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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
San Francisco Division

JOSE JESUS ZAVALA,
Plaintiff,

v.

COMMISSIONER OF SOCIAL
SECURITY,
Defendant.

Case No. 17-cv-02715-LB

**ORDER GRANTING PLAINTIFF'S
MOTION FOR SUMMARY
JUDGMENT AND REMANDING CASE**

Re: ECF No. 20

INTRODUCTION

Plaintiff Jose Jesus Zavala seeks judicial review of a final decision by the Commissioner of the Social Security Administration denying his claim for disability benefits under Title II of the Social Security Act.¹ He moved for summary judgment.² The Commissioner opposed the motion and filed a cross-motion for summary judgment.³ Under Civil Local Rule 16-5, the matter is submitted for decision by this court without oral argument. All parties consented to magistrate-judge

¹ Compl. – ECF No. 1 at 2; Motion for Summary Judgment – ECF No. 20 at 3. Citations refer to material in the Electronic Case File (“ECF”); pinpoint citations are to the ECF-generated page numbers at the top of documents.

² Mot. – ECF No. – 20.

³ Cross-Mot. – ECF No. 29.

1 jurisdiction.⁴ The court grants the plaintiff’s motion, denies the Commissioner’s cross-motion, and
2 remands for further proceedings.

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4 **STATEMENT**

5 **1. Procedural History**

6 On December 10, 2012, Mr. Zavala, born on December 27, 1967, and then age 44, filed a
7 claim for social-security disability insurance (“SSDI”) benefits under Title II of the Social
8 Security Act (“SSA”).⁵ He alleged a lower-back injury, with an onset date of November 28, 2012.⁶
9 The Commissioner denied his SSDI claim initially and on reconsideration.⁷ Mr. Zavala requested
10 a hearing.⁸

11 Administrative Law Judge Richard Laverdure (the “ALJ”) held two hearings in Oakland,
12 California — one on November 25, 2014 and the other on July 8, 2015.⁹ Attorney Eric Patrick
13 represented Mr. Zavala at both hearings.¹⁰ The ALJ heard testimony from Mr. Zavala, vocational
14 experts (“VE”) Jo Ann Yoshioka and Jeffrey Malmuth, and medical expert (“ME”) Anthony
15 Francis.¹¹ On July 30, 2015, the ALJ issued an unfavorable decision.¹² Mr. Zavala appealed the
16 decision to the Appeals Council on September 28, 2015.¹³ The Appeals Council denied his request
17 for review on March 14, 2017.¹⁴ On May 10, 2017, Mr. Zavala filed this action for judicial
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20 ⁴ Consent Forms – ECF Nos. 7, 8, 12.

21 ⁵ AR 318–324. Administrative Record (“AR”) citations refer to the page numbers in the bottom right
22 hand corner of the Administrative Record.

23 ⁶ AR 115, 318.

24 ⁷ AR 115–123 (initial determination); AR 124–136 (reconsideration).

25 ⁸ AR 162–63.

26 ⁹ AR 47–65 (November 2014 hearing transcript); AR 66–114 (July 2015 hearing transcript).

27 ¹⁰ AR 47, 66.

28 ¹¹ AR 47, 66.

¹² AR 26–41.

¹³ AR 24–25.

¹⁴ AR 1–9.

1 review¹⁵ and moved for summary judgment on June 26, 2018.¹⁶ The Commissioner opposed the
2 motion and filed a cross-motion for summary judgment on October 22, 2018.¹⁷

3 4 **2. Summary of Record and Administrative Findings**

5 **2.1 Medical Records**

6 **2.1.1 David Chow, M.D. — Treating**

7 David Chow, M.D., a spine-care and pain-management specialist, treated Mr. Zavala on
8 multiple occasions from February 2011 through July 2015.¹⁸ He saw Mr. Zavala primarily for
9 “bilateral low back pain radiating into the right buttock and right posterior thigh.”¹⁹ He noted that
10 Mr. Zavala stopped working in late November 2012 due to pain.²⁰

11 From December 2012 through July 2015, Dr. Chow repeated the following findings regarding
12 Mr. Zavala’s musculoskeletal and spine examinations: Mr. Zavala’s skin was within normal limits
13 in all limbs, except for a well-healed scar from his L5-S1 fusion.²¹ His “[l]umbar ranges of motion
14 were restricted by pain in all directions.”²² He had “tenderness upon palpation of the mid lumbar
15 spine overlying the L4 to S1 regions and bilateral lumbar paraspinal muscles overlying the L4 to
16 S1 facet joints.”²³ His “thoracolumbar muscle spasm” and “[l]umbar discogenic provocative

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20 ¹⁵ Compl. – ECF No. 1.

21 ¹⁶ Mot. – ECF No. 20.

22 ¹⁷ Cross-Mot. – ECF No. 29.

23 ¹⁸ See AR 545–603, 607–738, 800, 973-74. The court does not consider Dr. Chow’s opinions from
24 before the alleged onset date of November 28, 2012.

25 ¹⁹ See AR 545–603, 607–738, 800, 973-74.

26 ²⁰ AR 554.

27 ²¹ AR 546, 552, 555, 608, 611, 614, 617, 620, 623, 626, 629, 642, 645, 648, 651, 654, 657, 660, 663,
28 666, 669, 672, 675, 678, 681, 684, 687, 713, 717, 721, 725, 728, 731, 734, 737, 973.

²² AR 546, 552, 555, 608, 611, 614, 617, 620, 623, 626, 629, 642, 645, 648, 651, 654, 657, 660, 663,
666, 669, 672, 675, 678, 681, 684, 687, 713, 717, 721, 725, 728, 731, 734, 737, 973.

²³ AR 546, 552, 555, 608, 611, 614, 617, 620, 623, 626, 629, 642, 645, 648, 651, 654, 657, 660, 663,
666, 669, 672, 675, 678, 681, 684, 687, 713, 717, 721, 725, 728, 731, 734, 737, 973.

1 maneuvers” were both positive.²⁴ His nerve root tension signs were negative bilaterally, muscle
2 stretch reflexes were symmetric bilaterally in the lower extremities, and Clonus, Babinski’s, and
3 Hoffmann’s signs were absent bilaterally.²⁵ Mr. Zavala’s muscle strength was “5/5” in his bilateral
4 lower extremities.²⁶ Dr. Chow diagnosed Mr. Zavala with the following conditions: right S1
5 radiculopathy;²⁷ status post-percutaneous spinal-cord-stimulator trial; status post-L5-S1 lumbar
6 fusion with hardware removal; lumbar-disc protrusion; lumbar stenosis; lumbar-degenerative-disc
7 disease; lumbar-facet-joint arthropathy; lumbar sprain/strain; and gastrointestinal upset secondary
8 to industrially-related medications.²⁸

9 In addition to the above findings, beginning April 2013, Mr. Zavala’s muscle strength was “4+
10 /5 in the right extensor hallucis longus and gastrocnemius and soleus.”²⁹ His muscle strength
11 remained “5/5” in the bilateral lower extremities.³⁰

12 Dr. Chow noted that “[p]rolonged sitting and standing, lifting, twisting, driving, and any
13 activities” exacerbated Mr. Zavala’s conditions.³¹ “Lying down on [his] back, sitting, stretching,
14 and medications” mitigated them.³²

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²⁴ AR 546, 552, 555, 608, 611, 614, 617, 620, 623, 626, 629, 642, 645, 648, 651, 654, 657, 660, 663, 666, 669, 672, 675, 678, 681, 684, 687, 713, 717, 721, 725, 728, 731, 734, 737, 973.
²⁵ AR 546, 552, 555, 608, 611, 614, 617, 620, 623, 626, 629, 642, 645, 648, 651, 654, 657, 660, 663, 666, 669, 672, 675, 678, 681, 684, 687, 713, 717, 721, 725, 728, 731, 734, 737, 973.
²⁶ AR 546, 552, 555, 608, 611, 614, 617, 620, 623, 626, 629, 642, 645, 648, 651, 654, 657, 660, 663, 666, 669, 672, 675, 678, 681, 684, 687, 713, 717, 721, 725, 728, 731, 734, 737, 973.
²⁷ Radiculopathy is “a nerve disorder that causes radiating pain.” *Hanson v. Colvin*, 760 F.3d 759, 759 (7th Cir. 2014).
²⁸ AR 546, 552, 555, 608, 611, 614, 617, 620, 623, 626, 629, 642, 645, 648, 651, 654, 657, 660, 663
²⁹ AR 608, 611, 614, 617, 620, 623, 626, 642, 645, 648, 651, 654, 657, 660, 663, 666, 669, 672, 675, 678, 681, 684, 687, 713, 717, 725, 728, 731, 734 737, 973.
³⁰ AR 608, 611, 614, 617, 620, 623, 626, 642, 645, 648, 651, 654, 657, 660, 663, 666, 669, 672, 675, 678, 681, 684, 687, 713, 717, 725, 728, 731, 734 737, 973.
³¹ AR 545, 551, 607, 610, 613, 616, 619, 622, 625, 628, 641, 644, 647, 650, 653, 656, 659, 662, 665, 668, 671, 674, 677, 680, 683, 686, 712, 716, 720, 724, 727, 730, 733, 736, 972.
³² AR 545, 551, 607, 610, 613, 616, 619, 622, 625, 628, 641, 644, 647, 650, 653, 656, 659, 662, 665, 668, 671, 674, 677, 680, 683, 686, 712, 716, 720, 724, 727, 730, 733, 736, 972.

1 Throughout the course of his treatment, Dr. Chow prescribed Mr. Zavala several pain
 2 medications, including OxyContin, Percocet, Soma, and Baclofen.³³ He noted that OxyContin
 3 provided “60% improvement of [Mr. Zavala’s] pain with 60% improvement of his activities of
 4 daily living such as self-care, dressing.”³⁴ Percocet provided 40 to 50% “improvement of [Mr.
 5 Zavala’s] pain with 50% improvement of his activities of daily living.”³⁵ Soma provided 50 to
 6 80% improvement “of [his] spasms” and 50 to 80% “improvement of [his] activities of daily
 7 living.”³⁶ Baclofen was prescribed “for a short-term acute basis.”³⁷ It provided “40% improvement
 8 of his spasm with 40% improvement of his activities of daily living.”³⁸ Baclofen was not
 9 prescribed at the same time as Soma but only when Mr. Zavala was unable to get Soma.³⁹ Mr.
 10 Zavala reported that his “Oswestry Disability Index⁴⁰ score [was] a 26 (52% disability) with the
 11 use of Percocet, while [his] Oswestry Disability Index score [was] 37 (74% disability) without the
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16 ³³ See AR 546 (March 2013 exam); AR 552 (January 11, 2013 exam); AR 608 (October 7, 2013
 17 exam); AR 611 (September 11, 2013 exam); AR 614 (August 14, 2013 exam); AR 620 (June 17, 2013
 18 exam); AR 623 (May 20, 2013 exam); AR 626 (April 23, 2013 exam); AR 629 (March 29, 2013
 19 exam); AR 642 (October 28, 2014 exam); AR 646 (September 30, 2014 exam); AR 648 (September 2,
 20 2014 exam); AR 651 (August 5, 2014 exam); AR 655 (July 8, 2014 exam); AR 672 (March 17, 2014);
 AR 675 (February 17, 2014); AR 678 (January 22, 2014); AR 682 (December 27, 2013); AR 684
 (December 2, 2013); AR 687 (November 4, 2013); AR 714 (June 30, 2015); AR 718 (June 2, 2015);
 AR 722 (May 5, 2015); AR 726 (April 7, 2015); AR 729 (March 11, 2015); AR 732 (February 11,
 2015); AR 735 (January 15, 2015); AR 737 (November 25, 2014); AR 974 (July 28, 2015).

