

United States District Court
Northern District of California

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

C.B.,

Plaintiff,

v.

Martin O'Malley,

Defendant.

Case No. 22-cv-05579-LJC

**ORDER GRANTING PLAINTIFF'S
MOTION FOR SUMMARY
JUDGMENT AND DENYING
DEFENDANT'S CROSS-MOTION FOR
SUMMARY JUDGMENT**

Re: ECF Nos. 19, 24

Plaintiff C.B.¹ challenges the final decision of Defendant Martin O'Malley, Commissioner of Social Security (the Commissioner),² denying her application for disability insurance benefits under Title II of the Social Security Act. Both parties consented to magistrate judge jurisdiction (ECF Nos. 9, 10) and moved for summary judgment. ECF Nos. 19, 24. Having considered the parties' briefing, and for the reasons discussed below, C.B.'s Motion for Summary Judgment is **GRANTED**, the Commissioner's Cross-Motion for Summary Judgment is **DENIED**, and this matter is **REMANDED** for further proceedings.

I. BACKGROUND

C.B. is a 50-year-old woman who suffers from several medical and psychological impairments, including chronic fatigue syndrome (CFS) related to chronic Bartonella and Babesia infections, fibromyalgia, cognitive dysfunction, anxiety disorder, complex post-traumatic stress

¹ Because opinions by the Court are more widely available than other filings, and this Order contains potentially sensitive medical information, this Order refers to the plaintiff only by her initials. This Order does not alter the degree of public access to other filings in this action provided by Rule 5.2(c) of the Federal Rules of Civil Procedure and Civil Local Rule 5-1(c)(5)(B)(i).

² Martin O'Malley was sworn in as Commissioner of Social Security on December 20, 2023, and is therefore automatically substituted as the defendant in this case under Rule 25(d) of the Federal Rules of Civil Procedure.

1 disorder (PTSD), and depression. ECF Nos. 12-4 at 2–3, 12-11 at 10.³ Her medical records
2 contain numerous provider assessments that consistently describe C.B.’s symptoms in association
3 with her CFS and fibromyalgia diagnoses. *See, e.g.*, ECF No. 12-8 at 41, 481, 505. The Centers
4 for Disease Control and Prevention (CDC) describes CFS as a “disabling and complex illness,”
5 symptoms of which include severe fatigue, post-exertional malaise, sleep disturbance, impaired
6 memory or ability to concentrate, pain, and dizziness. *See* CDC, What is ME/CFS?,
7 <https://www.cdc.gov/me-cfs/about/index.html> (last reviewed Mar. 21, 2023). It defines
8 fibromyalgia as “a condition that causes pain all over the body (also referred to as widespread
9 pain), sleep problems, fatigue, and often emotional and mental distress.” *See* CDC, Fibromyalgia,
10 <https://www.cdc.gov/arthritis/basics/fibromyalgia.htm> (last reviewed May 25, 2022). C.B. was
11 diagnosed with CFS as early as 2018, with symptom onset in 2015–2016, and officially diagnosed
12 with fibromyalgia sometime in 2020. ECF No. 12-8 at 481, 486.

13 On October 22, 2018, C.B. filed an application for disability insurance benefits. ECF No.
14 12-3 at 18. The claim was initially denied on January 4, 2019, and upon reconsideration on May
15 16, 2019. *Id.* In October 2020, C.B. underwent a pacemaker implantation to treat her irregular
16 heart palpitations and potentially her severe fatigue. ECF No. 12-14 at 70. There were no
17 complications, and in November 2020, C.B. reported improvement in her chest discomfort
18 symptoms and was found to not be pacemaker dependent, although she continued to report daily
19 fatigue in the months after the procedure. ECF Nos. 12-7 at 130–31, 12-13 at 341, 393.

20 After the denial upon reconsideration, C.B. filed a written request for a hearing and the
21 administrative law judge (ALJ) held a telephonic hearing on June 22, 2021. ECF No. 12-3 at 18.
22 C.B. testified and vocational expert Luis Mas testified before the ALJ. *Id.* On August 31, 2021,
23 the ALJ issued a written decision finding that although C.B. is unable to perform any past relevant
24 work because of her medical and psychological impairments, considering her age, education, work
25 experience, and residual functional capacity, there are jobs that exist in significant numbers in the
26 national economy that C.B. can perform. *Id.* at 33–34. As to her RFC, the ALJ found that she can

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28 ³ Unless specified otherwise, the Court refers to the PDF page number generated by the Court’s e-
filing system.

1 perform sedentary work as defined in 20 C.F.R. § 404.1567(a), which requires in part “the ability
2 to lift/carry up to 10 pounds occasionally and 5 pounds frequently,” “stand and walk up to 2 hours
3 cumulatively in an 8-hour workday,” “occasional climbing of ramps and stairs,” and “frequent
4 stooping, kneeling, crouching, and crawling.” *Id.* at 25–26. Based on the vocational expert’s
5 testimony, the ALJ found that C.B. can perform the requirements of “unskilled” and “sedentary”
6 occupations such as “lens gauger,” “addresser,” and “circuit board assembler.” *Id.* at 34.

7 C.B. appealed the ALJ’s decision to the Appeals Council on October 21, 2021. ECF No.
8 12-5 at 104–08. The Appeals Council issued a denial of the Request for Review on August 19,
9 2022. ECF No. 12-3 at 2–8. At that point, the ALJ’s decision became the final decision of the
10 Commissioner pursuant to 42 U.S.C. § 405(g).

11 **II. STANDARD OF REVIEW**

12 Under Title II of the Social Security Act, disability insurance benefits are available when
13 an eligible claimant is unable to “engage in any substantial gainful activity by reason of any
14 medically determinable physical or mental impairment . . . which has lasted or can be expected to
15 last for a continuous period of not less than twelve months.” 42 U.S.C. § 423(d)(1)(A). To
16 determine a claimant’s eligibility for benefits, the ALJ engages in a five-step sequential evaluation
17 process. 20 C.F.R. § 404.1520(a)(1).⁴ To establish disability, the claimant bears the burden of
18 showing (1) that they are not working; (2) that they have a severe physical or mental impairment
19 or a combination of impairment(s) that is severe; (3) that the impairment(s) meet or equal the
20 requirements of a listed impairment; and (4) that their RFC precludes them from performing their
21 past relevant work. *Id.* § 404.1520(a)(4). At step five, the burden shifts to the Commissioner to
22 show that the claimant has the RFC to perform other work that exists in significant numbers in the
23 national economy. *Hoopai v. Astrue*, 499 F.3d 1071, 1074 (9th Cir. 2007). If the Commissioner
24 conclusively finds the claimant “disabled” or “not disabled” at any point in the five-step process,
25 he does not proceed to the next step. 20 C.F.R. § 404.1520(a)(4).

