**UNITED STATES DISTRICT COURT**

**CENTRAL DISTRICT OF CALIFORNIA**

CHRISTOPHER KIRKPATRICK,

Plaintiff,

v.

CAROLYN W. COLVIN, Acting Commissioner of the Social Security Administration,

Defendant.

Case No. EDCV 13-02034 SS

**MEMORANDUM DECISION AND ORDER**

## I.

## INTRODUCTION

Christopher Kirkpatrick ("Plaintiff") seeks review of the final decision of the Commissioner of the Social Security Administration (the "Commissioner" or the "Agency") finding him eligible for Disability Insurance Benefits and Supplemental Security Income from January 22, 2011 through February 16, 2012, but denying him those benefits after February 16, 2012 because of

medical improvement. The parties consented, pursuant to 28 U.S.C. § 636(c), to the jurisdiction of the undersigned United States Magistrate Judge. For the reasons stated below, the decision of the Commissioner is AFFIRMED.

## II.

## PROCEDURAL HISTORY

Plaintiff applied for Title II Disability Insurance Benefits ("DIB") and Title XVI Supplemental Security Income ("SSI") on January 31, 2011 and February 3, 2011 respectively. (Administrative Record ("AR") 129, 136). In both applications, Plaintiff alleged a disability onset date of January 22, 2011. (Id.). The Agency initially denied Plaintiff's applications on March 8, 2011, (AR 62-66), and upon reconsideration on June 24, 2011. (AR 60-61). On August 5, 2011, Plaintiff requested a hearing before an Administrative Law Judge ("ALJ"). (AR 73). Plaintiff testified before ALJ Marti Kirby on September 7, 2012. (AR 32-57). The ALJ subsequently issued a partially favorable decision on September 25, 2012. (AR 10-26). The ALJ found that Plaintiff was disabled within the meaning of the Social Security Act from January 22, 2011 to February 16, 2012. (AR 26). The ALJ concluded, however, that Plaintiff's disability ended on February 17, 2012 due to medical improvement. (AR 10-11). On October 10, 2012, Plaintiff requested review of the ALJ's decision, which the Appeals Council denied on September 18, 2013. (AR 1-5). Plaintiff filed the instant action on November 15, 2013.

## III.

## FACTUAL BACKGROUND

Plaintiff was born on November 6, 1978 and was thirty-two years old on the date that he allegedly became disabled. (AR 35). Plaintiff did not graduate high school or obtain a GED. (AR 36). Plaintiff alleged that he could not engage in substantial gainful activity after January 22, 2011 due to Stage IV Hodgkin's lymphoma. (AR 175, 178). Plaintiff also claimed that he suffered from blood clots in his arms, fatigue due to chemotherapy, deep vein thrombosis ("DVT") in his shoulders, and peripheral neuropathy in his feet and hands. (AR 198, 216). Plaintiff's examining physicians found that these symptoms decreased in severity in the months following Plaintiff's last cycle of chemotherapy on October 14, 2011. (AR 458). On June 5, 2012, Plaintiff underwent surgery on his right knee to repair a torn meniscus suffered in January of 2012, which resulted in a Grade IV cartilage change to the knee. (AR 365).

Plaintiff also claimed he suffered from severe depression. (AR 22). Plaintiff visited a mental health facility in January of 2012. (AR 349). Examining physicians concluded Plaintiff was depressed, but was not a risk to himself or others and recommended that Plaintiff begin counseling. (AR 349, 352). Plaintiff was later prescribed the antidepressant medication Lexapro in May of 2012. (AR 390, 392).

**A. Medical History: Treating And Examining Physicians' Findings**

**1. Physical Condition**

On January 22, 2011, Plaintiff presented to the Desert Regional Medical Center ("Desert Regional") in Palm Springs, California with fatigue, malaise, a lack of energy and weight loss. (AR 235). On January 25, 2011, Plaintiff underwent a left inguinal lymph node biopsy which revealed that Plaintiff had Stage IV Hodgkin's lymphoma with bone marrow involvement. (AR 241-44, 275). Plaintiff commenced chemotherapy in early 2011 and started taking Coumadin for "bilateral upper extremity DVT caused by his malignancy[.]" (AR 275). On March 9, 2011, Plaintiff's physician at Desert Regional's Comprehensive Cancer Center ("Cancer Center"), Dr. Murthy Andavolu, reported that Plaintiff was "doing well," having regained his appetite, and gained a "significant amount" of weight. (Id.). Plaintiff reported no nosebleeds or gum bleeding, no blood in his stool, no fevers or night sweats, no neck pain or swelling, no abdominal pain, and no leg swelling. (Id.).

On March 23, 2011, Plaintiff saw Dr. Andavolu for a follow-up visit. (AR 277). Plaintiff reported continued weight gain, and his exam was otherwise unremarkable. (Id.). Plaintiff remained on Coumadin for his DVT and continued to undergo chemotherapy. (Id.). Plaintiff returned to Dr. Andavolu on April 13, 2011 after completing his third cycle of chemotherapy. (AR 279). Plaintiff reported no complaints and continued to

receive treatment for his DVT. (Id.). On May 4, 2011, nurse practitioner Cathy Warne conducted a follow-up examination of Plaintiff. (AR 282). Plaintiff complained of itchy eyes, nasal congestion, and tenderness in his mouth. (Id.). He reported purposeful weight loss, but no headaches, fevers, night sweats, abdominal pain, chest pain, swelling, or shortness of breath. (Id.). Nurse Warne reported that Plaintiff "tolerated [his] chemotherapy well and had a good clinical response." (Id.). Plaintiff's PET-CT scan showed a "complete response." (Id.) Dr. Andavolu confirmed the nurse's findings in an additional report and noted he increased Plaintiff's Coumadin to 7.5 mg daily two days earlier. (AR 284).

On May 11, 2011, Plaintiff underwent a bone marrow biopsy. (AR 286). Plaintiff tolerated the procedure well, (id.), and a microscopic examination of his biopsied bone marrow revealed no evidence of Hodgkin's lymphoma. (AR 290). On June 1, 2011, Plaintiff reported muscle and bone aches, but no other remarkable symptoms. (AR 467). Dr. Andavolu noted on June 30, 2011 that Plaintiff continued to gain weight, his groin lymphadenopathy had disappeared, and he reported no chest or abdominal pain. (AR 466). Plaintiff continued to do well throughout July 2011 and showed signs of near-complete resolution of his Hodgkin's lymphoma. (AR 464). Plaintiff also improved throughout August 2011, showing no signs of fever, swelling, weight loss, chest pain, abdominal pain, or distress. (AR 462). Plaintiff continued to tolerate his chemotherapy well throughout September 2011. (AR 460). After briefly increasing Plaintiff's Coumadin

to 10 mg daily in late August 2011, Dr. Andavolu lowered Plaintiff's dose back to 7.5 mg daily on September 22, 2011. (AR 462, 460).

