United States District Court
Northern District of California

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

YOLANDA EVETTE MOODY,

Plaintiff,

v.

NANCY A. BERRYHILL,

Defendant.

Case No. 16-cv-03646-JSC

ORDER RE: CROSS-MOTIONS FOR SUMMARY JUDGMENT

Re: Dkt. Nos. 15, 16

Plaintiff Yolanda Evette Moody ("Plaintiff") seeks social security benefits for a combination of physical and mental impairments, including: complex partial epilepsy, lupus anticoagulant syndrome with history of pulmonary embolisms (PE) and deep vein thrombosis (DVT) on clot prophylaxis with Coumadin, uterine fibroids status post hysterectomy, hypertension, vertigo, migraines, asthma, and obstructive sleep apnea. (Administrative Record ("AR") 11.) Plaintiff brings this action pursuant to 42 U.S.C. Section 405(g) for judicial review of the final decision by Defendant Nancy A. Berryhill, the Acting Commissioner of the Social Security Administration, denying her disability benefits claim.[1] Now pending before the Court is

[1] Nancy Berryhill became the Acting Commissioner of Social Security on January 23, 2017, and is therefore substituted for Carolyn W. Colvin as the Defendant in this action. *See* 42 U.S.C. §405(g); Fed. R. Civ. P. 25(d).

Plaintiff's motion for summary judgment and Defendant's cross-motion for summary judgment.[2] (Dkt. Nos. 15, 16.) Because the Administrative Law Judge ("ALJ") improperly weighed the medical evidence and erred in her credibility determination of Plaintiff, the Court GRANTS Plaintiff's motion, DENIES Defendant's cross-motion, and REMANDS for further proceedings.

LEGAL STANDARD

A claimant is considered "disabled" under the Social Security Act if he meets two requirements. *See* 42 U.S.C. § 423(d); *Tackett v. Apfel*, 180 F.3d 1094, 1098 (9th Cir. 1999). First, the claimant must demonstrate "an inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." 42 U.S.C. § 423(d)(1)(A). Second, the impairment or impairments must be severe enough that he is unable to do his previous work and cannot, based on his age, education, and work experience "engage in any other kind of substantial gainful work which exists in the national economy." 42 U.S.C. § 423(d)(2)(A). To determine whether a claimant is disabled, an ALJ is required to employ a five-step sequential analysis, examining:

> (1) whether the claimant is "doing substantial gainful activity"; (2) whether the claimant has a "severe medically determinable physical or mental impairment" or combination of impairments that has lasted for more than 12 months; (3) whether the impairment "meets or equals" one of the listings in the regulations; (4) whether, given the claimant's "residual functional capacity," the claimant can still do his or her "past relevant work"; and (5) whether the claimant "can make an adjustment to other work."

Molina v. Astrue, 674 F.3d 1104, 1110 (9th Cir. 2012); *see also* 20 C.F.R. §§ 404.1520(a), 416.920(a).

PROCEDURAL BACKGROUND

Plaintiff applied for Title II Social Security Disability Benefits on June 3, 2014 and the Social Security Administration ("SSA") denied her benefits on November 19, 2014. (AR 9.) She applied for reconsideration and was denied on March 20, 2015. (*Id.*) Plaintiff then requested an

[2] Both parties have consented to the jurisdiction of a magistrate judge pursuant to 28 U.S.C. § 636(c). (Dkt. Nos. 3, 9.)

administrative hearing, which occurred on January 5, 2016. (AR 24.) During the ALJ hearing, Plaintiff and Jo Ann M. Yoshioka, a vocational expert ("VE"), testified. (*Id.*) On February 24, 2016, the ALJ issued a written decision denying Plaintiff's application and finding that Plaintiff was "not disabled under sections 216(i) and 223(d) of the Social Security Act." (AR 9-17.) Plaintiff applied for review of the ALJ's decision and the Appeals Council denied her request. (AR 1, 5.) Plaintiff commenced this action for judicial review on November 17, 2016 pursuant to 42 U.S.C. Section 405(g) and 1383 (c)(3). (Dkt. No. 1.) The parties' cross-motions for summary judgment are now pending before the Court. (Dkt. Nos. 15, 16.)

FACTUAL BACKGROUND

Plaintiff was born on December 24, 1965. (AR 760.) Plaintiff suffers from numerous conditions, including lupus, fibroids, asthma, migraines, and epilepsy. (AR 11.) She has struggled with severe depression and anxiety since she was a teenager. (AR 697.) Plaintiff is anxious and experiences loss of interest, reduced appetite, and suicidal thoughts. (*Id.*) Plaintiff alleges she became disabled on March 16, 2014. (AR 29.)

I. Medical Evaluations and History

Plaintiff has seen a variety of physicians as a result of her medical conditions. In addition, as part of her application for disability benefits, she participated in an SSA directed examination to determine whether her mental health impairments are disabling. A discussion of the relevant medical evidence follows.

A. Medical History

1. *Plaintiff's Medical History Before Surgery*

Plaintiff has suffered from rheumatoid arthritis, anxiety, and insomnia since April 2011. (AR 420.) Plaintiff was examined on July 21, 2013 for headaches, left-sided facial numbness, and dizziness that lasted four days. (AR 470.) About one month later, Dr. Marie McGlynn diagnosed Plaintiff with benign essential hypertension, insomnia, and thoracic back pain. (AR 374.) Plaintiff was subsequently treated for persistent abdominal pain in September, October, and November 2013. (AR 358-59, 368, 383, 389.) She also experienced faintness, decreased appetite,

and regular migraines. (AR 389, 445.) On September 10, 2013, Dr. McGlynn noted that Plaintiff had been unable to work due to cramping, gas, and decreased appetite. (AR 383.) About one month later, Dr. McGlynn documented that Plaintiff suffered from abdominal pain, vaginal discharge mucus, loss of control of her bowels, and passing out. (AR 389.) Dr. McGlynn opined that Plaintiff did not feel well enough to return to work due to her "generalized weakness." (*Id.*) Dr. McGlynn noted that Plaintiff continued to feel unable to return to work on October 29, 2013. (AR 396.) On December 10, 2013, Dr. McGlynn found that Plaintiff needed an "extension of off work due to chronic abdominal pain and thoracic pain" and that Plaintiff did not feel able to work until she had surgery. (*Id.*) Dr. McGlynn extended Plaintiff's leave from work until February 1, 2014. (AR 406.) Seven days later, Dr. Howard discovered Plaintiff's uterine fibroids. (AR 464.)

In January 2014, Dr. Edraki saw Plaintiff at the Cypress Women's Cancer Treatment Center and noted that she had a history of colitis and anemia and was suffering from enlarging symptomatic uterine fibroids and irregular vaginal bleeding. (AR 477.) Dr. Edraki recommended that Plaintiff have a hysterectomy. (*Id.*)

Plaintiff was hospitalized for a Davinci Laparoscopic Supracervical Hysterectomy from April 9, 2014 to April 13, 2014. (AR 339.)