21 ³⁴ AR 651, 654, 657, 660, 666, 672, 675, 678, 681, 684, 713.

22 ³⁵ AR 651 (August 5, 2014); AR 654 (July 8, 2014); AR 657 (June 11, 2014); AR 660 (May 14, 2014);
 AR 666 (April 16, 2014); AR 672 (March 17, 2014); AR 678 (January 22, 2014); AR 681 (December
 27, 2013); AR 714 (June 30, 2015).

23 ³⁶ AR 654, 657, 672, 675, 678, 681, 714.

24 ³⁷ AR 654, 657, 660.

25 ³⁸ AR 654, 657, 660, 663.

26 ³⁹ AR 663.

27 ⁴⁰ The Oswestry Disability Index is “a questionnaire which the patient himself fills out regarding his
 pain intensity, as well as his ability to walk, sit, stand, and lift items, among other things. . . . [It is n]o
 28 more than a vehicle for patients to self-report their symptoms[.]” *Hejazi v. Colvin*, No. 13-CV-11129-
 DPW, 2014 WL 3513398, at *12 (D. Mass. July 11, 2014).

1 use of Percocet.”⁴¹ He reported the same Oswestry Disability Index scores with respect to his
2 OxyContin use.⁴²

3 Dr. Chow advised Mr. Zavala regarding the risks and benefits of long-term opioid use for
4 chronic-pain treatment, including risks relating to sleepiness, respiratory depression, cognitive
5 dysfunction, physical dependency on medication, and possibility of addiction.⁴³ Mr. Zavala
6 continued opioid therapy despite these risks.⁴⁴ Dr. Chow noted that Mr. Zavala was on an “up-to-
7 date pain contract” and his previous drug screens were “consistent with no aberrant behaviors.”⁴⁵

8 In December 2012, March 2013, May 2013, January 2015, and May 2015, Mr. Zavala sought
9 early refills of his pain medications, including OxyContin and Percocet.⁴⁶

10 On April 23, 2013, Mr. Zavala reported “an aggravation of his right lower extremity S1
11 radiculopathy pain with increased muscle spasms.”⁴⁷ Dr. Chow recommended a “right S1
12 transforaminal epidural steroid injection” to treat Mr. Zavala’s increased pain.⁴⁸ He later
13 authorized that Mr. Zavala receive the epidural-steroid injection.⁴⁹

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16 ⁴¹ AR 642, 655, 737.

17 ⁴² AR 642, 737.

18 ⁴³ AR 546 (March 2013 exam); AR 552 (January 11, 2013 exam); AR 608 (October 7, 2013 exam);
19 AR 611 (September 11, 2013 exam); AR 614 (August 14, 2013 exam); AR 620 (June 17, 2013 exam);
20 AR 623 (May 20, 2013 exam); AR 626 (April 23, 2013 exam); AR 629 (March 29, 2013 exam); AR
21 642 (October 28, 2014 exam); AR 646 (September 30, 2014 exam); AR 648 (September 2, 2014
22 exam); AR 651 (August 5, 2014 exam); AR 655 (July 8, 2014 exam); AR 672 (March 17, 2014); AR
23 675 (February 17, 2014); AR 678 (January 22, 2014); AR 682 (December 27, 2013); AR 684
(December 2, 2013); AR 687 (November 4, 2013); AR 714 (June 30, 2015); AR 718 (June 2, 2015);
24 AR 722 (May 5, 2015); AR 726 (April 7, 2015); AR 729 (March 11, 2015); AR 732 (February 11,
25 2015); AR 735 (January 15, 2015); AR 737 (November 25, 2014); AR 974 (July 28, 2015).

26 ⁴⁴ AR 546, 552, 608, 611, 614, 620, 623, 626, 629, 643, 649, 651, 655, 672, 676, 679, 682, 684, 687,
27 714, 718, 722, 726, 729, 732, 735, 738, 974.

28 ⁴⁵ AR 642, 651, 654, 657–58, 663, 666, 675, 678, 681, 714.

⁴⁶ AR 554 (December 2012); AR 546 (March 2013) (“due to inadequate pain coverage”); AR 662
(May 2013); AR 730 (January 2015) (“due to increased pain from travel”); AR 720 (sought refills one
day early).

⁴⁷ AR 625.

⁴⁸ AR 626.

⁴⁹ AR 623.

1 In July 2013, Dr. Chow reviewed with Mr. Zavala his May 2013 urine-drug-screen results.⁵⁰
2 They showed “the presence of prescribed medications in addition to hydrocodone and its
3 metabolites.”⁵¹ Mr. Zavala reported “50% relief of right lower extremity radiculopathy symptoms
4 since receiving his right S1 selective nerve root block.”⁵² As a result, Dr. Chow found Mr. Zavala
5 could continue to be treated nonsurgically.⁵³ He recommended, however, that Mr. Zavala
6 reconsider a permanent spinal-cord-stimulator implant.⁵⁴

7 In August 2013, Dr. Chow recommended another in-office random “12-panel urine drug
8 screen for ‘cause’” because Mr. Zavala’s July 2013 drug-test results revealed “presence of
9 Hydrocodone and Oxycodone.”⁵⁵ Dr. Chow counseled Mr. Zavala regarding the appropriate use of
10 his prescribed medications.⁵⁶

11 During a November 2013 visit, Dr. Chow noted that Mr. Zavala was working “full-time” as a
12 carpenter.⁵⁷ The next month, Dr. Chow took another random “12-panel urine drug screen” because
13 of Mr. Zavala’s chronic opioid-pain-medication intake.⁵⁸ He also counseled Mr. Zavala regarding
14 the appropriate use of such medications.⁵⁹

15 In March 2014, Mr. Zavala reported a “depressed mood” and that he “d[id] not like being
16 around other people very much.”⁶⁰ He reported no plan to harm himself or others.⁶¹ His pain was
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19 ⁵⁰ AR 616.
20 ⁵¹ *Id.*
21 ⁵² *Id.*
22 ⁵³ AR 617.
23 ⁵⁴ *Id.*
24 ⁵⁵ AR 614.
25 ⁵⁶ *Id.*
26 ⁵⁷ AR 687.
27 ⁵⁸ AR 684.
28 ⁵⁹ *Id.*
⁶⁰ AR 671.
⁶¹ *Id.*

1 at “7/10 on visual analog scale.”⁶² Dr. Chow sought a psychological consultation to evaluate Mr.
2 Zavala’s “depressed mood secondary his industrial pain.”⁶³ He also prescribed Cymbalta to treat
3 Mr. Zavala’s low-back and neuropathic pain.⁶⁴ He noted that Mr. Zavala had completed his doses
4 of OxyContin, Percocet, and Soma as of March 17, 2014.⁶⁵ Dr. Chow ordered another random in-
5 house urine-drug screen because of Mr. Zavala’s chronic opioid pain-medication intake.⁶⁶ Dr.
6 Chow also noted that Mr. Zavala worked as a carpenter at that time.⁶⁷

7 In August 2014, Dr. Chow noted that Mr. Zavala’s July 2014 urine-drug-screen results were
8 consistent with his medications.⁶⁸

9 On November 25, 2014, Dr. Chow submitted a medical-source statement.⁶⁹ He found that Mr.
10 Zavala could stand/walk no more than two hours in an eight-hour workday and between two to
11 four hours total during the day.⁷⁰ Mr. Zavala could sit no more than two hours in an eight-hour
12 workday and between four to five hours total during the day.⁷¹ He had no restrictions in regard to
13 using his hands, fingers, or feet in repetitive motions or being exposed to environmental factors
14 such as heat, cold, dust, dampness, or height.⁷² Mr. Zavala could occasionally lift and carry
15 between ten to twenty pounds and could never lift or carry twenty-pounds or more.⁷³ He could
16 never climb, stoop, or reach below the knees or from waist to knees.⁷⁴ He could occasionally
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18 ⁶² *Id.*

19 ⁶³ AR 669.

20 ⁶⁴ *Id.*

21 ⁶⁵ AR 671.

22 ⁶⁶ AR 673.

23 ⁶⁷ AR 666.

24 ⁶⁸ AR 650 (August 5, 2014).

25 ⁶⁹ AR 689–90.

26 ⁷⁰ AR 689.

27 ⁷¹ *Id.*

28 ⁷² *Id.*

⁷³ AR 690.

⁷⁴ *Id.*

1 balance, kneel, crouch, crawl, and reach from waist to chest.⁷⁵ He could frequently reach from his
2 chest to above his shoulders.⁷⁶ Dr. Chow noted that Mr. Zavala took opioid-analgesic medications,
3 which caused dizziness and somnolence.⁷⁷

4 In January 2015, Dr. Chow reported that Mr. Zavala’s October 2014 drug-screen results
5 showed “presence of Tizanidine and Methocarbamol” in addition to his prescribed medications.⁷⁸

6 In June 2015, Dr. Chow ordered another random in-office urine-drug screen because of Mr.
7 Zavala’s opioid-pain-medication intake.⁷⁹ He noted that Mr. Zavala was “a ‘moderate’ risk due to
8 chronic opioid intake.”⁸⁰

9 **2.1.2 Calvin Pon, M.D. — Examining**

10 On October 15, 2013, Calvin Pon, M.D. completed a consultative orthopedic-disability
11 evaluation for Mr. Zavala.⁸¹ Mr. Zavala reported a history of low-back injury from 2001.⁸² He was
12 injured while working as a carpenter.⁸³ He had two lumbar-spine surgeries — the first in 2003,
13 and the second in 2004 for hardware removal.⁸⁴ It was recommended to Mr. Zavala that he have
14 another lumbar-spine surgery, but he chose not to.⁸⁵ Mr. Zavala complained of “associated left
15 lower extremity pain” and numbness.⁸⁶ He had those symptoms before his surgeries as well.⁸⁷

18 ⁷⁵ *Id.*

19 ⁷⁶ *Id.*

20 ⁷⁷ *Id.*

21 ⁷⁸ AR 733.

