limitations as the first, but adding that the individual would be off task for 15 percent of every eight-hour day due to severe neck pain. (R. at 92.) The VE responded that such an individual would be unable to sustain work. (R. at 92.)

The VE also agreed with Plaintiff's counsel that a hypothetical individual who was limited to sitting for two of every eight hours and standing for two of every eight hours would have less than a sedentary Residual Functional Capacity (RFC). (R. at 93.)

C. The ALJ's Opinion

ALJ Patricia A. Bucci issued an opinion dated April 18, 2014, in which she concluded Plaintiff was not disabled under sections 216(i) and 223(d) of the Act. (R. at 69.) The ALJ began her analysis by stating her finding that Plaintiff met the insured status requirement and had not engaged in substantial gainful activity during the period

from his date of alleged onset of January 2, 2011 through his DLI of June 30, 2011. (R. at 61.) The ALJ then listed cervical degenerative disc disease and hypertension as medically determinable impairments afflicting Plaintiff. (R. at 61.)

Proceeding with the five-step inquiry, the ALJ found that the impairments or combination of impairments did not significantly limit his ability to perform basic work-related activities and thus Plaintiff's impairments were not severe. (R. at 61.) The ALJ also evaluated Plaintiff's medically determinable mental impairment (depression and anxiety) and found it to be nonsevere under the criteria of Listing 12.00C paragraph B, finding no more than mild limitations in the first three functional areas and no decompensation in the fourth area. (R. at 68.)

The ALJ found that Plaintiff's medically determinable impairments could reasonably be expected to produce his alleged symptoms, but that Plaintiff's statements concerning the intensity, persistence and limiting effects were not entirely consistent and credible. (R. at 63.) The ALJ found Plaintiff's "minimal" medical record with significant gaps in treatment indicated only mild findings that were managed and controlled by proper medications and treatment, and did not support Plaintiff's allegations of greater restriction and pain. (R. at 63-64.)

With regard to medical opinions, the ALJ gave little weight to the opinion of Dr. Poles, Plaintiff's primary care physician, because she found he used a check-box form without further explanation for conclusions of extreme limitations. (R. at 67.) The ALJ determined that Dr. Poles's findings on that form were inconsistent with his own treatment notes and the objective findings of record, and instead based on the claimant's subjective complaints. (R. at 67.) Furthermore, the ALJ noted that there were significant gaps in treatment history and that Dr. Poles is a primary care physician and not a specialist in either orthopedics or mental health. (R. at 67.) Instead, the ALJ gave "greater weight" to Dr. Salk, Dr. Gallucci, and Dr. Keer, who reviewed the record and found it was insufficient to support a finding of severity for depression, anxiety, or any neurological deficits from degenerative spondylosis during the relevant period. (R. at 67.)

However, the ALJ also noted she gave only "partial weight" to the opinions of the State agency medical and psychological consultants because they did not personally examine the claimant, though they did provide "specific reasons" in finding the Plaintiff was not disabled. (R. at 67.)

II. LEGAL STANDARDS

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, but less than a preponderance; it is 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).

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. 20 C.F.R. § 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 (Listing of Impairments).

20 C.F.R. § 404.1520(a)(4)(iii). If so, the claimant is automatically found to be disabled. *Id*. If not, the ALJ proceeds to step four. *Id*. At step four, the ALJ assesses the claimant's RFC and determines whether the claimant is still capable of performing past relevant work. 20 C.F.R. § 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 he determines whether the claimant can perform any other work based on the claimant's RFC, age, education, and work experience. 20 C.F.R. § 404.1520(a)(4)(v). If so, the claimant is not disabled. *Id*. If not, the claimant is disabled. *Id*.

III. ANALYSIS

Plaintiff argues that the ALJ erred by finding Plaintiff did not have a severe impairment and committed harmful error by: (1) rejecting the testimony of the Plaintiff as a reliable source for determining the extent of his activity despite his impairments, and (2) discounting the opinion of Dr. Poles. (Pl.'s Br. at 8.) Defendant argues that Plaintiff did not meet his burden of showing a severe impairment prior to the DLI and supports the ALJ's rejection of Plaintiff's testimony and Dr. Poles's opinion. (Def.'s Br. at 5-14.) The Court notes the Defendant's motion to strike the "Glossary" filed with Plaintiff's Brief; however, the issue is moot because the Court did not use the "Glossary" to make its decision. (Def.'s Br. at 2-3.)