2. *Plaintiff's Medical History After Surgery*

Following surgery, Plaintiff was diagnosed with pelvic adhesions and was subsequently seen for blood clots and vaginal discharge. (AR 345, 478.) Plaintiff was assigned a home health care nurse to help her inject her medication, as well as an occupational therapist due to weakness in her extremities. (AR 480.) Shortly thereafter, on June 19, 2014, Plaintiff visited the Emergency Department of John Muir Health Concord Hospital due to continued headaches, abdominal pain, visual changes in her left eye, cough, decreased appetite, diarrhea, vaginal discharge and odor, and frequent falls. (AR 506.)

Plaintiff saw her primary care physician Dr. Watson for a follow-up appointment on August 28, 2014. (AR 758.) Dr. Watson noted that Plaintiff was suffering from multiple falls (syncope), hypertension, DVT, PE, vertigo, migraines, anxiety, insomnia, general abdominal

tenderness, and other related symptoms. (*Id.*) Dr. Watson also noted that Plaintiff was "disabled" under her employment information. (*Id.*) The next day, Dr. Watson opined in a long-term disability claim form that Plaintiff was able to engage only in limited stress situations and limited interpersonal relations, that she could sit for a maximum of two continuous hours, and stand or walk for at most one continuous hour. (AR 834.) Dr. Watson also reported that Plaintiff could occasionally (1-35% of the time) lift up to 10 pounds and could not climb, twist/bend/stoop, reach above shoulder level, or operate a motor vehicle. (*Id.*)

Plaintiff saw Dr. Watson for a second follow-up appointment on September 17, 2014. (AR 756.) Dr. Watson noted that Plaintiff continued to suffer from hypertension, arthritis, depression, syncope, asthma, and anxiety. (*Id.*) Plaintiff had a CT of her temporal bones and brain on September 19, 2014 and the results showed no abnormalities. (AR 729-32.)

At a third follow-up appointment on October 29, 2014, Dr. Watson reported that Plaintiff continued to experience hypertension, asthma, arthritis, depression, anxiety, and syncope. (AR 754.) The same day, Dr. Watson opined that Plaintiff could work four hours per day for five days per week from November 1 to December 1, 2014. (AR 823.) Dr. Watson noted that Plaintiff could resume regular work duties on December 1, 2014 with no further limitations. (AR 826.)

On December 18, 2014, Dr. Arnold, a neurologist, saw Plaintiff and noted her chronic migraines, post-surgery blood clots, fainting attacks (syncope), DVT, JAK2 gene mutation, and lupus anticoagulant positivity. (AR 702.) Dr. Arnold also documented Plaintiff's loss of appetite, trouble sleeping, and increased anxiety. (*Id.*) In January 2015, Plaintiff had an EEG for the nocturnal seizures that she developed in late 2014 and the results were normal. (AR 736, 856.) In April 2015, Plaintiff had MRIs of her brain and the results were unremarkable other than a benign abnormality. (AR 767-68.) On April 6, 2015, Dr. Watson restricted Plaintiff from working until June 6, 2015. (AR 817.) Moreover, on June 29, 2015, Plaintiff reported increased bilateral foot pain to Dr. Watson. (AR 907.)

In August 2015, Dr. Hegde noted that Plaintiff's daytime seizure activity could be panic attacks or simple focal seizures. (AR 863.) On August 28, 2015, Plaintiff saw Dr. Watson for

constipation issues and received a mental health referral. (AR 906.) Dr. Raskin diagnosed Plaintiff with nocturnal seizure disorder (secondary to cerebral emboli) and intractable but improved chronic migraines in September 2015. (AR 855.)

Later that year, in November 2015, Plaintiff was seen for symptoms similar to those she experienced when she was hospitalized in September 2013, including diarrhea, abdominal pain, musculoskeletal pain, anxiety, and depression. (AR 845.) Plaintiff also reported during this visit that she was not able to function at her normal level and that she was experiencing trouble thinking clearly and episodes of fainting. (AR 845-46.)

On November 9, 2015, Dr. Hegde recommended admitting Plaintiff into the epilepsy clinic due to her convulsive episodes. (AR 851.) Plaintiff's husband reported that Plaintiff experienced convulsive episodes throughout the night by awaking suddenly and shaking for a few minutes. (*Id.*) Plaintiff reported feeling depressed, sluggish, and having headaches or bowel and bladder incontinence during/after her nocturnal seizures. (AR 856.) Plaintiff was discharged from the epilepsy clinic on November 12, 2015 after "normal waking and sleep video-EEG." (AR 853.) Plaintiff was scheduled for a colonoscopy in December 2015. (AR 848.)

On January 6, 2016, Dr. Watson wrote the most recent report regarding Plaintiff's medical history. (AR 935.) Dr. Watson noted that he had been treating Plaintiff since January 2014. (*Id.*) He detailed Plaintiff's evaluation for systemic lupus erythematosus and referred to her clinical history as "concerning." (*Id.*) Dr. Watson also listed Plaintiff's other illnesses, namely her "worrisome neurological symptoms," which include "frequent severe headaches, often accompanied by vertigo," "balance issues," and "a seizure-type disorder." (*Id.*) He also noted that Plaintiff "has fallen several times recently," "struggles with severe anxiety and depression," and "is quite distressed about her medical condition, her physical limitations and her inability to work." (*Id.*) Dr. Watson opined that Plaintiff was restricted from working due to her fatigue, pain, and headaches. (*Id.*) He stressed that Plaintiff did not have the energy necessary to work full-time, and if she tried to work, she "would miss many days from work each month" and "would require numerous breaks throughout the day due to her fatigue and pain." (*Id.*)

B. Medical Evaluation

In addition to routine and emergency medical visits, Plaintiff underwent a mental health examination to determine her functional capacity in support of her application for disability benefits. Below is a summary of this evaluation.

Plaintiff began psychotherapy treatment with Ms. Poku on September 30, 2014. (AR 697.) She met with Ms. Poku on a weekly basis but missed four of her scheduled sessions, thus only attending three sessions. (*Id.*) During the ALJ hearing, Plaintiff testified that she has had ongoing problems accessing mental health treatment due to her medical insurance. (AR 40-41.) Ms. Poku noted that Plaintiff suffers from depression, helplessness, loss of appetite, loss of interest in activities previously enjoyed, thoughts of self-harm, hopelessness, and becomes easily agitated. (AR 697.) Plaintiff is also extremely anxious due to her deteriorating health and fears the high amount of medication she currently has to take. (*Id.*) Ms. Poku stated, "Mrs. Moody does not appear based upon her report and this clinician's observations to present with the ability to be functional in any work capacity at this time." (AR 698.) Furthermore, Ms. Poku remarked that Plaintiff's mental health problems are chronic and require long-term treatment. (*Id.)*

II. Plaintiff's ALJ Hearing

On January 5, 2016, Plaintiff appeared in person at the hearing before ALJ Mary P. Parnow, represented by her counsel Rosemary Daity. (AR 24.) Plaintiff and a VE, Ms. Yoshioka, testified at the hearing. (*Id.*) Plaintiff's husband, Antoin Moody, was present as an observer. (AR 28.)