26 Pursuant to 42 U.S.C. § 405(g), a district court has authority to review the Commissioner’s

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28 ⁴ Because the Title II and Title XVI regulations are identical, only the Title II regulations are cited
herein.

1 decision to deny disability benefits to a claimant. “The ALJ is responsible for determining
2 credibility, resolving conflicts in medical testimony, and for resolving ambiguities.” *Ahearn v.*
3 *Saul*, 988 F.3d 1111, 1115 (9th Cir. 2021) (quoting *Andrews v. Shalala*, 53 F.3d 1035, 1039 (9th
4 Cir. 1995)). The district court’s role is “to ensure that the [ALJ’s] decision was supported by
5 substantial evidence and a correct application of the law.” *Ludwig v. Astrue*, 681 F.3d 1047, 1051
6 (9th Cir. 2012). “‘Substantial evidence’ means more than a mere scintilla, but less than a
7 preponderance, i.e., such relevant evidence as a reasonable mind might accept as adequate to
8 support a conclusion.” *Robbins v. Social Sec. Admin.*, 466 F.3d 880, 882 (9th Cir. 2006). The
9 Court must “consider the entire record as a whole, ‘weighing both the evidence that supports and
10 the evidence that detracts from the Commissioner’s conclusion.’” *Lingenfelter v. Astrue*, 504 F.3d
11 1028, 1035 (9th Cir. 2007) (quoting *Reddick v. Chater*, 157 F.3d 715, 720 (9th Cir. 1998)).
12 “Where the evidence can reasonably support either affirming or reversing the decision, [this
13 Court] may not substitute [its] judgment for that of the Commissioner.” *Parra v. Astrue*, 481 F.3d
14 742, 746 (9th Cir. 2007).

15 **III. DISCUSSION**

16 C.B. raises four challenges to the ALJ’s decision. First, she argues that the ALJ erred in
17 her evaluation of C.B.’s subjective symptom testimony. Second, C.B. argues that the ALJ erred in
18 her evaluation of the medical opinion evidence. Third, C.B. argues that the ALJ erred in the
19 evaluation of the lay witness testimony, specifically, the testimony of C.B.’s partner, Beth.
20 Fourth, C.B. argues that the ALJ erred when it came to her findings at step five of the sequential
21 evaluation process. Separately, C.B. also challenges the Appeals Council’s failure to consider a
22 letter from Dr. Christopher R. Snell, dated September 14, 2020.

23 **A. C.B.’s Subjective Symptom Testimony**

24 With respect to the second step in the ALJ’s five-step sequential evaluation process, C.B.
25 has challenged the ALJ’s evaluation of her subjective testimony regarding the severity of her
26 impairments. This particular challenge requires the Court to address the applicable standard for
27 evaluating the claimant’s credibility. In the Cross-Motion for Summary Judgment, the
28 Commissioner does not cite to the “clear and convincing reasons” standard when analyzing the

1 ALJ’s evaluation of C.B.’s subjective symptom testimony. Instead, the Commissioner argues that
2 “[u]nder the substantial evidence standard of review, the Court should uphold the ALJ’s findings
3 [as to C.B.’s subjective symptom complaints].” ECF No. 24 at 10. C.B. claims that the
4 Commissioner improperly focuses on the “substantial evidence” standard of review “in order to
5 avoid the much higher standard of review that this circuit demands when evaluating a claimant’s
6 symptoms and testimony.” ECF No. 25 at 2. This Court is bound by Ninth Circuit precedent and
7 applies the “clear and convincing reasons” standard, as explained below.

8 The Ninth Circuit has “established a two-step analysis for determining the extent to which
9 a claimant’s symptom testimony must be credited.” *Trevizo v. Berryhill*, 871 F.3d 664, 678 (9th
10 Cir. 2017). “First, the ALJ must determine whether the claimant has presented objective medical
11 evidence of an underlying impairment which could reasonably be expected to produce the pain or
12 other symptoms alleged.” *Id.* (quoting *Garrison v. Colvin*, 759 F.3d 995, 1014–15 (9th Cir.
13 2014)). If the claimant meets this requirement and there is no evidence of malingering, “the ALJ
14 can reject the claimant’s testimony about the severity of her symptoms only by offering specific,
15 clear and convincing reasons for doing so. This is not an easy requirement to meet: The clear and
16 convincing standard is the most demanding required in Social Security cases.” *Id.* To satisfy the
17 “clear and convincing reasons” requirement, “[g]eneral findings are insufficient; rather, the ALJ
18 must identify what testimony is not credible and what evidence undermines the claimant’s
19 complaints.” *Brown-Hunter v. Colvin*, 806 F.3d 487, 493 (9th Cir. 2015) (quoting *Reddick*, 157
20 F.3d at 722).

21 In weighing the claimant’s credibility, the ALJ may consider many factors, including “(1)
22 ordinary techniques of credibility evaluation, such as the claimant’s reputation for lying, prior
23 inconsistent statements concerning the symptoms, and other testimony by the claimant that
24 appears less than candid; (2) unexplained or inadequately explained failure to seek treatment or to
25 follow a prescribed course of treatment; and (3) the claimant’s daily activities.” *Tommasetti v.*
26 *Astrue*, 533 F.3d 1035, 1039 (9th Cir. 2008) (quoting *Smolen v. Chater*, 80 F.3d 1273, 1284 (9th
27 Cir. 1996)). The ALJ’s reasons also must be supported by substantial evidence in the record.
28 *Thomas v. Barnhart*, 278 F.3d 947, 959 (9th Cir. 2002).

1 Here, the ALJ found at step two of the five-step sequential evaluation process that C.B. has
 2 several, medically determinable severe impairments, including, *inter alia*, CFS, fibromyalgia,
 3 PTSD, depression, and general anxiety disorder. ECF No. 12-3 at 20. The ALJ made no finding
 4 that C.B. was malingering and found that C.B.’s “medically determinable impairments could
 5 reasonably be expected to cause the alleged symptoms.” *Id.* at 33. Therefore, the ALJ could
 6 reject C.B.’s “testimony about the severity of her symptoms only by offering specific, clear and
 7 convincing reasons for doing so.” *Trevizo*, 871 F.3d at 678.

8 The ALJ gave several reasons for rejecting C.B.’s symptom complaints, none of which
 9 meet the “clear and convincing reasons” standard.

