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UNITED STATES DISTRICT COURT  
CENTRAL DISTRICT OF CALIFORNIA

CARLOS B. JR.,  
Plaintiff,  
v.  
ANDREW SAUL, Commissioner of  
Social Security,  
Defendant.

Case No. 2:20-cv-01359-KES

MEMORANDUM OPINION AND  
ORDER

**I.**

**BACKGROUND**

In September 2016, Carlos B. Jr. (“Plaintiff’s”) mother applied on behalf of Plaintiff for Supplemental Security Income (“SSI”) disability benefits alleging that he became unable to work on October 24, 2014. Administrative Record (“AR”) 163-72. On January 7, 2019, an Administrative Law Judge (“ALJ”) conducted a hearing at which Plaintiff, who was represented by counsel, appeared and testified with the assistance of a Spanish interpreter.<sup>1</sup> AR 47-65. On January 24, 2019, the ALJ issued an unfavorable decision. AR 34-42.

<sup>1</sup> Plaintiff was born and raised in the United States where he graduated from high school. He explained that he could speak English, but he preferred Spanish. AR 51-52.

1 The ALJ found that Plaintiff suffered from the medically determinable  
2 impairments of “seizure disorder; possible learning disorder versus possible  
3 borderline intellectual functioning; and mood disorder.” AR 36. The ALJ  
4 determined that Plaintiff’s mental impairments did not satisfy a Listing. AR 36-37.  
5 Despite his impairments, the ALJ found that Plaintiff had a residual functional  
6 capacity (“RFC”) to perform medium work with seizure precautions (i.e., “no  
7 working around unprotected heights, open bodies of water, and dangerous  
8 machinery”) and the following additional limitations to account for his mental  
9 impairments:

10 The claimant is limited to non complex routine tasks, but no tasks  
11 requiring hypervigilance, and is not responsible for the safety of  
12 others. Further, the claimant is precluded from jobs requiring public  
13 interaction, and no fast paced work such as rapid assembly or  
14 conveyor belt work.

15 AR 37.

16 Plaintiff had no past relevant work. AR 57-58. Based on this RFC and the  
17 testimony of a vocational expert, the ALJ found that Plaintiff could work as an  
18 industrial cleaner, furniture cleaner, or “Cleaner II.” AR 41. The ALJ concluded  
19 that Plaintiff was not disabled from the date of his September 2016 application  
20 through the date of the ALJ’s January 2019 decision. AR 42.

## 21 II.

### 22 ISSUE PRESENTED

23 Whether the ALJ erred in evaluating the September 2018 medical source  
24 statement (“MSS”) of treating physician Frederick Thomas, M.D., at AR 619-22.  
25 (Dkt. 24, Joint Stipulation [“JS”] at 4.)  
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**III.**  
**DISCUSSION**

**A. Law.**

“As a general rule, more weight should be given to the opinion of a treating source than to the opinion of doctors who do not treat the claimant.” Turner v. Comm’r of SSA, 613 F.3d 1217, 1222 (9th Cir. 2010) (citation omitted). This rule, however, is not absolute. Where, as here (see AR 75, 580-83), “a nontreating source’s opinion contradicts that of the treating physician . . . the opinion of the treating physician may be rejected only if the ALJ gives specific, legitimate reasons for doing so that are based on substantial evidence in the record.” Andrews v. Shalala, 53 F.3d 1035, 1041 (9th Cir. 1995) (citation omitted).<sup>2</sup>

**B. Summary of the Medical Evidence.**

Because Plaintiff applied for SSI benefits, the relevant period for establishing disability began at the time of his application on September 30, 2016. 20 C.F.R. § 416.335. For context, however, the Court has summarized all the AR’s medical records.

**1. Childhood through 2014.**

Plaintiff was born in February 1976. AR 410. He suffered from seizures since contracting meningitis at about the age of one.<sup>3</sup> AR 53, 410. He had a ventricular shunt installed to treat brain swelling. AR 673.