A. The ALJ Erred in Rejecting Plaintiff's Subjective Complaints

Plaintiff argues that the ALJ did not cite specific evidence to properly discredit Plaintiff's testimony. (Pl.'s Br. at 9.) The ALJ rejected Plaintiff's testimony about his symptoms because of inconsistencies with their intensity, persistence, and limiting effects. (R. at 63.) Neither the ALJ nor any doctor in this case alleged any findings of malingering, so the ALJ's rejection of Plaintiff's credibility should be supported by "specific findings as to credibility and stating clear and convincing reasons for each," which is the same standard used to reject a plaintiff's pain testimony. *Robbins v. Soc. Sec. Admin*, 466 F.3d 880, 883 (9th Cir. 2005); *Lester v. Chater*, 81 F.3d 821, 834 (9th Cir.1995). "The ALJ must specify what testimony is not credible and identify the

evidence that undermines the claimant's complaints—'[g]eneral findings are insufficient.'" *Burch v. Barnhart*, 400 F.3d 676, 680 (9th Cir. 2005) (quoting *Reddick v. Chater*, 157 F.3d 715, 722 (9th Cir. 1998)).

Although the ALJ notes that Plaintiff alleges restrictions and pain as part of his disability, the ALJ focuses on more "objective evidence" to evaluate Plaintiff's severity of disability and is unsatisfied by the "mild findings" from physical exams. (R. at 63.) "In evaluating the credibility of pain testimony after a [plaintiff] produces objective medical evidence of an underlying impairment, an ALJ may not reject a [plaintiff's] subjective complaints based solely on a lack of medical evidence to fully corroborate the alleged severity of pain." *Burch*, 400 F.3d at 680 (citing *Bunnell v. Sullivan*, 947 F.2d 341, 345 (9th Cir.1991)). Furthermore, a plaintiff does not need to show that their impairments could reasonably be expected to cause the severity of the symptom alleged, but only that it could reasonably have caused some degree of the symptom. *Smolen v. Chater*, 80 F.3d 1273, 1282 (9th Cir. 1996). The ALJ acknowledges that Plaintiff's medically determinable impairments (cervical spondylosis, objectively found in the 2010 MRI) could reasonably be expected to produce the alleged symptoms. (R. at 63, 266.) Therefore, Plaintiff's reports concerning the severity of his neck pain, headaches, and paresthesia should be credited as symptoms from his cervical spondylosis, as supported by the 2010 MRI, the objective medical evidence. (R. 260-359.)

Defendant further argues Plaintiff's testimony about headaches is inconsistent because Plaintiff "denied headaches during and around the relevant period" and that Dr. Bucholz describes the headaches as "minimal." (Def.'s Br. at 8-9.) The ALJ similarly tries to discredit Plaintiff's credibility by pointing out Dr. Bucholz's minimization of Plaintiff's headaches, and in the same sentence, Plaintiff's denial of radicular pain. (R. at 65, 322.) However, Dr. Bucholz's notes cited by both Defendant and the ALJ are from a visit one year past the DLI, and the ALJ overlooks evidence from the relevant period that shows Plaintiff was reporting headaches to Dr. Poles at both visits, and reporting and receiving treatments for cervical radicular pain or radiculopathy to Dr. Bucholz at both

visits. (R. at 260, 263, 275, 278.) An ALJ must review the whole record and not cherry-pick evidence to support his/her findings. *Holohan v. Massanari*, 246 F.3d 1195, 1207 (9th Cir. 2001). The ALJ must not accept a single point in isolation to support her rejection of Plaintiff's credibility concerning his headaches and radiculopathy after his DLI, while ignoring multiple, continued reports of headaches and radiculopathy during the relevant period that continued after the DLI. (R. at 260-359.)

The ALJ also determined that Plaintiff's impairments are not severely disabling because they are well controlled by medications and treatments. (R. at 64.) An ALJ can properly deny disability benefits when an alleged impairment is under control. *Sample v. Schweicker*, 694 F.2d 639, 641 (9th Cir. 1982) (ALJ properly denied benefits where doctors determined plaintiff's alleged impairments had stabilized or are controlled and plaintiff admitted to being able to work with a back brace). However, treatments and medications that only provide limited relief that is variable and brief from otherwise-constant pain also do not negate a plaintiff's credibility regarding subjective complaints. *Garrison v. Colvin*, 759 F.3d 995, 1015 (9th Cir. 2014) (epidural shots, which only provided relief for few days to a couple of months, did not support an ALJ's rejection of plaintiff's credibility concerning pain testimony).

