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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

GARY R.G.,

Plaintiff,

v.

NANCY A. BERRYHILL,
Deputy Commissioner for Operations of
Social Security Administration,

Defendant.

Case No. ED CV 17-1056-SP

MEMORANDUM OPINION AND
ORDER

I.

INTRODUCTION

On May 25, 2017, plaintiff Gary R.G. filed a complaint against defendant, the Commissioner of the Social Security Administration (“Commissioner”), seeking a review of a denial of a period of disability, disability insurance benefits (“DIB”), and supplemental security income (“SSI”). Both plaintiff and defendant have consented to proceed for all purposes before the assigned Magistrate Judge pursuant to 28 U.S.C. § 636(c). The court deems the matter suitable for adjudication without oral argument.

1 Plaintiff presents what are really four issues for decision: (1) whether the
2 administrative law judge (“ALJ”) gave specific, legitimate reasons for rejecting the
3 opinions of two treating physicians; (2) whether the ALJ’s residual functional
4 capacity (“RFC”) determination was supported by substantial evidence; (3)
5 whether the ALJ properly considered plaintiff’s credibility; and (4) whether the
6 ALJ failed to properly consider the opinions of a lay witness. Plaintiff’s
7 Memorandum in Support of the Complaint (“P. Mem.”) at 2-3; Defendant’s
8 Memorandum in Support of Answer (“D. Mem.”) at 1-10.

9 Having carefully studied the parties’ written submissions, the Administrative
10 Record (“AR”), and the decision of the ALJ, the court concludes that, as detailed
11 herein, the ALJ properly considered the opinions of plaintiff’s treating physicians,
12 and the ALJ’s RFC determination was supported by substantial evidence. But the
13 ALJ failed to properly consider plaintiff’s credibility, and failed to properly
14 consider lay witness testimony. The court therefore remands this matter to the
15 Commissioner in accordance with the principles and instructions enunciated in this
16 Memorandum Opinion and Order.

17 II.

18 **FACTUAL AND PROCEDURAL BACKGROUND**

19 Plaintiff was fifty-eight years old on his amended alleged disability onset
20 date.¹ AR at 45, 86, 97. Plaintiff completed the twelfth grade, and has past
21 relevant work as a combination shipping and receiving supervisor, receiving clerk,
22 and purchasing clerk. *Id.* at 73, 217.

23 Plaintiff filed an application for DIB on November 26, 2013 and for SSI on
24 November 30, 2013, due to two shoulder surgeries, neck surgery, diabetes, vertigo,
25

26
27 ¹ Plaintiff initially alleged an onset date of January 10, 2011 (*see* AR at 193),
28 but later amended his alleged onset date to August 5, 2013, the date of his
automobile accident. *Id.* at 43-45.

1 impaired hearing, and high cholesterol. *Id.* at 86-87, 97-98. The applications were
2 denied initially and upon reconsideration, after which he filed a request for a
3 hearing. *See id.* at 136-41, 144-49, 150-51.

4 On October 27, 2015, plaintiff, represented by counsel, appeared and
5 testified at a hearing before the ALJ. *Id.* at 39-85. The ALJ also heard testimony
6 from Corinne Porter, a vocational expert. *Id.* at 59-84. On January 27, 2016, the
7 ALJ denied plaintiff's claims for benefits. *Id.* at 20-33.

8 Applying the well-known five-step sequential evaluation process, the ALJ
9 found, at step one that plaintiff had not engaged in substantial gainful activity since
10 August 5, 2013, the amended alleged onset date. *Id.* at 25.

11 At step two, the ALJ found plaintiff suffered from the following severe
12 impairments: obesity, degenerative disc disease of the cervical spine status post
13 anterior cervical fusion at C5-C6, cervical radiculopathy, cervical spondylosis,
14 impingement syndrome of the right shoulder, degenerative disc disease of the
15 lumbar spine, and diabetes mellitus. *Id.*

16 At step three, the ALJ found plaintiff's impairments, whether individually or
17 in combination, did not meet or medically equal one of the listed impairments set
18 forth in 20 C.F.R. part 404, Subpart P, Appendix 1 (the "Listings"). *Id.* at 27.

19 The ALJ then assessed plaintiff's RFC,² and determined he had the RFC to
20 perform "light work," with the limitations that plaintiff: could occasionally push or
21 pull with his bilateral upper extremities; could occasionally climb ramps and stairs,
22 balance, stoop, kneel, crouch, or crawl; could occasionally reach overhead with the
23

24 ² Residual functional capacity is what a claimant can do despite existing
25 exertional and nonexertional limitations. *Cooper v. Sullivan*, 880 F.2d 1152, 1155-
26 56 n.5-7 (9th Cir. 1989). "Between steps three and four of the five-step evaluation,
27 the ALJ must proceed to an intermediate step in which the ALJ assesses the
28 claimant's residual functional capacity." *Massachi v. Astrue*, 486 F.3d 1149, 1151
n.2 (9th Cir. 2007).

1 bilateral upper extremities; and is precluded from climbing ladders, ropes or
2 scaffolds. *Id.*

3 The ALJ found, at step four, that plaintiff was unable to perform his past
4 relevant work as a combination shipping and receiving supervisor, receiving clerk,
5 or purchasing clerk. *Id.* at 30.

6 At step five, the ALJ determined that, based upon plaintiff's age, education,
7 work experience, and RFC, plaintiff could perform jobs that exist in significant
8 numbers in the national economy, including purchasing clerk and data entry. *Id.* at
9 31-32. Consequently, the ALJ concluded plaintiff did not suffer from a disability
10 as defined by the Social Security Act ("SSA"). *Id.* at 32-33.

11 Plaintiff filed a timely request for review of the ALJ's decision, which was
12 denied by the Appeals Council. *Id.* at 1-6. The ALJ's decision stands as the final
13 decision of the Commissioner.

14 III.

15 STANDARD OF REVIEW

16 This court is empowered to review decisions by the Commissioner to deny
17 benefits. 42 U.S.C. § 405(g). The findings and decision of the Social Security
18 Administration must be upheld if they are free of legal error and supported by
19 substantial evidence. *Mayes v. Massanari*, 276 F.3d 453, 458-59 (9th Cir. 2001)
20 (as amended). But if the court determines the ALJ's findings are based on legal
21 error or are not supported by substantial evidence in the record, the court may
22 reject the findings and set aside the decision to deny benefits. *Aukland v.*
23 *Massanari*, 257 F.3d 1033, 1035 (9th Cir. 2001); *Tonapetyan v. Halter*, 242 F.3d
24 1144, 1147 (9th Cir. 2001).

25 "Substantial evidence is more than a mere scintilla, but less than a
26 preponderance." *Aukland*, 257 F.3d at 1035. Substantial evidence is such
27 "relevant evidence which a reasonable person might accept as adequate to support
28

1 a conclusion.” *Reddick v. Chater*, 157 F.3d 715, 720 (9th Cir. 1998); *Mayes*, 276
2 F.3d at 459. To determine whether substantial evidence supports the ALJ’s
3 finding, the reviewing court must review the administrative record as a whole,
4 “weighing both the evidence that supports and the evidence that detracts from the
5 ALJ’s conclusion.” *Mayes*, 276 F.3d at 459. The ALJ’s decision “cannot be
6 affirmed simply by isolating a specific quantum of supporting evidence.”
7 *Aukland*, 257 F.3d at 1035 (quoting *Sousa v. Callahan*, 143 F.3d 1240, 1243 (9th
8 Cir. 1998)). If the evidence can reasonably support either affirming or reversing
9 the ALJ’s decision, the reviewing court “may not substitute its judgment for that
10 of the ALJ.” *Id.* (quoting *Matney v. Sullivan*, 981 F.2d 1016, 1018 (9th Cir.
11 1992)).

12 IV.

13 DISCUSSION

14 A. The ALJ Properly Assessed the Medical Opinion Evidence

15 Plaintiff asserts the ALJ erred because she failed to give specific and
16 legitimate reasons for rejecting the opinions of two treating physicians, Dr. Angela
17 C. Williams and Dr. James E. Shook. P. Mem. at 3-6.