A. Plaintiff's Testimony

Plaintiff suffers from a variety of physical medical conditions. (AR 33.) In March 2014, when she stopped working as a unit coordinator in a hospital, she was experiencing abdominal pain, bleeding, fainting, and falling. (*Id.*) Plaintiff had been diagnosed with vertigo in 2013 and was also suffering from migraines and loss of appetite. *(Id.*) Plaintiff was diagnosed with fibroids and had them removed during a hysterectomy on April 9, 2014. (AR 34.) Following the surgery, Plaintiff began to suffer from complications due to an accumulation of blood clots throughout her

whole body, including on her lung and heart. (AR 34-35.) Plaintiff suffers from a genetic disorder related to clotting, a type of lupus that causes her blood levels to constantly remain very low, and experiences seizures in her sleep. (AR 36, 38.)

Plaintiff also testified to her mental health challenges, including panic attacks and anxiety. (*See* AR 35.) Plaintiff has suffered from panic attacks for about two years. (AR 40.) Plaintiff's panic attacks are frequent (usually at least once a day) and involve her losing vision, sweating, and shaking when she is around too many people or loud noise. (AR 39.) Plaintiff takes medication to help with the attacks and has been referred to a psychiatrist. (AR 40.)

Due to her physical complications, as well as her mental health symptoms, Plaintiff has a difficult time performing activities in her daily life. (AR 35.) Plaintiff spends most of her day in bed sleeping, watching TV, or listening to music since she has limited ability to get up and move around. (AR 41.) Plaintiff has difficulty cooking dinner for her family, as well as interacting with others in general, since she feels very anxious, overwhelmed, and frequently has panic attacks. (*Id.*) Plaintiff also falls often and thus receives most of her medical treatment at home. (AR 37.) Her husband and daughter have to help her with the majority of her daily activities and sometimes she cannot walk at all. (AR 37, 38.) Plaintiff can barely eat and when she does, it takes her all day to eat one meal. (AR 46.)

In addition to her various conditions, Plaintiff experiences some side effects from the medications she is taking, namely loss of control of her bowels. (AR 46.)

B. Vocational Expert's Testimony

The ALJ asked the VE to speak about jobs that were classified as 2E. (AR 54.) The VE explained that this included an eligibility clerk (DOT code 195.267-010, SVP 6, strength sedentary), ER Registration or hospital admitting clerk (DOT code 205.362-018, SVP 4, strength sedentary), a front desk clerk for a hotel (DOT code 238.367-038, SVP 4, strength light), a unit coordinator or unit clerk (DOT code 245.362-014, SVP 3, strength light), an admissions registrar or admissions clerk (DOT code 205.362-018, SVP4, strength sedentary), customer service in a bank (DOT code 249.362-026, SVP 4, strength sedentary), and a PBX or telephone operator (DOT

code 235.662-022, SVP 3, strength sedentary). (AR 55.)

The ALJ presented the VE with five hypotheticals. In hypothetical one, an individual at Plaintiff's age (50 years old) has a high school education, "non-exertional limits," no "exertional limits," and cannot climb ladders, ropes, or scaffolds, be exposed to hazardous machinery, unprotected heights, or perform commercial driving. (*Id.*) The ALJ asked what work that individual qualifies for. (*Id*.) The VE testified that the individual could perform all of the jobs listed above. (*Id.*) For hypothetical two, the VE testified that an individual with "exertional limits" who can only perform light work could perform all of the jobs listed above. (AR 57.) For hypothetical three, the VE testified that an individual who can only perform sedentary work could be employed as an eligibility worker, admissions clerk, customer service clerk, and telephone operator. (AR 58.) For hypothetical four, the VE testified that an individual who is precluded from complex tasks due to the effects of medication and pain could only potentially work as a telephone operator. (*Id.*) In hypothetical five, the VE testified that an individual who is only capable of sedentary work and precluded from complex tasks could work as a telephone operator, telephone quotation clerk, food and beverage order clerk, and a charge account clerk. (AR 61.)

Plaintiff's attorney then presented a sixth hypothetical to the VE where an individual needs to miss two or more days of work per month. (AR 62.) The VE testified that the individual could not perform any of jobs listed above. (*Id.*) Plaintiff's attorney presented the VE with an additional hypothetical of an unskilled worker who needs to take two 15-minute breaks in the morning, a 30-minute lunch, and two 15-minute breaks in the afternoon. (AR 63.) The VE testified that an employer would not tolerate this type of schedule. (*Id.*)

III. The ALJ's Findings

In a written decision implementing the SSA's five-step sequential evaluation process for determining disability, the ALJ found that Plaintiff is not disabled under Sections 216(i) and 223(d) of the Social Security Act. (AR 9-17.)

At step one, the ALJ found that "Plaintiff has not engaged in substantial gainful activity since March 16, 2014." (AR 11.)

At step two, the ALJ found that Plaintiff has the following severe impairments: complex partial epilepsy, lupus anticoagulant syndrome with history of pulmonary embolisms, DVT on clot prophylaxis with Coumadin, uterine fibroids status post hysterectomy, hypertension, vertigo, migraines, asthma, and obstructive sleep apnea. (*Id.*) The ALJ found that Plaintiff's depression and anxiety "do not cause more than minimal limitation in the claimant's ability to perform basic mental work activities and are therefore nonsevere." (AR 11.) The ALJ analyzed Plaintiff's mental impairments according to the four functional areas ("paragraph B" criteria) in section 12.00C of the Listing of Impairments: daily living, social functioning, concentration, persistence, or pace, and episodes of decompensation. (AR 11-12.) With regard to daily living, the ALJ found that Plaintiff has mild limitation because she attends church and takes walks. (AR 11.) Additionally, the ALJ pointed to Plaintiff's hobbies and interests, which include cooking, listening to jazz, and singing, as evidence of her no-more-than-mild limitation. (*Id.*) The ALJ also reported that Plaintiff sleeps during the day, watches television, and tries to listen to music, cook, and socialize with others. (*Id.*) Nonetheless, the ALJ noted that "activities of daily living are difficult to objectively corroborate and therefore are of limited value in assessing functioning." (AR 12.)