Defendant argues that Plaintiff "reported significant improvement in his pain" after epidural injections. (Def.'s Br. at 9.) However, this was one week after receiving an injection and Defendant overlooks the rest of the record that shows that the effects from those injections are limited and do not control his pain effectively. (R. at 273, 275.) For example, at the same visit that Defendant cites, Plaintiff still rated his pain as a seven out of ten (decreased from an eight out of ten from a visit the week prior when he received the injection) and was treated with another injection, just one week later. (R. at 273, 275.) Dr. Poles noted that Plaintiff reported that the injections "don't seem to be doing any good" and "have lasted briefly," and despite having at least fifteen injections, he still needed four to five Percocet daily because he experienced breakthrough pain, for which he additionally took Oxycontin and Vicodin. (R. at 260, 263.) Plaintiff consistently

reported his response to the injections as "fluctuating," and these allegations of pain and its ineffective management continue well past the DLI, often specifically noting that the injections improved his pain initially but the relief did not last and that his responses to medications have worsened.[1] (R. at 260, 263, 273, 290, 294.) Plaintiff also reported many side effects from the medications he takes when the effects of the injections fade. (R. at 236.) Therefore, the ALJ erred in considering the brief relief that the injections and medication provided for Plaintiff's neck pain in evaluating the credibility of Plaintiff's testimony and the severity of Plaintiff's impairments.

The ALJ may have relied on Plaintiff's testimony that Xanax "does help" with his panic attacks when noting that impairments are well controlled by medications and thus non-severe. (R. at 89.) However, "[t]hat a person who suffers from severe panic attacks, anxiety, and depression makes some improvement does not mean that the person's impairments no longer seriously affect [their] ability to function in a workplace," and these statements should be taken in context with the plaintiff's overall diagnostic picture. *See, e.g., Holohan*, 246 F.3d at 1205. While Plaintiff may no longer be using breathing exercises for up to an hour to control his panic attacks, he was still taking Xanax at his hearing in April 2014. (R. at 89.) There is no evidence in the record that Plaintiff has improved to the point that his depression/anxiety is considered resolved, so the ALJ erred in discounting Plaintiff's mental impairments and their debilitating effects in considering the severity of his disability.

The ALJ and Defendant also try to minimize Plaintiff's impairments and additional pain as a result of activities he chose to perform (including exercise, leisure activities, and chores) that, they contend, go beyond his alleged physical and mental

---

[1] Defendant cites *Celaya v. Halter* to support a denial of benefits where plaintiff's pain was from an underlying complaint that was controlled. (Def.'s Br. at 9, citing *Celaya v. Halter*, 332 F.3d 1177, 1181 (9th Cir. 2003).) Unlike the plaintiff in *Celaya* whose pain was from obesity and diabetes, here Plaintiff's pain stems from a degenerative disc disease that cannot be similarly controlled. (R. at 91, 260-359). Although doctors note that degenerative diseases can stabilize, which could support a finding of denial of benefits, no doctor in this case has alleged such stabilization. *See Sample*, 694 F.2d at 643.

limitations. (R. at 65-66; Def.'s Br. at 6.) However, a plaintiff does not have to be "utterly incapacitated" to be considered disabled. *Fair v. Bowen*, 885 F.2d 597, 603 (9th Cir. 1989). A plaintiff's credibility as to their overall disability is not reduced because they have done certain daily activities that may not necessarily be transferable to the work setting with regard to the impact of pain. *Vertigan v. Halter*, 260 F.3d 1044, 1050 (9th Cir. 2001). "A [plaintiff] may do these activities *despite* pain for therapeutic reasons, but that does not mean [they] could concentrate on work despite the pain or could engage in similar activity for a longer period given the pain involved." *Id.* (emphasis in original). An ALJ should consider the difference between plaintiffs' ability to engage in sporadic physical activities that do not consume a substantial portion of the day (driving, shopping with assistance, walking for an hour in the mall, getting together with friends, playing cards, exercise, swimming, etc.) versus their ability to work eight hours a day, five consecutive days of the week while being held to a minimum standard of performance by an employer, especially concerning exercises that are therapeutic and unavailable at work. *See Carradine v. Barhart*, 360 F.3d 751, 756 (7th Cir. 2004) (citing *Vertigan*, 260 F.3d at 1049-50); *Bjornson v. Astrue,* 671 F.3d 640, 647 (7th Cir. 2012).