10 **1. C.B.’s Daily Activities**

11 The ALJ rejected C.B.’s testimony as to her CFS and fibromyalgia symptoms in part
 12 because she “reported a relatively full range of daily activities” such as “preparing simple meals,
 13 doing small amounts of laundry, cleaning, doing the dishes, vacuuming,” etc. ECF No. 12-3 at 33.
 14 But “[d]aily activity may be grounds for an adverse credibility finding only if it meets the
 15 threshold for transferable work skills or contradicts [the p]laintiff’s testimony,” and “[a]ctivities
 16 such as ‘[h]ouse chores, cooking simple meals, self-grooming, paying bills, writing checks...as
 17 well as occasional shopping outside the home, are not similar to typical work responsibilities.’”
 18 *Baig v. Kijakazi*, No. 21-CV-01839-HSG, 2023 WL 3688453, at *8 (N.D. Cal. May 26, 2023)
 19 (quoting *Diedrich v. Berryhill*, 874 F.3d 634, 643 (9th Cir. 2017)). The Ninth Circuit has
 20 repeatedly recognized that “many home activities are not easily transferable to what may be the
 21 more grueling environment of the workplace, where it might be impossible to periodically rest or
 22 take medication.” *Fair v. Bowen*, 885 F.2d 597, 603 (9th Cir. 1989), *superseded on other grounds*
 23 *by* 20 C.F.R. § 404.1502(a). The ability to “periodically rest” at home in between daily activities
 24 is especially important for individuals with CFS and fibromyalgia. *See Reddick*, 157 F.3d at 722
 25 (holding that the ALJ erred in finding that the claimant’s daily activities indicated an ability to
 26 work where activities “were sporadic and punctuated with rest,” which is consistent with CFS).

27 C.B.’s statements regarding her daily activities do not contradict her testimony as to her
 28 CFS and fibromyalgia symptoms. She testified that her pain is “inconsistent” and “some days”

1 her back pain is so bad that she can “barely even stand up.” ECF No. 12-3 at 69. C.B. referred to
2 these bouts of pain as “episodes” that sometimes happen close together and can go on for several
3 days. *Id.* She also completed a Social Security Administration (SSA) Function Report on April
4 22, 2019, which states that although she tries to go outside daily, she often must stay inside to rest
5 for two to four days a week because she is “too fatigued and sick.” ECF No. 12-7 at 78. C.B.
6 reported that she must do household chores “one at a time” and “spread them out over longer
7 periods of time.” *Id.* at 77. Her grocery shopping trips are usually only thirty minutes, including
8 driving and shopping time. *Id.* at 78. Although C.B. may engage in the daily activities
9 highlighted by the ALJ, these are “sporadic and punctuated with rest,” which is to be expected for
10 individuals with CFS. *Reddick*, 157 F.3d at 722; *see also Hatcher v. Apfel*, No. C98-03453WHA,
11 1999 WL 1029858, at *5 (N.D. Cal. Nov. 9, 1999) (“[T]he limitations in [the plaintiff’s] activities
12 reported at the hearing, to her doctor, and on disability forms are consistent with each other and
13 with the symptoms of CFS.”)

14 The Commissioner argues that “[e]ven where [a claimant’s daily] activities suggest some
15 difficulty functioning, they may be grounds for discrediting the claimant’s testimony to the extent
16 that they contradict claims of a totally debilitating impairment.” ECF No. 24 at 12 (quoting
17 *Molina v. Astrue*, 674 F.3d 1104, 1113 (9th Cir. 2012)). But C.B. is not alleging that her CFS or
18 fibromyalgia are “totally debilitating impairment[s]” that render her completely immobile and
19 unable to engage in typical daily activities such as cooking, cleaning, and grocery shopping.
20 *Molina*, 674 F.3d at 1113. Her statements and testimony are that she can only engage in such
21 activities sporadically when she has ample opportunity to rest and recover. “[D]isability claimants
22 should not be penalized for attempting to lead normal lives in the face of their limitations.”
23 *Reddick*, 157 F.3d at 722. Moreover, “[e]ven more prolonged undertakings might be consistent
24 with [CFS as it] is characterized by periods of exacerbation and remission.” *Id.* (internal quotation
25 marks and citation omitted); *see also Lee v. Kijakzi*, No. 222CV00068JDPSS, 2023 WL 2751985,
26 at *5 (E.D. Cal. Mar. 31, 2023) (holding that the plaintiff’s “activities of daily living do not
27 contradict her symptom testimony or allegations of total disability” where the plaintiff had a CFS
28 diagnosis and characterized her activities as “performed on a very limited basis, often with

1 assistance, and only as allowed by her condition”) (internal citation omitted).

2 **2. Pacemaker Implantation**

3 Another reason the ALJ gave for rejecting C.B.’s symptom testimony with respect to her
4 CFS, anxiety disorder, PTSD, and depression was her October 2020 pacemaker implantation. The
5 ALJ noted how the pacemaker was successfully implanted without any complications, resulted in
6 some symptom improvement, and C.B. was ultimately not deemed “pacemaker dependent.” ECF
7 No. 12-3 at 32–33. Yet the ALJ also acknowledged the “rule-out nature” of the pacemaker (*id.* at
8 23), as documented in C.B.’s medical records, where C.B. was informed by her doctor that the
9 “pacemaker would not address many of her symptoms,” only her irregular heart palpitations and
10 “potentially” her fatigue. ECF No. 12-14 at 70.

11 C.B.’s doctor’s uncertainty about the ability of the pacemaker to address many of her
12 symptoms aligns with the medical community’s general understanding of CFS, which is
13 notoriously difficult to diagnose and requires that medical providers attempt to exclude other
14 possible medical causes. *See* Social Security Ruling, SSR 14-1p: Titles II and XVI: Evaluating
15 Claims Involving Chronic Fatigue Syndrome, 2014 WL 1371245, at *2 (Apr. 3, 2014) (“In
16 accordance with the CDC case definition of CFS, a physician should make a diagnosis of CFS
17 only after alternative medical and psychiatric causes of chronic fatiguing illness have been
18 excluded”) (internal quotation marks and citation omitted); *Reddick*, 157 F.3d at 724 (noting that
19 the claimant met the CDC’s criteria for the diagnosis of CFS and had “underwent years of testing
20 and examination to rule out other possible illnesses.”) The fact that the pacemaker implantation
21 “ruled out” severe cardiac impairments does not discredit her symptom testimony concerning the
22 severe fatigue and pain attributable to CFS and fibromyalgia. If anything, it bolsters the evidence
23 of CFS as an impairment by showing that the cause of her fatigue is not due to a cardiac condition.