On October 3, 2011, Plaintiff visited Dr. Apollo Gulle in Yucca Valley, California to discuss his lab results. (AR 342). Plaintiff reported no fatigue, fever, night sweats, coughing, chest pain, irregular heartbeat, abdominal pain, constipation, diarrhea, or vomiting. (Id.). Plaintiff was not under any apparent distress, appeared well-nourished, and well-developed. (Id.). Plaintiff's lungs were clear, his heart rhythm was regular, his abdomen was soft and non-tender, and his extremities showed no signs of edema or cyanosis. (Id.). Dr. Gulle noted that Plaintiff's cancer was in remission and his DVT in the upper extremities remained chronic. (Id.). Dr. Gulle prescribed Plaintiff Fenofibrate (160 mg) and Nexium (40 mg), and modified his Coumadin dosage to 5 mg. (AR 343). At the time of his visit, Plaintiff weighed 234 pounds. (AR 342).

On October 19, 2011, Plaintiff visited Dr. Andavolu for a follow-up appointment. (AR 458). Dr. Andavolu reported that Plaintiff was doing well after completing his last cycle of chemotherapy on October 14, 2011. (Id.).

On November 22, 2011, Plaintiff returned to Dr. Gulle for a follow-up examination. (AR 340). Plaintiff reported itchy and dry feet, but no other remarkable symptoms. (Id.). Dr. Gulle prescribed Lidex solution (.05%) for Plaintiff's skin condition

and Plaintiff continued to take Fenofibrate, Coumadin and Nexium. (Id.). At the time of his visit, Plaintiff weighed 237 pounds.

On December 8, 2011, Plaintiff again presented with no signs of fatigue, fever, night sweats, distress, respiratory problems, or any other remarkable complications. (AR 338). Plaintiff reported chest congestion, an itchy throat, a runny nose and body aches. (Id.). Dr. Gulle prescribed Plaintiff amoxicillin (500 mg) in addition to his regular medications. (AR 339). Plaintiff weighed 236 pounds at the time of his examination. (AR 338).

Plaintiff returned to Dr. Gulle on January 16, 2012 complaining of a swollen right knee due to an attempt to return to work as a construction worker. (AR 336). Dr. Gulle noted that although Plaintiff experienced swelling and pain in his right knee, x-rays of the knee were unremarkable and Plaintiff reported no history of trauma, weakness or numbness. (Id.). Dr. Gulle diagnosed Plaintiff with a sprained right knee and recommended treatment with NSAIDs, ice and a wearable immobilizer. (Id.).

On January 18, 2012, Plaintiff returned to Dr. Andavolu. (AR 457). Dr. Andavolu noted that Plaintiff's cancer was in complete remission, although his DVT persisted. (Id.). Plaintiff complained of an injury to his right knee, which required the use of crutches. (Id.). Plaintiff reported no additional complaints. (Id.).

On February 1, 2012, Plaintiff visited Dr. Jeffrey Seip in Yucca Valley for a knee examination. (AR 422). Plaintiff reported mild joint pain and denied any locking, popping, or other mechanical symptoms of the right knee. (Id.). Plaintiff also described a stable and nonprogressive pattern of symptoms. (Id.). Dr. Seip concluded Plaintiff was not at risk of falling, diagnosed Plaintiff with a sprain of the right lateral collateral knee ligament, and referred Plaintiff to physical therapy. (AR 423).

At a February 8, 2012 physical therapy session, Plaintiff reported mild to moderate knee pain, which the physical therapist noted was "significantly decrease[d]" by his knee brace. (AR 359). The physical therapist began Plaintiff on a treatment plan that included therapeutic and strengthening exercises, electric stimulation, and hot/cold packs, with a frequency of one treatment per day, twice a week for six weeks. (AR 360).

Plaintiff returned to Dr. Andavolu on February 16, 2012 for a follow-up visit regarding Plaintiff's lymphoma. (AR 451). Dr. Andavolu reiterated that Plaintiff was doing well and noted that Plaintiff had stopped taking Coumadin for his DVT two weeks earlier. (AR 451). Plaintiff's right knee showed signs of swelling and tenderness. (AR 452).

On February 20, 2012, Plaintiff visited Dr. Chahat Thakur in Yucca Valley for a variety of lab tests related to his lymphoma. (AR 419). There, Plaintiff reported that he was still taking

Coumadin at that time, in contrast to what Dr. Andavolu noted about Plaintiff's Coumadin dosage four days earlier. (AR 420).

Plaintiff also listed Coumadin as a current medication the following day, during a follow-up appointment for his knee. (AR 416). Nurse practitioner Hector Alvarez reported Plaintiff had no pain during several knee examinations, but did note lateral joint line tenderness during an exam of Plaintiff's right meniscus. (AR 418). Plaintiff underwent a procedure to drain the right knee joint of fluid and reported no complications afterwards. (Id.). Nurse Alvarez ordered Plaintiff to continue with physical therapy. (Id.).

On March 5, 2012, Plaintiff returned to Dr. Thakur for further lab tests, this time to evaluate Plaintiff for hypertriglyceridemia. (AR 413). Dr. Thakur noted Plaintiff was taking Lopid for the condition, and had been complying with the treatment and taking his medicine as directed. (Id.). Plaintiff denied experiencing any symptoms related to hypertriglyceridemia. (Id.). Dr. Thakur prescribed Tricor (145 mg), to be taken once daily for 30 days, with two refills following. (AR 414). Plaintiff did not list Coumadin as one of his current medications at this visit. (Id.). Plaintiff weighed 246 pounds at the time of his examination. (Id.).

Plaintiff returned to Nurse Alvarez on March 6, 2012 for a follow-up appointment on his knee and was referred for more physical therapy. (AR 410). During sessions held on March 14

and March 29, 2012, Plaintiff continued to report mild to moderate knee pain, and the physical therapist remarked that Plaintiff was making slow progress at both sessions. (AR 362). Plaintiff was discharged from physical therapy following the March 29, 2012 session. (AR 363).

On March 27, 2012, Plaintiff visited Dr. Navid Zenooz for a chest x-ray and CT scan of his abdomen and pelvis after experiencing abdominal pain. (AR 356, 428). Dr. Zenooz reported that the CT scan revealed Plaintiff was suffering from umbilical and bilateral inguinal hernias. (AR 356). Dr. Zenooz otherwise reported unremarkable and normal findings from both examinations. (AR 356, 428). The next day, Dr. Thakur referred Plaintiff to a general surgeon for the hernias. (AR 406).

On April 10, 2012, Plaintiff visited Dr. Renato Guzman in Yucca Valley following Dr. Thakur's referral. (AR 399). Dr. Guzman noted that both of Plaintiff's hernias "have been present for years," and that "[t]he umbilical hernia only bothers [Plaintiff] when he lays on his stomach. The inguinal hernias are asymptomatic." (Id.). Dr. Guzman's notes reveal no other assessments or orders for further treatment. (AR 399-400). Plaintiff also did not list Coumadin as one of his current medications. (AR 400). Plaintiff weighed 241 pounds at the time of his examination with Dr. Guzman. (Id.).