22 ⁷⁹ AR 718.

23 ⁸⁰ *Id.*

24 ⁸¹ AR 604.

25 ⁸² *Id.*

26 ⁸³ *Id.*

27 ⁸⁴ *Id.*

28 ⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ *Id.*

1 After the lumbar-spine surgery, his symptoms “slightly improve[d].”⁸⁸ Mr. Zavala never had any
2 electrodiagnostic studies.⁸⁹

3 Mr. Zavala reported being able to sit and stand for one hour each.⁹⁰ He could walk for less than
4 one mile.⁹¹ He could climb stairs.⁹² Mr. Zavala lived in a house with one step leading to the front
5 door.⁹³ He also ambulated without aid.⁹⁴ He did not cook or prepare his own meals, but he ate
6 independently.⁹⁵ He needed “some assistance” with grocery shopping.⁹⁶ He managed his personal
7 hygiene independently.⁹⁷ In regard to housework, Mr. Zavala washed dishes, took out the garbage,
8 vacuumed, swept, and mopped the floor.⁹⁸ He did not do laundry.⁹⁹ He drove and put gasoline in
9 the car.¹⁰⁰

10 Dr. Pon noted that, during the evaluation, Mr. Zavala sat “comfortably” in a chair, alert, and in
11 no acute distress.¹⁰¹ Mr. Zavala could rise from the chair and “stand erect normally.”¹⁰² When he
12 stood, Mr. Zavala placed most of his weight on his left lower extremity.¹⁰³ His gait was stable.¹⁰⁴
13 But his gait velocity and stride length were “slightly less than normal.”¹⁰⁵ He had a “slight limp”

14 ⁸⁸ *Id.*

15 ⁸⁹ *Id.*

16 ⁹⁰ *Id.*

17 ⁹¹ *Id.*

18 ⁹² *Id.*

19 ⁹³ *Id.*

20 ⁹⁴ *Id.*

21 ⁹⁵ *Id.*

22 ⁹⁶ *Id.*

23 ⁹⁷ *Id.*

24 ⁹⁸ *Id.*

25 ⁹⁹ *Id.*

26 ¹⁰⁰ *Id.*

27 ¹⁰¹ AR 605.

28 ¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

1 on his right.¹⁰⁶ He could squat “approximately one-half of the way down” but was “limited by low
2 back pain and right lower extremity pain and numbness.”¹⁰⁷ He could move to an upright position
3 and get on and off the exam table normally.¹⁰⁸

4 In regard to Mr. Zavala’s upper extremities, Dr. Pon noted that he had “relativity full active
5 ROM [range of motion]” in his neck.¹⁰⁹ Mr. Zavala was able to “abduct and forward flex” both
6 shoulders to 150 degrees. He had full active range of motion of his elbows and wrists in flexion
7 and extension.¹¹⁰ Dr. Pon found the following with respect to Mr. Zavala’s manual motor-muscle
8 testing: “[s]houlder bilaterally 5/5, right grip strength 5/5, left grip strength 5/5, bilateral pinch
9 strength normal.”¹¹¹ Mr. Zavala’s fine-finger movements were intact bilaterally, he could pick up a
10 coin normally with both hands, and he was able to write legibly with his right hand.¹¹²

11 In regard to Mr. Zavala’s lower extremities, Dr. Pon noted that he could “extend both hips to
12 neutral, flex his left hip to approximately 70 degrees limited by low back pain, [and] flex his right
13 hip approximately 30 degrees limited by low back pain.”¹¹³ He had full active range of motion of
14 his left knee in extension and flexion, but left knee flexion was approximately 130 degrees
15 “limited by low back pain and right lower extremity pain and numbness.”¹¹⁴ Dr. Pon found the
16 following with respect to Mr. Zavala’s manual motor-muscle testing: “[l]eft hip 4-/5 limited by
17 low back pain, right hip 2+ to 3-/5 limited by low back pain, left knee extensors and flexors 5/5,
18 right knee extensors 5/5, right knee flexors 4/5 limited by low back pain, bilateral ankle
19 dorsiflexors and plantar flexors 5/5.”¹¹⁵

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21 ¹⁰⁶ *Id.*

22 ¹⁰⁷ *Id.*

23 ¹⁰⁸ *Id.*

24 ¹⁰⁹ *Id.*

25 ¹¹⁰ *Id.*

26 ¹¹¹ *Id.*

27 ¹¹² *Id.*

28 ¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ *Id.*

1 Dr. Pon opined that, with respect to his history of lumbar-spine surgery, Mr. Zavala had
2 lumbar-disc disease, lumbar stenosis, lumbar-degenerative-disc disease, and lumbar-facet-joint
3 arthropathy.¹¹⁶ With respect to his right lower-extremity pain and numbness, Dr. Pon opined that
4 Mr. Zavala had right S1 radiculopathy.¹¹⁷ In support of this finding, Dr. Pon noted that Mr. Zavala
5 had a “slight limp on the right during ambulation and symptomatic limitations in his ability to
6 squat.”¹¹⁸

7 Dr. Pon further opined that Mr. Zavala had the following functional capacity:

8 [He] should be able to stand and/or walk for a total of 6 hours during an 8 hour
9 workday. He should be able to sit for a total of 6 hours during an 8 hour workday.
10 Stooing should be limited to occasionally. He is able to perform limited
11 crouching, kneeling, and squatting occasionally. Climbing stairs should be limited
12 to occasionally. Climbing ladders should be limited from rarely to occasionally.
13 Crawling should be limited to occasionally.

14 There is no restriction in performing bilateral pushing and pulling arm/hand
15 control. There is no restriction in performing pushing left leg/foot control. In spite
16 of his complaint of right lower extremity pain and numbness, he should still be able
17 to perform pushing right leg/foot control frequently. He should be able to lift and
18 carry frequently 10 lbs. and occasionally 20 lbs. There is no limitation in reaching
19 bilaterally. There is no limitation in his ability to perform gross and fine
20 manipulative tasks with both hands.

21 Regarding his ability to travel, he does drive. He is also able to take public
22 transportation.¹¹⁹

23 **2.1.3 Jogendra Singh, M.D. — Non-Examining**

24 Jogendra Singh, M.D., a state-agency medical consultant, considered the following evidence in
25 support of Mr. Zavala’s claims: Mr. Zavala reported he could sit and stand for one hour each; he
26 could walk less than one mile (at most ten minutes) without aid; his gait was stable, and his
27 velocity and stride length were slightly less than normal; he had a slight limp on his right side; his
28 thoracolumbar spine with flexion at forty-five degrees was limited by pain; he had left-hip flexion
at seventy degrees, right hip at thirty degrees, and left knee at 130 degrees limited by pain; he

26 ¹¹⁶ AR 606.

27 ¹¹⁷ *Id.*

28 ¹¹⁸ *Id.*

¹¹⁹ *Id.*

1 could squat at fifty percent; he dressed and took care of his personal hygiene independently,
2 prepared his own meals, but needed help shopping; he reportedly could not cook or do housework;
3 he went outside daily and could drive; he could lift approximately eight pounds (a gallon of
4 milk).¹²⁰ Dr. Singh opined that the above evidence did not support the degree of impairment
5 alleged by Mr. Zavala and found his statements were thus only partially credible.¹²¹

6 **2.1.4 Eric D. Schmitter, M.D. — Non-Examining**

7 In March 2015, at the ALJ’s request, Eric D. Schmitter, M.D., an orthopedic surgeon,
8 submitted a medical-source statement evaluating Mr. Zavala’s alleged disability.¹²² Dr. Schmitter
9 opined as follows. Mr. Zavala had chronic lumbar spine pain and post-fusion L5-S1.¹²³
10 Consequently, he could never lift or carry over twenty pounds, he could occasionally lift and carry
11 between eleven and twenty pounds, and he could frequently lift and carry up to ten pounds.¹²⁴ Mr.
12 Zavala could sit, stand, and walk for up to four hours without interruption.¹²⁵ He could sit, stand,
13 and walk for up to six hours total in an eight-hour workday.¹²⁶ He did not need a cane to
14 ambulate.¹²⁷

15 Mr. Zavala had no upper-extremity pathology.¹²⁸ Accordingly, he could “continuously”
16 perform reaching, handling, fingering, feeling, pushing, and pulling with both hands.¹²⁹ He also
17 had no neurologic deficit and could operate both feet “continuously.”¹³⁰

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¹²⁰ AR 129.

21 ¹²¹ AR 130.

22 ¹²² AR 691–700.

23 ¹²³ AR 692.

24 ¹²⁴ *Id.*

25 ¹²⁵ AR 693.

26 ¹²⁶ *Id.*

27 ¹²⁷ *Id.*

28 ¹²⁸ AR 694.

¹²⁹ *Id.*

¹³⁰ *Id.*

1 In regard to postural activities, Mr. Zavala could do the following: occasionally climb
2 ladders/scaffolds, stoop, kneel, crouch, and crawl; frequently balance; and continuously climb
3 stairs and ramps.¹³¹ Mr. Zavala could frequently tolerate exposure to unprotected heights, moving
4 mechanical parts, humidity and wetness, dust, odors, fumes, pulmonary irritants, extreme cold,
5 extreme heat, and vibrations.¹³² He could continuously tolerate exposure to operating a motor
6 vehicle.¹³³

7 Mr. Zavala was physically capable to shop, travel alone without assistance, ambulate without
8 aid, use public transportation, climb “a few steps at a reasonable pace with the use of a single hand
9 rail,” prepare simple meals, feed himself, care for his personal hygiene, and manage paper/files.¹³⁴

10 In sum, Dr. Schmitter found that Mr. Zavala’s “subjective complaints appear to exceed [the]
11 physical finding[s].”¹³⁵ He also found that Mr. Zavala was addicted to proscribed narcotics.¹³⁶ Dr.
12 Schmitter opined that Mr. Zavala had the residual functional capacity (“RFC”) to perform light
13 activity only.¹³⁷

14 **2.2 Mr. Zavala’s Testimony**

15 Mr. Zavala previously worked as a lead carpenter.¹³⁸ He last worked on November 28, 2012.¹³⁹
16 He stopped working because his “pain got so bad that [he] could barely move.”¹⁴⁰ As of July 2015,
17 he had not gone back to work or looked for any other work, including less strenuous work.¹⁴¹ He
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19
20 ¹³¹ AR 695.

21 ¹³² AR 696.

22 ¹³³ *Id.*

23 ¹³⁴ AR 697.

24 ¹³⁵ *Id.*

25 ¹³⁶ *Id.*

26 ¹³⁷ AR 700.

27 ¹³⁸ AR 53.

28 ¹³⁹ AR 53–54.

¹⁴⁰ AR 53.

¹⁴¹ AR 53–54, 71.