In 2014, he reported that a jail physician five years earlier had started him on Keppra (brand name for levetiracetam), which had helped control his seizures. AR 308. Shortly after being released from prison in 2014, he had a series of visits to

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<sup>2</sup> This case law applied regulations in place for applications filed before March 27, 2017. As Plaintiff’s application was filed in 2016, the Court need not apply the new regulations to Plaintiff’s claim.

<sup>3</sup> Elsewhere, he stated that his seizures started at about the age of 14. AR 308.

1 hospital emergency rooms complaining of chest pain, headaches, and seizures. See  
2 AR 676, 688 (8/22/14 admit date at Downey Regional Medical Center [“Downey”]  
3 which prescribed anti-seizure medication), AR 640 (9/6/14 admit date at Downey).  
4 The ER staff noted that since his release from prison, he had “not established ...  
5 new MD” to refill his prescriptions. AR 647. He was given Dilantin (brand name  
6 for phenytoin) and counselled to follow up with a primary care doctor. AR 647-  
7 48.

8 Just one day later on September 7, 2014, Plaintiff was admitted to the  
9 Cedars-Sinai ER complaining of headaches. AR 252-53, 344.<sup>4</sup> Lab tests showed a  
10 low phenytoin level of 2.0, and he received more Dilantin. AR 275, 346-47.  
11 Plaintiff returned to the Cedars-Sinai ER on September 9, 2014, where he was  
12 vomiting on arrival. AR 252-53. He reported taking Dilantin regularly and not  
13 suffering a seizure for 5 days, but his phenytoin level was still low at 5.1. AR 255,  
14 265, 272-73; see also AR 289 (9/14/14 admit date at Cedars-Sinai ER).

15 Plaintiff established regular treatment at Cedars-Sinai through the rest of  
16 2014. Those records show that Plaintiff had a low phenytoin level of 2.0 on  
17 September 19, 2014. AR 302. He started taking Depakote (brand name for  
18 valproic acid or VPA) to address his headaches and seizures. AR 312. By  
19 October, his doctors had developed a plan to discontinue Dilantin over three  
20 weeks. AR 302. His VPA level in October was 70, which is in the therapeutic  
21 range for epilepsy. AR 305, 312, 348. By November, he was reporting 5-10  
22 seizures per month. AR 304. By December 2014, his phenytoin level was 2.0  
23 (apparently consistent with discontinuing Dilantin) and his VPA level was 70, but  
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25 <sup>4</sup> During this September 2014 visit, Plaintiff stated that seven years earlier he  
26 had quit drugs and alcohol. AR 253. He had been at that time drinking 18 beers a  
27 day and taking cocaine, crack, and marijuana. Id. In October 2014, he reported  
28 drinking alcohol every week. AR 574. At the hearing, he denied ever having used  
alcohol or non-prescribed drugs. AR 50-51.

1 he had another ER visit at Cedars-Sinai. AR 306-07, 452. He was still reporting  
2 “frequent breakthrough seizures but does not keep a log.” AR 307. His doctor  
3 recommended that he keep a seizure log, but the administrative record does not  
4 contain one. AR 308, 623.

5 In connection with a prior application for disability benefits, Plaintiff  
6 attended psychological and internal medicine consultative examinations. AR 573,  
7 581. He reported experiencing seizures 2-3 times per week. AR 581.

## 8 **2. 2015.**

9 In January 2015, Plaintiff had his initial visit with the Central Neighborhood  
10 Health Foundation (“CNHF”) and reported that his primary care physician was at  
11 Cedars-Sinai. AR 450. He returned for a physical in February, at which point  
12 CNHF ordered lab work and sought a referral to a “neurologist ASAP.” AR 453.  
13 The same request was repeated in March (AR 455) and April (AR 457). In April,  
14 CNHF requested lab work to determine Plaintiff’s Keppra and Depakote levels  
15 “stat.” AR 457; see also AR 461, 466, and 448 (showing high VPA level in April,  
16 normal Depakote level in July, low VPA level in August).