18 1. The Medical Evidence

19 Plaintiff was involved in a motor vehicle accident on August 5, 2013, in
20 which he immediately experienced pain in his neck and upper back, and began to
21 experience shoulder pain the next day. AR at 304. Prior to the date of the
22 accident, which is also the amended alleged disability onset date, plaintiff
23 underwent neck surgery in 2008, left shoulder surgery in 2003, and right shoulder
24 surgery in 2000. *See id.* at 306, 316. Plaintiff also had a bulging disc injury at C3-
25 C4 in December 2008, which was treated with pain medicine and from which he
26 fully recovered. *Id.*

27 On August 30, 2013, plaintiff underwent a CT scan of his cervical spine. *Id.*

1 at 302-03. Notably, the examination revealed a finding in the left side facet joint at
2 C2-C3 likely secondary to severe facet arthropathy, post-surgical changes
3 consistent with anterior cervical discectomy, fusion at C3-C4 with anterior fixation
4 plate, and screws and evidence for partial fusion at C5-C6 and C6-C7. *Id.*

5 On May 4, 2014, plaintiff presented to the emergency department at Chino
6 Valley Medical Center in Chino, California with a chief complaint of low back
7 pain. *Id.* at 371-73. Plaintiff described dull, intermittent, 8/10 pain, but denied
8 numbness or tingling. *Id.* at 372. Plaintiff had a negative straight leg raise
9 bilaterally. *Id.* at 373. Plaintiff was taking 400mg of Motrin without
10 improvement. *Id.* Plaintiff was treated with 60mg of Toradol, and he was
11 discharged home to be treated with further medications. *Id.* at 373, 374, 379.

12 On July 4, 2014, plaintiff again presented to the emergency department at
13 Chino Valley Medical Center with a chief complaint of lower back pain. *Id.* at
14 360-62. Plaintiff took pain medications, primarily Norco and some ibuprofen, yet
15 this provided him insufficient pain relief. *Id.* at 361. Both plaintiff and his wife
16 indicated a stronger pain medication or muscle relaxer may be more beneficial to
17 treat his pain, though he had not undergone physical therapy, chiropractic
18 evaluation or treatment, or image testing. *Id.* A physical examination revealed
19 plaintiff was not in distress, and he denied weakness or numbness in his lower
20 extremities. *Id.* at 361-62. An x-ray of plaintiff's lumbosacral spine was ordered,
21 and he was diagnosed with chronic low back pain. *Id.* at 363, 366-69. The x-ray
22 results revealed degenerative disc disease at L2-L3, and to a lesser extent at L3-L4,
23 and facet hypertrophy at L5-S1 bilaterally. *Id.* at 366, 370.

24 On August 14, 2014, plaintiff underwent an MRI examination of his lumbar
25 spine. *Id.* at 443-44. The MRI revealed: a broad-based 2mm disc bulge, slight
26 increased signal in the facets, anterior osteophytic spurring, and loss of height of
27 the disc at L2-L3; a broad-based 2mm disc bulge with loss of height of the disc,
28 slight bilateral neuroforaminal encroachment, and slight increased signal in the

1 facets at L3-L4; slight increased signal in the facets at L4-L5; and slight increased
2 signal in the facets at L5-S1. *Id.*

3 **2. The Medical Opinions**

4 **a. Treating Physicians**

5 **Dr. Etemadian**

6 Dr. Ali Mohammad Etemadian intermittently treated plaintiff between 2009
7 and 2014. *See id.* at 418-20, 429-32, 434-38. On July 28, 2014, Dr. Etemadian
8 treated plaintiff's neck pain, and noted diagnoses of cervical spine degeneration,
9 low back pain, osteoarthritis, and herniated cervical spine with radiculopathy. *Id.*
10 at 429-31. Dr. Etemadian noted plaintiff reported he was "unsteady on his
11 walking" and had some numbness in his left leg. *Id.* at 429. Dr. Etemadian
12 reviewed the lumbar spine x-ray results discussed above. *Id.* at 418, 430.

13 **Dr. Fu**

14 On August 8, 2014, Dr. Morgan Mau Jin Fu treated plaintiff. *Id.* at 439,
15 440-42. In a treatment progress note, Dr. Fu observed the absence of both ankle
16 jerks and an unsteady gait that requires the assistance of plaintiff's wife. *Id.* at 439.
17 Dr. Fu assessed plaintiff had lumbar radiculopathy and cervical radiculopathy. *Id.*

18 **Dr. Williams**

19 Dr. Angela C. Williams was plaintiff's treating physician at the Jerry L.
20 Pettis Memorial Veterans Hospital in Loma Linda, California from January 2015 to
21 October 2015. *See id.* at 543-49, 554, 572, 578-79, 579-81, 615-16, 625-30, 686,
22 695, 703-08. On January 8, 2015, Dr. Williams performed an initial consultation.
23 *Id.* at 704. Dr. Williams noted plaintiff had diabetes, numbness at his distal legs, a
24 history of cervical spine surgery in 2008, neck pain, right knee pain, and a ventral
25 hernia. *Id.* Plaintiff screened positive for depression. *Id.* at 707. In February
26 2015, plaintiff described his level of pain as being at "5," and Dr. Williams
27 increased plaintiff's prescription of hydrocodone and acetaminophen to improve
28 his pain control. *Id.* at 658. In April 2015, Dr. Williams noted improvement in

1 plaintiff's diabetes control, but he had ongoing chronic neck pain, elbow pain, and
2 sleep disturbance. *Id.* at 628. Dr. Williams increased plaintiff's dosage of
3 Gabapentin. *Id.* Dr. Williams opined on April 23, 2015 that plaintiff had trouble
4 with "lifting and prolonged sitting and standing," and that he "would likely have
5 continued difficulty with employment." *Id.* at 426, 615-16.

6 On June 9, 2015, Dr. Williams completed a medical opinion questionnaire
7 about plaintiff's ability to do work-related activities. *Id.* at 718-20. Dr. Williams
8 assessed plaintiff could occasionally lift or carry 10 pounds, frequently lift or carry
9 less than 10 pounds, and stand, walk, or sit about two hours during a workday. *Id.*
10 at 718. Dr. Williams further opined plaintiff could occasionally twist, stoop,
11 crouch, climb stairs, and climb ladders, but he had limitations reaching and
12 pushing or pulling based on subjective numbness in his upper extremities. *Id.* at
13 719. She also found plaintiff had to avoid concentrated exposure to noise, fumes,
14 odors, dusts, gases, poor ventilation, and hazards, avoid moderate exposure to
15 extreme heat, and avoid all exposure to extreme cold, wetness, and humidity. *Id.* at
16 720. Dr. Williams also limited plaintiff's kneeling and crawling due to lumbar
17 spine radiculopathy. *Id.*

18 In July 2015, Dr. Williams reviewed hip and spine x-rays, and observed
19 diffuse increased radioactivity in the cervical vertebral bodies with degenerative
20 change, particularly along C5, C6, and C7. *Id.* at 579-81. During a visit in August
21 2015, Dr. Williams observed plaintiff had successfully improved control over his
22 diabetic condition, but neck and shoulder pain remained. *Id.* at 543. Upon review
23 of CT scans of plaintiff's neck, Dr. Williams assessed the left C3-C4 facet joint
24 was markedly narrowed, chronic facet degenerative changes were worst at C2-C3
25 on the left side, multilevel chronic degenerative disc disease with mild central
26 spinal canal narrowing at C7-T1, and neuroforaminal stenoses. *Id.* at 545. Pain
27 management with Norco and Gabapentin was prescribed. *Id.* at 546.

28 **Dr. Shook**

1 Dr. James E. Shook, an orthopedic surgeon at the Jerry L. Pettis Memorial
2 Veterans Hospital, also treated plaintiff. *See id.* at 52, 554-55, 588-89. On June
3 11, 2015, Dr. Shook noted plaintiff ambulated without myelopathic findings. *Id.* at
4 588-89.

5 On August 15, 2015, Dr. Shook submitted a questionnaire opining on
6 plaintiff's ability to perform work-related activities. *Id.* at 510-12. Dr. Shook
7 opined plaintiff had the functional capacity to occasionally lift and carry 10
8 pounds, frequently lift and carry less than 10 pounds, and stand, walk, and sit for
9 about two hours during an eight-hour workday. *Id.* at 510. Dr. Shook further
10 opined plaintiff had postural limitations, as he could only occasionally twist and
11 climb stairs, but he could never stoop, crouch, or climb ladders. *Id.* at 511. He
12 noted impairments in plaintiff's physical functions, including reaching, handling,
13 fingering, feeling, and pushing or pulling due to pain in plaintiff's neck and
14 shoulder numbness, and based on x-ray, CT, MRI findings. *Id.* Lastly, Dr. Shook
15 assessed plaintiff had environmental limitations to avoid concentrated exposure to
16 extreme heat or cold, and to avoid all exposure to hazards such as machinery and
17 heights. *Id.* at 512. Dr. Shook opined that plaintiff's impairments would cause
18 him to be absent from work more than three times per month. *Id.*

19 Later in August 2015, Dr. Shook scheduled plaintiff to have injections for
20 his pain management, and noted plaintiff was to return to orthopedic surgery one
21 month after injections in his neck. *Id.* at 555.