Here, the ALJ erred in discounting Plaintiff's credibility about his pain symptoms due to his vigorous exercise that would exacerbate his pain because the exercise was recommended by his doctors for therapeutic reasons. (R. at 232.) Similarly unconvincing is the list of limited activities that the ALJ and Defendant both cite as precluding a severe impairment, including driving very limited distances before his neck pain and tingling in his fingers stops him (although he usually lets his wife drive), occasionally taking out the trash or dusting or carrying laundry to the laundry room (but no mention of actually doing laundry), grocery shopping (with the assistance of his wife), and activities at the adult center (playing cards, puzzles, and bingo). (R. at 65, 90, 232; Def.'s Br. at 6.) Plaintiff testified these activities were done only if his condition permits, and thus are occasional or limited. (R. at 90.) Although the ALJ argues that these activities are greater than what Plaintiff had generally reported, she does not specify which activity contradicts

which specific limitation.[2] (R. at 89-91.) Further, Plaintiff had admitted to being able to carry less than ten pounds (which is consistent with Dr. Poles's assessment) and testimony of these limited activities at his hearing is corroborated by his responses to a questionnaire in 2012. (R. at 89-91, 231-33, 257.) There is no indication that Plaintiff's exercise or activities involved the same amount of daily, consecutive rigor that a job would involve, and so at this step in the DIB proceedings, the ALJ should not have discounted Plaintiff's credibility about his symptoms, limitations, and severity of his disability because of these activities.

B. The ALJ Erred in Assigning Little Weight to Plaintiff's Treating Physician's Opinion

An ALJ "may only reject a treating or examining physician's uncontradicted medical opinion based on 'clear and convincing reasons.'" *Carmickle v. Comm'r of Soc. Sec.*, 533 F.3d 1155, 1164 (9th Cir. 2008) (citing *Lester*, 81 F. 3d at 830-31). "Where such an opinion is contradicted, however, it may be rejected for 'specific and legitimate reasons that are supported by substantial evidence in the record." *Id.* Dr. Poles's opinion is contradicted by the opinion of non-examining physicians who found that Plaintiff's impairments were not severe. (R. at 89-119.)

The ALJ rejects Dr. Poles's opinion because she finds it is based on Plaintiff's subjective complaints, which she found to be unreliable. (R. at 67.) However, since the Court has determined the ALJ erred in considering the Plaintiff an unreliable source, the

---

[2] If the ALJ is referring to Plaintiff's use of a stepmaster and stationary bike during his exercises being greater than the exercise he reported, that information is far past the DLI, from January 10, 2014. (R. at 333). Plaintiff subsequently returned to Dr. Poles two months after that report of exercise and still reported chronic neck pain rated at a seven out of ten, for which he was renewed a pain prescription. (R. at 325.) Plaintiff consistently reports his exercise to his doctors and does report exercising in February 2012 on his "Exertional Daily Activities Questionnaire" but doesn't ever clarify what type of exercise, which was not discussed at his hearing in April 2014. (R. at 76-91, 231.) Furthermore, the ALJ does not state which specific limitations this activity would contradict. (R. at 66.) The ALJ and Defendant later noted that Plaintiff's limitations as determined by Dr. Poles were inconsistent with reports of Plaintiff exercising. (R. at 66; Def.'s Br. at 12.) However, the therapeutic benefits of exercises and the inability for such skills to transfer to meaningful work ability, as previously discussed, should not discredit Dr. Poles's opinion. See *Vertigan*, 260 F.3d at 1050.

treating physician's opinion cannot be validly rejected simply because it was based on Plaintiff's subjective complaints. *Lapeirre-Gutt v. Astrue*, 382 F. App'x 662, 665 (9th Cir. 2010). Here, even the further reasons were not substantial enough to support the ALJ's rejection of Dr. Poles's conclusions.