17 In April, Plaintiff started seeing a neurologist, Munther Hijazin, M.D., who  
18 took over management of Plaintiff’s anti-seizure medications. AR 458-59. In  
19 May, July, and August 2015, Plaintiff received medication refills from CNHF. AR  
20 460, 464, 470. CNHF continued to request lab work to determine the level of  
21 medications in Plaintiff’s blood and, as a result of test results in September,  
22 administered extra VPA tablets. AR 471, 475. In October 2015, Dr. Hijazin  
23 advised him to increase his dosage of Depakote. AR 440. In December 2015, he  
24 had another blood draw to assess his medication levels. AR 439.

## 25 **3. 2016.**

26 Plaintiff continued under the care of both his neurologist and CNHF. AR  
27 428-31 (CNHF appointments from May-August 2016). On June 1, 2016, CNHF  
28 referred him to the ER due to “uncontrolled seizure with hypoglycemia.” AR 394,

1 420.

2 On June 15, 2016, Plaintiff visited Dr. Hijazin. Plaintiff reported having  
3 seizures “a few times a month,” but Dr. Hijazin noted that he was a “poor  
4 historian” who could not provide medical records, and his seizure disorder was  
5 “not well controlled.” AR 506-07, 566-67. Dr. Hijazin increased Plaintiff’s  
6 dosage of Depakote. AR 507.

7 Plaintiff saw CNHF on August 3 and 17, 2016. AR 421, 428. He reported  
8 that his last seizure had occurred in July. AR 421. On August 19, 2016, however,  
9 Plaintiff went to the ER reporting several recent seizures. AR 410, 630. Although  
10 he reported taking his medications as prescribed, his Dilantin level was less than  
11 2.5 and he was diagnosed with a “subtherapeutic dilantin level.” AR 632, 410-12.

12 In September 2016, CNHF noted, “He isn’t to [sic] medications,” and Dr.  
13 Hijazin adjusted his medications. AR 564. Lab work from November 2016  
14 showed “no Dilantin” but “Depakote OK.” AR 517-18.

#### 15 4. 2017.

16 In January 2017, CNHF noted a “need to obtain blood work” to ascertain  
17 Plaintiff’s medication levels. AR 562. In February 2017, Plaintiff underwent a  
18 psychiatric consultative examination, reporting his anti-seizure medications. AR  
19 553. The examiner found that Plaintiff had “poor effort” during the examination  
20 and a “lack of cooperation with testing.” AR 554.

21 In March 2017, Dr. Hijazin opined, “he is doing very well on fycompa  
22 [brand name for perampanel]; he is able to tolerate well but he still having  
23 breakthrough seizures and his medication level are subtherapeutic.” AR 560; AR  
24 561 (“noncompliant with medication”). Dr. Hijazin also noted that Plaintiff was  
25 “an excellent candidate for VNS [vagus nerve stimulation] but he refused.” AR  
26 561.

27 In May 2017, Dr. Hijazin assessed that Plaintiff was doing “about the same”  
28 but Plaintiff still wanted only “conservative care.” AR 701-02. On September 18,

1 2017, CNHF recorded that Plaintiff has a seizure “yesterday,” noting “Dilantin  
2 level.” AR 611.

3 **5. 2018.**

4 In January 2018, CNHF noted “breakthrough sz [seizure] off rx  
5 [prescription].” AR 607. In February, Dr. Hijazin increased Plaintiff’s Fycompa  
6 and again recommended VNS. AR 705. After watching a video about VNS,  
7 Plaintiff reported that he still “wanted to think about it.” AR 707. By April,  
8 Plaintiff had “improved” with Fycompa, and he chose to “continue conservative  
9 treatment” rather than pursuing VNS. AR 709.

10 By May, however, Plaintiff’s primary care provider (“PCP”) at CNHF, John  
11 Rastegar, M.D., noted, “Patient is non-compliant.” AR 215, 601. Dr. Rastegar  
12 registered frustration, stating “suggests if he [does ]not listen needs to change pcp.”  
13 AR 601.

14 Plaintiff continued with the same medications in June (AR 711), but in July,  
15 lab work showed a low Dilantin level of 1.24 (AR 716). He continued to have low  
16 Dilantin levels in August and September. AR 593 (“Dilantin level  
17 subtherapeutic”); AR 591 (same); AR 588 (same).