With respect to social functioning, the ALJ found that Plaintiff has mild limitation because she lives with her husband, is generally cooperative, and interacted with the judge during the hearing without any problems. (AR 12.) For the third functional area, which assesses concentration, persistence, or pace, the ALJ also found that Plaintiff has mild limitation because she did not report any issues with memory or concentration. (*Id.*) Additionally, Plaintiff has "normal mental status examinations, including cooperative and appropriate mood and affect." (*Id.*) The ALJ also pointed to Plaintiff being able to "concentrate and persist through what turned out to be a fairly lengthy hearing." (*Id.*) For the fourth functional area, the ALJ found that Plaintiff has not had any episodes of decompensation of extended durations. (*Id.*) The ALJ concluded that since Plaintiff's "medically determinable mental impairments cause no more than 'mild' limitation in any of the three functional areas and 'no episodes of decompensation which have been of extended duration in the fourth area, they are nonsevere.'" (*Id.*)

At step three, the ALJ found that Plaintiff "does not have an impairment or combination of impairments that meets or medically equals the severity of one of the listed impairments in 20 CFR Part 404, Subpart P, Appendix 1" or any of the cardiovascular, neurological, immunological, genitourinary, or respiratory listings. (AR 12.)

At step four of the disability determination, the ALJ found that Plaintiff had the Residual Functional Capacity ("RFC") necessary to engage in the full range of sedentary work defined by 20 CFR 404.1567(a). (AR 12.) The ALJ made this finding based on Plaintiff's symptoms and the extent to which they are consistent with the objective medical evidence, as well as with additional evidence and opinions. (AR 13.) The ALJ concluded that Plaintiff's medically determinable impairments could reasonably be expected to cause the alleged symptoms but questioned Plaintiff's credibility regarding the intensity, persistence, and limiting effects of the symptoms. (AR 15.)

As to opinion evidence, the ALJ assigned "very limited weight" to Dr. Watson's August 2014 opinion that Plaintiff could only perform sedentary work because the ALJ found it inconsistent with Dr. Watson's October 2014 opinion that Plaintiff could work reduced hours for a limited period of time. (AR 16.) Similarly, the ALJ assigned "limited weight" to Dr. Watson's January 2016 opinion because it did not list Plaintiff's specific limitations and was inconsistent with the treatment records, prior opinions that Plaintiff could work, and the exam findings of other medical professionals. (*Id.*) The ALJ placed "limited weight" on the Disability Determination Services medical consultant's opinion that Plaintiff had a risk of seizures and thus could only perform medium work because the consultants did not examine Plaintiff and, according to the ALJ, could thus not consider Plaintiff's condition as a whole. (*Id.*)

The ALJ placed "no weight" on Dr. Chen's opinion because his opinion was too far removed from the onset of Plaintiff's symptoms. (*Id.*) The ALJ assigned "significant weight" to Dr. Watson's opinion that Plaintiff was disabled from the date of her hysterectomy through November 2014. (*Id.*)

At step five, the ALJ found that there was other work in the national economy that Plaintiff

could perform, such as an eligibility clerk, hospital admitting clerk, customer service agent (banking), and telephone operator. (AR 17.) The ALJ noted that this was consistent with the VE's testimony regarding hypothetical number three. (*Id.*) The ALJ therefore concluded that Plaintiff was not disabled under the Social Security Act. (*Id.*)

IV. Appeals Council

Plaintiff filed a request for review arguing that she remains disabled and unable to work. (AR 5.) The Appeals Council denied Plaintiff's appeal, concluding there was no reason to grant review of the ALJ's decision. (AR 1.) In reaching this decision, the Appeals Council considered the entire record and a recording of the hearing. The Appeals Council's decision rendered the ALJ's opinion final.

STANDARD OF REVIEW

Pursuant to 42 U.S.C. § 405(g), the Court has authority to review an ALJ's decision to deny benefits. When exercising this authority, however, the "Social Security Administration's disability determination should be upheld unless it contains legal error or is not supported by substantial evidence." *Orn v. Astrue*, 495 F.3d 625, 630 (9th Cir. 2007). Substantial evidence is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion"; it is "more than a mere scintilla, but may be less than a preponderance." *Molina*, 674 F.3d at 1110-11 (internal citations and quotation marks omitted). To determine whether the ALJ's decision is supported by substantial evidence, the reviewing court "must consider the entire record as a whole and may not affirm simply by isolating a specific quantum of supporting evidence." *Hill v. Astrue*, 698 F.3d 1153, 1159 (9th Cir. 2012) (internal citations and quotation marks omitted).

Determinations of credibility, resolution of conflicts in medical testimony, and all other ambiguities are roles reserved for the ALJ. *See Andrews v. Shalala*, 53 F.3d 1035, 1039 (9th Cir. 1995). "The ALJ's findings will be upheld if supported by inferences reasonably drawn from the record." *Tommasetti v. Astrue*, 533 F.3d 1035, 1038 (9th Cir. 2008) (internal citations and quotation marks omitted); *see also Batson v. Comm'r of Soc. Sec.*, 359 F.3d 1190, 1198 (9th Cir. 2004) ("When the evidence before the ALJ is subject to more than one rational interpretation, we

must defer to the ALJ's conclusion."). "The court may not engage in second-guessing." *Tommasetti*, 533 F.3d at 1039. "It is immaterial that the evidence would support a finding contrary to that reached by the Commissioner; the Commissioner's determination as to a factual matter will stand if supported by substantial evidence because it is the Commissioner's job, not the Court's, to resolve conflicts in the evidence." *Bertrand v. Astrue*, No. 08-CV-00147-BAK, 2009 WL 3112321, at *4 (E.D. Cal. Sept. 23, 2009). Similarly, "[a] decision of the ALJ will not be reversed for errors that are harmless." *Burch v. Barnhart*, 400 F.3d 676, 679 (9th Cir. 2005). However, the Court can only affirm the ALJ's findings based on reasoning that the ALJ herself asserted. *See Connett v. Barnhart*, 340 F.3d 871, 874 (9th Cir. 2003). In other words, the Court's consideration is limited to "the grounds articulated by the agency[.]" *Cequerra v. Sec'y*, 933 F.2d 735, 738 (9th Cir. 1991).

DISCUSSION

Plaintiff contends that the ALJ erred as a matter of law by (1) incorrectly evaluating treating source opinions; (2) discrediting Plaintiff's testimony without clear and convincing reasons; (3) improperly finding that Plaintiff's mental health impairments were not severe; and (4) failing to develop the record by not engaging the services of a psychiatric or medical expert. Plaintiff urges the Court to grant summary judgment and remand for payment of benefits, or in the alternative, further proceedings.