Plaintiff returned to Nurse Alvarez on May 9, 2012 for a follow-up appointment on his knee. (AR 393). Nurse Alvarez

referred Plaintiff to an orthopedist and also ordered an x-ray of Plaintiff's knee. (AR 395). Plaintiff weighed 236 pounds at the time of his visit with Nurse Alvarez. (AR 394).

On May 17, 2012, Plaintiff returned to Dr. Andavolu for a follow-up appointment regarding his lymphoma. (AR 445). Dr. Andavolu reported Plaintiff had a high red blood cell count, stemming from Plaintiff's history of smoking, but noted that Plaintiff was doing well otherwise and his lymphoma was in "complete remission." (Id.). Dr. Andavolu also commented that Plaintiff admitted to smoking marijuana. (Id.). Plaintiff was ordered to undergo lab tests and a PET-CT scan and follow up with Dr. Andavolu in another three months. (Id.).

On May 29, 2012, Plaintiff saw Nurse Alvarez for a pre-operation appointment on his knee. (AR 386). Plaintiff reported moderate pain in the knee. (Id.). Nurse Alvarez noted Plaintiff had a family history of osteoarthritis. (Id.). Plaintiff described joint stiffness, as well as locking, popping, and giving away of his knee. (Id.). Plaintiff told Nurse Alvarez these symptoms occurred for less than fifteen minutes upon waking up each morning, but later said his symptoms occurred several times daily. (Id.). Plaintiff estimated he could walk five to ten blocks, walk up stairs normally, and walk down stairs with a rail. (Id.). Plaintiff denied the need of an assistive device during any of these estimated activities. (Id.). Plaintiff weighed 233 pounds at the time of his visit with Nurse Alvarez, and did not report Coumadin as one of his current medications.

(AR 387-388). Nurse Alvarez prescribed Plaintiff thirty tablets of Norco, a hydrocodone/acetaminophen medication, with no refills. (AR 388).

Plaintiff underwent arthroscopic surgery on his right knee on June 5, 2012 in Yucca Valley. (AR 365). Dr. Seip performed the surgery and made a post-operation diagnosis of Grade IV cartilage change to the majority of Plaintiff's right knee joint. (Id.). Dr. Seip reported no other complications from the procedure. (Id.).

Plaintiff returned to Nurse Alvarez on June 12, 2012 for a post-operation appointment. (AR 383). Nurse Alvarez noted "[Plaintiff's] course has improved," and that despite Plaintiff's family history of osteoarthritis, Plaintiff's personal medical history was negative for the condition. (Id.). Nurse Alvarez also reported that Plaintiff had been prescribed Vicodin following the surgery. (Id.). Nurse Alvarez reported similar findings one week later on June 19, 2012, and ordered Plaintiff to visit Dr. Seip to remove Plaintiff's remaining sutures. (AR 379-381).

On June 20, 2012, Plaintiff visited Dr. Thakur to treat a toenail fungal infection that Plaintiff claimed had been bothering him for about six days. (AR 376). Dr. Thakur confirmed the infection on the right toenail and prescribed Plaintiff antibiotics. (AR 378).

Plaintiff saw Dr. Thakur again on June 27, 2012 for a follow-up appointment regarding Plaintiff's hypertriglyceridemia. (AR 373). Plaintiff denied experiencing any symptoms related to the condition and Dr. Thakur noted Plaintiff's overall compliance with the treatment plan. Dr. Thakur prescribed Plaintiff Crestor (20 mg), to be taken once daily for 30 days with no refills. (AR 375).

On July 2, 2012, Plaintiff visited Nurse Alvarez for a follow-up appointment on Plaintiff's knee. (AR 370). During the patellofemoral and meniscal exams, Nurse Alvarez noted some tenderness in Plaintiff's medial and lateral joint lines. (AR 372). Nurse Alvarez prescribed Plaintiff Naprosyn, a naproxen medication, to be taken twice daily for 10 days. (Id.).

Plaintiff visited Dr. Renato Guzman in Yucca Valley on July 3, 2012 to address his toenail infection. (AR 368). Dr. Guzman reported no infection, but that examinations revealed ingrown toenails on both of Plaintiff's big toes, and recommended surgery. (AR 369). However, there is no other evidence in the medical records indicating Plaintiff has undergone any such procedure.

On August 14, 2012, Plaintiff visited Dr. Sumit Mahajan in Yucca Valley for an appointment regarding Plaintiff's peripheral neuropathy. (AR 635). Dr. Mahajan notes the condition was "diagnosed [six] months ago." (Id.). Dr. Mahajan also remarked that "[t]he course has been progressively worsening" and is of

"moderate intensity." (Id.). Plaintiff reported symptoms that occurred several times daily, were aggravated by walking and exertion, and were relieved by "lying perfectly still." (Id.). Dr. Mahajan prescribed Plaintiff thirty tablets of Neurontin (300 mg) to control the nerve pain. (AR 637).

Plaintiff saw Dr. Thakur on August 20, 2012 after experiencing shortness of breath, which Dr. Thakur noted had bothered Plaintiff "for the past [two] weeks." (AR 632). Plaintiff reported an associated cough symptom but denied any other symptoms. (Id.). Dr. Thakur noted Plaintiff's CT scan of his chest was negative for a pulmonary embolism and that all other examinations were unremarkable. (AR 643, 633-634). However, because of Plaintiff's history of cancer, Dr. Thakur recommended Plaintiff visit Dr. Andavolu two days later for a follow-up appointment. (AR 634). Plaintiff later testified before the ALJ that he never received a diagnosis from the August 20, 2012 visit but was eventually prescribed an inhaler. (AR 42).

**2. Mental Condition**

On January 23, 2012, Plaintiff visited Morongo Basin Mental Health Services ("Morongo Basin") in Yucca Valley. (AR 349). Plaintiff reported experiencing stress and anxiety due to unemployment, his cancer diagnosis, and finances. (Id.). Plaintiff was treated by examining clinician Dana Conner and Dr. Paul True, Psy. D. (AR 349, 354). Ms. Conner reported Plaintiff

also complained of irritability, trouble sleeping, short term memory lapses, "lash[ing] out if confronted with too many tasks," and emotions that "change drastically." (Id.). However, later in the same report, boxes were checked indicating Plaintiff had neither sleeping nor eating problems. (AR 351). Plaintiff reported no other interpersonal impairment. (AR 349). Plaintiff used marijuana a few times a week, but "ceased using speed 15 years ago." (AR 350).

Dr. True diagnosed Plaintiff with chronic adjustment disorder with anxiety, cannabis dependence without physiological dependence, memory impairment due to chemotherapy, and chronic pain. (AR 354). Dr. True also diagnosed Plaintiff with hypercholesterolemia, digestive disorders, ulcers, inadequate social support, and occupational problems. (Id.). The doctors also concluded Plaintiff was not a danger to himself or others. (AR 349). They ruled Plaintiff's appearance and behavior as "appropriate/normal" and Plaintiff's mood as "depressed." (AR 352). The doctors recommended that Plaintiff begin counseling. (Id.).