24 Notably, the ALJ did not elaborate as to how C.B.’s pacemaker implantation is a “clear
25 and convincing reason” for rejecting her symptom testimony as to her psychological impairments,
26 such as her anxiety disorder, PTSD, and depression. *See Fischman v. Astrue*, No. CV 08-7720-
27 RC, 2010 WL 477600, at *3 (C.D. Cal. Feb. 3, 2010) (holding that the ALJ’s “grossly conclusory”
28 finding as to the plaintiff’s contentions with respect to the severity of her symptoms, which “the

1 ALJ did not further elaborate on,” did not “provide a clear and convincing reason for rejecting
 2 plaintiff’s testimony.”) Finally, the ALJ also observed that “[o]ther than the pacemaker implant,
 3 the claimant has not required extensive, invasive or inpatient treatment.” ECF No. 12-3 at 30.
 4 “[T]o the extent the ALJ suggests plaintiff’s credibility is suspect because she has received only
 5 conservative treatment for her illness, this is not a clear and convincing reason for rejecting her
 6 subjective complaints in this case since no definitive treatment for [CFS] exists.” *Nelson v.*
 7 *Astrue*, 610 F. Supp. 2d 1070, 1077–78 (C.D. Cal. 2009) (citing *Reddick*, 157 F.3d at 727); *see*
 8 *also Baig*, 2023 WL 3688453, at *8 (noting that the ALJ cited no basis in support of the
 9 suggestion that the plaintiff “would need to have been hospitalized or admitted to inpatient care.”)

10 **3. Mental Status Evaluation Findings**

11 The ALJ also rejected C.B.’s statements as to her CFS, anxiety disorder, PTSD, and
 12 depression symptoms in part because “the mental status evaluation findings by treating
 13 psychiatrist Dr. Lee were consistently and invariably benign.” ECF No. 12-3 at 33. Dr. Lee
 14 described C.B. as “pleasant and cooperative, with logical thought processes, normal attention,
 15 normal concentration, and intact memory.” *Id.* at 28.

16 However, the medical records that the ALJ cites to tell a different story. There are notes
 17 from Dr. Lee alongside her mental status findings describing significant mental health symptoms
 18 that are consistent with C.B.’s psychiatric diagnoses. *See, e.g.*, ECF No. 12-9 at 218 (“Reports
 19 triggered sometime in June – memories of trauma, couldn’t sleep well... Jumpy/startle, low stress
 20 tolerance, ongoing, can only focus on 1 thing at a time.”) “Narrative sections” in mental health
 21 records can “provide pertinent details inconsistent” with a “normal” or “intact” mental status
 22 examination. *De La Cruz v. Kijakazi*, No. 20-CV-05852-MMC, 2022 WL 1556411, at *8 (N.D.
 23 Cal. May 17, 2022). As C.B.’s treating psychiatrist, Dr. Lee’s statements “must be read in context
 24 of the overall diagnostic picture [s]he draws.” *Holohan v. Massanari*, 246 F.3d 1195, 1205 (9th
 25 Cir. 2001). Findings that C.B. was “pleasant and cooperative” or presented with “logical thought
 26 processes” during their sessions are not inconsistent with C.B.’s statements to Dr. Lee as to the
 27 severity of her mental health symptoms.

28 To the extent the ALJ suggests that Dr. Lee’s “benign” mental status evaluation findings

1 are inconsistent with C.B.’s CFS symptom testimony, the Court notes that Dr. Lee is C.B.’s
 2 treating psychiatrist, and never purported to diagnose or evaluate her CFS and/or fibromyalgia.
 3 *See Astir F. v. Comm’r of Soc. Sec.*, No. C21-1350-MAT, 2022 WL 2192922, at *4 (W.D. Wash.
 4 June 17, 2022) (holding that the “ALJ did not provide clear and convincing reasons for
 5 discounting [the p]laintiff’s testimony based on” doctor’s statement that her chronic pain was
 6 stable on medication where the doctor “did not treat [the p]laintiff specifically for pain
 7 management.”); 20 C.F.R. § 404.1527(c)(5) (more weight is given to the medical opinion of a
 8 specialist about medical issues related to their area of specialty). And Dr. Lee’s finding that
 9 C.B.’s concentration was sometimes “normal” and her memory “intact” during their twenty-
 10 minute or so psychiatric sessions (*see, e.g.*, ECF No. 12-9 at 222) does not discredit her testimony
 11 as to cognitive difficulties significant enough to disrupt day-to-day activities.

12 **4. Neuropsychological Evaluations**

13 In terms of C.B.’s statements regarding her chronic cognitive dysfunction, the ALJ found
 14 them contradicted by the fact that she scored “on both neuropsychological evaluation[s] in June
 15 2018 and September 2020 in the high average and even superior range of intellectual functioning
 16 on neuropsychological testing.” ECF No. 12-3 at 32. Though the September 2020
 17 neuropsychological evaluation from Maya Yutsis, PhD found that “C.B.’s premorbid level of
 18 intelligence was estimated to have been high average,” Dr. Yutsis went on to conclude that “[t]he
 19 extent and severity of her cognitive deficits was more likely than not of sufficient severity to
 20 interfere with her ability to work in her occupation due to attention/concentration and processing
 21 speed deficits and executive deficits.” ECF No. 12-8 at 498–99; *see also id.* at 500 (attributing
 22 C.B.’s cognitive deficits in part to the “well documented and most persistent cognitive difficulties
 23 in the domains of attention and processing speed in persons with CFS...”) In the 2018
 24 neuropsychological report from Elinor S.W. Dorsett PhD, Dr. Dorsett opined that C.B.’s
 25 “cognitive symptoms are most likely due to secondary factors such as fatigue and mood
 26 symptoms. Both chronic fatigue and mood symptoms, both individually and in concert, are
 27 known to negatively disrupt cognitive functioning throughout daily life as well as impacting
 28 overall quality of life.” *Id.* at 518. Thus, C.B.’s measured high average intelligence does not