I. ALJ'S Consideration of Medical Opinion Evidence

A. Standard for Weighing Medical Opinion Evidence

In the Ninth Circuit, courts must "distinguish among the opinions of three types of physicians: (1) those who treat the claimant (treating physicians); (2) those who examine but do not treat the claimant (examining physicians); and (3) those who neither examine nor treat the claimant (nonexamining physicians)." *Lester v. Chater*, 81 F.3d 821, 830 (9th Cir. 1995) (as amended (Apr. 9, 1996)). "Generally, the opinions of examining physicians are afforded more weight than those of non-examining physicians, and the opinions of examining non-treating physicians are afforded less weight than those of treating physicians." *Orn*, 495 F.3d at 631

(internal citation omitted). If a treating doctor's opinion is not contradicted by another doctor, it may be rejected only for "clear and convincing" reasons. *Baxter v. Sullivan*, 923 F.2d 1391, 1396 (9th Cir. 1991). And "even if the treating doctor's opinion is contradicted by another doctor, the Commissioner may not reject this opinion without providing 'specific and legitimate reasons' supported by substantial evidence in the record for so doing." *Lester*, 81 F.3d at 830 (internal citations and quotations omitted). Likewise, "the opinion of an examining doctor, even if contradicted by another doctor, can only be rejected for specific and legitimate reasons that are supported by substantial evidence in the record." *Id*. at 830-31.

"The ALJ can meet this burden by setting out a detailed and thorough summary of the facts and conflicting clinical evidence, stating his interpretation thereof, and making findings." *Cotton v. Bowen*, 799 F.2d 1403, 1408 (9th Cir. 1986). "The opinion of a nonexamining physician cannot by itself constitute substantial evidence that justifies the rejection of the opinion of either an examining physician or a treating physician." *Lester*, 81 F.3d at 831 (internal citation omitted). Ultimately, "the ALJ must do more than offer his conclusions. He must set forth his own interpretations and explain why they, rather than the doctors', are correct." *Embrey v. Bowen*, 849 F.2d 418, 421-22 (9th Cir. 1988).

"When an ALJ does not explicitly reject a medical opinion or set forth specific, legitimate reasons for crediting one medical opinion over another, he errs. In other words, an ALJ errs when he rejects a medical opinion or assigns it little weight while doing nothing more than ignoring it, asserting without explanation that another medical opinion is more persuasive, or criticizing it with boilerplate language that fails to offer a substantive basis for his conclusion." *Garrison v. Colvin*, 759 F.3d 995, 1012-13 (9th Cir. 2014) (internal citation omitted). In conducting its review, the ALJ "must consider the entire record as a whole and may not affirm simply by isolating a 'specific quantum of supporting evidence.'" *Hill*, 698 F.3d at 1159 (internal citations omitted). An ALJ may not cherry-pick and rely on portions of the medical record which bolster his findings. *See, e.g., Holohan v. Massanari*, 246 F.3d 1195, 1207-08 (9th Cir. 2001) (holding that an ALJ may not selectively rely on some entries and ignore others "that indicate continued,

severe impairment"). "Particularly in a case where the medical opinions of the physicians differ so markedly from the ALJ's[,]" "it is incumbent on the ALJ to provide detailed, reasoned, and legitimate rationales for disregarding the physicians' findings." *Embrey*, 849 F.2d at 422.

B. Analysis

To reject the opinions of Plaintiff's treating physician, Dr. Watson, and the medical evidence regarding Plaintiff's mental health, the ALJ was required to provide specific and legitimate reasons supported by substantial evidence. *See Lester*, 81 F.3d at 830-31. The ALJ did not do so.

1) Dr. Watson

The ALJ placed "limited weight" on Dr. Watson's January 2016 opinion that Plaintiff could not work due to her fatigue, pain, and headaches because (1) he did not specify limitations other than Plaintiff needing to miss many days of work per month; (2) his opinion was "inconsistent with his prior opinions;" and (3) his opinion was "not consistent with his treatment records." (AR 16.) Additionally, the ALJ noted that Dr. Watson's January 2016 opinion was "at odds with the physical exam findings of other providers" and "consistent with a physician advocating for his client." (*Id.*)

The ALJ's critiques of Dr. Watson's January 2016 opinion are not supported by substantial evidence. First, Dr. Watson did specify limitations other than Plaintiff requiring several days off work per month. (AR 935.) Although Dr. Watson opined that Plaintiff "would miss many days of work per month," he also noted that Plaintiff could not "tolerate the physical demands of a job, even if she were allowed to sit all day" and that "she would require numerous breaks throughout the day due to her fatigue and pain." (*Id.*) Dr. Watson also generally noted that Plaintiff "appears chronically ill and looks quite fatigued." (*Id.*)

Second, Dr. Watson's January 2016 opinion was not inconsistent with his prior opinions and treatment records or those of other providers; indeed, Dr. Watson had restricted Plaintiff's ability to work on three separate occasions (August 2014, October 2014, and April 2015). (AR 834, 823, 817.) The ALJ nonetheless found that because Dr. Watson opined in October 2014 that

Plaintiff could resume full time work in December 2014, his January 2016 opinion that Plaintiff could not work due to her poor medical state was inconsistent. However, Dr. Watson's October 2014 opinion was based on the information available to him at the time. Although Dr. Watson believed in October 2014 that Plaintiff could return to work two months later, he continued to see Plaintiff for various medical issues and found in January 2016 that she had not improved enough to work (indeed, he found the same in April 2015). A treating physician's opinion of how a patient's condition will change may, and indeed, should evolve as time progresses and the physician learns more information. Dr. Watson's change in opinion regarding Plaintiff's ability to work does not demonstrate inconsistency. Rather, it reflects "only that Plaintiff's condition changed over time, and as Plaintiff's treating physician, it was proper for [Dr. Watson] to document any such changes." *Williams v. Colvin*, 24 F.Supp.3d 901, 912 (N.D. Cal. 2014).

Third, the ALJ's finding that Dr. Watson "generally noted normal physical findings and recommended only routine and conservative treatment" is not supported by substantial evidence. (AR 16.) The ALJ cited a progress note from January 28, 2014 as evidence of Dr. Watson's "routine normal physical findings." (AR 16, 920.) However, Plaintiff's hysterectomy occurred in April 2014, months after this visit. (AR 339.) The record shows that Plaintiff experienced numerous complications post-surgery and that her overall medical state worsened significantly. (AR 345, 478, 758.) Nonetheless, at the January 2014 visit, Dr. Watson noted that Plaintiff suffered from insomnia, migraines, and colitis, and was seeing him subsequent to a vertigo episode and a fall. (AR 920.) The ALJ seemingly referred to the bottom portion of Dr. Watson's treatment note, which denotes a "physical exam" of Plaintiff and allows Dr. Watson to check either "normal or abnormal" for a variety of categories. (*See id.*) However, this bottom portion is not dispositive of Plaintiff's overall medical condition and medical reports in the form of summary checklists without clarifying explanations "are not entitled to significant weight." *See Bell-Shier v. Astrue*, 312 F. App'x 45, 48 (9th Cir. 2009) (internal citations omitted). Furthermore, Dr. Watson left several of the categories on this form, including mental status, either blank or illegible during Plaintiff's January 28, 2014 visit. (AR 920.)