22 **Dr. Patchett**

23 On October 1, 2013, Dr. Clayton Patchett, an orthopedic surgeon, performed
24 an evaluation based on a review of plaintiff's medical records and a physical
25 examination, shortly after plaintiff's August 5, 2013 vehicular accident. *See id.* at
26 304-14. Plaintiff complained of moderate headaches and neck pain, slight bilateral
27 shoulder pain and upper back pain, stiffness and grinding in his neck, and pain at
28 night in his head and neck. *Id.* at 305. With respect to plaintiff's cervical spine,

1 Dr. Patchett opined plaintiff had tenderness of the posterior neck muscles
2 bilaterally, and gross muscle strength testing was 3/5 with left lateral flexion and
3 left rotation. *Id.* at 307. Dr. Patchett also assessed plaintiff's deep tendon reflexes
4 were 1+ at the biceps, triceps, and brachioradialis bilaterally, and his range of
5 motion was restricted. *Id.* Dr. Patchett noted a Supraspinatus test was positive,
6 there was general muscle weakness in the shoulders secondary to pain, and manual
7 muscle testing of the shoulder girdles was 4+/5 with abduction, adduction, internal
8 rotation, external rotation, extension, and flexion. *Id.* at 308. Plaintiff's range of
9 motion was restricted, he had tenderness over the anterior aspect of the
10 acromioclavicular joints, and there was a 7-finger saber cut over the incision of the
11 left shoulder. *Id.* Plaintiff had normal gait and posture without apparent distress.
12 *Id.* at 312. Dr. Patchett noted plaintiff's grip strength was 30/28/26 kilograms on
13 the right, and 30/28/28 kilograms on the left, and he had no diminished feeling,
14 numbness, or tingling in his hands. *Id.* at 312, 314. Dr. Patchett recommended
15 plaintiff seek further care and treatment, while commenting the treatment to that
16 point was "conservative with traditional static therapy techniques." *Id.* at 313.

17 Dr. Patchett treated plaintiff until November 2013. *See id.* at 326-42. Dr.
18 Patchett advised a spine consultation and possible therapy. *Id.* at 339, 341-42.
19 Over the course of treatment, plaintiff initially described shoulder and neck pain as
20 being between 4/10 and 5/10 (*see id.* at 336, 337), but both levels of pain were later
21 described as 4/10 and improving, although still constant. *See id.* at 330, 334, 336.
22 Dr. Patchett prescribed pain medications, anti-inflammatory medications, and
23 muscle relaxants, along with rehabilitation. *Id.* at 326, 333.

24 **b. Examining Physicians**

25 **Dr. Etemad**

26 On November 1, 2013, Dr. Alex H. Etemad, an orthopedic spine surgeon,
27 evaluated plaintiff's complaints of headaches, neck pain, and bilateral shoulder
28 pain upon reviewing his past medical history and performing a physical

1 examination. *Id.* at 315-24. Dr. Etemad observed plaintiff's cervical spine had
2 tenderness of the posterior neck muscles on the right, trigger points in the posterior
3 neck area on the right, and a spasm over the right trapezius muscle. *Id.* at 317. Dr.
4 Etemad assessed muscle testing revealed 4/5 strength with flexion, extension,
5 lateral flexion and rotation, restricted range of motion, and general muscle
6 weakness secondary to pain on the right. *Id.* Dr. Etemad noted a Supraspinatus
7 test was positive in the right and left shoulders, Hawkin's, Neer's, O'Brien's, and
8 Abduction's tests were 2+ in plaintiff's right shoulder and 1+ in his left shoulder,
9 4/5 strength with abduction, internal rotation, and flexion, and restricted range of
10 motion in the shoulders due to pain. *Id.* at 317-18. He also observed plaintiff had
11 full motion of the hands, no gross weakness in the hands or wrists, no complaints
12 of numbness in the fingers, and no loss of motion in the wrists. *Id.* at 319.
13 Plaintiff's grip strength was measured as 22/24/26 on the right, and 30/30/28 on
14 the left. *Id.* at 321. Dr. Etemad did not assess any issues with plaintiff's ankles,
15 feet, or knees, and found plaintiff was able to ambulate without complaint. *Id.*

16 Dr. Etemad opined plaintiff was temporarily or partially disabled, but that he
17 could continue working with restrictions limiting overhead work and lifting over
18 25 pounds. *Id.* at 323. Dr. Etemad advised a treatment plan of physical therapy
19 rehabilitation, pain medications, and epidural steroid injections. *Id.* at 324, 329.

20 **Dr. Bernabe**

21 On May 8, 2014, Dr. Vicente R. Bernabe, another orthopedic surgeon,
22 performed a complete orthopedic consultation of plaintiff's conditions based on his
23 examination and a review of plaintiff's medical records and complaints. *Id.* at 352-
24 58. Plaintiff presented with complaints of neck and shoulder pain arising from his
25 auto accident. *Id.* at 352. Plaintiff described his pain as sharp and throbbing. *Id.*
26 Plaintiff had received heat and massage treatment; although, at the time of the
27 consultation, he was only receiving pain medication including ibuprofen, which he
28 found unhelpful. *Id.* Dr. Bernabe noted plaintiff had tenderness of the

1 cervicothoracic junction in the cervical spine and a positive Spurling's test on the
2 right. *Id.* at 353-54. On plaintiff's upper extremities, Dr. Bernabe assessed
3 positive impingement sign on the right shoulder, pain and crepitus at the
4 acromioclavicular joint, and range of motion within normal limits with pain at the
5 terminal range of motion. *Id.* at 354. He did not find any issues with plaintiff's
6 elbows, wrists, or hands. *Id.* Plaintiff had a normal gait. *Id.* at 353.

7 Dr. Bernabe opined plaintiff had the functional capacity to: lift and carry 50
8 pounds occasionally and 25 pounds; frequently push and pull; walk, stand, and sit
9 for six hours out of an eight-hour day; and frequently walk on uneven terrain,
10 climb ladders, and work at heights. *Id.* at 356. Dr. Bernabe found plaintiff did not
11 have manipulative restrictions for fingering, handling, feeling, and reaching. *Id.*
12 As to postural limitations, Dr. Bernabe opined plaintiff could bend, crouch, stoop,
13 and crawl frequently. *Id.*

14 **Dr. Ali**

15 Dr. Mohsen Ali, a neurologist, performed a neurological evaluation of
16 plaintiff on October 18, 2014 to address plaintiff's complaint of neck pain. *Id.* at
17 487-88, 490-91. Dr. Ali found plaintiff had significantly reduced range of motion
18 in his neck in all directions, and reduced range of motion in his lumbar spine with
19 positive straight leg raising sign on the left side. *Id.* at 488. Dr. Ali observed
20 plaintiff's stance and gait were normal, and there was no evidence of focal muscle
21 atrophy or weakness. *Id.* Dr. Ali opined plaintiff had cervical radiculopathy and
22 lumbar radiculopathy, and scheduled an EMG examination of his left arm and left
23 leg. *Id.* Dr. Ali performed the EMG and a nerve conduction study on November 8,
24 2014. *Id.* at 477-86. The nerve conduction study revealed normal motor and serve
25 nerve conduction, but the EMG was abnormal due to the presence of chronic
26 denervation involving C5 and C6, which was consistent with chronic cervical
27 radiculopathy. *Id.* at 477.

28 **c. Non-Examining Physicians**

1 **Dr. Kalmar**

2 On May 29, 2014, Dr. F. Kalmar, a non-examining state physician, reviewed
3 plaintiff's medical records and assessed his RFC. *Id.* at 91-95. Dr. Kalmar found
4 plaintiff could occasionally lift or carry 20 pounds, frequently lift or carry 10
5 pounds, and stand, walk, and sit about six hours during a workday. *Id.* at 93. Dr.
6 Kalmar further opined plaintiff had pushing or pulling limitations in both his upper
7 extremities due to cervical radiculitis and right upper extremity impingement
8 syndrome. *Id.* Dr. Kalmar also opined plaintiff had postural limitations, in that he
9 could occasionally climb ramps or stairs, balance, stoop, kneel, crouch, and crawl,
10 but he could never climb ladders, ropes, or scaffolds. *Id.* at 93-94. He found
11 plaintiff had some manipulative limitations – including limited left and right
12 overhead reaching, limited handling on his right side, and unlimited fingering and
13 feeling – but no visual or communicative limitations. *Id.* at 94. He also found
14 plaintiff had environmental limitations to avoid concentrated exposure to extreme
15 cold, vibration, and hazards such as machinery and heights. *Id.* at 94-95.