On May 14, 2012, Plaintiff visited Dr. Thakur to evaluate Plaintiff for depression. (AR 390). Dr. Thakur noted this appointment was a "routine follow-up" and that "[t]he diagnosis of depression was made [ten] years ago." (Id.). Plaintiff reported a "mild degree of depression" with "fairly infrequent" symptoms to Dr. Thakur. (Id.). Dr. Thakur also noted that "[c]urrent medications include an antidepressant," but Plaintiff

did not report any such medications at the May 14, 2012 appointment or at other doctor visits leading up to May 14, such as the appointments on April 11 and May 9, 2012. (AR 391, 397, 394). Dr. Thakur prescribed Plaintiff thirty tablets of Lexapro, to be taken once daily, with no refills. (AR 392).

Plaintiff subsequently reported Lexapro as a current medication at doctor visits on May 29 and June 12, 2012. (AR 387, 384). Plaintiff then did not list Lexapro as a current medication during visits on June 19, June 20, or June 27, 2012. (AR 380, 377, 374). However, Plaintiff again listed Lexapro as one of his medications during doctor visits in August, 2012. (AR 638, 636, 633).

## IV.

## THE FIVE-STEP SEQUENTIAL EVALUATION PROCESS

To qualify for disability benefits, a claimant must demonstrate a medically determinable physical or mental impairment that prevents her from engaging in substantial gainful activity and that is expected to result in death or to last for a continuous period of at least twelve months. Reddick v. Chater, 157 F.3d 715, 721 (9th Cir. 1998) (citing 42 U.S.C. § 423(d)(1)(A)). The impairment must render the claimant incapable of performing the work she previously performed and incapable of performing any other substantial gainful employment that exists in the national economy. Tackett v. Apfel, 180

F.3d 1094, 1098 (9th Cir. 1999) (citing 42 U.S.C. § 423(d)(2)(A)).

To decide if a claimant is entitled to benefits, an ALJ conducts a five-step inquiry. 20 C.F.R. §§ 404.1520, 416.920. The steps are:

> (1) Is the claimant presently engaged in substantial gainful activity? If so, the claimant is found not disabled. If not, proceed to step two.
> (2) Is the claimant's impairment severe? If not, the claimant is found not disabled. If so, proceed to step three.
> (3) Does the claimant's impairment meet or equal one of the specific impairments described in 20 C.F.R. Part 404, Subpart P, Appendix 1? If so, the claimant is found disabled. If not, proceed to step four.
> (4) Is the claimant capable of performing his past work? If so, the claimant is found not disabled. If not, proceed to step five.
> (5) Is the claimant able to do any other work? If not, the claimant is found disabled. If so, the claimant is found not disabled.

Tackett, 180 F.3d at 1098-99; see also Bustamante v. Massanari, 262 F.3d 949, 953-54 (9th Cir. 2001) (citations omitted); 20 C.F.R. §§ 404.1520(b)-(g)(1) & 416.920(b)-(g)(1).

The claimant has the burden of proof at steps one through four, and the Commissioner has the burden of proof at step five. Bustamante, 262 F.3d at 953-54. Additionally, the ALJ has an affirmative duty to assist the claimant in developing the record at every step of the inquiry. Id. at 954. If, at step four, the claimant meets her burden of establishing an inability to perform past work, the Commissioner must show that the claimant can perform some other work that exists in "significant numbers" in the national economy, taking into account the claimant's residual functional capacity ("RFC"), age, education, and work experience. Tackett, 180 F.3d at 1098, 1100; Reddick, 157 F.3d at 721; 20 C.F.R. §§ 404.1520(g)(1), 416.920(g)(1). The Commissioner may do so by the testimony of a vocational expert or by reference to the Medical-Vocational Guidelines appearing in 20 C.F.R. Part 404, Subpart P, Appendix 2 (commonly known as "the Grids"). Osenbrock v. Apfel, 240 F.3d 1157, 1162 (9th Cir. 2001). When a claimant has both exertional (strength-related) and non-exertional limitations, the Grids are inapplicable and the ALJ must take the testimony of a vocational expert. Moore v. Apfel, 216 F.3d 864, 869 (9th Cir. 2000) (citing Burkhart v. Bowen, 856 F.2d 1335, 1340 (9th Cir. 1988)).

## V.

## THE ALJ'S DECISION

The ALJ employed the five-step sequential evaluation process and concluded that Plaintiff was initially under a disability within the meaning of the Social Security Act from January 22,

2011 through February 16, 2012. (AR 10). At step one, the ALJ found that Plaintiff had not engaged in substantial gainful employment since January 22, 2011. (AR 14).

At step two, the ALJ found that from January 22, 2011 through February 16, 2012, Plaintiff had the severe impairments of Stage IV Hodgkin's lymphoma with bone marrow involvement, currently in remission after eight months of chemotherapy, but with complications due to DVT in both shoulders and residual peripheral neuropathy; depression; and obesity. (AR 14).

At step three, the ALJ found that during this period, Plaintiff did not have an impairment or combination of impairments that met or medically equaled one of the listed impairments in 20 C.F.R. Part 404, Subpart P, Appendix 1. (AR 15).

The ALJ then found that Plaintiff was "unable to sustain full time work activity on a regular and continuing basis because of chronic fatigue, and the frequency and effect of medical treatment." (AR 16). In making this finding, the ALJ noted that the objective medical evidence supported the credibility of Plaintiff's testimony, as well as written statements from Plaintiff and his wife, regarding the severity of his symptoms and limitations. (AR 17-18).

Consequently, the ALJ gave little weight to the opinions of the non-examining State physicians at the initial and

reconsideration levels, who "did not have the benefit of considering additional evidence that was only available after they assessed [Plaintiff], including treatment notes and [Plaintiff's] testimony at the hearing," and who thereby failed to "adequately consider [Plaintiff's] subjective allegations." (AR 18-19). In particular, the ALJ noted that the initial non-examining physician, Dr. Vu, expected Plaintiff "to be functionally nonsevere after 12 months from the [alleged onset date]," and Dr. Cooper, the non-examining physician at the reconsideration level, expected that after the same 12 month period, Plaintiff "would be able to perform work at the light exertional level . . . [and] occasionally perform postural activities." (AR 18).

At step four, the ALJ determined that Plaintiff could not perform his relevant past work as a construction worker. (AR 19). At step five, the ALJ considered Plaintiff's age, education, work experience and RFC and determined that "there were no jobs that existed in significant numbers in the national economy that [Plaintiff] could have performed." (Id.). The ALJ noted that "[Plaintiff's] limitations prevented the performance of sustained work-related physical activities in a work setting on a regular and continuing basis at any exertional level." (AR 20). Thus, the ALJ found after the five-step evaluation that Plaintiff was disabled, as defined by the Social Security Act, from January 22, 2011 through February 16, 2012. (AR 20).