1 received formal training as a carpenter, including attending seventeen classes over the course of
2 four years.¹⁴²

3 Mr. Zavala stated that his low back pain would go up “higher, and . . . down to [his] legs.”¹⁴³ It
4 was worse in his right leg than in his left.¹⁴⁴ The pain went down to his toes on his right leg and to
5 his calf on his left leg.¹⁴⁵ The pain was “burning [,] sharp[,] stabbing[,] numb[, and] tingly.”¹⁴⁶ He
6 experienced numbness approximately three or four times per week.¹⁴⁷ He felt the pain both sitting
7 down and standing up — “not [in] a specific position.”¹⁴⁸

8 In 2003, Mr. Zavala had surgery on his back and then went back to work, up until the alleged
9 onset date of November 2012.¹⁴⁹ His pain was “pretty much the same” during the course of his
10 career, but he also experienced an “increase” in pain “down to [his] legs.”¹⁵⁰

11 In January 2012, Mr. Zavala underwent a four-day trial for a spine stimulator.¹⁵¹ Rather than
12 decreasing his pain, he experienced “real sharp, strong pains. Sharp, punching pain . . . like
13 electric shock” with “[e]very move” he made.¹⁵²

14 Because of his pain, Mr. Zavala “continually” changed positions throughout the day.¹⁵³ He
15 moved between positions of sitting, laying down, standing up, and walking “a little bit.”¹⁵⁴ He
16 estimated that he spent eight to ten of his waking hours laying down each day.¹⁵⁵ He also took

17
18 ¹⁴² AR 54.

19 ¹⁴³ *Id.*

20 ¹⁴⁴ *Id.*

21 ¹⁴⁵ AR 54–55.

22 ¹⁴⁶ AR 55.

23 ¹⁴⁷ *Id.*

24 ¹⁴⁸ *Id.*

25 ¹⁴⁹ AR 58.

26 ¹⁵⁰ AR 58–59.

27 ¹⁵¹ AR 55.

28 ¹⁵² AR 56.

¹⁵³ *Id.*

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

1 naps about three or four times per week for one to two hours at a time.¹⁵⁶ Mr. Zavala took
2 medication for his pain, including Percocet, Soma, OxyContin, Lyrica, and Methocarbamol.¹⁵⁷ His
3 medications made him feel “drowsy all the time” and nauseous and made concentrating
4 difficult.¹⁵⁸ Mr. Zavala could not help with household chores because of his pain.¹⁵⁹ Whenever he
5 did, his pain got “really bad.”¹⁶⁰

6 In July 2013, Mr. Zavala completed a function report in support his disability claims.¹⁶¹ He
7 described his daily routine as follows: he gets up to make coffee; lies down and watches
8 television; visits his mother; drives short distances; goes back and lies down; his wife cooks for
9 him; he watches television; and then goes to bed.¹⁶² His wife took care of cooking, caring for their
10 kids, putting on his shoes and socks, and sometimes helped him bathe when he was in “bad
11 pain.”¹⁶³ He woke up “a lot with pain.”¹⁶⁴ He did not do household chores (including cleaning,
12 laundry, repairs, ironing, or mowing) because he was in “too much pain.”¹⁶⁵ He could visit his
13 mom “nearby,” pick up his kids, and go to doctors’ appointments on his own.¹⁶⁶ He went grocery
14 shopping with his wife. She carried “heavier stuff,” and he helped with “small stuff.”¹⁶⁷ He was
15 able to pay bills, count change, handle a savings account, and use a checkbook or money orders.¹⁶⁸
16 His pain affected his ability to lift, squat, bend, stand, reach, walk, sit, kneel, climb stairs,

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18 ¹⁵⁶ AR 57.
19 ¹⁵⁷ *Id.*
20 ¹⁵⁸ *Id.* As of July 2015, Mr. Zavala had been taking both OxyContin and Percocet for approximately
21 three years. AR 95.
22 ¹⁵⁹ AR 58.
23 ¹⁶⁰ *Id.*
24 ¹⁶¹ AR 468–75.
25 ¹⁶² AR 469.
26 ¹⁶³ *Id.*
27 ¹⁶⁴ *Id.*
28 ¹⁶⁵ AR 469–70.
¹⁶⁶ AR 471–72.
¹⁶⁷ AR 471.
¹⁶⁸ *Id.*

1 complete tasks, get along with others, and remember certain information.¹⁶⁹ It also affected his
2 mood, causing him to feel “more depressed” and “stressed out.”¹⁷⁰ He could walk ten minutes
3 before he needed to stop and rest.¹⁷¹ He could not handle stress well because he was “depressed,
4 angry,” and slept “a lot.”¹⁷² He took Percocet, Dexilant, Oxycodone, Lyrica, Methocarbamol, and
5 Soma.¹⁷³ His medications made him “sleepy, constipated, depressed” and caused “mood
6 swings.”¹⁷⁴

7 **2.3 Vocational Expert Testimony**

8 Vocational Expert (“VE”) Jo Ann Yoshioka testified at the November 2014 hearing,¹⁷⁵ and VE
9 Jeffrey Malmuth testified at the July 2015 hearing.¹⁷⁶

10 **2.3.1 VE Jo Ann Yoshioka’s testimony**

11 VE Yoshioka classified Mr. Zavala’s past work as a carpenter as medium strength and
12 performed at “the very heavy level.”¹⁷⁷ The ALJ asked whether there were unskilled jobs at the
13 light and sedentary levels in the economy for the following hypothetical individual: “someone of
14 claimant’s age, education and work experience. . . . No ladders, ropes or scaffolds. Ramps and
15 stairs and stooping, crouching, crawling, kneeling and balancing are occasional. And no use of
16 foot pedals or controls.”¹⁷⁸ VE Yoshioka testified that such an individual could perform the
17 following jobs: assembler of small products (706.684-022, SVP two, light); weight tester

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¹⁶⁹ AR 473.

22 ¹⁷⁰ *Id.*

23 ¹⁷¹ *Id.*

24 ¹⁷² *Id.*

25 ¹⁷³ AR 475.

26 ¹⁷⁴ *Id.*

27 ¹⁷⁵ AR 59–64.

28 ¹⁷⁶ AR 95–112.

¹⁷⁷ AR 59.

¹⁷⁸ AR 59–60.

1 (539.485-010, SVP two, sedentary); box inspector of wooden crates (762.687-014, SVP two,
2 light); and electrical-equipment patcher (723.687-010, SVP two, sedentary).¹⁷⁹

3 VE Yoshioka then considered a second hypothetical: the individual in the first hypothetical
4 needed an “hourly change of position for up to ten minutes” (for example, if the job primarily
5 involved standing, the individual would need to sit for minutes, and vice versa).¹⁸⁰ VE Yoshioka
6 testified that such a hypothetical individual could work as either a weight tester or electrical-
7 equipment patcher (the two sedentary jobs) because both jobs had a sit-or-stand option.¹⁸¹

8 VE Yoshioka considered a third hypothetical: the above hypothetical individual could not be
9 exposed to hazardous machinery (*i.e.*, machinery that could threaten life or limb).¹⁸² She testified
10 that such a limitation would not prevent those individuals from performing the above jobs.¹⁸³

11 She also testified that if a fourth hypothetical individual could only occasionally reach
12 bilaterally (waist to chest) and could never reach below the knees, bend, or stoop, that individual
13 would be precluded from all jobs (including those listed above).¹⁸⁴

14 In considering a fifth hypothetical individual who could never stoop but who otherwise had no
15 bilateral reaching limitations, VE Yoshioka testified that such an individual could work as a box
16 inspector, but that all other jobs listed above required some stooping.¹⁸⁵

17 VE Yoshioka further testified that if an individual needed to be off task approximately twenty
18 percent of the day due to medication side-effects, that individual would be precluded from the
19 above jobs.¹⁸⁶ An individual who needed to take unscheduled work breaks “above and beyond the
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22 ¹⁷⁹ AR 60.

23 ¹⁸⁰ AR 60–61.

24 ¹⁸¹ AR 61.

25 ¹⁸² AR 62.

26 ¹⁸³ *Id.*

27 ¹⁸⁴ AR 63.

28 ¹⁸⁵ *Id.*

¹⁸⁶ *Id.*

1 normal breaks to rest” would also be precluded from such jobs.¹⁸⁷ Similarly, if the individual
2 needed not only to change positions “up to ten minutes every hour” by sitting and standing
3 intermittently but also occasionally needed to walk “away from the work station” to relieve pain,
4 that individual would be precluded from the above jobs.¹⁸⁸

5 **2.3.2 VE Jeffrey Malmuth’s testimony**

6 The ALJ posed the following hypothetical: an individual with a sedentary RFC who could
7 never climb ladders, ropes, or scaffolds; could frequently use bilateral lower-extremities; needed
8 to avoid extremes of cold and industrial vibration, unprotected heights, hazardous machinery, and
9 dangerous industrial moving parts; and needed standing or stretching breaks for ten minutes every
10 hour (*e.g.*, if the job provided a raised work bench and a stool).¹⁸⁹ VE Malmuth testified that such
11 an individual might be able to do “telephone work,” where he wore a headset and could perform
12 work “standing as well as sitting.”¹⁹⁰ Furthermore, such an individual could perform work as a nut
13 sorter (521.687-086, sedentary, SVP two), if performed at a raised bench.¹⁹¹ He estimated that, for
14 light and sedentary jobs, there would be twenty-five percent fewer jobs for an individual who
15 required a sit/stand option.¹⁹²

16 VE Malmuth testified that if the above hypothetical individual also could not reach below the
17 waist and could only occasionally reach between the waist and chest bilaterally, that individual
18 would not be able to perform the jobs listed above.¹⁹³ Moreover, if the individual had to take
19 unscheduled work breaks between one to two hours per day to lie down, due to pain medication
20 side-effects, the individual would be precluded from all work.¹⁹⁴

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22 _____
23 ¹⁸⁷ AR 63–64.

24 ¹⁸⁸ AR 64.

25 ¹⁸⁹ AR 104.

26 ¹⁹⁰ AR 105.

27 ¹⁹¹ AR 106.

28 ¹⁹² AR 107–08.

¹⁹³ AR 111.

¹⁹⁴ AR 112.