16 **Dr. Pancho**

17 On August 26, 2014, Dr. L. Pancho, another non-examining state physician,
18 also reviewed plaintiff's medical records and assessed his RFC. *Id.* at 114-18. Dr.
19 Pancho's opinions as to plaintiff's exertional, postural, manipulative, visual,
20 communicative, and environmental limitations were identical to those found by Dr.
21 Kalmar. *See id.* at 116-18.

22 **3. The ALJ's Findings**

23 Based on her reading of the medical evidence, the ALJ determined plaintiff
24 had the RFC to perform light work, but with the limitations that he: could
25 occasionally use his bilateral upper extremities for pushing, pulling, and reaching
26 overhead; could occasionally climb ramps and stairs, balance, stoop, kneel, crouch,
27 or crawl; and is precluded from climbing ladders, ropes, or scaffolds. *Id.* at 27.

28 The ALJ gave little weight to the opinions of Dr. Williams and Dr. Shook

1 “that the claimant can lift no more than 10 pounds, can sit or stand/walk fewer than
2 two hours, and would be subject to further environmental and environmental
3 limitations,” because she found them unsupported by clinical findings, exceeded
4 limitations reflected by clinical examinations, and were based largely on plaintiff’s
5 subjective allegations. *Id.* at 30. The ALJ gave significant weight to Dr. Etemad’s
6 opinions because they were consistent with his documented observations. *Id.* The
7 ALJ also afforded some weight to the opinions of the non-examining state
8 physicians because, although the ALJ agreed plaintiff was able to perform light
9 work, their limitations on handling for plaintiff’s right upper extremity were not
10 consistent with the objective evidence showing no observation of deficient
11 functionality for his manipulation and nerve testing found no abnormality
12 suggesting a loss of capability. *Id.* Some weight was also accorded to Dr.
13 Bernabe’s opinion, but found further restrictions than those opined by Dr. Bernabe
14 were appropriate given plaintiff’s treatment history, diagnoses, and some of his
15 subjective allegations. *Id.*

16 **4. The ALJ Did Not Err in Rejecting the Opinions of Dr. Williams**
17 **and Dr. Shook**

18 The ALJ has a duty to consider all relevant medical evidence to reach an
19 RFC determination. *See* 20 C.F.R. § 404.1545(a)(1) (it is the responsibility of the
20 ALJ to reach an RFC determination by reviewing and considering all of the
21 relevant evidence).³ In evaluating medical opinions, the regulations distinguish
22 among three types of physicians: (1) treating physicians; (2) examining physicians;
23 and (3) non-examining physicians. 20 C.F.R. §§ 404.1527(c), (e), 416.927(c), (e);
24 *Lester v. Chater*, 81 F.3d 821, 830 (9th Cir. 1995). “Generally, a treating
25 physician’s opinion carries more weight than a reviewing physician’s.” *Holohan v.*

26
27 ³ All citations to the Code of Federal Regulations refer to regulations
28 applicable to claims filed before March 27, 2017.

1 *Massanari*, 246 F.3d 1195, 1202 (9th Cir. 2001); 20 C.F.R. §§
2 404.1527(c)(1)-(2), 416.927(c)(1)-(2). The opinion of the treating physician is
3 generally given the greatest weight because the treating physician is employed to
4 cure and has a greater opportunity to understand and observe a claimant. *Smolen v.*
5 *Chater*, 80 F.3d 1273, 1285 (9th Cir. 1996); *Magallanes v. Bowen*, 881 F.2d 747,
6 751 (9th Cir. 1989).

7 The ALJ is not bound by the opinion of the treating physician. *Smolen*, 80
8 F.3d at 1285. If a treating physician’s opinion is uncontradicted, the ALJ must
9 provide clear and convincing reasons for giving it less weight. *Lester*, 81 F.3d at
10 830. If the treating physician’s opinion is contradicted by other opinions, the ALJ
11 must provide specific and legitimate reasons supported by substantial evidence for
12 rejecting it. *Id.* Likewise, the ALJ must provide specific and legitimate reasons
13 supported by substantial evidence in rejecting the contradicted opinions of
14 examining physicians. *Id.* at 830-31. The opinion of a non-examining physician,
15 standing alone, cannot constitute substantial evidence. *Widmark v. Barnhart*, 454
16 F.3d 1063, 1066 n.2 (9th Cir. 2006); *Morgan v. Comm’r of Soc. Sec. Admin.*, 169
17 F.3d 595, 602 (9th Cir. 1999); *see also Erickson v. Shalala*, 9 F.3d 813, 818 n.7
18 (9th Cir. 1993).

19 Here, the ALJ determined plaintiff could perform light work subject to
20 certain limitations. The federal regulations and Social Security policy define light
21 work as involving “lifting no more than 20 pounds at a time with frequent lifting or
22 carrying of objects weighing up to 10 pounds.” 20 C.F.R. §§ 404.1567(b),
23 416.967(b); Social Security Ruling (“SSR”) 83-10.⁴ The SSR notes the

24
25 ⁴ “The Commissioner issues Social Security Rulings to clarify the Act’s
26 implementing regulations and the agency’s policies. SSRs are binding on all
27 components of the SSA. SSRs do not have the force of law. However, because
28 they represent the Commissioner’s interpretation of the agency’s regulations, we
give them some deference. We will not defer to SSRs if they are inconsistent with

1 requirement of “a good deal of walking or standing” is the characteristic that most
2 often distinguishes light work from sedentary work. SSR 83-10. According to the
3 SSR, “the full range of light work requires standing or walking, off and on, for a
4 total of approximately 6 hours of an 8-hour workday,” with the possibility of
5 sitting intermittently during the remaining two hours of the day. *Id.*

6 Plaintiff here argues the ALJ failed to properly assess the opinions of Dr.
7 Williams and Dr. Shook, and instead improperly relied on the opinion of Dr.
8 Bernabe. P. Mem. at 3-4, 6. Both Dr. Williams and Dr. Shook opined plaintiff
9 could only stand, walk, or sit for about two hours during an eight-hour workday.
10 *See* AR at 510, 718. By contrast, Dr. Bernabe opined plaintiff could stand, walk,
11 or sit for six hours during a workday. *Id.* at 356. And both Dr. Etemad and Dr.
12 Bernabe opined plaintiff could lift and carry more than 10 pounds. *See id.* at 323,
13 356. Thus, in finding plaintiff could perform light work, the ALJ more closely
14 followed Dr. Bernabe’s opinion rather than Dr. Williams’s or Dr. Shook’s
15 opinions. The court notes, however, that the ALJ only gave the opinion of Dr.
16 Bernabe some weight, as she expressly rejected, or downgraded, portions of Dr.
17 Bernabe’s opinion suggesting a capacity for plaintiff to perform medium work.
18 *See id.* at 30. The ALJ also considered the medical opinions of other physicians,
19 and in fact gave Dr. Etemad’s opinion greater weight than Dr. Bernabe’s. *Id.* The
20 ALJ credited the opinions of both of these examining physicians, Dr. Bernabe and
21 Dr. Etemad, to the extent she found them consistent with their own clinical
22 observations. *Id.* The opinions of examining physicians may constitute substantial
23 evidence when they make “‘independent clinical findings that differ from the
24 findings of the treating physician.’” *Orn v. Astrue*, 495 F.3d 625, 632 (9th Cir.
25 2007) (quoting *Miller v. Heckler*, 770 F.2d 845, 849 (9th Cir. 1985)).

26 _____
27 the statute or regulations.” *Holohan*, 246 F.3d at 1203 n.1 (internal citations
28 omitted).