However, the ALJ then determined that beginning February 17, 2012, Plaintiff experienced medical improvement that increased Plaintiff's RFC, despite retaining all pre-existing impairments. (AR 21-22). Thus, because Plaintiff's increased RFC improved Plaintiff's ability to work, the ALJ found that Plaintiff's disability ended as of February 17, 2012. (AR 21). The ALJ then provided the following description of Plaintiff's increased RFC:

> [Plaintiff] can lift and/or carry 20 pounds occasionally and 10 pounds frequently; he can stand and/or walk for six hours out of an eight-hour workday with regular breaks; he can sit for six hours out of an eight-hour workday with regular breaks; he can alternate between sitting and standing at one hour intervals; he can frequently perform postural activities; he is precluded from climbing ladders, ropes, or scaffolds; he is precluded from working at heights, around moving machinery or other hazards; he is precluded from performing jobs that requires hypervigilance or intense concentration on a particular task; and he is precluded from concentrated exposure to extreme temperatures.

(AR 22). In contrast to the ALJ's previous disability finding, the ALJ found the objective medical evidence inconsistent with both Plaintiff's testimony and the written statements from Plaintiff and his wife regarding the intensity, persistence, and limiting effects of Plaintiff's symptoms since February 17, 2012.

(AR 22). As a result, the ALJ found Plaintiff's subjective complaints were "less than fully credible." (AR 24.)

More specifically, the ALJ took issue with Plaintiff's statements regarding the severity of the three main impairments allegedly limiting Plaintiff's ability to work after February 16, 2012: the ongoing effects of Plaintiff's June 5, 2012 surgery on his right knee; Plaintiff's severe residual fatigue and weakness upon completion of chemotherapy; and Plaintiff's ongoing depression. (AR 22-24).

Regarding Plaintiff's knee surgery, the ALJ disagreed with Plaintiff's contention that the surgery failed. (AR 22, 43). The ALJ noted Plaintiff's gait was normal while moving about the hearing room and that Plaintiff did not use an assistive device for ambulation. (AR 22). Furthermore, Plaintiff admitted to the ALJ during the hearing that he could stand and/or walk for over an hour and vacuum at home. (Id.). The ALJ also noted that Plaintiff admitted at a post-operative appointment that he could walk five to ten blocks, climb stairs normally, and had only occasional, moderate pain in his knee. (Id.).

Similarly, the ALJ concluded the objective evidence for Plaintiff's progress following chemotherapy did not support Plaintiff's allegations of continued severe residual fatigue and weakness. (Id.). The ALJ found no evidence in the medical records that Plaintiff ever reported such symptoms to a physician during a follow-up appointment, but notes that Plaintiff did in

fact on several occasions deny having any ill effects. (Id.). Further, the ALJ pointed to diagnostic testing that "revealed unremarkable findings" during this period. (Id.).

Lastly, the ALJ found no support in the record for claims that Plaintiff and his wife made regarding the severity of Plaintiff's depression. (Id.). The ALJ noted that "on several occasions, [Plaintiff] described his depression as 'mild,' and stated that his symptoms are infrequent," and that Plaintiff admitted to not receiving ongoing mental health treatment beyond an initial prescription for medication. (Id.). The ALJ also acknowledged the lack of any evidence that Plaintiff was hospitalized for mental impairments. (AR 22-23). For these reasons, the ALJ found testimony from Plaintiff's wife that Plaintiff continued to experience problems with his memory, fatigue, and pain to be lacking credibility in light of the lack of clinical or diagnostic medical evidence. (AR 23).

In finding the Plaintiff's RFC had increased, the ALJ gave some weight to the opinions of the State non-examining physicians at the reconsideration level, who concluded that "beginning on January 22, 2012, [Plaintiff] could perform work at the light exertional level; he could occasionally perform postural activities; and he was precluded from concentrated exposure to pulmonary irritants and temperature extremes." (AR 24). However, the ALJ determined that while "this opinion is generally consistent with the totality of the medical evidence . . . this

opinion does not adequately consider [Plaintiff's] obesity or his subjective allegations of knee pain and residual fatigue."

Taking Plaintiff's obesity and subjective allegations into consideration, the ALJ assigned Plaintiff a more restrictive, and thus more favorable, RFC to accommodate the deficiencies the ALJ perceived in the opinions of the non-examining physicians. (AR 22, 24). Returning to step four, the ALJ determined that even with an increased RFC, Plaintiff was still unable to perform his relevant past work as a construction worker. (AR 24-25). At step five, the ALJ considered Plaintiff's age, education, work experience, and increased RFC. (AR 25). Based in part on the testimony of a vocational expert, the ALJ found that there were jobs existing in significant numbers in the national economy that Plaintiff could perform as of February 17, 2012, such as a cashier, garment sorter, and production solderer. (Id.). Accordingly, the ALJ determined that Plaintiff was no longer disabled as of February 17, 2012. (Id.).

## VI.

## STANDARD OF REVIEW

Under 42 U.S.C. § 405(g), a district court may review the Commissioner's decision to deny benefits. The court may set aside the Commissioner's decision when the ALJ's findings are based on legal error or are not supported by substantial evidence in the record as a whole. Aukland v. Massanari, 257 F.3d 1033, 1035 (9th Cir. 2001) (citing Tackett, 180 F.3d at 1097); Smolen

v. Chater, 80 F.3d 1273, 1279 (9th Cir. 1996) (citing Fair v. Bowen, 885 F.2d 597, 601 (9th Cir. 1989)).

"Substantial evidence is more than a scintilla, but less than a preponderance." Reddick, 157 F.3d at 720 (citing Jamerson v. Chater, 112 F.3d 1064, 1066 (9th Cir. 1997)). It is "relevant evidence which a reasonable person might accept as adequate to support a conclusion." Id. (citing Jamerson, 112 F.3d at 1066; Smolen, 80 F.3d at 1279). To determine whether substantial evidence supports a finding, the court must "'consider the record as a whole, weighing both evidence that supports and evidence that detracts from the [Commissioner's] conclusion.'" Aukland, 257 F.3d at 1035 (quoting Penny v. Sullivan, 2 F.3d 953, 956 (9th Cir. 1993)). If the evidence can reasonably support either affirming or reversing that conclusion, the court may not substitute its judgment for that of the Commissioner. Reddick, 157 F.3d at 720-21 (citing Flaten v. Sec'y, 44 F.3d 1453, 1457 (9th Cir. 1995)).