After the ALJ summarizes Plaintiff's medical record and his visits with Dr. Poles and Dr. Bucholz during the relevant period, she goes on to conclude that these findings are "minimal" because Plaintiff is missing several functional limitations stemming from a degenerative disc disease. (R. at 65 ("there is no evidence of nerve root impingement, muscle wasting or atrophy, central canal stenosis, loss of motor function, or inability to effective [sic] ambulate").) However, "[a]n ALJ may not exclude a physician's testimony for lack of objective evidence of impairments not referenced by the physician. Rather, an ALJ must evaluate the physician's assessment using the grounds on which it is based." *Orn*, 495 F.3d at 635 (an ALJ was not permitted to reject a doctor's opinion of plaintiff's limitations based on decreased range of motion or neurological deficits when the doctor did not claim that plaintiff's limitations were caused by those issues). Dr. Poles's assessment is specifically based on limitations due to Plaintiff's neck pain from his cervical spondylosis and anxiety/panic attacks. (R. at 257.) The ALJ thus erred in discounting Dr. Poles's opinion of Plaintiff's limitations because his opinion is based on Plaintiff's neck pain and anxiety/panic attacks, and not any neurological deficits or any other symptoms the ALJ listed.

Defendant also argues that Dr. Poles's opinion on Plaintiff's moderate/moderately severe limitations on mental functioning is inconsistent with the lack of mental treatment Plaintiff sought during the relevant period. (Def.'s Br. at 13.) Defendant further argues that Plaintiff did not consistently report nor discuss his mental health symptoms with Dr. Poles or Dr. Bucholz, who both consistently noted appropriate affect at visits. (Def.'s Br. at 8.) The ALJ similarly notes that Plaintiff did not seek any formal mental health treatment for his mental impairments. (R. at 66.) However, the ALJ can consider evidence past Plaintiff's DLI that is probative of Plaintiff's pre-DLI disability. *Turner v.*

Comm'r of Social Security, 613 F.3d 1217, 1228–29 (9th Cir. 2010). Therefore, the diagnosis of Plaintiff's depression/anxiety and subsequent (and continuing) treatment with Xanax on January 30, 2012 should have at least been considered to clarify the severity of Plaintiff's reported depression/anxiety at the two appointments with Dr. Poles during the relevant period and its disabling effects. (R. at 281, 290-367.)

Although Defendant argues that Dr. Poles's opinion on mental impairments should be given less weight because he is not specialized in mental health, Plaintiff is correct in stating that Dr. Poles's opinion on Plaintiff's depression as his treating physician should not be minimized just because he is not specialized in mental health. (Def.'s Br. at 14-15; Pl.'s Br. at 14-15); s*ee Lester*, 81 F.3d at 833 (ALJ improperly rejected treating physician's opinion on plaintiff's mental health impairments because his opinion is still "competent psychiatric evidence" and cannot be discredited just because he is not a board certified psychiatrist); *see Sprague v. Bowen*, 812 F.2d 1226, 1232 (9th Cir. 1987) (it is "clearly erroneous" to require that psychiatric evidence only come from Board-certified psychiatrists). This was especially true in *Lester* and *Sprague*, where the treating physician provided treatment for the plaintiff's psychiatric impairment, including the prescription of psychotropic medication. *Lester*, 81 F.3d at 833; *Sprague*, 812 F.2d at 1232. Similarly, despite Dr. Poles's lack of mental health specialty, his opinion as Plaintiff's treating physician should not be rejected because he diagnosed Plaintiff with anxiety/depression and continually prescribed Xanax for treatment of this mental disorder.

The ALJ notes there is "no objective evidence" in support of the rate or frequency of panic attacks, nor subsequent indication of limitations to Plaintiff's functioning during the relevant period. (R. at 66, 281.) Unlike medical impairments, psychiatric impairments are not as readily supported by traditional objective evidence like laboratory tests. *Sanchez v. Apfel*, 85 F. Supp 2d. 986, 992 (C.D. Cal. 2000) (citing *Sprague*, 812 F.2d at 1232). At this step in Plaintiff's DIB proceedings, the evidence need only satisfy step two's "de minimis" standard, meant to "dispose of groundless claims." *Smolen*, 80 F.3d