1 The ALJ expressly gave only little weight to the opinions of Drs. Williams
2 and Shook for three reasons. First, the ALJ found their assessments were “not
3 supported by detailed citation to clinical findings.” AR at 30. Indeed, Dr.
4 Williams presented her opinion regarding plaintiff’s limitations on a form
5 questionnaire in which she checked boxes to indicate the limitations and provided
6 only ultimate diagnoses as the bases for the opined limitations. *See id.* at 718-20.
7 Dr. Shook completed the same questionnaire and provided only slightly more
8 detailed bases. *See id.* at 510-12. An “ALJ need not accept a treating physician’s
9 opinion which is brief and conclusionary in form with little in the way of clinical
10 findings to supports [its] conclusions.” *Magallanes*, 881 F.2d at 751 (internal
11 quotation marks and citations omitted); *see Batson v. Comm’r of Soc. Sec. Admin.*,
12 359 F.3d 1190, 1195 (9th Cir. 2004) (ALJ properly discounted treating physician’s
13 opinion because, inter alia, “it was in the form of a checklist”; “an ALJ may
14 discredit treating physicians’ opinions that are conclusory, brief, and unsupported
15 by the record as a whole”). Thus, the ALJ’s first reason for discounting the treating
16 physicians’ opinions was specific and legitimate.

17 The second and thirds reasons given by the ALJ were, relatedly, that Dr.
18 Williams’s and Dr. Shook’s opinions “exceed any limitations reflected on clinical
19 examination, and appear to be based largely on the claimant’s subjective
20 allegations.” AR at 30. These too were specific and legitimate reasons supported
21 by substantial evidence.

22 The ALJ first rejected the treating physicians’ limitation of plaintiff to light
23 work. *Id.* As discussed above, Drs. Williams and Shook both opined plaintiff
24 could only stand, walk, or sit for two hours in a workday, and lift or carry no more
25 than ten pounds. Dr. Williams’s notes reflect plaintiff’s complaints of numbness
26 and pain, but little in the way of clinical observations prior to her rendering her
27 June 2015 opinion. *See, e.g., id.* at 615, 658, 704. Dr. Williams noted plaintiff’s
28 lumbar radiculopathy and bulging disc, and may have relied on x-rays and an MRI

1 from the summer of 2014 that support these diagnoses. *See id.*; *see also id.* at 363,
2 366-70, 443-44. And indeed, the ALJ found plaintiff suffered from the severe
3 impairment of degenerative disc disease of the lumbar spine. *Id.* at 25. But
4 nothing in Dr. Williams’s treatment notes or other clinical evidence indicates that
5 plaintiff’s lumbar spine disc disease resulted in limitations to the degree she
6 opined.

7 Dr. Shook more clearly cites to the x-rays showing lumbar spine problems to
8 support the limitations he opined as to plaintiff’s standing and walking (*id.* at 511),
9 but at the same time he observed plaintiff “ambulates without myelopathic
10 findings.” *See id.* at 589. In the summer of 2014, plaintiff reported to Dr.
11 Etemadian that he was unsteady and had some numbness in his leg, and Dr. Fu
12 observed plaintiff to have an unsteady gait and the absence of ankle jerk reflexes.
13 *Id.* at 429, 439. But both before and after that, Drs. Patchett, Bernabe, Etemad, and
14 Ali all observed plaintiff to have a normal gait and no apparent distress. *Id.* at 312,
15 321, 353, 488. The ALJ discussed the foregoing evidence, and also considered the
16 impact of plaintiff’s weight on his ability to ambulate, and reasonably concluded
17 the evidence from the clinical examinations did not support the extreme limitations
18 on sitting, standing, and walking opined by the treating physicians. *See id.* at 28-
19 30.

20 As for the other limitations opined by the treating physicians to which the
21 ALJ gave little weight, while Dr. Shook opined plaintiff had handling, fingering,
22 and feeling limitations, Dr. Williams rejected that plaintiff had such physical
23 impairments. *Id.* at 511, 719. Neither Dr. Patchett nor Dr. Etemad noted issues
24 with plaintiff’s hands, wrists, or fingers that would warrant handling, fingering, or
25 feeling limitations, despite plaintiff exhibiting inconsistent grip strength in his
26 hands. *Id.* at 312, 314, 319, 321. Thus, the ALJ properly rejected that portion of
27 Dr. Shook’s opinion.

28 The ALJ also properly rejected the environmental limitations opined by Dr.

1 Williams and Dr. Shook. Dr. Williams opined plaintiff should be limited in his
2 exposure to noise, fumes, odors, dusts, gases, poor ventilation, hazards, and
3 extreme temperatures, humidity, and wetness, and hazards. *Id.* at 512, 720. Dr.
4 Williams's environmental limitations were solely based on concern that extreme
5 temperatures could worsen plaintiff's levels of pain, which does not even address
6 most of these opined limitations, much less citing any clinical evidentiary support.
7 *Id.* at 720. Dr. Shook sought to limit plaintiff's concentrated exposure to extreme
8 cold and heat and all exposure to machinery and other hazards. *Id.* at 512. Dr.
9 Shook reasoned plaintiff had poor reflexes and control of his hands and feet. *Id.* at
10 512. Yet the medical record indicates there was little evidence of diabetic
11 neuropathy or poor balance. *Id.* at 353-55, 488, 645, 705. Multiple doctors found
12 no abnormalities or complaints in plaintiff's hands or feet. *Id.* at 309-11, 319-21,
13 354-55. And Dr. Patchett and Dr. Bernabe found plaintiff's reflexes were normal.
14 *Id.* at 311, 355. The medical record therefore provides a specific and legitimate
15 reason supported by substantial evidence to reject the treating physicians' opined
16 environmental limitations.

17 The ALJ implicitly adopted Dr. Williams's opined postural limitations that
18 plaintiff be limited to occasional pushing and pulling, climbing ramps or stairs,
19 stooping, crouching, kneeling, and crawling. *See id.* at 27, 719-20. This opinion is
20 supported in part by the opinions of the non-examining state physicians. *See id.* at
21 93-94, 116-17 (ALJ adopted postural limitations, including pushing or pulling and
22 reaching limitations); *see also Thomas v. Barnhart*, 278 F.3d 947, 957 (9th Cir.
23 2002) (opinions of non-examining physicians "serve as substantial evidence when
24 the opinions are consistent with independent clinical findings or other evidence in
25 the record"). The ALJ therefore had a valid basis to reject Dr. Shook's opinion
26 that plaintiff could never stoop, crouch, or climb ladders. *See AR* at 511.

27 In sum, the ALJ properly assessed the opinions of Dr. Williams and Dr.
28 Shook, and she did not err in rejecting those opinions.

1 **B. The ALJ’s RFC Assessment Is Supported by Substantial Evidence**

2 Residual function capacity is what one “can still do despite [his or her]
3 limitations.” 20 C.F.R. §§ 404.1545(a)(1)-(2), 416.945(a)(1). The Commissioner
4 reaches an RFC determination by reviewing and considering all of the relevant
5 evidence, including non-severe impairments. *Id.* Plaintiff argues that the ALJ’s
6 RFC determination is not supported by substantial evidence. P. Mem. at 16-17.
7 Specifically, plaintiff contends the ALJ failed to address the effect of plaintiff’s
8 pain in his RFC determination, and failed to account for his mental impairments at
9 all.

10 **1. Physical Impairments**

11 As noted above, the ALJ determined plaintiff had the RFC to perform light
12 work, except he could only occasionally use his bilateral upper extremities for
13 pushing, pulling, and reaching overhead, and could occasionally climb ramps and
14 stairs, balance, stoop, kneel, crouch, or crawl, and is precluded from climbing
15 ladders, ropes, or scaffolds. AR at 27. In reaching this determination, the ALJ
16 discussed all of the medical evidence and opinions, and found the medical record
17 does not support limitations that exceed the RFC finding. *Id.* at 29. Although
18 plaintiff injured his shoulders and neck in a motor vehicle accident on the alleged
19 onset date of disability, the ALJ reasoned plaintiff only received conservative
20 treatment based on medication and a cervical medial branch block. *Id.* The ALJ
21 further stated EMG and nerve conduction testing did not show cervical
22 radiculopathy, while physical examinations were consistent with the RFC finding.
23 *Id.* at 29-30; *see id.* at 497.

24 An “ALJ does not need to discuss every piece of evidence.” *Howard v.*
25 *Barnhart*, 341 F.3d 1006, 1012 (9th Cir. 2003) (internal quotations and citation
26 omitted). But the ALJ is required to discuss significant and probative evidence.
27 *See id.*; *Vincent v. Heckler*, 739 F.2d 1393, 1394-95 (9th Cir. 1984).