1 contradict the evidence of her cognitive difficulties due to fatigue and mood symptoms.
 2 Considering Dr. Yutsis’s and Dr. Dorsett’s neuropsychological reports in their entirety, it is clear
 3 both doctors found there was objective medical evidence to corroborate C.B.’s cognitive deficits—
 4 as a result of her chronic fatigue symptoms—that affect her daily functioning, which is consistent
 5 with C.B.’s testimony and statements. The ALJ improperly “cherry-picked” from Dr. Yutsis’s and
 6 Dr. Dorsett’s reports yet ignored their conclusions as to how C.B.’s severe fatigue significantly
 7 disrupts her cognitive functioning. *See Holohan*, 246 F.3d at 1207 (concluding that the ALJ’s
 8 basis for rejecting the treating physician’s medical opinion was not supported by substantial
 9 evidence because the ALJ “selectively relied on some entries ... and ignored the many others that
 10 indicated continued, severe impairment.”) Additionally, with respect to C.B.’s CFS and
 11 fibromyalgia symptom testimony, the ALJ’s preference for “objective clinical findings” like the
 12 neurological testing over C.B.’s self-reports “contravenes this circuit’s case law, which holds that
 13 such reasoning ‘runs counter to the [CDC’s] published framework for evaluating and diagnosing
 14 CFS.’” *Lee*, 2023 WL 2751985, at *4 (quoting *Reddick*, 157 F.3d at 726); *see also Rau v.*
 15 *Comm’r of Soc. Sec.*, No. 14-CV-03534-DMR, 2016 WL 705983, at *7 (N.D. Cal. Feb. 23, 2016)
 16 (explaining that CFS is diagnosed based on self-reports and by ruling out other possible causes).

17 Accordingly, for all the above reasons, the Court finds that the ALJ failed to provide clear
 18 and convincing reasons supported by substantial evidence for rejecting C.B.’s symptom testimony,
 19 particularly her statements regarding her limitations due to CFS and fibromyalgia.

20 **B. Medical Opinion Evidence**

21 C.B. challenges the ALJ’s evaluation of medical opinion evidence from Drs. Christopher
 22 R. Snell., Hector Bonilla, Steven Harris, Jennifer Sugden, S. Hanna, and D. Brodsky. ECF No. 19
 23 at 4–15. “[A]n ALJ cannot reject an examining or treating doctor’s opinion as unsupported or
 24 inconsistent without providing an explanation supported by substantial evidence.” *Woods v.*
 25 *Kijakazi*, 32 F.4th 785, 792 (9th Cir. 2022). In reviewing medical source opinions, an ALJ must
 26 “articulate ... how persuasive” he or she finds “all of the medical opinions” based on several
 27 factors. 20 C.F.R. § 404.1520c(b). The ALJ must address the two most important factors:
 28 supportability and consistency. *Id.* Supportability is “the extent to which a medical source

1 supports the medical opinion by explaining the ‘relevant ... objective medical evidence.’” *Woods*,
2 32 F.4th at 791 (quoting 20 C.F.R. § 404.1520c(c)(1)). Consistency is “the extent to which a
3 medical opinion is ‘consistent ... with the evidence from other medical sources and nonmedical
4 sources in the claim.’” *Id.* at 792 (quoting 20 C.F.R. § 404.1520c(c)(2)).

5 An ALJ may, but is not required to, explain how other factors were considered, including
6 the medical source’s relationship with the claimant, the length and purpose of the treatment
7 relationship, the frequency of examinations, and the source’s specialization. 20 C.F.R.
8 § 404.1520c(b)(2), (c). If the ALJ finds that two or more medical opinions about the same issue
9 are equally well-supported and consistent with the record but are not exactly the same, then the
10 ALJ will have to articulate how it considered the other factors listed. 20 C.F.R.
11 § 404.1520c(b)(3). An ALJ satisfies the “substantial evidence” requirement by “setting out a
12 detailed and thorough summary of the facts and conflicting clinical evidence, stating his
13 interpretation thereof, and making findings.” *Garrison*, 759 F.3d at 1012 (quoting *Reddick*, 157
14 F.3d at 725). “The ALJ must do more than state conclusions. He must set forth his own
15 interpretations and explain why they, rather than the doctors, are correct.” *Id.*

16 **1. Dr. Snell**

17 Dr. Snell performed a Cardiopulmonary Exercise Test (CPET) over two days from March
18 9–10, 2020, to gauge C.B.’s “functional capacity and fatigue” by determining “peak oxygen
19 consumption,” in connection with her CFS diagnosis. ECF No. 12-16 at 23, 26–32. The ALJ
20 determined that Dr. Snell’s findings are “unsupported, conclusory, vague, and not persuasive,” in
21 part because they “appear to include only two sentences with conclusion of work preclusions
22 while another note describes a severely positive stress test with episode of overall depletion...”
23 ECF No. 12-3 at 31. According to the ALJ, Dr. Snell’s findings “do not correlate with [C.B.’s]
24 grossly normal stress tests and cardiopulmonary findings, contained in the records from Kaiser
25 Hospital and Stanford Health Care.” *Id.*

26 Dr. Snell’s medical opinion is not as vague and conclusory as the ALJ describes it. The
27 aforementioned “two sentences” are actually the introductory paragraph in the CPET Evaluation
28 Report summarizing Dr. Snell’s overall findings. ECF No. 12-16 at 26. He otherwise explains the

1 test procedure and results and includes a more detailed summary of his findings in the CPET
 2 Evaluation Report’s conclusion. *Id.* at 26–33. Dr. Snell also describes various aspects of the
 3 CPET results in substantial detail. *See, e.g., id.* at 28 (“Peak oxygen consumption was only 66-
 4 65% of predicted and below the 17.5 ml kg⁻¹ min⁻¹ [SSA] criteria for disability in cases of
 5 cardiovascular disease...”) The CPET Evaluation Report is also accompanied by a four-page
 6 letter from Dr. Snell further clarifying the CPET results and opining on C.B.’s functional capacity.
 7 *Id.* at 22–25. Thus, the ALJ incorrectly characterized Dr. Snell’s description of the positive CPET
 8 results as a “note,” when in reality, Dr. Snell more than adequately supported his medical opinion
 9 by explaining in detail the relevant and objective medical evidence underpinning the CPET results.
 10 *See Woods*, 32 F.4th at 791.

11 Moreover, a CPET is an SSA-approved method to establish the existence and severity of a
 12 medically determinable impairment because of CFS. *See SSR 14-1p*, 2014 WL 1371245, at *5
 13 (identifying “abnormal exercise stress test” as a laboratory finding that can be relied upon by the
 14 SSA in its disability determination); *Clemmons v. Berryhill*, No. 18-CV-00578-EDL, 2019 WL
 15 3852495, at *17 (N.D. Cal. June 27, 2019) (remanding in part because the ALJ “may not be
 16 current on the international standards for incorporat[ing] CPET evaluations into assessments of
 17 CFS,” and noting that the ALJ should “reconsider the potential for using CPET results to diagnose
 18 CFS in this case.”) The medical community’s recognition of the CPET as a reputable tool in
 19 assessing CFS is at odds with the ALJ’s finding that Dr. Snell’s opinion is “unsupported,” when
 20 Dr. Snell otherwise explains the “relevant ... objective medical evidence” underlying the CPET
 21 data. *Woods*, 32 F.4th at 791 (quoting 20 C.F.R. § 404.1520c(c)(1)); *see* ECF No. 12-16 at 22–23,
 22 27.