## VII.

## DISCUSSION

Plaintiff contends the ALJ "erred in holding that Plaintiff's disability ended on February 16, 2012." (Memorandum in Support of Plaintiff's Complaint ("MSPC") at 2). Plaintiff makes two specific challenges to the ALJ's decision. First, Plaintiff argues that pursuant to Social Security Ruling ("SSR") 96-8p ("the Ruling"), the second RFC assessment that led to the

determination of non-disability is erroneous because "the ALJ failed to provide a proper narrative discussion describing how the evidence supports her conclusion that Plaintiff became able to perform a limited range of light work on February 17, 2012." (Id. at 3) (citing SSR 96-8p, 1996 WL 374184). Second, Plaintiff claims that also pursuant to the Ruling, "the ALJ failed to resolve the numerous ambiguities present in the medical evidence that she relied on in reaching her decision." (Id. at 5).

The Court disagrees with Plaintiff on both grounds. The ALJ provided substantial evidence to support her RFC assessment and provided clear and convincing reasons for finding Plaintiff's subjective testimony less than fully credible. To the extent that the medical evidence after February 17, 2012 presented any material ambiguities, the ALJ properly discussed and resolved them with citations to substantial evidence from the objective medical record. Accordingly, for the reasons discussed below, the ALJ's decision must be AFFIRMED.

**A. The ALJ Adequately Supported Her RFC Assessment**

Plaintiff contends the ALJ did not properly support her RFC assessment because the decision "relies on a handful of clinical observations that may or may not indicate that Plaintiff's condition improved" as of February 17, 2012. (MSPC at 3). The Court disagrees, and finds the ALJ supported her RFC assessment with extensive citation to and discussion of both medical and nonmedical evidence contained in the record.

**1. SSR 96-8P And The Relevant Legal Standard**

The Ruling provides that the RFC assessment "is a function-by-function assessment based upon all of the relevant evidence of an individual's ability to do work-related activities," which also "must include a narrative discussion describing how the evidence supports each conclusion...." SSR 96-8p, 1996 WL 374184 at 3-7. In particular, the ALJ must "cit[e] specific medical facts (e.g., laboratory findings) and nonmedical evidence (e.g., daily activities, observations)," and address "the individual's ability to perform sustained work activities in an ordinary work setting on a regular and continuing basis (i.e., 8 hours a day, for 5 days a week, or an equivalent work schedule)." (Id. at 7). In addition, the ALJ must "describe the maximum amount of each work-related activity the individual can perform based on the evidence available in the case record." (Id.).

When discussing cases in which subjective symptoms, such as pain, are alleged, the RFC assessment "must include a discussion of why reported symptom-related functional limitations and restrictions can or cannot reasonably be accepted as consistent with the medical and other evidence." (Id.). Similarly, when considering medical opinions, "[i]f the RFC assessment conflicts with an opinion from a medical source, the adjudicator must explain why the opinion was not adopted." (Id.). "If a treating source's medical opinion on an issue of the nature and severity of an individual's impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is

not inconsistent with the other substantial evidence in the case record, the adjudicator must give it controlling weight." (Id.).

SSR rulings are binding on an ALJ. 20 C.F.R. § 402.35(b)(1). When the ALJ fails to identify specific reasons for the stated findings, supported by evidence in the case record, the Court cannot affirm an ALJ's determination "even if the ALJ had given facially legitimate reasons for his . . . finding, [because] the complete lack of meaningful explanation gives [the Court] nothing with which to assess its legitimacy." Robbins v. Soc. Sec. Admin., 466 F.3d 880, 884 (9th Cir. 2006).

**2. Substantial Evidence Supports The ALJ's Finding That Plaintiff Was Not Disabled Beginning February 17, 2012**

The Court finds the ALJ supported her finding that Plaintiff was no longer disabled after February 17, 2012 with substantial evidence. The ALJ provided evidence of Plaintiff's improved condition and continuing limitations as of February 16, 2012, and also discussed how she reconciled her conclusions with any conflicting evidence from Plaintiff's own testimony or other medical opinions.

As required by the Ruling, the ALJ cited to several "specific medical facts" that show Plaintiff's condition improved. SSR 96-8p, 1996 WL 374184 at 7. The ALJ stated:

> The evidence shows [Plaintiff] completed chemotherapy in October 2011. [Plaintiff's] cancer went into remission, and his condition has been stable since he completed cancer treatments. Although [Plaintiff] developed a deep vein thrombosis during the course of his chemotherapy, by February 2012, [Plaintiff's] blood thinners were discontinued. Additionally, despite the fact that [Plaintiff] initially lost weight before he began his chemotherapy treatments, the record demonstrates he regained weight during and after his treatment. At a follow-up appointment on February 16, 2012, [Plaintiff] stated he had no complaints; and physical examination revealed generally unremarkable findings. Similarly, diagnostic testing after February 2012[] revealed generally normal findings.

(AR 21) (citations omitted). The ALJ went on to note that "[a] PET scan performed in February 2012, demonstrated [Plaintiff] had persistent, but nonmetabolicaly active lymph nodes" and "[l]aboratory testing from February 16, 2012, revealed benign findings." (AR 23, 453). Also, "[l]aboratory testing from May and June 2012 showed [Plaintiff's] white blood count was slightly elevated; but the results were otherwise unremarkable." (AR 23, 447). The ALJ finally noted that a July 30, 2012 PET scan revealed Plaintiff "had a single left inguinal lymph node, with low-grade metabolic activity that was not present in prior studies" and a CT scan from the same day "reconfirmed that

several of [Plaintiff's] lymph nodes had significantly diminished in size after chemotherapy." (AR 23-24, 644).

The ALJ also discussed relevant "nonmedical evidence," such as Plaintiff's daily activities and the ALJ's own observations of Plaintiff. SSR 96-8p, 1996 WL 374184 at 7. For example, the ALJ noted that "during the hearing, [Plaintiff] admitted that as of February 2012, he only sees his physician every three months." (AR 21). Regarding Plaintiff's knee pain, which Plaintiff alleged was severe following an unsuccessful surgery, the ALJ observed Plaintiff "ambulate around the hearing room," and noted that Plaintiff's "gait was normal and he did not use an assistive device for ambulation." (AR 22). Moreover, the ALJ stressed that Plaintiff admitted at the hearing "he was able to stand and/or walk for over an hour, and he acknowledged he was able to vacuum." (Id.). Plaintiff made similar statements during an August 13, 2012 appointment, where he "admitted that he was able to walk five to 10 blocks; he could climb stairs normally; and he stated he had only occasional moderate pain in his knee." (AR 22, 638).

In addition, the ALJ properly considered "[Plaintiff's] ability to perform sustained work activities in an ordinary work setting on a regular and continuing basis ([such as] 8 hours a day, for 5 days a week, or an equivalent work schedule)." SSR 96-8p, 1996 WL 374184 at 7. The ALJ also described "the maximum amount of each work-related activity [Plaintiff] can perform based on the evidence available in the case record." (Id.).

Specifically, the ALJ performed a separate analysis of steps four and five in the five-step evaluation process after determining Plaintiff's increased RFC. (AR 24-25). The ALJ concluded at step four that Plaintiff was still unable to perform his relevant past work as a construction worker. (AR 24). At step five, the ALJ concluded Plaintiff could perform a limited range of unskilled and light work. (AR 25-26).