Additionally, although the ALJ found that Dr. Watson only prescribed Plaintiff "routine" and "conservative" treatment, there is no evidence in the record that any different type of treatment was available for Plaintiff nor does the ALJ specify what "conservative" treatment Plaintiff allegedly received. Dr. Watson referred Plaintiff to other specialists and for further tests on several occasions, although many of these examinations were inconclusive. (AR 702, 922-952.) Thus, the record does not support the ALJ's finding that Dr. Watson restricted Plaintiff to "conservative" treatment. However, even if Dr. Watson had, "[a] claimant cannot be discredited for failing to pursue non-conservative treatment options where none exist." *Lapeirre-Gutt v. Astrue*, 382 F. App'x 662, 664 (9th Cir. 2010). "Moreover, the failure of a treating physician to recommend a more aggressive course of treatment, absent more, is not a legitimate reason to discount the physician's subsequent medical opinion about the extent of disability." *Trevizo v. Berryhill*, No. 15-162772017, WL 2925434, at *8 (9th Cir. July 10, 2017) (internal citation omitted).

Fourth, the ALJ discredited Dr. Watson's January 2016 opinion because it was "at odds with the physical exam findings of other providers, including specialists." (AR 16.) However, the ALJ failed to specify which specialists and/or how Dr. Watson's opinion was "at odds" with these other providers. Plaintiff saw two treating neurologists, Dr. Arnold and Dr. Raskin, and both noted her chronic migraines, while Dr. Arnold additionally documented Plaintiff's loss of appetite, trouble sleeping, and increased anxiety. (AR 702, 855.)

Defendants further contend that "Plaintiff's condition did not deteriorate since October 2014, which would be required to support Dr. Watson's more restrictive opinion [in January 2016.]" (Dkt. No. 16 at 14.) However, since the time of Dr. Watson's October 2014 opinion, by late 2014, Plaintiff began to experience nocturnal seizures accompanied by depression and headaches the morning after. (AR 856.) Beginning in 2015, Plaintiff had EEGs and MRIs and saw different physicians due to her convulsive episodes. (AR 736, 767-68.) Plaintiff was diagnosed with nocturnal seizure disorder in September 2015, almost a year after Dr. Watson's October 2014 opinion and months before his January 2016 report. (AR 855.)

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The ALJ erred in discrediting Dr. Watson's opinions because she did not provide specific and legitimate reasons supported by substantial evidence for doing so.

2) Plaintiff's Mental Health Examinations

The ALJ's decision to disregard the medical evidence of Plaintiff's mental impairments was also erroneous because she did not provide specific and legitimate reasons supported by substantial evidence for doing so. The ALJ found that Plaintiff's allegations of depression and anxiety were not corroborated by medical evidence because Plaintiff only met with psychotherapist Ms. Poku three times (missed four visits) and Plaintiff did not regularly seek treatment for her symptoms. (AR 16.) However, the record shows multiple instances of physicians noting Plaintiff's mental health symptoms. At an appointment following Plaintiff's surgery on August 28, 2014, Dr. Watson noted that Plaintiff suffered from anxiety. (AR 758.) Dr. Watson further opined that Plaintiff was very limited in both the amount of stress she could handle and her interpersonal relations. (AR 834.) About a month later, in September 2014, Dr. Watson documented that Plaintiff continued to suffer from anxiety and depression. (AR 756.) The same was true when Plaintiff saw Dr. Watson in October 2014. (AR 754.) It was during this October 29, 2014 visit that Dr. Watson restricted how much Plaintiff could work between November 1 and December 1, 2014. (AR 823.)

Additionally, on December 18, 2014, Plaintiff saw Dr. Arnold, a neurologist who noted Plaintiff's loss of appetite, trouble sleeping, and increased anxiety. (AR 702.) In August 2015, Plaintiff saw Dr. Hegde, who reported that it was possible for her daytime seizures to actually be panic attacks. (AR 863.) A few months later, in November 2015, Plaintiff visited the East Bay Center for Digestive Health and complained of anxiety and depression. (AR 845.) At this visit, Plaintiff reported that she was not able to function at her normal level and that she was experiencing trouble thinking clearly and episodes of fainting. (*Id.*) Moreover, Plaintiff reported feeling depressed during/after her nocturnal seizures when she was examined in November 2015. (AR 856.) Finally, on January 6, 2016, Dr. Watson reported that Plaintiff was suffering from

"severe anxiety and depression" and noted that Plaintiff did not have the energy to work full-time. (AR 935.)

The ALJ nonetheless contends that Plaintiff received "consistent notes of normal mental status findings" from her medical providers. (AR 16.) This statement is misleading. Several of the examinations Defendant cites as "normal mental or psychiatric examinations of Plaintiff" describe Plaintiff's psychiatric state by noting that she "shows a pleasant, appropriate effect, without delirium, dementia, confusion, or intoxication." (Dkt. No. 16 at 9; AR 509, 540.) This does not necessarily amount to a "normal examination" and contradicts neither Plaintiff's testimony that she suffers from anxiety and depression or past medical records corroborating her allegations. In other words, that Plaintiff does not suffer from delirium, dementia, confusion, or intoxication does not mean that she is not depressed or anxious.

The ALJ seemingly relied on a minor part of these examinations which asks the physician to record Plaintiff's "mental status" as either "normal" or "abnormal." (AR 758.) Dr. Watson checked "normal" for Plaintiff on multiple occasions, despite noting Plaintiff's history of depression and anxiety on the same form. (*Id.*) This "normal" designation of Plaintiff's "mental status" is not only ambiguous and but is also not dispositive of Plaintiff's mental health as a whole. Medical reports in a summary checklist format require additional explanation. *Bell-Shier*, 312 F. App'x at 48. Plaintiff having a composed and "normal" demeanor during doctor visits does not preclude her from experiencing anxiety and depression in other contexts. Furthermore, "[t]he Social Security Act does not require that claimants be utterly incapacitated to be eligible for benefits." *Fair v. Bowen*, 885 F.2d 597, 603 (9th Cir. 1989) (internal quotation marks and citations omitted).