28 Plaintiff complained of neck pain, and doctors noted degenerative spinal

1 issues along the neck, including degenerative changes and disease, tender neck
2 muscles, and limited range of motion. AR at 307, 317, 429-31, 488, 545, 579-81.
3 Similarly, plaintiff's complaints of shoulder pain are supported by a positive
4 impingement sign on the right shoulder, positive Supraspinatus test in both
5 shoulders, positive Hawkins', Neer's, O'Brien's, and Abduction's tests, and
6 general muscle weakness. *Id.* at 308, 317-18. With regard to back pain, an MRI
7 and x-ray revealed degenerative disc disease and 2mm disc bulges at L2-3 and L3-
8 4. *Id.* at 366, 370, 443-44. A CT scan revealed severe facet arthropathy in the
9 cervical spine. *Id.* at 302-03.

10 The objective medical evidence supports a finding of severe medical
11 impairments. But portions of the medical evidence do not support the degree of
12 symptoms plaintiff alleged. Although plaintiff complained of shooting pain,
13 neurological examinations were normal. *See id.* at 311, 355. And despite
14 complaints about difficulty with standing and walking, plaintiff ambulated without
15 discomfort, with a normal gait, and with only slightly reduced leg strength. *See id.*
16 at 373-75, 390, 393, 401, 488. In some examinations, plaintiff exhibited adequate
17 strength and range of motion in the cervical spine and shoulders. *Id.* at 307-08,
18 313-14, 317-18, 322-23. The ALJ considered all of the opinion evidence,
19 explaining which portions she gave weight to, and plaintiff's subjective
20 complaints.

21 The ALJ did mischaracterize certain of the medical evidence. While the
22 ALJ stated EMG testing did not indicate cervical radiculopathy (*see id.* at 29), Dr.
23 Ali specifically noted that an EMG study conducted November 8, 2014 was
24 "consistent with chronic cervical radiculopathy involving C5 and [sic] C6." *Id.* at
25 477. The ALJ thus erroneously mischaracterized the EMG study to support her
26 RFC determination. Defendant concedes this, but accurately notes the ALJ
27 identified cervical radiculopathy as a severe impairment at Step Two. D. Mem. at
28 3 n.2; *see* AR at 25. Therefore, despite the misstatement about the EMG study, the

1 ALJ did in fact consider plaintiff's cervical radiculopathy in her RFC
2 determination. Though objective evidence of cervical radiculopathy could affect
3 findings regarding plaintiff's pain or weakness in his upper extremities, thereby
4 subjecting him to additional lifting, carrying, or reaching limitations, nothing in the
5 record suggests the ALJ's mischaracterization affected her RFC finding, which
6 was ultimately supported by substantial evidence in the medical record.

7 **2. Mental Impairments**

8 Plaintiff also argues that his mental impairments, although found to be non-
9 severe, still should have been considered in his RFC determination. P. Mem. at 7-
10 8; *see* SSR 96-8p ("In assessing RFC, the adjudicator must consider limitations and
11 restrictions imposed by all of an individual's impairments, even those that are not
12 'severe.'"). In determining plaintiff's RFC, the ALJ found plaintiff has no mental
13 limitations. AR at 27.

14 The ALJ discussed plaintiff's mental impairments – namely, posttraumatic
15 stress disorder and major depressive disorder – in determining which impairments
16 were severe.⁵ *Id.* First, in activities of daily living, the ALJ found plaintiff had
17 only mild limitations because he could do light housework, walk the dog, do the
18 dishes, shop, and vacuum with limitations due to pain. AR at 26; *see id.* at 238-41,
19 264-72. Second, in the area of social functioning, the ALJ found that plaintiff had
20 mild limitation without further explanation. *Id.* at 26. Third, in the area of
21 concentration, persistence, or pace, the ALJ again found only mild limitations
22 without noting evidentiary support. *Id.* Fourth, the ALJ found no episodes of
23 decompensation which have been of extended duration, pointing to plaintiff's

24 ⁵ The ALJ "considered the four broad functional areas set out in the disability
25 regulations for evaluating mental disorders," which are known as the "paragraph
26 B" criteria. AR at 26. The four areas of function, in which the ALJ must rate the
27 degree of functional limitation, are: (a) activities of daily living; (b) social
28 functioning; (c) concentration, persistence, or pace; and (d) episodes of
decompensation. 20 C.F.R. § 416.920a(c)(3).

1 diagnoses of major depressive disorder and post-traumatic stress disorder, but
2 noting conservative medication treatment, and his failure to participate in group or
3 individual therapy. *Id.*; *see id.* at 564, 638. The ALJ thus found plaintiff’s mental
4 impairments were non-severe and did not assess any mental impairment limitations
5 in her RFC determination. *Id.* at 26-27.

6 Though plaintiff was diagnosed with major depressive disorder and
7 posttraumatic stress disorder, he responded well to medical treatment. *See id.* at
8 418, 564 (noting plaintiff’s mood as “moderately depressed”), 611-12 (plaintiff
9 was aware that psychotropic medication was “working”). No episodes of
10 decompensation were evident in the record. That plaintiff’s mental conditions
11 improved due to medication supports the ALJ’s finding of no mental limitations.
12 *See Warre v. Comm’r of Soc. Sec.*, 439 F.3d 1001, 1006 (9th Cir. 2006)
13 (“Impairments that can be controlled effectively with medication are not disabling
14 for the purpose of determining eligibility for SSI benefits.”).

15 Plaintiff also did not exhibit a loss of mental functioning that would impact
16 his concentration, persistence, or pace. For example, plaintiff generally had good
17 and appropriate affect, thought, insight, and judgment. *See AR* at 563-64, 612,
18 641-42, 699-701. On March 26, 2015, intake notes found plaintiff had sleep
19 disturbance, decreased energy, concentration, and appetite, and he was distracted
20 and irritable due to financial and medical stressors. *Id.* at 638. Yet this alone is not
21 sufficient to establish that plaintiff’s limitations in concentration, persistence, or
22 pace were more than mild.

23 With regard to social functioning, plaintiff appeared pleasant with others and
24 without apparent distress, such that a more restrictive limitation was not warranted.
25 *See id.* at 361, 372, 419, 488. Plaintiff’s activities of daily living similarly did not
26 indicate such restrictive mental impairment limitation was evident. Nothing
27 suggests plaintiff’s mental impairments imposed any limitation on his mental
28 functional capacity that warranted inclusion in his RFC.

1 Accordingly, the ALJ did not err in determining plaintiff’s RFC, at least as
2 discussed above. But plaintiff’s RFC could change based on proper consideration
3 of plaintiff’s subjective complaints of pain, as discussed next.

4 **C. The ALJ Did Not Offer Clear and Convincing Reasons for Discounting**
5 **the Credibility of Plaintiff’s Subjective Complaints**

6 Plaintiff argues the ALJ failed to make a proper credibility determination. P.
7 Mem. at 9-10; Reply at 5-6. Specifically, plaintiff contends the ALJ’s reasons for
8 discounting the credibility of his subjective complaints were not supported by
9 substantial evidence. P. Mem. at 9-10.

10 The ALJ must make specific credibility findings, supported by the record.
11 SSR 96-7p. To determine whether testimony concerning symptoms is credible, the
12 ALJ engages in a two-step analysis. *Lingenfelter v. Astrue*, 504 F.3d 1028, 1035-
13 36 (9th Cir. 2007). First, the ALJ must determine whether a claimant produced
14 objective medical evidence of an underlying impairment ““which could reasonably
15 be expected to produce the pain or other symptoms alleged.”” *Id.* at 1036 (quoting
16 *Bunnell v. Sullivan*, 947 F.2d 341, 344 (9th Cir. 1991) (en banc)). Second, if there
17 is no evidence of malingering, an “ALJ can reject the claimant’s testimony about
18 the severity of her symptoms only by offering specific, clear and convincing
19 reasons for doing so.” *Smolen*, 80 F.3d at 1281; *Benton v. Barnhart*, 331 F.3d
20 1030, 1040 (9th Cir. 2003).

21 “[A]n ALJ does not provide specific, clear, and convincing reasons for
22 rejecting a claimant’s testimony by simply reciting the medical evidence in support
23 of his or her residual functional capacity determination.” *Brown-Hunter v. Colvin*,
24 806 F.3d 487, 489 (9th Cir. 2015). To permit a meaningful review of the ALJ’s
25 credibility determination, the ALJ must “specify which testimony she finds not
26 credible, and then provide clear and convincing reasons, supported by evidence in
27 the record, to support that credibility determination.” *Id.*; see *Treichler v. Comm’r*
28 *of Soc. Sec.*, 775 F.3d 1090, 1102 (9th Cir. 2014) (The ALJ must ““specifically

1 identify the testimony [from a claimant] that she or he finds not to be credible and .
2 . . . explain what evidence undermines the testimony.’”) (quoting *Holohan*, 246 F.3d
3 at 1208).