at 1290 (citing *Bowen v. Yuckert*, 482 U.S. 137, 153-54 (1987)). Although Dr. Poles did not note any specific symptoms of depression/anxiety at Plaintiff's appointments, he did note depression under the "Problem List" for both appointments during the relevant period, in January 2012 he noted why Plaintiff's anxiety had developed (Plaintiff's father moving into his group home due to Parkinson's), and he subsequently diagnosed and treated for "depression/anxiety" with Xanax. (R. at 260, 263, 280.) Dr. Bucholz does not mention specific findings about Plaintiff's mental health at appointments during the relevant period, but similarly mentions Plaintiff is positive for depression and/or anxiety multiple times after the DLI, and twice mentions difficulties with concentration. (R. at 291, 295, 299, 303, 307, 310, 314, 317, 320.) Further, Plaintiff testified that he suffered from three panic attacks per week in 2011, which would incapacitate him for up to an hour while he did breathing exercises, until Dr. Poles prescribed him Xanax. (R. at 88-89.) Considering both the *de minimis* standard for step two and the ALJ's lack of sufficient reasoning to discount Plaintiff's testimony, the ALJ should not have rejected Dr. Poles's opinion about Plaintiff's depression/anxiety and its limiting effects.

The ALJ also discredits Dr. Poles because he did not use any examples of examination findings to support his conclusion on a check-box form. (R. at 67; Def.'s Br. at 14.) An ALJ can reject check-off reports that do not contain any explanation for the bases of their conclusions. *Crane v. Shalala*, 76 F.3d 251, 253 (9th Cir. 1996). However, opinions in check-box form can be entitled to substantial weight when adequately supported, which could include experience with the patient and numerous medical records that have notes in support of the opinion. *Garrison,* 759 F.3d at 1013-14. Dr. Poles did provide some additional written explanation on his form to clarify that his opinion was based on Plaintiff's severe neck pain and anxiety/panic attacks. (R. at 259.) Additionally, the treatment record, both in the relevant period and after the DLI, does provide support in further explaining Plaintiff's neck pain with range of motion limitations, as well as reports, diagnosis, and treatment of his depression/anxiety. (R. at 324-365.) Therefore, the ALJ should not have discredited Dr. Poles's opinion just

because he used a check-box form, because it was accompanied by some explanation and further supported by the medical record and his relationship as Plaintiff's treating physician.

The ALJ and Defendant both cite a treatment gap as part of discrediting Dr. Poles's knowledge about Plaintiff's impairments. (R. at 63.) Plaintiff argues the treatment gap can be explained by difficulties in obtaining medical insurance due to his prescription narcotics for pain. (Pl.'s Br. at 9.) However, the ALJ states that the 2012 letter from Dr. Poles, which supports Plaintiff's insurability for medical coverage due to his use of prescription high dose opioids, has "no bearing to disability." (R. at 67.) This argument is furthered by Defendant, who argues that there was no evidence of any difficulties in obtaining treatment. (Def's Br. at 11.) However, the "[ALJ] cannot draw any inferences about an individual's symptoms and their functional effects from a failure to seek or pursue regular medical treatment without first considering any explanations that the individual may provide, or other information in the case record, that may explain infrequent or irregular medical visits." S.S.R. 96–7p at 7–8. Furthermore, "[a plaintiff's] failure to receive medical treatment during the period that he had no medical insurance cannot support an adverse credibility finding." *Orn*, 495 F.3d at 638. In addition to Dr.Poles's letter in the record, Plaintiff testified that he "couldn't find health insurance for the longest time" because of his pre-existing neck condition, which raised the cost of the limited available insurance $2,000 per month, and that he had "just" been approved for Arizona Health Care Cost Containment System (AHCCCS, Arizona Medicaid) and benefits at his April 2014 hearing. (R. at 82.) Therefore, the ALJ erred in stating that the reasoning behind the gaps in Plaintiff's treatment was not relevant and instead should have taken into account Plaintiff's lack of insurance and its possible effect on his ability to see his physicians.

Defendant also argues that Dr. Poles's report does not have any indication of when his conclusions about Plaintiff's limitations would apply, which undermines his opinion because the report was done more than one year after Plaintiff's DLI and is based on

limited knowledge of Plaintiff's everyday functioning. (Def.'s Br. at 11, 14.) However, "medical evaluations made after the expiration of claimant's insured status are relevant to an evaluation of the preexpiraiton condition." *Smith v. Bowen*, 849 F.2d 1222, 1225 (9th Cir. 1988). Although an ALJ can give less weight to the opinion of a treating physician who has had only limited observation of the plaintiff, this does not justify giving comparably greater weight to the opinion of a doctor who has never examined the plaintiff, such as a non-examining physician, unless the treating physician had not seen the plaintiff in several years. *Lester*, 81 F.3d at 832; *Vincent v. Heckler*, 739 F.3d 1393, 1395 (9th Cir. 1984). Therefore, the ALJ cannot reject Dr. Poles's report simply because it was done one year after Plaintiff's DLI nor because Dr. Poles had last seen Plaintiff only six months, but not several years, prior to completing the report. (R. at 66.) The ALJ could give comparably less weight to Dr. Poles's opinion based on limited observation of Plaintiff, but not to such an extent that she gave greater weight to the opinions of the non-examining physicians. Therefore, the ALJ erred in heavily disregarding Dr. Poles's opinion on the grounds that it was completed a few months after his last visit and a year after the DLI.