1 **2.4 Medical Expert Testimony**

2 Anthony Francis, M.D. testified at the July 2015 hearing.¹⁹⁵ Dr. Francis testified that, based on
3 his review of the record, Mr. Zavala had right S1 radiculopathy, status post-lumbar-fusion surgery
4 and post-spinal-cord stimulator.¹⁹⁶ He noted that Mr. Zavala underwent lumbar-fusion surgery in
5 2003 and then later had the previously implanted metal surgically removed — a “sign that . . .
6 things are . . . hurting pretty badly.”¹⁹⁷ He also noted that Mr. Zavala underwent a trial spinal-cord
7 stimulator, but it was unsuccessful.¹⁹⁸ Dr. Francis stated that Mr. Zavala had continued
8 radiculopathy, which may return following surgery or sometimes such patients are “no better than
9 they were before the surgery.”¹⁹⁹ He indicated that when a patient gets to the point where he needs
10 a spinal-cord stimulator, “that’s almost always a . . . salvage procedure on a pretty bad
11 situation.”²⁰⁰ A patient typically does not undergo such a procedure “unless they’re fairly
12 debilitated from just chronic pain.”²⁰¹

13 Dr. Francis opined that Mr. Zavala’s case appeared to be a “failed spinal surgery case” that
14 “[p]robably ought to equal a 1.04(a).”²⁰² He stated that the record contained the following
15 objective evidence indicating a 1.04(a) radiculopathy listing: lumbar spasms; lumbar range of
16 motion restricted by pain in all directions; complaints of pain in dermatomal pattern; numbness in
17 various positions; a slightly antalgic gait; tenderness upon palpation of the mid-lumbar spine
18 overlying the L4 to S1 regions; bilateral lumbar-perispinal muscles overlying the L4 to S1 facet
19 joints; positive thoracolumbar-muscle spasm upon physical examination; and lumbar-discogenic

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¹⁹⁵ AR 73–95.

23 ¹⁹⁶ AR 74, 83, 89.

24 ¹⁹⁷ AR 75.

25 ¹⁹⁸ AR 74–75.

26 ¹⁹⁹ AR 75.

27 ²⁰⁰ AR 75, 87.

28 ²⁰¹ AR 87.

²⁰² AR 75, 87–88.

1 provocative maneuvers.²⁰³ In a failed spinal-surgery case, the “main thing that . . . patients are
2 going to have is pain,” specifically pain “at a dermatomal pattern.”²⁰⁴ Dr. Francis stated that “it’s a
3 rare case where [a patient] ha[s] everything that’s in 1.04(a) present in the chart.”²⁰⁵ Furthermore,
4 radiculopathy symptoms “tend to wax and wane, come and go.”²⁰⁶ In other words, a patient with
5 radiculopathy “may have a fairly good exam and then the next time around they’re fairly
6 restricted.”²⁰⁷ Such a patient “may be able to go out and do something fairly rigorously for a day
7 or two, but then whether [that patient] can do that in competitive employment, day after day, is
8 kind of another question.”²⁰⁸

9 Dr. Francis did not ultimately conclude whether Mr. Zavala had a sedentary or light RFC
10 because he believed that was “up to the trier of fact.”²⁰⁹ He opined, however, that if Mr. Zavala
11 had a light (rather than sedentary) RFC, Mr. Zavala would be limited in the following ways: lifting
12 and carrying twenty pounds occasionally and ten pounds frequently; standing and walking for six
13 out of eight hours; sitting for six out of eight hours; climbing ramps frequently but never climbing
14 stairs; never using ropes, ladders, or scaffolds; occasionally stooping, bending, crawling, kneeling,
15 squatting, balancing; no upper-extremity limitations; frequent lower-extremity limitations; no
16 unprotected heights; and should avoid excessive industrial vibration, excessive cold, and exposure
17 to hazardous or dangerous machinery with moving parts.²¹⁰ Dr. Francis further stated that it was
18 possible that an individual with Mr. Zavala’s conditions and who took the same medication

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²⁰³ AR 83–85, 91.
²⁰⁴ AR 86.
²⁰⁵ AR 85.
²⁰⁶ *Id.*
²⁰⁷ AR 88.
²⁰⁸ AR 92.
²⁰⁹ AR 88–93.
²¹⁰ AR 89.

1 (Percocet, Soma, and OxyContin) would experience pain throughout the day and that such pain
2 might cause the individual to be off task or take unscheduled breaks throughout the day.²¹¹

3 **2.5 Administrative Findings**

4 The ALJ followed the five-step sequential evaluation process to determine whether Mr. Zavala
5 was disabled and concluded that he was not.²¹²

6 At step one, the ALJ found that Mr. Zavala had not engaged in substantial gainful activity
7 since November 28, 2012, the alleged onset date.²¹³

8 At step two, the ALJ found that Mr. Zavala had two severe impairments — degenerative-disc
9 disease, and status post-fusion and hardware removal.²¹⁴

10 At step three, the ALJ found that Mr. Zavala did not have an impairment or combination of
11 impairments that met or medically equaled the severity of one of the listed impairments (namely,
12 Section 1.04 for degenerative-disc disease).²¹⁵ He found that Mr. Zavala had a history of lumbar
13 fusion at L5-S1 in 2003, with hardware removal in 2004.²¹⁶ The medical records lacked objective
14 findings, however, showing radiculopathy, neuroanatomic distribution of pain, limitation of
15 motion of the spine, motor loss, and sensory or reflex loss “as contemplated by Section 1.04A.”²¹⁷
16 Furthermore, there was no evidence of spinal arachnoiditis or lumbar spinal stenosis “as
17 contemplated by Section 1.04B and 1.04C.”²¹⁸ Although the record indicated Mr. Zavala had
18 “limited range of motion of the lumbar spine and muscle spasms,” he had only “occasional
19 positive straight leg raising tests” and demonstrated “mostly 5/5 motor strength and normal
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22 ²¹¹ AR 94.

23 ²¹² AR 33–41.

24 ²¹³ AR 34.

25 ²¹⁴ *Id.*

26 ²¹⁵ AR 35.

27 ²¹⁶ *Id.*

28 ²¹⁷ *Id.*

²¹⁸ *Id.*

1 sensation throughout.”²¹⁹ Moreover, although Dr. Chow diagnosed Mr. Zavala with right S1
2 radiculopathy, the ALJ found “no nerve conduction studies and no objective findings of motor or
3 sensory or reflex loss in the record.”²²⁰ He also found no sufficient objective findings or medical
4 evidence to support a conclusion that Mr. Zavala was limited to a six-hour workday.²²¹

5 With respect to Dr. Francis’s testimony that this “looked like a failed back surgery case,” the
6 ALJ credited only Dr. Francis’s opinion that Mr. Zavala had an RFC to perform light work.²²² The
7 ALJ discredited Dr. Francis’s opinion that Mr. Zavala’s impairments “potentially” equaled a
8 Section 1.04 listing because “[a] ‘potential’ does not satisfy the claimant’s burden of proving
9 ‘more likely than not’” at step three of the analysis.²²³

10 Before considering the fourth step, the ALJ determined that Mr. Zavala had the residual
11 functional capacity to perform light work, with the following limitations: lifting and carrying
12 twenty pounds occasionally and ten pounds frequently; standing and/or walking for six hours in an
13 eight-hour workday; sitting for six hours in an eight-hour workday; never climbing ladders, ropes,
14 or scaffolds and occasionally balancing, stooping, kneeling, crouching, crawling, and climbing
15 ramps or stairs; frequently using foot controls with bilateral lower extremities; never working at
16 unprotected heights or around hazards such as dangerous machinery or moving mechanical parts;
17 avoiding concentrated exposure to extreme cold and industrial vibration; and changing of position
18 from standing to sitting (and vice versa) hourly for ten minutes at his workstation.²²⁴

19 In making this determination, the ALJ discounted Mr. Zavala’s testimony finding it was only
20 partially corroborated by the medical record.²²⁵ He found that although the record indicated
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23 ²¹⁹ *Id.*

24 ²²⁰ *Id.*

25 ²²¹ *Id.*

26 ²²² *Id.*

27 ²²³ *Id.*

28 ²²⁴ *Id.*

²²⁵ AR 36.

1 ongoing pain-management treatment from Dr. Chow, there were few objective findings since the
2 alleged onset date of November 28, 2012.²²⁶

3 For example, while Mr. Zavala
4 exhibited a limited range of motion of the lumbar spine and muscle spasms, and
5 had positive straight leg raising tests occasionally, . . . he [] also demonstrated
6 *mostly 5/5 strength throughout the upper and lower extremities, no atrophy, and no*
decreased range of motion in the lower extremities[.] There are no imaging studies
or nerve conduction studies in the record.²²⁷

7 During an October 2013 orthopedic consultative examination, Dr. Pon found that Mr. Zavala had a
8 limited range of motion in the lumbar spine and was limited by low-back pain and right lower-
9 extremity pain and numbness.²²⁸ He opined, however, that Mr. Zavala could stand and/or walk for
10 a total of six hours in an eight-hour workday, sit for a total of six hours in an eight-hour workday,
11 occasionally stoop, crouch, kneel, squat and crawl, occasionally climb stairs, and frequently push
12 or use foot controls with the right foot.²²⁹ Based on these findings, the ALJ concluded that while
13 the objective medical evidence showed the Mr. Zavala had a “severe” lumbar impairment, they did
14 not demonstrate “an inability to perform a range of light work (or complete disability, as alleged
15 by the claimant).²³⁰

16 The ALJ noted that Mr. Zavala sought narcotic medications refills early.²³¹ This “at least raises
17 the question of opiate addition or drug-seeking behavior, notwithstanding that Dr. Chow
18 apparently thinks all is well.”²³² The ALJ also found that certain reported activities undermined
19 Mr. Zavala’s allegations of disability as well as his testimony that he spend ten hours per day
20 laying down.²³³ For example, Mr. Zavala testified that he stopped working in November 2012 (his
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22 ²²⁶ AR 37.

23 ²²⁷ *Id.* (emphasis in original).

24 ²²⁸ *Id.*

25 ²²⁹ *Id.*

26 ²³⁰ *Id.*

27 ²³¹ *Id.*

28 ²³² AR 38.

²³³ *Id.*

1 alleged onset date.²³⁴ But the record indicated that he worked as a carpenter in November 2013
2 and March 2014.²³⁵ Moreover, he reported increased pain due to increased travel in February and
3 May 2015.²³⁶

4 To the extent their opinions were consistent with his opinion, the ALJ gave “great weight” to
5 the opinions of Drs. Pon and Singh.²³⁷ He accorded “great weight” to Dr. Francis’s RFC opinion,
6 but only to the extent that he opined that Mr. Zavala could perform light work.²³⁸ The ALJ found
7 Dr. Francis’s conclusion that Mr. Zavala’s impairments equaled Listing 1.04A “entirely
8 speculative.”²³⁹ The ALJ found that Dr. Schmitter did not “adequately and persuasively explain
9 the basis for his opinion” that Mr. Zavala could perform “a range of light work (with postural
10 limitations).”²⁴⁰ The ALJ did not rely on that opinion.²⁴¹

11 Finally, the ALJ considered Dr. Chow’s RFC: Mr. Zavala could stand and walk for at most
12 two hours at one time and between two to four hours total during an eight-hour day; he could sit
13 for at most two hours at a time and between four to six hours in an eight-hour workday; he
14 occasionally could carry up to twenty pounds; he could never climb, stoop, or reach below the
15 knees or from his waist to knees; he could occasionally balance, kneel, crouch, crawl, and reach
16 from the chest to the shoulders and above the shoulders.²⁴² The ALJ found that Dr. Chow “did not
17 reveal any basis” for his opinion, and “no other medical opinion is consistent” with it.²⁴³
18 Accordingly, the ALJ gave “little weight” to Dr. Chow’s RFC assessment.²⁴⁴

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²³⁴ *Id.*

²³⁵ AR 38.