23 The ALJ also determined that Dr. Snell’s medical opinion did not “correlate” with records
 24 from Kaiser Hospital and Stanford Health Care, which contain “grossly normal stress tests and
 25 cardiopulmonary findings.” ECF No. 12-3 at 31. The Kaiser Hospital records show that C.B.
 26 underwent exercise stress tests in February 2017 (ECF No. 12-10 at 15–17) and September 2019
 27 (ECF No. 12-9 at 454–56). The February 2017 stress test results were “adequate” and showed
 28 “normal heart rate response to exercise,” (ECF No. 12-10 at 15), while the September 2019 stress

1 test demonstrated “[g]ood exercise tolerance” but the results were “inconclusive...due to
2 borderline ECG changes.” ECF No. 12-9 at 457. The Stanford Health Care records show that
3 C.B. underwent a “tilt test” which was performed by neurologist Dr. Safwan Jaradeh. *Id.* at 477–
4 79. That test showed “mild but significant orthostatic changes,” yet otherwise normal
5 cardiopulmonary results. *Id.* at 478. The Stanford Health Care records also document C.B.’s
6 October 2020 pacemaker implantation, and the fact that medical providers found she displayed
7 normal cardiac functioning after its implantation. ECF No. 12-12 at 2–4, 482–84.

8 As an initial matter, according to the SSA, there are no “specific laboratory findings that
9 are widely accepted as being associated with CFS” and “standard laboratory test results in the
10 normal range are characteristic for many people with CFS,” therefore, “they should not be relied
11 upon to the exclusion of all other clinical evidence in decisions regarding the presence and
12 severity of a [medically determinable impairment].” SSR 14-1p, 2014 WL 1371245, at *4; *Lee*,
13 2023 WL 2751985, at *4 (“[A] general litany of negative lab tests does not undermine plaintiff’s
14 CFS allegations, since ‘[t]here is no blood test or other objective laboratory test for [CFS]’”)
15 (quoting *Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666, 677 (9th Cir. 2011)). If
16 anything, as noted above, “abnormal exercise stress tests” like the CPET are a specific type of
17 laboratory finding explicitly identified by the SSA as being associated with CFS. SSR 14-1p,
18 2014 WL 1371245, at *4. To the extent the ALJ suggests that “normal” cardiopulmonary test
19 results invalidate C.B.’s CPET results, this is contrary to SSR 14-1p and with the CDC’s
20 “published framework for evaluating and diagnosing CFS.” *Reddick*, 157 F.3d at 726. In this
21 respect, when evaluating the consistency of Dr. Snell’s opinion with the medical evidence of
22 record, the ALJ erred in relying on evidence that is not actually inconsistent with Dr. Snell’s
23 findings.

24 As for the “grossly normal stress tests,” the ALJ did not explain how they are inconsistent
25 with C.B.’s CPET results. Dr. Snell opined that the CPET is different than the September 2019
26 exercise stress test because the latter “is well known to overestimate peak oxygen consumption,”
27 and is also a one-time test that did not involve follow up with C.B. “to inquire about possible post-
28 visit symptom exacerbation.” ECF No. 12-16 at 22–23. According to Dr. Snell, “[t]he severity of

1 ME/CFS symptoms can fluctuate during the day, from day to day, and throughout the illness,” and
2 “[s]ymptoms may not occur for hours or even days after the triggering event,” thus, “healthcare
3 providers may not see patients when their symptoms are most severe.” *Id.* at 24. The ALJ failed
4 to address this part of Dr. Snell’s opinion. As such, she failed to describe “the extent to which”
5 Dr. Snell’s medical opinion is or is not “consistent ... with the evidence from other medical
6 sources and nonmedical sources in the claim,” as she was required to do by the regulations.
7 *Woods*, 32 F.4th at 792 (quoting 20 C.F.R. § 404.1520c(c)(2)).

8 According to C.B., “[a]ssuming, arguendo,” that Dr. Snell’s medical opinion and the
9 Kaiser Hospital stress test results were both “equally supported...the ALJ had an obligation to
10 articulate the other persuasiveness factors in paragraphs (c)(3) through (c)(5) of [20 C.F.R.
11 § 404.1520c]. This the ALJ failed to do.” ECF No. 19 at 8. These factors include the length of
12 the treatment relationship, frequency of examinations, medical source specialization, etc. 20
13 C.F.R. § 404.1520c(b)(3). The Commissioner did not address this argument in the Cross-Motion
14 for Summary Judgment. But the Court is not convinced that Section 404.1520c(b)(3) applies in
15 this instance, given that the February 2017 and September 2019 stress test results are noted in
16 C.B.’s medical records and not necessarily a medical “opinion.” Nevertheless, the Court need not
17 determine whether the ALJ erred in her failure to evaluate the other persuasiveness factors, given
18 that the ALJ’s explanation for finding Dr. Snell’s opinion unpersuasive based on the mandatory
19 factors of supportability (Section 404.1520c(c)(1)) and consistency (Section 404.1520c(c)(2)) is
20 deficient and not supported by substantial evidence.

21 **2. Dr. Bonilla**

22 Dr. Bonilla, a chronic fatigue specialist at Stanford Health Care, opined in a letter dated
23 January 20, 2021, that C.B.’s “history and symptoms are consistent with” CFS, and recommended
24 that until C.B.’s “fatigue has measurably improved...[she] refrain from any exertion, both physical
25 and cognitive... [Her] treatment plan is to limit activities, including walking, lifting, bending, and
26 similar physical exertion and cognitive tasks that require focus.” ECF No. 12-12 at 16, 19. The
27 ALJ found Dr. Bonilla’s letter not persuasive because it only reflects C.B.’s limitations since
28 December 2, 2020, which is when he first began treating C.B. ECF No. 12-3 at 31. The ALJ also

1 found that Dr. Bonilla’s opinion is “vague as to the degree of exertional capacity remaining,” and
2 what C.B. “could do now and for any continuous 12-month period.” *Id.* Finally, the ALJ found
3 that “Dr. Bonilla appears to overly rely upon the subjective complaints” of C.B. *Id.*