C. The ALJ Erred in Assigning Greater Weight to Opinions of Non-Examining Physicians Relative to Plaintiff's Treating Physician

While both the ALJ and Defendant gave "little weight" to Plaintiff's treating physician, Dr. Poles, they support the use of the opinions of the non-examining State agency medical and psychological consultants. (R. at 67, Def.'s Br. at 14-15.) "The opinion of a non-examining physician cannot by itself constitute substantial evidence that justifies the rejection of the opinion of an examining of treating physician." *Lester*, 813 F.3d at 831. An ALJ can reject a treating or examining physician's opinion based in part on the testimony of a non-examining physician, but only when supported by an "abundance of evidence." *Magallanes v. Bowen*, 881 F.2d 747, 751-52 (9th Cir. 1989) (Court upheld the ALJ's rejection of the treating physician's opinion based on non-examining physician testimony with further support from laboratory test results, contrary

reports from examining physicians, and plaintiff's testimony that conflicted with her treating physician's opinion). However, "[m]erely to state that a medical opinion is not supported by enough objective findings 'does not achieve the level of specificity our prior cases have required, even when the objective factors are listed seriatim.'" *Rodriguez v. Brown*, 876 F.2d 759, 762 (9th Cir. 1989) (quoting *Embrey v. Bowen*, 849 F.2d 418, 421 (9th Cir. 1988)). The ALJ gave greater weight to the opinions of the state consultants (Dr. Elliot Salk, Ph.D.; Dr. Adrienne Gallucci, Psy.D.; and Dr. Nadine Keer, D.O.) because they provided "specific reasons" to support their findings that Plaintiff was not disabled. (R. at 67.) However, the non-examining physicians briefly summarized a list of Plaintiff's medical record for the relevant period and then concluded there is "insufficient evidence" to find that Plaintiff's impairments were of a great enough severity to be disabling. (R. at 98-119.) Simply listing Plaintiff's medical record and concluding there is a lack of evidence in his medical record is not enough to support the ALJ's use of the non-examining physicians' opinions instead of Plaintiff's treating physician's opinion.

The only other specific reason that the ALJ pointed out to support the non-examining physicians' findings was that Plaintiff does not have any neurological deficits despite his degenerative spondylosis. (R. at 67.) However, the ALJ cannot use this reason to exclude Dr. Poles's opinion of Plaintiff's impairment. As discussed above, Dr. Poles did not claim Plaintiff's limitations were caused by a neurological deficit, and the ALJ must evaluate his assessment on the grounds on which he based it (neck pain and anxiety/panic attacks). *See Orn*, 295 F.3d at 635. Both the ALJ and the non-examining physicians simply listed findings from Plaintiff's medical record and then concluded there was not enough evidence to support Dr. Poles's opinions without pointing to specific, objective evidence from the record that contradicted or otherwise did not support his opinion. Thus, the ALJ erred in rejecting the treating physician's opinion because there was not the "abundance" of information required to support the opinion of the non-examining physicians.

Defendant also further supports the ALJ's reliance on the non-examining physicians by arguing that two consultants were mental health specialists and did not conclude that Plaintiff suffered from a severe mental impairment that was disabling. (Def.'s Br. at 14-15.) Opinions of a specialist are given more weight in a disability benefits proceeding than the opinions of a nonspecialist. 20 C.F.R. § 404.1527(d)(5). However, a treating physician's opinion that considers the combined impact of a plaintiff's physical and mental limitations is entitled to special weight. *Lester*, 81 F.3d at 833. Considering that their opinions cite a lack of evidence or are unsupported by the record, the non-examining psychological consultants' specialties in mental health are not enough to constitute the substantial evidence to supersede the treating physician's opinion that considered Plaintiff's combined impairments.