²³⁶ *Id.*

²³⁷ *Id.*

²³⁸ *Id.*

²³⁹ *Id.*

²⁴⁰ *Id.*

²⁴¹ *Id.*

²⁴² *Id.*

²⁴³ AR 38–39.

²⁴⁴ AR 39.

1 At step four, the ALJ concluded that Mr. Zavala was unable to perform his past work as a
2 carpenter (which was medium work).²⁴⁵

3 At step five, the ALJ determined that, given Mr. Zavala’s age, education, work experience, and
4 RFC, and based on the VE Malmuth’s testimony, Mr. Zavala could successfully adjust “to other
5 work that exists in significant numbers in the national economy.”²⁴⁶

6
7 **STANDARD OF REVIEW**

8 Under 42 U.S.C. § 405(g), district courts have jurisdiction to review any final decision of the
9 Commissioner if the claimant initiates a suit within sixty days of the decision. A court may set
10 aside the Commissioner’s denial of benefits only if the ALJ’s “findings are based on legal error or
11 are not supported by substantial evidence in the record as a whole.” *Vasquez v. Astrue*, 572 F.3d
12 586, 591 (9th Cir. 2009) (internal citation and quotation marks omitted); 42 U.S.C.
13 § 405(g). “Substantial evidence means more than a mere scintilla but less than a preponderance; it
14 is such relevant evidence as a reasonable mind might accept as adequate to support a
15 conclusion.” *Andrews v. Shalala*, 53 F.3d 1035, 1039 (9th Cir. 1995). The reviewing court should
16 uphold “such inferences and conclusions as the [Commissioner] may reasonably draw from the
17 evidence.” *Mark v. Celebrezze*, 348 F.2d 289, 293 (9th Cir. 1965). If the evidence in the
18 administrative record supports the ALJ’s decision and a different outcome, the court must defer to
19 the ALJ’s decision and may not substitute its own decision. *Tackett v. Apfel*, 180 F.3d 1094, 1097–
20 98 (9th Cir. 1999). “Finally, [a court] may not reverse an ALJ’s decision on account of an error
21 that is harmless.” *Molina v. Astrue*, 674 F.3d 1104, 1111 (9th Cir. 2012).

22
23 **GOVERNING LAW**

24 A claimant is considered disabled if (1) he or she suffers from a “medically determinable
25 physical or mental impairment which can be expected to result in death or which has lasted or can
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²⁴⁵ *Id.*

28 ²⁴⁶ AR 40.

1 be expected to last for a continuous period of not less than twelve months,” and (2) the
2 “impairment or impairments are of such severity that he or she is not only unable to do his
3 previous work but cannot, considering his age, education, and work experience, engage in any
4 other kind of substantial gainful work which exists in the national economy. . . .” 42 U.S.C. §
5 1382c(a)(3)(A) & (B). The five-step analysis for determining whether a claimant is disabled
6 within the meaning of the Social Security Act is as follows. *Tackett*, 180 F.3d at 1098 (citing 20
7 C.F.R. § 404.1520).

8 **Step One.** Is the claimant presently working in a substantially gainful activity? If so,
9 then the claimant is “not disabled” and is not entitled to benefits. If the claimant is
10 not working in a substantially gainful activity, then the claimant’s case cannot be
11 resolved at step one, and the evaluation proceeds to step two. *See* 20 C.F.R.
12 § 404.1520(a)(4)(i).

13 **Step Two.** Is the claimant’s impairment (or combination of impairments) severe? If
14 not, the claimant is not disabled. If so, the evaluation proceeds to step three. *See* 20
15 C.F.R. § 404.1520(a)(4)(ii).

16 **Step Three.** Does the impairment “meet or equal” one of a list of specified
17 impairments described in the regulations? If so, the claimant is disabled and is
18 entitled to benefits. If the claimant’s impairment does not meet or equal one of
19 the impairments listed in the regulations, then the case cannot be resolved at step
20 three, and the evaluation proceeds to step four. *See* 20 C.F.R. § 404.1520(a)(4)(iii).

21 **Step Four.** Considering the claimant’s RFC, is the claimant able to do any work that
22 he or she has done in the past? If so, then the claimant is not disabled and is not
23 entitled to benefits. If the claimant cannot do any work he or she did in the past, then
24 the case cannot be resolved at step four, and the case proceeds to the fifth and final
25 step. *See* 20 C.F.R. § 404.1520(a)(4)(iv).

26 **Step Five.** Considering the claimant’s RFC, age, education, and work experience, is
27 the claimant able to “make an adjustment to other work?” If not, then the claimant is
28 disabled and entitled to benefits. *See* 20 C.F.R. § 404.1520(a)(4)(v). If the claimant
is able to do other work, the Commissioner must establish that there are a significant
number of jobs in the national economy that the claimant can do. There are two ways
for the Commissioner to show other jobs in significant numbers in the national
economy: (1) by the testimony of a vocational expert or (2) by reference to the
Medical-Vocational Guidelines at 20 C.F.R., part 404, subpart P, app. 2.

For steps one through four, the burden of proof is on the claimant. At step five, the
burden shifts to the Commissioner. *Gonzales v. Sec’y of Health & Human Servs.*, 784 F.2d 1417,
1419 (9th Cir. 1986).

ANALYSIS

Mr. Zavala contends that the ALJ erred by failing to (1) provide specific and legitimate reasons for rejecting the opinion of his treating physician, and (2) properly consider Mr. Zavala’s testimony.²⁴⁷ The court considers each argument in turn.

1. Whether the ALJ Properly Weighed Medical-Opinion Evidence

Mr. Zavala argues that the ALJ erred in failing to properly weigh the opinion of Dr. Chow, Mr. Zavala’s treating physician. The court agrees. The court first discusses the law governing the ALJ’s weighing of medical-opinion evidence and then analyzes the medical-opinion evidence under the appropriate standard.

The ALJ is responsible for ““resolving conflicts in medical testimony, and for resolving ambiguities.”” *Garrison v. Colvin*, 759 F.3d 995, 1010 (9th Cir. 2014) (quoting *Andrews*, 53 F.3d at 1039). In weighing and evaluating the evidence, the ALJ must consider the entire case record, including each medical opinion in the record, together with the rest of the relevant evidence. 20 C.F.R. § 416.927(b); *see also Orn v. Astrue*, 495 F.3d 625, 630 (9th Cir. 2007) (“[A] reviewing court [also] must consider the entire record as a whole and may not affirm simply by isolating a specific quantum of supporting evidence.”) (internal quotation marks and citation omitted).

“In conjunction with the relevant regulations, [the Ninth Circuit has] developed standards that guide [the] analysis of an ALJ’s weighing of medical evidence.”²⁴⁸ *Ryan v. Comm’r of Soc. Sec.*, 528 F.3d 1194, 1198 (9th Cir. 2008) (citing 20 C.F.R. § 404.1527). Social Security regulations distinguish between three types of physicians: (1) treating physicians; (2) examining physicians; and (3) non-examining physicians. 20 C.F.R. § 416.927(c), (e); *Lester v. Chater*, 81 F.3d 821, 830 (9th Cir. 1995). “Generally, a treating physician’s opinion carries more weight than an examining physician’s, and an examining physician’s opinion carries more weight than a reviewing [non-

²⁴⁷ Mot. – ECF No. 20 at 5–17.

²⁴⁸ The Social Security Administration promulgated new regulations, including a new § 404.1521, effective March 27, 2017. The previous version, effective to March 26, 2017, governs based on the date of the ALJ’s hearing, November 16, 2016.

1 examining] physician’s.” *Holohan v. Massanari*, 246 F.3d 1195, 1202 (9th Cir. 2001) (citing
2 *Lester*, 81 F.3d at 830); *Smolen v. Chater*, 80 F.3d 1273, 1285 (9th Cir. 1996).

3 An ALJ may disregard the opinion of a treating physician, whether or not controverted.
4 *Andrews*, 53 F.3d at 1041. “To reject [the] uncontradicted opinion of a treating or examining
5 doctor, an ALJ must state clear and convincing reasons that are supported by substantial
6 evidence.” *Ryan*, 528 F.3d at 1198 (internal quotation marks and citation omitted). By contrast, if
7 the ALJ finds that the opinion of a treating physician is contradicted, a reviewing court will
8 require only that the ALJ provide “specific and legitimate reasons supported by substantial
9 evidence in the record.” *Reddick v. Chater*, 157 F.3d 715, 725 (9th Cir. 1998) (internal quotation
10 marks and citation omitted); *see also Garrison*, 759 F.3d at 1012 (“If a treating or examining
11 doctor’s opinion is contradicted by another doctor’s opinion, an ALJ may only reject it by
12 providing specific and legitimate reasons that are supported by substantial evidence.”) (internal
13 quotation marks and citation omitted). The opinions of non-treating or non-examining physicians
14 may serve as substantial evidence when the opinions are consistent with independent clinical
15 findings or other evidence in the record. *Thomas v. Barnhart*, 278 F.3d 947, 957 (9th Cir. 2002).
16 An ALJ errs, however, when he “rejects a medical opinion or assigns it little weight” without
17 explanation or without explaining why “another medical opinion is more persuasive, or criticiz[es]
18 it with boilerplate language that fails to offer a substantive basis for his conclusion.” *Garrison*,
19 759 F.3d at 1012–13.

20 “If a treating physician’s opinion is not given ‘controlling weight’ because it is not ‘well-
21 supported’ or because it is inconsistent with other substantial evidence in the record, the [Social
22 Security] Administration considers specified factors in determining the weight it will be given.”
23 *Orn*, 495 F.3d at 631. “Those factors include the ‘[l]ength of the treatment relationship and the
24 frequency of examination’ by the treating physician; and the ‘nature and extent of the treatment
25 relationship’ between the patient and the treating physician.” *Id.* (quoting 20 C.F.R. §
26 404.1527(d)(2)(i)–(ii)) (alteration in original). “Additional factors relevant to evaluating any
27 medical opinion, not limited to the opinion of the treating physician, include the amount of
28 relevant evidence that supports the opinion and the quality of the explanation provided[,] the

1 consistency of the medical opinion with the record as a whole[, and] the specialty of the physician
2 providing the opinion” *Id.* (citing 20 C.F.R. § 404.1527(d)(3)–(6)).