18 In October, Dr. Hijazin again noted that Plaintiff was “noncompliant” with  
19 his prescribed medications. AR 713. Plaintiff had not been taking his Fycompa  
20 and his Dilantin level was “not therapeutic.” *Id.*

21 **C. The ALJ’s Evaluation of Dr. Thomas’s MSS.**

22 On September 28, 2018, CNHF’s Dr. Thomas wrote an MSS. AR 619. He  
23 had treated Plaintiff in May 2016. *See* AR 431 (noting increased dosage of VPA  
24 and referral to neurologist pending), January 2018 (AR 607 noting “breakthrough  
25 sz off rx”), September 2018 (AR 586 noting Dr. Thomas is now “PCP”).

26 Despite Plaintiff being a 42-year-old man with no reported orthopedic  
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1 injuries,<sup>5</sup> Dr. Thomas opined that Plaintiff could not lift 10 pounds more than  
2 occasionally. AR 621; compare AR 200 (Plaintiff’s friend did not identify  
3 “lifting” as an area of difficulty). Dr. Thomas opined that Plaintiff could not stand  
4 longer than 15-20 minutes or sit longer than 30-45 minutes at a time. AR 620-21.  
5 He opined that Plaintiff could stand/walk for less than 2 hours/day and sit for a  
6 total of 2-4 hours/day, implying that Plaintiff would need to spend the remainder of  
7 each day lying down. Id. Regarding Plaintiff’s seizure disorder, he noted, “pt on  
8 dual anti-sz regimen w/o complete control.” AR 619. He also noted, “Pt is unable  
9 to consistently adequately sustain ADLs, instrumental ADLs, and mobility  
10 required ADLs. Pt is under neuro psychiatric management for his symptoms as  
11 well.” AR 622. He opined that Plaintiff was “incapable” of even “low stress”  
12 work and would need 2 or 3 unscheduled breaks every 2 hours, and he would still  
13 miss work more than 4 days each month. AR 620-21. He opined that Plaintiff had  
14 limitations reaching, handling, and fingering above shoulder level. AR 621. If  
15 credited, Dr. Thomas’s extreme opinions would preclude all work. AR 63.

16 The ALJ gave Dr. Thomas’s MSS statement “little” weight. AR 39. The  
17 ALJ noted its extreme nature, limiting Plaintiff to “less than sedentary work,”  
18 restricting him from even “low stress” work, and finding that Plaintiff would miss  
19 work more than 20% of the time. Id. The ALJ found these opinions inconsistent  
20 with the medial evidence. Id. Regarding his mental health, the ALJ noted that  
21 Plaintiff had generally normal mental status examinations that did not indicate  
22 significant symptoms of anxiety or depression. Id. citing AR 631 (8/19/16 ER visit  
23 noting normal speech, appropriate affect, and cooperative attitude) and AR 707  
24 (2/27/18 neurology appointment noting no dizziness, headaches, or symptoms  
25 other than seizures, no medications other than anti-seizure medications, and  
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27 <sup>5</sup> Plaintiff sought SSI benefits on the basis of “seizures” and a “learning  
28 disability.” AR 186.

1 Plaintiff was able to follow instructions and consider treatment choices). The ALJ  
2 found that Plaintiff's "mood disorder" caused some mild or moderate functional  
3 limitations, but the restrictions in the RFC adequately accounted for those  
4 limitations. AR 36-37. Regarding Plaintiff's seizure disorder, the ALJ noted that  
5 Plaintiff had admitted at the hearing that he was non-compliant with his  
6 medications. AR 39.

7 This last observation was based on Plaintiff's hearing testimony. Plaintiff  
8 initially testified that he was compliant with his medications. AR 53. When the  
9 ALJ questioned why so many of his treating records found subtherapeutic levels of  
10 medication if he was compliant, he admitted that he would "sometimes" forget.  
11 AR 59-60.