4 The ALJ did not make any findings regarding the mandatory supportability and
5 consistency factors when evaluating the persuasiveness of Dr. Bonilla’s medical opinion. 20
6 C.F.R. § 404.1520c(c)(1)–(2). Instead, she emphasized Dr. Bonilla’s two-month treatment
7 relationship with C.B. ECF No. 12-3 at 31. Length of the treatment relationship is a factor that
8 the ALJ can consider, but she is not required to explain this factor in all cases, as she is required to
9 do for supportability and consistency. *See Lilita H. v. Kijakazi*, No. 21-CV-04063-JSC, 2022 WL
10 4225395, at *4 (N.D. Cal. Sept. 13, 2022) (“The ALJ must explain how he considered
11 supportability and consistency, *may* explain how he considered the relationship factors, and is not
12 required to explain the other factors”) (emphasis added). The fact that Dr. Bonilla and C.B. had a
13 two-month treatment relationship does not mean that Dr. Bonilla did not properly explain the
14 relevant, objective medical evidence to support his opinion, or that his opinion is inconsistent with
15 evidence from other medical sources. The Commissioner cites to *Benton v. Barnhart*, 331 F.3d
16 1030 (9th Cir. 2003), which held that “duration of treatment relationship and frequency and nature
17 of contact [are] relevant in weighing [a medical source] opinion.” *Id.* at 1038. However, the issue
18 is not the relevancy of these factors, as they are clearly relevant. The issue is that the ALJ did not
19 explain how she considered the supportability and consistency factors in evaluating Dr. Bonilla’s
20 medical opinion, as she is required to do under the revised 2017 SSA regulations. *See Woods*, 32
21 F.4th at 792.

22 Nor does the ALJ’s finding that Dr. Bonilla’s opinion is “vague as to the degree of
23 exertional capacity remaining” (ECF No. 12-3 at 31) suggest anything about its supportability or
24 consistency. The fact that Dr. Bonilla did not opine on what type of work C.B. can or cannot not
25 do moving forward does not mean that he failed to provide objective medical evidence to support
26 what he did opine on, which is that in his “professional opinion,” C.B. “meets the clinical criteria”
27 for CFS, the symptoms of which are exacerbated by physical and cognitive exertion. ECF No. 12-
28 12 at 19. To the contrary, Dr. Bonilla’s letter is accompanied and informed by a detailed, eight-

1 page initial evaluation where he reviewed C.B.’s medical records, such as her treatment history,
 2 symptoms, and objective medical findings, and documented his eighty-minute, in-person
 3 examination of C.B. *Id.* at 10–17. And the lack of detail provided as to C.B.’s exertional capacity
 4 remaining does not mean that Dr. Bonilla’s opinion is irreconcilable with the rest of the medical
 5 evidence in the record. The ALJ did not cite to any medical evidence as being either consistent or
 6 inconsistent with Dr. Bonilla’s opinion.

7 The Commissioner argues that the ALJ “properly highlighted [the fact that] Dr. Bonilla did
 8 not opine permanent limitations based on [C.B.’s] condition or limitations for any continuous 12-
 9 month period, but instead opined temporary restrictions.” ECF No. 24 at 15; *see* ECF No. 12-12
 10 at 19 (recommending that C.B. refrain from any exertion, both physical and cognitive, “[u]ntil her
 11 fatigue has measurably improved.”) She cites to *Fisher v. Berryhill*, 708 F. App’x 384 (9th Cir.
 12 2017), an unpublished Ninth Circuit opinion which held that the record supported the ALJ’s
 13 “observation that [the doctor’s] opinion does not indicate limitations that would last more than 12
 14 months” and therefore was entitled to “little weight.” *Id.* at 385. However, in Dr. Bonilla’s initial
 15 evaluation, he noted C.B.’s “four years history of severe and incapacitated fatigue[,]” the fact that
 16 her “symptoms exacerbate and [worsen] by physical activities, stress, and overstimulation,” and
 17 the fact that she has had “evaluations by multiple health care providers” and “received multiple
 18 unsuccessful treatments.” ECF No. 12-12 at 16. These findings do not suggest that Dr. Bonilla
 19 opined only temporary restrictions for C.B. Rather, Dr. Bonilla recommended that C.B. “[a]void
 20 crash by limiting the actions that will exacerbate” her symptoms, with no indication that this is
 21 meant to be only a temporary limitation. *Id.* To interpret Dr. Bonilla’s statement as opining
 22 temporary restrictions just because he made reference to C.B.’s fatigue potentially “measurably
 23 improving” is inconsistent with his medical opinion as a whole, as well as with the medical
 24 community’s understanding of CFS, specifically, the lack of permanent treatment options. *See*
 25 *Reddick*, 157 F.3d at 727 (“[T]he CDC has made it clear that no definitive treatment for CFS
 26 exists.”) Moreover, the notion that C.B. could experience some improvement as to her CFS and
 27 fibromyalgia symptoms “is not inconsistent with disability.” *See Trevizo*, 871 F.3d at 680.

28 Finally, the ALJ’s statement that Dr. Bonilla “overly rel[ies] upon the subjective

1 complaints” of C.B. “cannot be the rationale for finding evidence not credible when a plaintiff
2 asserts disability based on CFS.” *Baig*, 2023 WL 3688453, at *10; *Reddick*, 157 F.3d at 726
3 (citing definition of CFS in CDC report as “*self-reported* persistent or relapsing fatigue lasting six
4 or more consecutive months”) (emphasis in original). The ALJ found that the “subjective
5 symptoms” C.B. reported to Dr. Bonilla are inconsistent with her “description of daily activities of
6 living” and “are not probative as to greater limitation since they are not reflected in the overall
7 treatment record and contemporaneous medical treatment notes.” ECF No. 12-3 at 29–30.
8 However, the ALJ did not cite to any treatment notes in the record which are supposedly
9 inconsistent with the symptoms C.B. reported to Dr. Bonilla. More importantly, the Court has
10 already rejected this line of reasoning as to the ALJ’s evaluation of C.B.’s symptom testimony and
11 likewise rejects it as to the ALJ’s evaluation of Dr. Bonilla’s medical opinion. *See Baig*, 2023 WL
12 3688453, at *10.