4 The ALJ may consider several factors in weighing a claimant’s credibility,
5 including: (1) ordinary techniques of credibility evaluation such as a claimant’s
6 reputation for lying; (2) the failure to seek treatment or follow a prescribed course
7 of treatment; and (3) a claimant’s daily activities. *Tommasetti v. Astrue*, 533 F.3d
8 1035, 1039 (9th Cir. 2008); *Bunnell*, 947 F.2d at 346-47. But “subjective pain
9 testimony cannot be rejected on the *sole* ground that it is not fully corroborated by
10 objective medical evidence.” *Rollins v. Massanari*, 261 F.3d 853, 857 (9th Cir.
11 2001) (emphasis added) (citation omitted).

12 At the first step, the ALJ here found plaintiff’s medically determinable
13 impairments could reasonably be expected to cause the symptoms alleged. AR at
14 27. At the second step, because the ALJ did not find any evidence of malingering,
15 the ALJ was required to provide clear and convincing reasons for discounting the
16 credibility of plaintiff’s testimony.

17 As an initial matter, the ALJ failed to specifically identify the testimony
18 from plaintiff that she found not credible. *See Brown-Hunter*, 806 F.3d at 489;
19 *Treichler*, 775 F.3d at 1102. Here, the ALJ merely stated: “The claimant alleges
20 disabling limitations due to his symptoms including difficulties with maneuvering,
21 manipulation and exertion.” AR at 27. This falls short of specifying the testimony
22 she found not credible, and makes it difficult for this court to review the credibility
23 determination.

24 But even if the ALJ had specified the testimony she discounted, her reasons
25 given were not clear and convincing. The ALJ found plaintiff’s testimony to be
26 not entirely credible because: (1) plaintiff’s alleged limitations were not
27 corroborated by the objective medical evidence; and (2) plaintiff received only
28 conservative treatment. *Id.* at 29-30. Defendant also argues plaintiff’s credibility

1 is undermined because he left his most recent job due to being laid off, rather than
2 due to his medical condition, and his daily activities are inconsistent with his
3 allegations. D. Mem. at 8. The court rejects defendant’s arguments that the ALJ’s
4 credibility determination should be upheld because plaintiff left his most recent
5 work due to being laid off and because of his daily activities. These were not
6 reasons cited by the ALJ for her credibility determination. The court can only
7 review the reasons actually provided by the ALJ. *See Orn*, 495 F.3d at 630 (“We
8 review only the reasons provided by the ALJ in the disability determination and
9 may not affirm the ALJ on a ground upon which he did not rely.”) (citation
10 omitted).

11 The court will not analyze the first reason given by the ALJ in detail
12 because, as noted above, lack of corroboration by the objective medical evidence
13 cannot, standing alone, constitute a clear and convincing reason for rejecting
14 plaintiff’s subjective complaints. *See Rollins*, 261 F.3d at 857. The court does
15 note, however, that in addition to failing to identify what testimony she found
16 incredible in light of the medical record, the ALJ also failed to explain how the
17 medical record undermines plaintiff’s credibility.

18 The ALJ also rejected plaintiff’s testimony because he obtained only
19 conservative treatment for his alleged pain conditions. AR at 29. Evidence of
20 conservative treatment may form the basis for undermining plaintiff’s credibility
21 regarding the severity of the ailment. *Tommasetti*, 533 F.3d at 1039; *see Parra v.*
22 *Astrue*, 481 F.3d 742, 750-51 (9th Cir. 2007) (“evidence of ‘conservative
23 treatment’ is sufficient to discount a claimant’s testimony regarding severity of an
24 impairment”) (citation omitted); *Johnson v. Shalala*, 60 F.3d 1428, 1434 (9th Cir.
25 1995) (reasoning “conservative treatment” is indicative of “a lower level of both
26 pain and functional limitation”); SSR 96-7 (“the [plaintiff]’s statements may be
27 less credible if the level or frequency of treatment is inconsistent with the level of
28 complaints”).

1 Plaintiff here testified that he relied on pain medication treatments for his
2 nerve pain. AR at 55. The medical record reflects plaintiff regularly took various
3 pain medications that did not relieve his pain symptoms. *See id.* at 352, 361, 372.
4 Dr. Patchett characterized plaintiff’s medication-based treatment as “conservative.”
5 *Id.* at 313. Dr. Bernabe noted plaintiff also received heat and massage treatment.
6 *Id.* at 352. In 2013, both Dr. Patchett and Dr. Etemad recommended plaintiff seek
7 physical therapy or rehabilitation treatment, and Dr. Etemad additionally
8 recommended steroid injections. *See id.* at 324, 326, 329, 333.

9 When plaintiff presented to the emergency department for his low back pain
10 in 2014, his only documented treatment was prescription medication and sporadic
11 intake of ibuprofen; he had not undergone physical therapy, chiropractic evaluation
12 or treatment, or image testing. *Id.* at 361. Both plaintiff and his wife expressed an
13 interest in stronger pain medication. *Id.* In March 2015, plaintiff was evaluated
14 for occupational therapy, but he missed an earlier appointment. *Id.* at 645-47, 648.

15 Plaintiff used an array of medications, including narcotics such as Norco and
16 hydrocodone, and non-narcotics such as ibuprofen, Gabapentin, and Toradol. The
17 use of prescribed narcotic medication, by itself, may be considered conservative
18 treatment. *See Huizar v. Comm’r*, 428 Fed. Appx. 678, 680 (9th Cir, 2011)
19 (finding that plaintiff responded to conservative treatment, which included the use
20 of narcotic medication); *Higinio v. Colvin*, 2014 WL 47935, at *5 (C.D. Cal. Jan.
21 7, 2014) (holding that, despite the fact that plaintiff had been prescribed narcotic
22 medication at various times, plaintiff’s treatment as a whole was conservative).
23 But, in general, the Ninth Circuit and its district courts have viewed the use of
24 narcotic pain medication as non-conservative treatment, at least when in
25 conjunction with other treatments that were also not conservative. *See, e.g.*,
26 *Lapierre-Gutt v. Astrue*, 382 Fed. Appx. 662, 664 (9th Cir. 2010 (treatment
27 consisting of “copious” amounts of narcotic pain medication, occipital nerve
28 blocks, and trigger point injections was not conservative); *Christie v. Astrue*, 2011

1 WL 4368189, at *4 (C.D. Cal. Sept. 18, 2015) (treatment with narcotics, steroid
2 injections, trigger point injections, epidural injections, and cervical traction was not
3 conservative).

4 Plaintiff here also received epidural injections for his pain management. *See*
5 AR at 555. At the hearing, plaintiff testified he had just undergone a bilateral
6 cervical medial block to locate the nerves in his neck for potential surgery. *Id.* at
7 48. Plaintiff was scheduled to have “another set of shots” – likely four more shots
8 – within a week from the hearing. *Id.* at 48, 54. The injections were supposed to
9 numb the nerve pain in his neck, but it did not last long and plaintiff “felt hardly
10 any relief.” *Id.* at 54. Some courts have characterized limited or one-time
11 injections as conservative treatment. *See, e.g., Jones v. Comm’r*, 2014 WL
12 228590, at *7 (E.D. Cal. Jan. 21, 2014) (occasional use of epidural injections in
13 conjunction with massages and anti-inflammatory medications could be considered
14 conservative); *Gonzales v. Colvin*, 2015 WL 685347, at *11 (C.D. Cal. Feb. 18,
15 2015) (treatment consisting of medication and a single steroid injection was
16 conservative). In contrast, other courts have deemed this treatment not
17 conservative, in particular when a claimant was treated with other injections and
18 narcotic pain medication. *See, e.g., Yang v. Colvin*, 2015 WL 685347, at *11 (C.D.
19 Cal. Jan. 20, 2015) (collecting cases finding spinal epidural injections not
20 conservative); *Christie*, 2011 WL 4368189, at *4. Here, plaintiff received at least
21 one set of injections, and he had another set scheduled shortly after his hearing
22 before the ALJ, in addition to the narcotics medication. Considering the injection
23 and medication treatment in totality, the court rejects the ALJ’s finding that the use
24 of a medial block amounted to plaintiff receiving conservative treatment.