3 The ALJ gave little weight to treating physician Dr. Chow’s RFC assessment.²⁴⁹ He found:

4 Dr. Chow did not explain why the claimant can only sit for 2 to 4 hours or stand/walk
5 for only 4 to 6 hours, as opposed to sitting, standing, and walking during a full 8-
6 hour day. Further, he did not explain why reaching (rather than lifting/carrying) from
7 the waist to chest is limited to occasionally. The medical evidence, including his own
8 treatment records, does not reveal any basis for that opinion. Further, no other
9 medical opinion is consistent with Dr. Chow’s opinion. Notably, Dr. Chow’s
10 treatment notes repeatedly indicate that the claimant’s “work status” and “work
restrictions” were “as per permanent and stationary report” []. Although I requested
this report, it has not been produced. [] Thus, I find insufficient objective medical
evidence to support the degree of limitation opined by Dr. Chow, and accord his
opinion little weight.²⁵⁰

11 The ALJ’s first reason for discounting Dr. Chow’s opinion — that he “did not explain why”
12 Mr. Zavala had certain restrictions around sitting, standing, walking, and reaching — is not a
13 specific and legitimate reason. Treating sources cannot be rejected solely because they “are not
14 well-supported by medically acceptable clinical and laboratory . . . techniques.” SSR 96-2p.²⁵¹ *See*
15 *also Bennett v. Colvin*, 202 F. Supp. 3d 1119, 1133 (N.D. Cal. 2016) (holding that a “fail[ure] to
16 reveal the type of significant and laboratory abnormalities one would expect if the claimant were
17 in fact disabled” did not constitute a specific and legitimate reason for rejecting a physician’s
18 opinion because the ALJ failed to “specify which clinical and laboratory abnormalities one should
19 expect” or “any other support for this conclusion”).

20 The ALJ’s second reason for discounting Dr. Chow’s opinion — that “no other medical
21 opinion is consistent with Dr. Chow’s opinion” — is boilerplate and inaccurate. Here, for instance,
22 ME Dr. Francis provided an opinion consistent with Dr. Chow’s. Specifically, ME Francis opined
23 that the standing, sitting, and walking limitations evaluated by Dr. Chow could be reasonable.²⁵²

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25 ²⁴⁹ AR 38–39.

26 ²⁵⁰ AR 38–39.

27 ²⁵¹ SSR 96-2p has since been rescinded (as of March 27, 2017) but was in effect at the time of Mr.
Zavala’s ALJ hearings.

28 ²⁵² AR 92–94.

1 He also testified that, based on his review of the record, Mr. Zavala had right S1 radiculopathy,
2 status post lumbar-fusion surgery and post spinal-cord stimulator.²⁵³ He stated Mr. Zavala’s
3 lumbar surgeries were a “sign that . . . things are . . . hurting pretty badly.”²⁵⁴ Moreover, he
4 testified that a patient typically does not undergo a “salvage” spinal-cord-stimulator procedure
5 “unless they’re fairly debilitated from just chronic pain.”²⁵⁵

6 ME Francis found that the following evidence indicated Mr. Zavala had debilitating
7 radiculopathy: lumbar spasms; lumbar range of motion restricted by pain in all direction;
8 complaints of pain in dermatomal pattern; numbness in various positions; a slightly antalgic gait;
9 tenderness upon palpation of the mid-lumbar spine overlying the L4 to S1 regions; bilateral
10 lumbar perispinal muscles overlying the L4 to S1 facet joints; positive thoracolumbar muscle
11 spasm upon physical examination; and lumbar discogenic provocative maneuvers.²⁵⁶ With respect
12 to a failed spinal surgery case, the “main thing that . . . patients are going to have is pain,”
13 specifically pain “at a dermatomal pattern.”²⁵⁷ In sum, ME Francis testified that Mr. Zavala *might*
14 have a light RFC.²⁵⁸ But he also testified that Mr. Zavala’s case appeared to be a “failed spinal
15 surgery case” that “[p]robably ought to equal a 1.04(a) [listing].”²⁵⁹ *Cf. Carter v. Astrue*, No. C
16 08-5095 VRW, 2009 WL 2084446, at *2–4 (N.D. Cal. July 14, 2009) (where ME Francis testified
17 that nothing in the medical record “indicated motor weakness, loss of reflexes or a demonstrable
18 dermatome change supporting radiculopathy” and that the plaintiff’s case was ““not the most
19 severe chronic pain case that we’ve seen’ because ibuprofen, not narcotic pain medication, was
20 used”).

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23 ²⁵³ AR 74, 83, 89.

24 ²⁵⁴ AR 75.

25 ²⁵⁵ AR 87.

26 ²⁵⁶ AR 83–85, 91.

27 ²⁵⁷ AR 86.

28 ²⁵⁸ AR 88–91.

²⁵⁹ AR 75, 87–88.

1 Here, the ALJ discredited Dr. Francis’s testimony only to the extent that it was consistent with
2 Dr. Chow’s opinion.²⁶⁰ But the ALJ’s reasoning for doing so was contradictory. The ALJ
3 discredited Dr. Francis’s opinion that the severity of Mr. Zavala’s impairments equaled a 1.04(a)
4 listing because he found it was “entirely speculative.”²⁶¹ But, by the same logic, Dr. Francis’s
5 opinion that Mr. Zavala *might* have a light RFC was also entirely speculative.²⁶² The ALJ erred in
6 discrediting Dr. Francis’s opinion to the extent that it was consistent with Dr. Chow’s assessment.

7 Furthermore, the ALJ found that the opinions of one-time examining physician Dr. Pon and
8 non-examining state-agency medical consultant Dr. Singh were inconsistent with Dr. Chow’s
9 opinion and accordingly afforded those opinions “great weight.”²⁶³ As the Ninth Circuit noted in
10 *Orn*, however, “[w]hen an examining physician relies on the same clinical findings as a treating
11 physician, but differs only in his or her conclusions, the conclusions of the examining physician
12 are not ‘substantial evidence.’” 495 F.3d at 632. Here, Dr. Pon’s opinion confirmed the diagnoses
13 of radiculopathy, lumbar-disc disease, lumbar stenosis, lumbar-degenerative-disc disease, and
14 lumbar-facet-joint arthropathy.²⁶⁴ His opinion differed from treating-physician Dr. Chow’s only as
15 to the severity and impact of those impairments. As such, under *Orn*, to the extent that the
16 conclusions of Dr. Pon, as opposed to his “clinical findings,” differ from Dr. Chow’s conclusions,
17 they are not substantial evidence. *See id.* Similarly, with respect to non-examining medical
18 consultant Dr. Singh, “[t]he opinion of a nonexamining medical advisor cannot by itself constitute

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²⁶⁰ AR 38.

²⁶¹ *Id.*

²⁶² AR 88–89 (ALJ: “So, if I pressed you a little harder and said do you have an opinion about an RFC, are you able to formulate one out of this, if I decide it’s not a listing level case?” ME Francis: “If it’s not a listing level, then the question is going to be – I mean what we have here is kind of an ongoing radiculopathy that is probably intermittent. Sort of waxes and wanes. Probably better on some days than others. . . . So, the question is going to be would he be either at a light or a sedentary. So, what I’ll do is I’m going to give you a light RFC. That would be the maximum RFC that he would be reasonably expected to function at, based on the accommodation of having an S1 radiculopathy present, status post surgery.”); *id.* at 91 (ALJ: “So, which way are you going?” ME Francis: “Well, I went all over the map. I said it could equal a 1.04(a). Then I gave a light RFC. So, I think it’s up to the trier of fact whichever way the trier of fact deems it should go.”).

²⁶³ AR 38.

²⁶⁴ AR 606.

1 substantial evidence that justifies the rejection of an examining or treating physician.” *Morgan v.*
 2 *Comm’r of Soc. Sec. Admin.*, 169 F.3d 595, 602 (9th Cir. 1999). Although the ALJ gave Dr.
 3 Singh’s opinion “great weight,” it does not constitute substantial evidence to support the limited
 4 weight given to Dr. Chow’s opinion. The ALJ accordingly erred in discounting Dr. Chow’s
 5 opinion.

6 The ALJ’s third reason for discounting Dr. Chow’s opinion — that “insufficient medical
 7 evidence” supported the “degree of limitation” in Dr. Chow’s assessment — is itself insufficient.
 8 The ALJ did not consider the factors discussed in *Orn*. As stated above, where an ALJ does not
 9 give a treating physician’s opinion “‘controlling weight’ because it is not ‘well-supported’ or
 10 because it is inconsistent with other substantial evidence in the record” — both of which are
 11 grounds that the ALJ gives here — then the Social Security regulations “consider[] specified
 12 factors in determining the weight [that opinion] will be given.” *Orn*, 495 F.3d at 631. “Those
 13 factors include the [l]ength of the treatment relationship and the frequency of examination’ by the
 14 treating physician; and the ‘nature and extent of the treatment relationship’ between the patient
 15 and the treating physician.” *Id.* (quoting 20 C.F.R. § 404.1527(b)(2)(i)–(ii)) (alteration in original).
 16 Here, Dr. Chow treated Mr. Zavala on a nearly monthly basis — more than forty times total —
 17 beginning February 2011 through at least July 2015.²⁶⁵ He evaluated whether Mr. Zavala’s
 18 conditions could continue to be treated non-surgically, including by authorizing an epidural-
 19 steroid injection.²⁶⁶ He also closely monitored Mr. Zavala’s opioid-drug intake to ensure it was
 20 compatible with Mr. Zavala’s level of pain.²⁶⁷ The ALJ discussed none of facts. Their absence
 21 from the analysis here further undermines the ALJ’s reasoning on this crucial point.

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 23 ²⁶⁵ See AR 545–603, 607–738, 800, 973-74.

24 ²⁶⁶ AR 623.