The ALJ supported her findings at both steps by relying in part on the testimony of Ms. Porter, a vocational expert. (AR 48-53). An ALJ may properly rely on the testimony of a vocational expert where the ALJ poses a hypothetical "contain[ing] all the limitations the ALJ found credible and supported by substantial evidence in the record." Bayliss v. Barnhart, 427 F.3d 1211, 1217 (9th Cir. 2005). Moreover, an ALJ may rely on a vocational expert's testimony regarding the number of relevant jobs in the national economy, as "[a]n ALJ may take administrative notice of any reliable job information, including information provided by a [vocational expert]." Id. at 1218 (citing Johnson v. Shalala, 60 F.3d 1428, 1435 (9th Cir. 1995)).

At step four, the ALJ confirmed with Ms. Porter that Plaintiff could not perform his past work as a construction worker. (AR 49). At step five, the ALJ next asked Ms. Porter whether jobs existed in the national economy for an individual with Plaintiff's age, education, work experience and RFC. (AR 48-49). The ALJ specified six different hypotheticals for Ms. Porter to consider, ranging from jobs requiring light to medium

work; both with and without a sit/stand option; and accommodating brief breaks each day and absences each week due to chronic pain and ongoing medical treatment. (AR 48-52). Ms. Porter then testified that an individual sharing Plaintiff's age, education, experience and mental and physical limitations could perform light, unskilled work with a sit/stand option, such as a cashier, garment sorter, and production solderer. (AR 51). She testified that Plaintiff could perform medium work, but also with the opportunity for short daily breaks and weekly absences, as a laundry laborer, hospital cleaner, and industrial cleaner. (AR 52). Finally, she testified that Plaintiff could perform light, unskilled work, allowing for similar breaks and absences, as a sales attendant, mail clerk, and router. (AR 52-53). Ms. Porter also noted that all of these jobs existed in significant numbers in the national economy and in Plaintiff's local economy. (AR 49-53). The ALJ accepted Ms. Porter's testimony and concluded that "beginning February 17, 2012, [Plaintiff] has been capable of making a successful adjustment to work that exists in significant numbers in the national economy." (AR 26).

### 3. The ALJ Cited Clear And Convincing Reasons For Finding Plaintiff's Subjective Allegations Less Than Fully Credible

The ALJ emphasized that Plaintiff's subjective testimony regarding the severity and limitations of his symptoms as of February 17, 2012 "cannot reasonably be accepted as consistent with the medical and other evidence," as required by the Ruling. SSR 96-8p, 1996 WL 374184 at 7.

When assessing the credibility of a claimant, the ALJ must engage in a two-step analysis. Molina v. Astrue, 674 F.3d 1104, 1112 (9th Cir. 2012). First, the ALJ must determine if there is medical evidence of an impairment that could reasonably produce the symptoms alleged. (Id.). Then, if there is, in order to reject the testimony, the ALJ must make specific credibility findings. (Id.). In assessing the claimant's testimony, the ALJ may use "ordinary techniques of credibility evaluation." Turner, 613 F.3d at 1224 (internal quotations omitted). The ALJ may also consider any inconsistencies in the claimant's conduct and any inadequately or unexplained failure to pursue treatment or follow treatment. Tommasetti v. Astrue, 533 F.3d 1035, 1039 (9th Cir. 2008). Additionally, the ALJ may discredit the claimant's testimony where his normal activities can transfer to the work setting. Morgan v. Comm'r of Soc. Sec. Admin., 169 F.3d 595, 600 (9th Cir. 1999). Here, there was medical evidence of an underlying impairment. However, the ALJ articulated specific,

clear and convincing reasons for discounting Plaintiff's testimony about the severity of her physical and mental symptoms.

The ALJ first summarized Plaintiff's allegations of symptom-related functional limitations in his testimony and written statements, noting specifically Plaintiff's claims of limitations caused by the knee surgery, post-chemotherapy treatment, and depression. (AR 22-23). The ALJ noted that "[Plaintiff testified he had an unsuccessful right knee surgery in 2012, and he continued to have severe knee pain . . . [Plaintiff] alleged he continued to have severe residual fatigue and weakness after he completed his chemotherapy . . . [and Plaintiff] and his wife alleged he has severe depression." (AR 22).

Then, the ALJ contrasted those subjective symptoms with evidence from the medical record to support the conclusion that "the claimant's allegations concerning the intensity, persistence and limiting effects of his symptoms are less than fully credible since February 17, 2012." (AR 22). Regarding Plaintiff's knee, the ALJ noted that although Plaintiff alleged his surgery failed and still caused severe pain, he presented at the hearing with a normal gait and without an assistive device. (AR 22). Moreover, Plaintiff "admitted he was able to stand and/or walk for over an hour, and he acknowledged he was able to vacuum." (Id.). Plaintiff made similar statements at a post-operative appointment and stated he only had occasional, moderate pain in the knee. (Id.).

The Court agrees with the ALJ's finding that Plaintiff's limited pursuit of mental health treatment undermined his subjective testimony. The ALJ noted although Plaintiff received medications for his depression, "there is no evidence [Plaintiff] was ever hospitalized for his mental impairments and he admitted he has not received ongoing mental health treatments," and that "[o]n several occasions, [Plaintiff] described his depression as "mild," and stated that his symptoms are infrequent." (AR 22-23). Were Plaintiff's symptoms as severe as he claimed, it seems likely that he would have needed and sought treatment more often than the record reflects, as he sought treatment for his other medical problems. Further, as a matter of law, the ALJ's reliance on and citation to Plaintiff's failure to seek more treatment, as part of the ALJ's evaluation of Plaintiff's subjective testimony, was proper. See Tommasetti, 533 F.3d at 1039 (an ALJ may consider many factors in weighing a claimant's credibility, including "unexplained or inadequately explained failure to seek treatment") (internal quotation marks omitted). Where, as here, "a claimant[] fail[s] to assert a good reason for not seeking treatment," an ALJ may consider this inaction as "cast[ing] doubt on the sincerity of the claimant's" subjective testimony. Molina, 674 F.3d at 1113).

The ALJ discussed similar reasons for discrediting Plaintiff's allegations of ongoing severe fatigue following chemotherapy treatment. The ALJ noted "the positive objective clinical and diagnostic findings since February 17, 2012 . . . do not support more restrictive functional limitations than those

assessed herein." (Id.). The ALJ pointed to the opinion of Plaintiff's treating physician, Dr. Andavolu, who noted Plaintiff's cancer was in complete remission and that Plaintiff was "doing well [and] . . . had no complaints" at a February 16, 2012 appointment. (Id.). The ALJ also supported her findings with evidence of unremarkable physical examinations and PET-CT scans ranging from February 2012 to late July 2012. (Id.). The ALJ also used these findings to discredit the testimony and written statements from Plaintiff's wife regarding Plaintiff's condition. (AR 23).