Moreover, Plaintiff underwent a mental health examination with social worker Ms. Poku to determine her functional capacity in support of her application for disability benefits. During Plaintiff's psychotherapy treatment with Ms. Poku, beginning in September of 2014, Ms. Poku noted that Plaintiff suffers from depression, high anxiety, helplessness, loss of appetite, loss of interest, and thoughts of self-harm. (AR 697.) Ms. Poku opined that Plaintiff is not functional to

work and that her mental health problems are chronic and require long-term treatment. (*Id.*) In discounting Plaintiff's mental health impairments, the ALJ relied on Plaintiff not seeking treatment until the psychotherapy with Ms. Poku in 2014, as well as Plaintiff missing multiple appointments. (AR 16.) This is not substantial evidence that Plaintiff's mental health condition is not supported by medical evidence, especially since Plaintiff testified that it has been difficult for her to access mental health treatment because of her insurance. (AR 40-41.) "Disability benefits may not be denied because of the claimant's failure to obtain treatment [s]he cannot obtain for lack of funds." *Trevizo*, 2017 WL 2925434, at *11 (internal citation omitted).

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In sum, the ALJ did not provide specific and legitimate reasons supported by substantial evidence to reject Plaintiff's medical history regarding her mental health.

II. ALJ's Credibility Determination

A. Standard for Assessing Credibility

The SSA policy on determining RFC directs ALJs to give "[c]areful consideration ... to any available information about symptoms because subjective descriptions may indicate more severe limitations or restrictions than can be shown by medical evidence alone." SSR 96-8P, 1996 WL 374184, at *5 (S.S.A. July 2, 1996). If the record establishes the existence of an impairment that could reasonably give rise to such symptoms, the "ALJ must make a finding as to the credibility of the claimant's statements about the symptoms and their functional effect." *Robbins v. Soc. Sec. Admin.*, 466 F.3d 880, 883 (9th Cir. 2006); *see also Chaudhry v. Astrue*, 688 F.3d 661, 670 (9th Cir. 2012) ("Because the RFC determination must take into account the claimant's testimony regarding [her] capability, the ALJ must assess that testimony in conjunction with the medical evidence.").

To "determine whether a claimant's testimony regarding subjective pain or symptoms is credible," an ALJ must use a "two-step analysis." *Garrison*, 759 F.3d at 1014. "First, the ALJ must determine whether the claimant has presented objective medical evidence of an underlying impairment which could reasonably be expected to produce the pain or other symptoms alleged."

Lingenfelter v. Astrue, 504 F.3d 1028, 1036 (9th Cir. 2007) (internal citations and quotation marks omitted). "Second, if the claimant meets this first test, and there is no evidence of malingering, the ALJ can reject the claimant's testimony about the severity of her symptoms only by offering specific, clear and convincing reasons for doing so." *Id*. (internal citations and quotation marks omitted). The clear and convincing standard is "the most demanding required in Social Security cases." *Moore v. Comm'r of the Soc. Sec. Admin.*, 278 F.3d 920, 924 (9th Cir. 2002). "General findings are insufficient; rather, the ALJ must identify what testimony is not credible and what evidence undermines the claimant's complaints." *Ghanim v. Colvin*, 763 F.3d 1154, 1163 (9th Cir. 2014) (citation omitted).

B. Analysis

The ALJ concluded that Plaintiff's testimony regarding the severity and functional consequences of her disability was not fully credible "for the reasons explained in this decision." (AR 15.) The ALJ seemingly relied on the following: Plaintiff's headaches pre-date the alleged onset date of her disability; Plaintiff worked despite her headaches; Plaintiff's headaches improved; Plaintiff's symptoms are not corroborated by objective findings; and Plaintiff received "routine" and "conservative" treatment for her complaints. (AR 15-16.) The ALJ also noted that she considered the credibility factors outlined in SSR 96-7p: the claimant's complaints; the clinical findings; the diagnostic findings; the claimant's receipt of routine and conservative treatment; and the claimant's activities of daily living. (AR 15.)

The ALJ's reasons for discounting Plaintiff's credibility do not comport with the "clear and convincing" standard. First, the ALJ focused primarily on Plaintiff's headaches in discounting her overall credibility. However, the ALJ found that Plaintiff suffers from several severe impairments, including complex partial epilepsy, lupus anticoagulant syndrome with history of pulmonary embolisms and DVT on clot prophylaxis with Coumadin, uterine fibroids status post hysterectomy, hypertension, vertigo, asthma, and obstructive sleep apnea, in addition to her migraines. (AR 11.) Plaintiff's headaches comprise only a minor part of her overall medical condition. "[T]he treatment records must be viewed in light of the overall diagnostic record."

Trevizo, 2017 WL 2925434, at *11 (internal citation omitted).

Additionally, the ALJ's contention that Plaintiff "reported significant improvement with regards to her headaches" is misleading. (*See* AR 855.) Dr. Raskin's diagnosis on September 15, 2015 was that although Plaintiff had been prescribed medication for her migraines, she continued to suffer from "Chronic migraine, intractable but improved." (AR 855.) On January 6, 2016, the date of Plaintiff's latest evaluation, Dr. Watson noted that Plaintiff continued to suffer from "frequent severe headaches, often accompanied by vertigo." (AR 935.)

The ALJ further noted that Plaintiff's "many symptoms could not be corroborated by objective findings, such as an EEG and CT scan, or confirmatory diagnoses." (AR 15.) However, the ALJ found that Plaintiff suffers from multiple severe conditions (complex partial epilepsy, lupus anticoagulant syndrome with history of pulmonary embolisms and DVT on clot prophylaxis with Coumadin, uterine fibroids status post hysterectomy, hypertension, vertigo, migraines, asthma, and obstructive sleep apnea) and that these "could reasonably be expected to cause the alleged symptoms." (AR 11, 15.) Thus, the ALJ's decision is contradictory because it does not explain how Plaintiff could both suffer from numerous severe conditions and not be credible regarding the extent of her symptoms and their associated limitations. "An individual's statements about the intensity and persistence of pain or other symptoms or about the effect the symptoms have on his or her ability to work may not be disregarded solely because they are not substantiated by objective medical evidence." SSR 96-7P, 1996 WL 374186, at *1 (S.S.A. July 2, 1996).[3] The

[3] In 2016, the Social Security Administration issued Social Security Ruling 16-3p, which supersedes S.S.R. 96-7p and states that "[i]n evaluating an individual's symptoms, our adjudicators will not assess an individual's overall character or truthfulness in the manner typically used during an adversarial court litigation." This ruling emphasizes that inconsistency between a claimant's allegations of disability and evidence in the record may not be used broadly to discredit the claimant's credibility but only insofar as the evidence contradicts a specific assertion relevant to the disability determination. *Walsh*, 2017 WL 1130366, at *10; *see also Sherrard v. Colvin*, No. 16-CV-02353-EMC, 2017 WL 878063, at *8, n. 6 (N.D. Cal. Mar. 6, 2017) (discussing whether SSR 16-3p applies retroactively); *Cole v. Colvin*, 831 F.3d 411, 412 (7th Cir. 2016) ("The change in wording is meant to clarify that administrative law judges aren't in the business of impeaching claimants' character; obviously administrative law judges will continue to assess the credibility of pain assertions by applicants, especially as such assertions often cannot be either credited or rejected on the basis of medical evidence."). The Court's decision here is not predicated on the new Social Security Ruling and thus the Court makes no finding as to whether the ruling applies retroactively; however, on remand, the ALJ must follow

ALJ was required to give specific reasons for discrediting Plaintiff's testimony of her symptoms.