25 ²⁶⁷ See AR 546 (March 2013 exam); AR 552 (January 11, 2013 exam); AR 608 (October 7, 2013
 26 exam); AR 611 (September 11, 2013 exam); AR 614 (August 14, 2013 exam); AR 620 (June 17, 2013
 27 exam); AR 623 (May 20, 2013 exam); AR 626 (April 23, 2013 exam); AR 629 (March 29, 2013
 28 exam); AR 642 (October 28, 2014 exam); AR 646 (September 30, 2014 exam); AR 648 (September 2,
 2014 exam); AR 651 (August 5, 2014 exam); AR 655 (July 8, 2014 exam); AR 672 (March 17, 2014);
 AR 675 (February 17, 2014); AR 678 (January 22, 2014); AR 682 (December 27, 2013); AR 684
 (December 2, 2013); AR 687 (November 4, 2013); AR 714 (June 30, 2015); AR 718 (June 2, 2015);

1 **2. Whether the ALJ Failed to Properly Consider Mr. Zavala’s Testimony**

2 Mr. Zavala contends that the ALJ erred in discrediting his testimony.²⁶⁸ In assessing a
 3 claimant’s credibility, an ALJ must make two determinations. *Molina*, 674 F.3d at 1112. “First,
 4 the ALJ must determine whether there is ‘objective medical evidence of an underlying impairment
 5 which could reasonably be expected to produce the pain or other symptoms alleged.’” *Id.* (quoting
 6 *Ligenfelter v. Astrue*, 504 F.3d 1028, 1036 (9th Cir. 2007)). Second, if the claimant produces that
 7 evidence, and “there is no evidence of malingering,” the ALJ must provide “specific, clear and
 8 convincing reasons” for rejecting the claimant’s testimony regarding the severity of the claimant’s
 9 symptoms. *Id.* (internal quotation marks and citations omitted). “At the same time, the ALJ is not
 10 ‘required to believe every allegation of disabling pain, or else disability benefits would be
 11 available for the asking, a result plainly contrary to 42 U.S.C. § 423(d)(5)(A).” *Id.* (quoting *Fair*
 12 *v. Bowen*, 885 F.2d 597, 603 (9th Cir. 1989)). “Factors that an ALJ may consider in weighing a
 13 claimant’s credibility include reputation for truthfulness, inconsistencies in testimony or between
 14 testimony and conduct, daily activities, and unexplained, or inadequately explained, failure to seek
 15 treatment or follow a prescribed course of treatment.” *Orn*, 495 F.3d at 636 (internal quotation
 16 marks omitted). “[T]he ALJ must identify what testimony is not credible and what evidence
 17 undermines the claimant’s complaints.” *Burrell v. Colvin*, 775 F.3d 1133, 1138 (9th Cir. 2014)
 18 (citing *Lester*, 81 F.3d at 834); *see, e.g., Morris v. Colvin*, No. 16-CV-0674-JSC, 2016 WL
 19 7369300, at *12 (N.D. Cal. Dec. 20, 2016).

20 The ALJ found the following regarding Mr. Zavala’s testimony:

21 The treatment records show that the claimant has regularly sought narcotic pain
 22 medication refills early [], which at least raises the question of opiate addiction or
 23 drug-seeking behavior, notwithstanding that Dr. Chow apparently thinks all is well.
 24 [A]lthough the claimant testified that he stopped working November 2012, the
 25 treatment records report him working full-time as a carpenter in November 2013 and
 26 March 2014 []. Further the claimant reported increased pain due to travel in February
 27 and May [] 2015[]. These reported activities undermine his allegations of disability

27 AR 722 (May 5, 2015); AR 726 (April 7, 2015); AR 729 (March 11, 2015); AR 732 (February 11,
 2015); AR 735 (January 15, 2015); AR 737 (November 25, 2014); AR 974 (July 28, 2015).

28 ²⁶⁸ Mot. – ECF No. 20 at 13–17.

1 as well has [sic] his testimony that he spends 10 hours per day laying down (between
2 6 am and 11 pm).

3 Thus, after careful consideration of the entire record, I find that the claimant is
4 capable of performing work within the residual functional capacity established
5 herein.²⁶⁹

6 The ALJ gave two reasons for discounting Mr. Zavala’s testimony — his (1) purported “drug-
7 seeking behavior,” and (2) activities of daily living.²⁷⁰ The court considers each in turn.

8 First, “[w]hen a claimant has a nonmedical motive to exaggerate symptoms in order to obtain
9 drugs, an ALJ may permissibly discredit the claimant.” *Jaureque v. Colvin*, No. 11-06358, 2013
10 WL 1149587, at *5 (N.D. Cal. Mar. 19, 2013) (citing *Edland v. Massanari*, 253 F.3d 1152, 1157
11 (9th Cir. 2001) (holding that the likelihood claimant exaggerated his pain complaints to his
12 physician to obtain painkillers was a clear and convincing reason to discredit claimant)). “Thus, a
13 court must defer to an ALJ’s reasonable interpretation that a claimant has engaged in drug-seeking
14 behavior and is therefore not entirely credible.” *Potter v. Colvin*, No.:3-14-cv-02562-JSC, 2015
15 WL 1966715, at *21 (N.D. Cal. Apr. 29, 2015) (citing *Massey v. Comm’r Sec. Sec. Admin.*, 400 F.
16 App’x 192, 194 (9th Cir. 2010). Although such behavior may constitute a clear and convincing
17 reason to discredit a claimant, *see Jaureque*, 2013 WL 1149587, at *5, when discounting pain
18 testimony, an ALJ must “point to specific facts which demonstrate that [the claimant] is in less
19 pain than [he] claims,” *Potter*, 2015 WL 1966715, at *21; *Vasquez*, 572 F.3d at 591–92. For
20 example, in *Edland*, the ALJ concluded the claimant was likely not credible because he was
21 deceiving a specific doctor about his need for pain medication due to a “Valium addiction.” 253
22 F.3d at 1157–58. Similarly, in *Alexander v. Commissioner of Social Security*, the record indicated
23 the claimant was barred from seeking narcotics from certain doctors, and multiple doctors
24 questioned her underlying diagnoses and suggested her pain complaints were hyperbolic. 373 F.
25 App’x 741, 743–44 (9th Cir. 2010).

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27 ²⁶⁹ AR 37–38.

28 ²⁷⁰ AR 37–38.

1 Here, in contrast, the ALJ stated that “the treatment records show that the claimant has
2 regularly sought narcotic pain medication refills early . . . which at least raises the question of
3 opiate addition or drug-seeking behavior.”²⁷¹ While Dr. Chow did note that Mr. Zavala sought
4 refills early on occasion, in at least one instance, Mr. Zavala sought a refill only one day early.²⁷²
5 On two other occasions, Mr. Zavala sought early refills “due to inadequate pain coverage”²⁷³ and
6 “increased pain from travel.”²⁷⁴ Furthermore, Dr. Chow consistently reported that Mr. Zavala was
7 on an “up-to-date pain contract” and his drug screens were “consistent with no aberrant
8 behaviors.”²⁷⁵ The ALJ did not sufficiently analyze how the record demonstrates that Mr. Zavala
9 “is in any less pain than [he] claims to be.” *Potter*, 2015 WL 1966715, at *22. Moreover, the
10 record contains significant evidence that Mr. Zavala sought drugs to treat his underlying pain. *Id.*;
11 *cf. Carter*, 2009 WL 2084446, at *2–4 (where ME Francis testified that that the plaintiff’s case
12 was “‘not the most severe chronic pain case that we’ve seen’ because ibuprofen, not narcotic pain
13 medication, was used.”). Because the ALJ did not adequately analyze conflicting evidence
14 regarding Mr. Zavala’s purported drug-seeking behavior, this does not constitute a clear and
15 convincing reason to discount his testimony. *See Potter*, 2015 WL 1966715, at *22.

16 Second, the ALJ explained that Mr. Zavala’s reported travel and work performed after the
17 alleged onset date undermined his claimed disability.²⁷⁶ On the one hand, with respect to Mr.
18 Zavala’s travel, the Ninth Circuit has “repeatedly warned that ALJs must be especially cautious in
19 concluding that daily activities are inconsistent” with eligibility for disability benefits. *Garrison*,
20 759 F.3d at 1017. In *Garrison*, the Ninth Circuit recognized that “disability claimants should not
21 be penalized for attempting to lead normal lives in the face of their limitations,” and found that
22 “only if her level of activity were inconsistent with a claimant’s claimed limitations would these

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²⁷¹ AR 37–38.

²⁷² AR 720.

²⁷³ AR 546.

²⁷⁴ AR 730.

²⁷⁵ AR 642, 651, 654, 657–58, 663, 666, 675, 678, 681, 714.

²⁷⁶ AR 37–38.

1 activities have any bearing on her credibility.” *Id.* at 1016 (quotations and citations omitted); *see*
 2 *also Smolen*, 80 F.3d at 1287 n.7 (“The Social Security Act does not require that claimants be
 3 utterly incapacitated to be eligible for benefits, and many home activities may not be easily
 4 transferable to a work environment where it might be impossible to rest periodically or take
 5 medication.”). Mr. Zavala’s reported travel thus does not constitute a sufficient reason for
 6 discounting his testimony.

7 On the other hand, if Mr. Zavala engaged in work after the alleged onset date, then his
 8 “misleading testimony to the contrary would easily qualify as a ‘clear and convincing’ reason
 9 justifying the ALJ’s adverse credibility determination.” *Slotnick v. Colvin*, No. C 13-02283 RS,
 10 2015 WL 2251266, at *5 (N.D. Cal. May 13, 2015). But it is not clear from the record whether
 11 Mr. Zavala in fact worked full- or part-time as a carpenter (or in any other capacity) after the
 12 alleged onset date.²⁷⁷ Because the record is ambiguous regarding Mr. Zavala’s work history from
 13 November 2012 through July 2015, this case will be remanded for further proceedings. *Benecke v.*
 14 *Barnhart*, 379 F.3d 587, 593 (9th Cir. 2004) (“Remand for further administrative proceedings is
 15 appropriate if enhancement of the record would be useful.”). On remand, the ALJ should consider
 16 any additional evidence submitted by the parties (including, if Mr. Zavala so elects, further
 17 testimony) relevant to Mr. Zavala’s history of paid employment from November 2012 through the
 18 date of the July 15 hearing. *See Slotnick*, 2015 WL 2251266, at *5. Based on that evidence, the
 19 ALJ should reconsider the accuracy (or lack thereof) of Mr. Zavala’s hearing testimony and
 20 reassess his credibility accordingly. *See id.* If the ALJ again finds that Mr. Zavala misstated his
 21 work history, depending on the exact content of the additional evidence to that effect, Mr. Zavala’s
 22 description of the intensity, persistence, and limiting effects of his symptoms may permissibly be
 23 discredited. *See id.* If, in contrast, the evidence demonstrates that Mr. Zavala’s testimony was not
 24 inaccurate, the ALJ will lack any clear and convincing reason to make an adverse credibility
 25 determination and must give appropriate weight to Mr. Zavala’s description of the intensity,
 26 persistence, and limiting effects of his impairments. *See id.*

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28 ²⁷⁷ AR 666 (Dr. Chow noted that Mr. Zavala worked as a carpenter); AR 687 (same).

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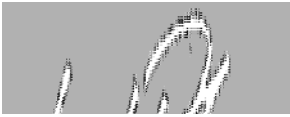
Moreover, because the ALJ’s discrediting of Mr. Zavala’s testimony was based in part on his assessment of the medical evidence, including Dr. Chow’s and Dr. Francis’s evaluations, the court remands on this ground, too. The ALJ can reassess Mr. Zavala’s credibility on remand in context of the entire record.

CONCLUSION

The court grants Mr. Zavala’s motion for summary judgment, denies the Commissioner’s cross-motion for summary judgment, and remands this case for further proceedings consistent with this order.

IT IS SO ORDERED.

Dated: December 27, 2018



LAUREL BEELER
United States Magistrate Judge