#### 12 **D. Analysis of Claimed Errors.**

13 Plaintiff argues that the ALJ "failed to articulate a single specific and  
14 legitimate reason for rejecting Dr. Thomas's" MSS. (JS at 7.) First, Plaintiff  
15 argues that the ALJ's finding that Dr. Thomas's MSS was inconsistent with the  
16 weight of the medical evidence is not supported by substantial evidence. (*Id.* at 6.)  
17 Plaintiff points to medical records showing that Plaintiff had significant seizure  
18 activity in 2017 and 2018. (*Id.* at 6-7.)

19 While Dr. Thomas's opinion that Plaintiff suffers from an inadequately  
20 controlled seizure disorder is consistent with the medical evidence, the extreme  
21 functional limitations that he opines result from that disorder are not. Plaintiff fails  
22 to cite any other medical records suggesting that he could not lift 10 pounds  
23 frequently or stand/walk for at least 2 hours per day. To the contrary, he reported  
24 going on walks, shopping, and going to church 4 or 5 times per week. AR 58-59,  
25 198, 575. Plaintiff fails to cite any other medical records suggesting that the  
26 symptoms of his depression and anxiety were so severe that he could not handle  
27 even low-stress work. The ALJ cited records noting appropriate affect and no  
28 symptoms other than seizures. AR 39, citing AR 631 and 707. Thus, substantial

1 evidence supports the ALJ's finding of inconsistency.

2       Second, Plaintiff argues that Plaintiff's lack of medical compliance is not a  
3 legitimate reason to reject Dr. Thomas's MSS. (JS at 7.) As the ALJ noted (and as  
4 confirmed by the summary of Plaintiff's treating records above), Plaintiff  
5 consistently had subtherapeutic levels of anti-seizure medication in his blood  
6 whenever it was tested. Plaintiff therefore could not demonstrate that his seizure  
7 disorder would have caused functional limitations beyond those in the RFC even if  
8 he had taken his medications. AR 60 ("You can't say it's working or not working  
9 because you're not taking it every time. So we don't know what would happen if  
10 you took it all the time."). "Impairments that can be controlled effectively with  
11 medication are not disabling for the purpose of determining eligibility for SSI  
12 benefits." Warre v. Comm'r of the SSA, 439 F.3d 1001, 1006 (9th Cir. 2006). Dr.  
13 Thomas assessed Plaintiff's functional limitations based on an inadequately  
14 controlled seizure disorder. AR 619. The ALJ could properly give his MSS little  
15 weight rather than crediting opinions assessing functional limitations that might  
16 not have existed if Plaintiff had been compliant with his prescribed medications.

17       Lastly, Plaintiff argues that even if his seizures could be controlled with  
18 medication, the ALJ should have credited Dr. Thomas's MSS, because Plaintiff's  
19 forgetfulness is a symptom of his mental impairments. (JS at 7.) Plaintiff does not  
20 point to any medical evidence that his memory was too impaired for him to  
21 manage his medical appointments and prescriptions. Based on testing, his memory  
22 was assessed as "fair," and his ability to remember simple instructions was within  
23 normal limits. AR 575-76. He displayed "normal" behavior, judgment, and  
24 thought content. AR 441, 547. Plaintiff could understand discussions with his  
25 doctor. AR 486. He answered questions posed by his doctors properly. AR 701.  
26 He lived with his mother, and she would remind him to take his medications. AR  
27 59-60. None of his medical records reflect Plaintiff asking for help or strategies to  
28 remember his medication, such as using a special container or setting a kitchen

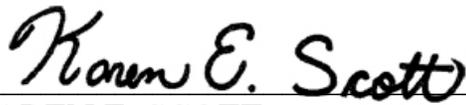
1 timer. Plaintiff has failed to demonstrate that he was too mentally impaired to  
2 remember to take his anti-seizure medications, such that Dr. Thomas's MSS  
3 reflects Plaintiff's highest level of potential functioning.

4 **IV.**

5 **CONCLUSION**

6 For the reasons stated above, IT IS ORDERED that the decision of the  
7 Commissioner shall be AFFIRMED. Judgment shall be entered consistent with  
8 this order.

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10 DATED: February 16, 2021

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13 KAREN E. SCOTT  
14 United States Magistrate Judge  
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