Moreover, the ALJ's reasoning that Plaintiff was receiving "routine" and "conservative" treatment and that her daily activities challenged her credibility is not supported by substantial evidence. First, the ALJ did not point to what "conservative" treatment Plaintiff was receiving, nor did she explain what additional treatment Plaintiff was supposed to receive. Additionally, the record does not support the ALJ's contention that Plaintiff is unrestricted in her daily activities. The ALJ points to Plaintiff's interest in cooking and listening to music as indicators of her no-more-than-mildly impaired daily activity. (AR 11-12.) However, Plaintiff's impairments have affected her daily activities since 2014. On June 10, 2014, Plaintiff was assigned a home health care nurse to help her inject her medication, as well as an occupational therapist due to weakness in her extremities. (AR 480.) Plaintiff testified that she continues to need professional medical help caring for herself at home. (AR 37.) Additionally, Plaintiff reported that she can do minimal to zero activity at home without the help of her family. (AR 225-232.) Plaintiff can barely sleep throughout the night, needs reminders to take care of personal needs and grooming, needs help preparing meals, is unable to cook or clean due to panic attacks, and needs help getting up every morning. (*Id.*) Plaintiff tries to talk on the phone at least once a week but is limited because she feels depressed. (*Id.*) Plaintiff needs to be reminded to go to church or walk in the park and also requires the company of either her husband or other family members when she does so. (*Id.*) Moreover, Plaintiff reported communicating less with her family since the onset of her conditions, that her medication affects how long she can pay attention, and that it is very difficult for her to handle both stress and any changes in her routine. (*Id.*) "Engaging in daily activities that are incompatible with the severity of symptoms alleged can support an adverse credibility determination." *Trevizo*, 2017 WL 2925434, at *12 (internal citation omitted). Plaintiff's inability to engage in daily activities is compatible with the severity of her symptoms.

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In sum, the ALJ's reasons for discounting Plaintiff's testimony are not specific, clear, or

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SSR 16-3p for any credibility finding.

convincing.

IV. Plaintiff's Remaining Arguments

Plaintiff also argues that the ALJ improperly found that Plaintiff's mental health impairments were not severe and that the ALJ did not fulfill her duty to fully develop the record because she failed to obtain medical expert testimony. The Court need not reach either argument in light of the Court's holding that the ALJ's weighing of the medical evidence and adverse credibility finding were in error. These errors were harmful, as they directly informed the ALJ's RFC, the hypotheticals posed to the VE, and the ALJ's ultimate conclusion that Plaintiff was not disabled. *See Tommasetti*, 533 F.3d at 1038; *see also Stout v. Comm'r, Soc. Sec. Admin.*, 454 F.3d 1050, 1055 (9th Cir. 2006) (defining harmless error as such error that is "inconsequential to the ultimate nondisability determination"). The Court therefore remands to the agency as discussed below.

IV. The Scope of Remand

Finally, the Court must determine whether to remand this case to the SSA for further proceedings or with instructions to award benefits. A district court may "revers[e] the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing," *Treichler v. Comm'r of Soc. Sec. Admin.*, 775 F.3d 1090, 1099 (9th Cir. 2014) (citing 42 U.S.C. § 405(g)) (alteration in original), but "the proper course, except in rare circumstances, is to remand to the agency for additional investigation or explanation." *Id.* (citation omitted).

A district court is precluded from "remanding a case for an award of benefits unless certain prerequisites are met." *Dominguez v. Colvin*, 808 F.3d 403, 407 (9th Cir. 2015) (internal citations and quotations omitted). "The district court must first determine that the ALJ made a legal error, such as failing to provide legally sufficient reasons for rejecting evidence." *Id*. (citation omitted). "If the court finds such an error, it must next review the record as a whole and determine whether it is fully developed, is free from conflicts and ambiguities, and all essential factual issues have been resolved." *Id*. (internal quotation marks and citation omitted). If the record has been so developed, "the district court must consider the testimony or opinion that the ALJ improperly

rejected, in the context of the otherwise undisputed record, and determine whether the ALJ would necessarily have to conclude that the claimant were disabled if that testimony or opinion were deemed true." *Id.* If the answer is yes, "the district court may exercise its discretion to remand the case for an award of benefits." *Id.* Each part of this three-part standard must be satisfied for the court to remand for an award of benefits, *id.*, and "[i]t is the 'unusual case' that meets this standard." *Williams*, 24 F.Supp.3d at 919 (internal citations omitted).

Notably, district courts "retain 'flexibility' in determining the appropriate remedy [.]" *Burrell v. Colvin*, 775 F.3d 1133, 1141 (9th Cir. 2014) (quoting *Garrison*, 759 F.3d at 1021). Specifically, the court "may remand on an open record for further proceedings 'when the record as a whole creates serious doubt as to whether the claimant is, in fact, disabled within the meaning of the Social Security Act.'" *Id.* (quoting *Garrison*, 759 F.3d at 1021); *see also Connett*, 340 F.3d at 874-76 (finding that a reviewing court retains discretion to remand for further proceedings even when the ALJ fails to "assert specific facts or reasons to reject [the claimant's] testimony"). In addition, "[i]f additional proceedings can remedy defects in the original administrative proceedings," the case should be remanded. *Lewin v. Schweiker*, 654 F.2d 631, 635 (9th Cir. 1981).

Applying these principles here, the Court's conclusion regarding the ALJ's errors in weighing the medical evidence and with respect to the adverse credibility finding meets the threshold requirement of legal error. While a close question, the Court finds that the medical record leaves open the question of Plaintiff's exact disability status. The Court will therefore remand to the ALJ for further proceedings.

Because the matter is being remanded for reconsideration of the medical opinions, and the ALJ must reconsider Plaintiff's RFC in light of the record evidence, on remand the ALJ must also provide specific, clear, and convincing reasons for discounting Plaintiff's subjective symptom testimony, if warranted. *See Treichler*, 775 F.3d at 1103 (citation omitted) (the "ALJ must identify the testimony that was not credible, and specify 'what evidence undermines the claimant's complaints.'").

CONCLUSION

For the reasons described above, the Court GRANTS Plaintiff's Motion for Summary Judgment (Dkt. No. 15) and DENIES Defendant's Cross-Motion for Summary Judgment (Dkt. No. 16).

This Order disposes of Docket Nos. 15 & 16.

IT IS SO ORDERED.

Dated: July 28, 2017

JACQUELINE SCOTT CORLEY

United States Magistrate Judge

United States District Court
Northern District of California