The ALJ also properly discounted Plaintiff's wife's testimony either because it was identical to Plaintiff's testimony (which, for reasons stated above, was properly discounted), her testimony was inconsistent with the medical evidence, or for other reasons germane to the witness, i.e., that as a lay witness she was not competent to render a diagnosis about Plaintiff.

For the above reasons, the Court finds the ALJ amply supported the determination that Plaintiff experienced medical improvement and an increased RFC as a result. The Court also finds the ALJ provided clear and convincing reasons for discounting Plaintiff's subjective testimony, as well as that of Plaintiff's wife.

**B. The ALJ Properly Discussed And Resolved Any Material Ambiguities In The Evidence**

Plaintiff claims that the ALJ erred by finding non-disability despite "numerous ambiguities [in the medical evidence] which the ALJ's decision failed to address." (MSPC at 3). According to Plaintiff, the ALJ was obligated to, but did not, "explain how any material inconsistencies or ambiguities in the evidence in the case record were considered and resolved." (MSPC at 3-5) (citing SSR 96-8p, 1996 WL 374184 at 7). The Court disagrees that the ALJ failed to address any material ambiguities, and finds that to the extent the medical evidence created any ambiguities, the ALJ's decision addressed and resolved them with substantial evidence.

An ALJ has a duty to develop the record "only when there is ambiguous evidence or when the record is inadequate to allow for proper evaluation of the evidence." Ludwig v. Astrue, 681 F.3d 1047, 1055 (9th Cir. 2012) (quoting Mayes v. Massanari, 276 F.3d 453, 459-60 (9th Cir. 2001). More specifically, that duty requires the ALJ to recontact the treating physician to clarify or amplify the reports if the medical evidence is insufficient. Tonapetyan v. Halter, 242 F.3d 1144, 1151 (9th Cir. 2001).

If the ALJ fails to develop the record despite ambiguous or inadequate medical evidence, the Ninth Circuit has held that social security disability cases are subject to the same harmless error rule as generally applies to civil cases. Ludwig, 681 F.3d

at 1054 (citing McLeod v. Astrue, 640 F.3d 881, 887 (9th Cir.2011)). Plaintiff "need not necessarily show what other evidence might have been obtained had there not been error, but does have to show at least a 'substantial likelihood of prejudice.'" McLeod, 640 F.3d at 888.

Here, Plaintiff claims the ALJ failed to resolve several ambiguities, but does not explain how any of them had a substantial likelihood of prejudicing Plaintiff, assuming any of Plaintiff's observations identified ambiguities at all. (MSPC at 3-5). For example, the ALJ observed that "during several medical appointments after February 17, 2012, Plaintiff reported no subjective complaints and was found to have few ongoing symptoms caused by his impairments," despite "other treatment records from the time period in question indicat[ing] that Plaintiff continued to suffer from symptoms and limitations caused by his Hodgkin's lymphoma . . ." (MSPC at 3). Plaintiff claims that during two follow-up appointments after February 16, 2012, Plaintiff still reported "symptoms of moderate intensity, which were aggravated by walking and relieved by 'lying perfectly still.'" (Id. at 3-4).

Similarly, Plaintiff contends that physical examinations that found back pain and reduced range of motion during these same appointments are evidence of unaddressed ambiguities that nonetheless influenced the ALJ's decision. (Id.). Plaintiff also alleges that despite the ALJ's overall finding of medical improvement as of February 17, 2012, "[o]n August 14, 2012,

Plaintiff was diagnosed with peripheral neuropathy and prescribed Neurontin (Gabapentin)." (Id. at 5). Lastly, Plaintiff points to inconsistencies in the Cancer Center's "Interval History" notes reflecting his appointments at the Center following completion of his final chemotherapy treatment. Plaintiff notes that the ALJ's finding of increased RFC recognized "by February 2012, [Plaintiff's] blood thinners were discontinued" but records from the Cancer Center at that time state both that "Plaintiff discontinued Coumadin 2 weeks ago" and that "he continues on Coumadin." (MSPC at 4; AR 451).

The Court concludes that Plaintiff fails to demonstrate how these observations demonstrate the medical record was inadequate or insufficient to allow for a proper evaluation of Plaintiff's condition as of February 17, 2012. Identifying evidence that is contrary to an ALJ's decision does not by itself establish that the decision is unsupported by substantial evidence or is otherwise prejudicial to Plaintiff. See D.A.R.E. Am. v. Rolling Stone Magazine, 270 F.3d 793, 793 (9th Cir. 2001) ("A bare assertion of an issue does not preserve a claim[]") (internal quotation marks omitted).

Moreover, even if Plaintiff's observations presented true medical inconsistencies, such that the ALJ failed to address and resolve them, the ALJ nonetheless provided enough evidence in support of the non-disability finding that the errors would have been harmless.

For example, the ALJ's RFC assessment provided several specific references to objective medical evidence indicating that Plaintiff experienced medical improvement as of February 17, 2012, all of which were noted "after careful consideration of the entire record." Though Plaintiff points to Cancer Center's allegedly inconsistent notations regarding Plaintiff's Coumadin prescription, the ALJ's review of the "entire record" more clearly indicates that no such inconsistency existed. Dr. Andavolu's treatment notes from February 16, 2012 state that Plaintiff's Coumadin prescription will be discontinued. (AR 451).

At subsequent medical appointments starting at least in March, 2012, Plaintiff did not list Coumadin as one of his medications. (AR 413). Coumadin is not listed under Plaintiff's medications at appointments on March 5, March 28, April 4, May 9, June 12, and August 20, 2012. (AR 413, 405, 402, 394, 384, 633). Considering the ample other evidence supporting the ALJ's conclusion that Plaintiff's medical condition improved, the Court does not view the alleged ongoing presence of Coumadin as a dispositive fact that Plaintiff continued to suffer from severe fatigue and weakness after February 2012. If anything, such evidence supports the inference that any lasting ambiguity over Plaintiff's Coumadin prescription after February 2012 is caused only by an oversight in Cancer Center's medical notes. Accordingly, in light of the above evidence provided by the ALJ,

the Court finds the alleged inconsistencies identified by Plaintiff to be harmless and insufficient to overcome the ALJ's increased RFC assessment and non-disability finding.

In sum, the ALJ's RFC assessment properly satisfied the narrative discussion requirement and provided substantial evidence to resolve any inconsistencies raised by Plaintiff.

## III.

## CONCLUSION

Consistent with the foregoing, IT IS ORDERED that Judgment be entered AFFIRMING the decision of the Commissioner.

DATED: November 13, 2014

/S/
SUZANNE H. SEGAL
UNITED STATES MAGISTRATE JUDGE

## NOTICE

**THIS DECISION IS NOT INTENDED FOR PUBLICATION IN WESTLAW, LEXIS, OR ANY OTHER LEGAL DATABASE.**