25 Moreover, plaintiff’s diabetic condition precluded surgery during earlier
26 periods of treatment. *See* AR at 626 (noting plaintiff was previously not
27 considered an operative candidate); *see also Orn*, 495 F.3d at 638 (conservative
28 treatment is “not a proper basis to reject a claimant’s credibility where the claimant

1 has a good reason for not seeking more aggressive treatment”). At the hearing,
2 plaintiff testified he was now able to undergo surgery to treat his neck pain because
3 his diabetic condition was under control, though it was unclear at the time of the
4 hearing whether surgery was an available option. *See* AR at 52-58. While plaintiff
5 was no longer excused from avoiding surgery due to his improved diabetes
6 condition, he appeared ready to pursue such treatment if, and when, it became
7 necessary. Thus, although it appears plaintiff initially failed to pursue all available
8 courses of treatment such as physical therapy or rehabilitation, his later use of pain
9 medications, including narcotics and epidural injections, reflected his pursuit of
10 aggressive, not conservative, treatment. The ALJ’s finding that plaintiff received
11 conservative treatment was not supported by substantial evidence.

12 In sum, the ALJ failed to cite sufficient clear and convincing reasons for
13 discounting plaintiff’s credibility. As such, the ALJ erred in discounting the
14 credibility of plaintiff’s subjective complaints.

15 **D. The ALJ’s Erred by Failing to Properly Consider the Lay Testimony**

16 Plaintiff argues the ALJ failed to properly evaluate the statement of lay
17 witness Marlene G. P. Mem. at 10. Specifically, plaintiff contends the ALJ failed
18 to provide legitimate reasons for disregarding the observations of the lay witness.

19 *Id.*

20 “[L]ay testimony as to a claimant’s symptoms or how an impairment affects
21 ability to work *is* competent evidence and therefore *cannot* be disregarded without
22 comment.” *Stout v. Comm’r*, 454 F.3d 1050, 1053 (9th Cir. 2006) (internal
23 quotation marks, ellipses, and citation omitted); *see Smolen*, 80 F.3d at 1288; *see*
24 *also* 20 C.F.R. §§ 404.1513(d)(4), 416.913(d)(4) (explaining that the Commissioner
25 will consider all evidence from “non-medical sources,” including “spouses, parents
26 and other caregivers, siblings, other relatives, friends, neighbors, and clergy”). The
27 ALJ may only discount the testimony of a lay witness if he provides specific
28 “reasons that are germane to each witness.” *Dodrill v. Shalala*, 12 F.3d 915, 919

1 (9th Cir. 1993); *see Lewis v. Apfel*, 236 F.3d 503, 511 (9th Cir. 2001) (“Lay
2 testimony as to a claimant’s symptoms is competent evidence that an ALJ must
3 take into account, unless he or she expressly determines to disregard such
4 testimony and give reasons germane to each witness for doing so.”).

5 Marlene G., plaintiff’s wife, completed a Third Party Function Report in
6 August 2014, while she and plaintiff resided in a mobile home. AR at 252-60. In
7 the Function Report, Ms. G. reported plaintiff could not lift objects over 5 pounds,
8 could not bend or stand very long, had trouble raising his arms over his head, and
9 had a herniated disc in his lower back. *Id.* at 252. Ms. G. stated she assisted
10 plaintiff with bathing, dressing, caring for their dog, and “every thing he does.”
11 *Id.* at 253-54. Ms. G. observed plaintiff sits and lays down most of the day due to
12 the pain in his neck and back, the pain keeps plaintiff up at night, and he cannot do
13 house or yard work; however, plaintiff could drive a car, shop in stores for food,
14 handle money, and could walk 1/2 a block before needing to rest. *Id.* at 253-58.

15 The ALJ gave Ms. G.’s opinion only limited weight because Ms. G.’s
16 opinion merely reiterated plaintiff’s subjective allegations and were “not fully
17 corroborated by the medical evidence.” *Id.* at 30. In other words, the ALJ rejected
18 Ms. G.’s opinion to the extent it was not supported by the medical evidence.

19 An ALJ may reject lay testimony if it is *inconsistent* with medical evidence,
20 but not if it is simply *unsupported* by medical evidence. *Compare Lewis*, 236 F.3d
21 at 511 (“One reason for which an ALJ may discount lay testimony is that it
22 conflicts with medical evidence.”) (citing *Vincent*, 739 F.2d at 1395) with *Diedrich*
23 *v. Berryhill*, 874 F.3d 634, 640 (9th Cir. 2017) (a lack of support from the medical
24 evidence is not a proper basis for disregarding lay observations); *Bruce v. Astrue*,
25 577 F.3d 1113, 1116 (9th Cir. 2009) (same). In finding that a lack of support from
26 medical evidence is not a germane reason to discount lay testimony, the Ninth
27 Circuit notes that the “fact that lay testimony . . . may offer a different perspective
28 than medical records alone is precisely why such evidence is valuable at a

1 hearing.” *Diedrich*, 874 F.3d at 640 (citing *Smolen*, 80 F.3d at 1289).

2 Arguably, Ms. G.’s statement that plaintiff was unable to perform daily
3 activities was inconsistent with the objective findings and record. For example, the
4 record undermines Ms. G.’s report that plaintiff had difficulty walking or standing.
5 As discussed above, on some occasions plaintiff demonstrated unsteady gait,
6 numbness in his leg, or a positive straight leg raising sign on the left side. *See AR*
7 *at 429, 439, 704.* But on other occasions plaintiff also exhibited a normal walk, a
8 negative straight leg raise bilaterally, and no numbness or weakness in his lower
9 extremities. *See id.* at 312, 321, 353, 361-62, 373, 488. Yet the ALJ reasoned that
10 the medical record did not support Ms. G.’s lay opinion regarding plaintiff’s
11 condition, rather than reason that Ms. G.’s statement was inconsistent with the
12 medical record. The ALJ’s reason was thus improper.

13 Accordingly, the ALJ did not provide a germane reason for discounting the
14 Third Party Function Report of Ms. G.

15 V.

16 **REMAND IS APPROPRIATE**

17 The decision whether to remand for further proceedings or reverse and
18 award benefits is within the discretion of the district court. *McAllister v. Sullivan*,
19 888 F.2d 599, 603 (9th Cir. 1989). Typically, in accordance with the “ordinary
20 remand rule,” the reviewing court will remand to the Commissioner for additional
21 investigation or explanation upon finding error by the ALJ. *Treichler*, 775 F.3d at
22 1099. Nonetheless, it is appropriate for the court to exercise its discretion to direct
23 an immediate award of benefits where: “(1) the record has been fully developed
24 and further administrative proceedings would serve no useful purpose; (2) the ALJ
25 has failed to provide legally sufficient reasons for rejecting evidence, whether
26 claimant testimony or medical opinions; and (3) if the improperly discredited
27 evidence were credited as true, the ALJ would be required to find the claimant
28 disabled on remand.” *Garrison v. Colvin*, 759 F.3d 995, 1020 (9th Cir. 2014)

1 (setting forth three-part credit-as-true standard for remanding with instructions to
2 calculate and award benefits). But where there are outstanding issues that must be
3 resolved before a determination can be made, or it is not clear from the record that
4 the ALJ would be required to find a plaintiff disabled if all the evidence were
5 properly evaluated, remand for further proceedings is appropriate. *See Benecke v.*
6 *Barnhart*, 379 F.3d 587, 595-96 (9th Cir. 2004); *Harman v. Apfel*, 211 F.3d 1172,
7 1179-80 (9th Cir. 2000). In addition, the court must “remand for further
8 proceedings when, even though all conditions of the credit-as-true rule are
9 satisfied, an evaluation of the record as a whole creates serious doubt that a
10 claimant is, in fact, disabled.” *Garrison*, 759 F.3d at 1021.


11 Here, there are outstanding issues to be resolved and remand is required. On
12 remand, the ALJ shall reconsider plaintiff’s subjective complaints and either credit
13 his testimony or provide clear and convincing reasons supported by substantial
14 evidence for rejecting it, and reconsider the lay testimony and either credit it or
15 provide germane reasons supported by substantial evidence for rejecting it. The
16 ALJ must then reassess plaintiff’s RFC and proceed through steps four and five to
17 determine what work, if any, plaintiff was capable of performing.

18 **VI.**

19 **CONCLUSION**

20 IT IS THEREFORE ORDERED that Judgment shall be entered
21 REVERSING the decision of the Commissioner denying benefits, and
22 REMANDING the matter to the Commissioner for further administrative action
23 consistent with this decision.

24
25
26 DATED: January 31, 2019

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28 _____
SHERI PYM
United States Magistrate Judge