Furthermore, the mental health consultants were unable to support their own assertions. As noted above, Dr. Gallucci's opinion that there was "insufficient evidence" is not enough to support rejection of Dr. Poles's opinion. *See Rodriguez*, 876 F.2d at 762. Dr. Salk determined Plaintiff's mental impairments were not disabling because his anxiety was managed by medication, an assertion similarly noted by the ALJ. (R. at 66, 101-02.) But, as noted above, while it is true that a finding of disability cannot be supported when an impairment is well-controlled by medication, these assertions must be supported by evidence from the medical record. *See Berry v. Astrue*, 622 F.3d 1288, (9th Cir. 2010) (ALJ used medical records that specifically supported his conclusion that plaintiff's impairments had improved and were well controlled by the prescribed treatment, resulting in minimal limitations); *Ramirez v. Comm'r of Soc. Sec. Admin.*, 463 Fed. App'x 640, 642 (9th Cir. 2011) (ALJ properly concluded that plaintiff's mental impairment was well controlled by medication with only mild restrictions in functioning because plaintiff's record showed treatment and resolution of his mood disorder). Neither the ALJ nor Dr. Salk justify their opinion by referencing any information from the record showing adequate improvement or resolution of Plaintiff's mental impairment, even past the DLI. (R. at 67, 101-02.) Indeed, Dr. Poles continued to prescribe Xanax for Plaintiff's

anxiety/depression through his last visit with Plaintiff in the record, and Dr. Bucholz began to note Plaintiff's depression or anxiety on June 28, 2012 and continued to note it until his last visit in the record. (R. at 292, 296, 300, 304, 314, 318, 320, 352.)

D. The Credit-As-True Rule Does Not Apply

For all of these reasons, the ALJ erred by not providing substantial evidence to find that Plaintiff does not have a medically severe impairment or combination of impairments. The credit-as-true rule only applies in cases that raise "rare circumstances" that permit the Court to depart from the ordinary remand rule under which the case is remanded for additional investigation or explanation. *Treichler v. Comm'r of Soc. Sec. Admin.*, 775 F.3d 1090, 1099–1102 (9th Cir. 2014). These rare circumstances arise when three elements are present. First, the ALJ fails to provide legally sufficient reasons for rejecting medical evidence. *Id*. at 1100. Second, the record must be fully developed, there must be no outstanding issues that must be resolved before a determination of disability can be made, and further administrative proceedings would not be useful. *Id*. at 1101. Further proceedings are considered useful when there are conflicts and ambiguities that must be resolved. *Id*. Third, if the above elements are met, the Court may "find[] the relevant testimony credible as a matter of law . . . and then determine whether the record, taken as a whole, leaves 'not the slightest uncertainty as to the outcome of [the] proceeding.'" *Id*. (citations omitted).

The ordinary remand rule applies here. This case involves evidentiary conflicts that must still be resolved, and there is still uncertainty as to the outcome of the proceeding, principally because the ALJ improperly stopped at step two of the disability analysis.

IV. CONCLUSION

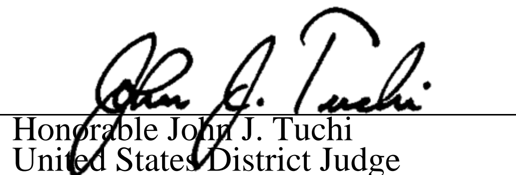
The ALJ improperly rejected Plaintiff's testimony about his subjective complaints, and treating physician Dr. Poles's opinions about Plaintiff's limitations. She thus improperly weighed the opinions of non-examining physicians and did not have "substantial evidence to find that the medical evidence clearly established that [Plaintiff]

did not have a medically severe impairment or combination of impairments." *See Webb,* 433 F.3d at 687. The Court does not intimate that Plaintiff will or will not succeed in proving that he is entitled to DIB. *See Webb*, 433 F.3d at 688. But it does find that the ALJ lacked substantial evidence to conclude that Plaintiff did not satisfy step two's "de minimis" standard, meant only to "dispose of groundless claims." *Smolen*, 80 F.3d at 1290 (citing *Bowen v. Yuckert*, 482 U.S. 137, 153-54 (1987)).

IT IS THEREFORE ORDERED reversing the decision of the Administrative Law Judge (R. at 59-69) as upheld by the Appeals Council. (R. at 4-7.) The Court remands this matter for further proceedings consistent with this Order.

IT IS FURTHER ORDERED directing the Clerk of Court to enter judgment accordingly and close this matter.

Dated this 14th day of July, 2017.



Honorable John J. Tuchi
United States District Judge