13 **3. Drs. Harris and Sugden**

14 C.B. provided a medical opinion letter from Dr. Harris, co-signed by his colleague Dr.
15 Sugden of Pacific Frontier Medical, Inc. and dated May 24, 2018. ECF No. 12-8 at 2–5. She also
16 provided a fibromyalgia medical opinion form completed by Dr. Harris and dated August 31,
17 2020. *Id.* at 505–13. As to the May 2018 letter, the ALJ found that it contained “conclusory
18 statements...not supported by the contemporaneous medical record,” and was “thus not
19 persuasive.” ECF No. 12-3 at 30. She also found that Dr. Sugden’s treatment notes “reflect
20 homeopathic, dietary and supplement remedies with grossly normal physical examination findings
21 and improvements in energy and pain control not requiring frequent or potent treatments or
22 medications.” *Id.*

23 As an example of a “conclusory statement,” the ALJ points to Dr. Harris’s opinion that
24 C.B. is “unable to perform the basic and essential duties of her position and thus is unable to
25 work...” *Id.* at 30. But this is just one sentence towards the end of the last paragraph in Dr.
26 Harris’s letter, which is three and a half pages long. *See* ECF No. 12-8 at 2–5. In the rest of the
27 letter, Dr. Harris describes many of C.B.’s “presenting” symptoms. *Id.* at 2. For example, he
28 notes C.B.’s high antibody count and low blood pressure, the latter of which indicates a “clear

1 adrenal deficiency” that could be the cause of her dizziness spells which require her to sit to avoid
2 passing out. *Id.* at 2, 4. Dr. Harris also states his and Dr. Sugden’s “concerns of continued
3 neurological deficit, that at this time is still coming and going,” because of their physical exam
4 findings documenting weakness in C.B.’s lower leg reflexes. *Id.* at 2–3. He concludes that
5 although C.B.’s fatigue had improved, she continues to have trouble multitasking, carrying out
6 short and detailed instructions, “deficits with sustaining concentration and attention for both short
7 and long durations,” among other specific limitations. *Id.*

8 The ALJ did not explain how any of these can be considered “conclusory statements.”
9 According to the Commissioner, Dr. Harris’s opinion that C.B. is “unable to work... encroached
10 upon the sole responsibility of the Commissioner to make that disability determination.” ECF No.
11 24 at 16 (citing *Nyman v. Heckler*, 779 F.2d 528, 531 (9th Cir. 1985) (“Conclusory opinions by
12 medical experts regarding the ultimate question of disability are not binding on the ALJ.”)) It is
13 true that the ALJ is not required to credit Dr. Harris’s conclusory opinion that C.B. is unable to
14 work. This does not mean, however, that the rest of his findings as to how C.B.’s symptoms are
15 manifesting and affecting her ability to concentrate must be rejected. And although the ALJ found
16 that Dr. Harris’s May 2018 letter is “not supported by the contemporaneous medical record,” she
17 did not cite to any specific medical records that contradict Dr. Harris’s findings. As such, the ALJ
18 once again failed to articulate how she considered the supportability and consistency factors under
19 20 C.F.R. § 404.1520c when evaluating Dr. Harris’s medical opinion.

20 The ALJ also rejected Dr. Harris’s May 2018 letter because of the treatment notes from Dr.
21 Sugden, purportedly because they reflect “homeopathic, dietary and supplement remedies” and
22 show C.B. does not require “frequent or potent treatments or medications.” ECF No. 12-3 at 30.
23 To the extent the ALJ is repudiating the alternative medicine remedies prescribed by Dr. Sugden,
24 she did not identify any medical opinions “stating what sort of treatment *should* be expected for a
25 totally disabled individual suffering from [C.B.’s] impairments, suggesting that the ALJ
26 impermissibly relied on her own, lay medical opinion.” *Schultz v. Colvin*, 32 F. Supp. 3d 1047,
27 1060 (N.D. Cal. 2014). According to C.B., she has “received all of the treatments and tests
28 commensurate with her diagnoses including antiviral medications, Cymbalta, multiple

1 antidepressants, low-dose naltrexone cardiopulmonary exercise stress test, tilt table testing, and
2 cardiac medications,” and “[n]otably, she had poor tolerance for all fibromyalgia medications.”
3 ECF No. 25 at 5 (citing ECF No. 12-12 at 10).

4 Thus, “[t]he record reflects that [C.B.] consistently sought treatment from both her primary
5 care doctor and from a naturopathic doctor for the recognized symptoms of CFS. The ALJ does
6 not identify a less-conservative treatment option rejected by [C.B.], and there is no indication that
7 further treatment for CFS would be fruitful.” *Lee*, 2023 WL 2751985, at *4. As explained above,
8 fibromyalgia and CFS symptoms “wax and wane,” so treatment notes that at times document
9 “improvements in energy and pain control” do not necessarily discredit C.B.’s overall complaints
10 to Dr. Sugden of debilitating fatigue. *See Trevizo*, 871 F.3d at 680.

11 Finally, the ALJ also determined that Dr. Sugden’s treatment notes contained “grossly
12 normal physical examination findings.” ECF No. 12-3 at 30. The treatment notes she cites to
13 indicate that C.B. was “alert and oriented x 3 in no acute distress,” had “regular [heart] rate and
14 rhythm,” and “normal bowel sounds.” ECF No. 12-8 at 11. However, they also note “[d]ark
15 circles under her eyes, pale, and very low energy today,” “pain in muscles in her arm muscles,
16 knees and hip painful,” and “bilateral knee reflexes weakness.” *Id.* To characterize these as
17 “grossly normal physical examination findings” is misleading and “cherry-picking” Dr. Sugden’s
18 treatment notes instead of reviewing them “in context of the overall diagnostic picture [s]he
19 draws.” *See Holohan*, 246 F.3d at 1205, 1207.

20 In the August 2020 fibromyalgia medical opinion form, Dr. Harris identifies C.B.’s
21 symptoms and signs of fibromyalgia (ECF No. 12-8 at 505–06) as well as her tender points (*id.* at
22 507), describes her history with CFS and which impairments have been excluded as a cause for
23 C.B.’s fatigue (*id.* at 508), notes how abnormal CPET results and “neurally mediated hypotension
24 as shown by tilt table testing” are two laboratory findings that support the CFS diagnosis (*id.* at
25 510) and opines that C.B. is limited in using her hands, fingers, and arms, and can only use them 5
26 percent of the workday (*id.* at 512).

27 The ALJ found that Dr. Harris’s medical opinion form is not persuasive because it is
28 “contradicted by the valid neuropsychological testing present in the file and grossly normal mental

1 status evaluation findings throughout the record.” ECF No. 12-3 at 31. But as noted above, the
2 two neuropsychological evaluations from Dr. Yutsis and Dr. Dorsett provide that C.B. has
3 significant cognitive dysfunction, consistent with her CFS diagnosis, such that it disrupts her day-
4 to-day life activities. ECF No. 12-8 at 498–99, 518. The ALJ did not explain how they are
5 otherwise inconsistent with Dr. Harris’s findings. And the “grossly normal mental status
6 evaluation findings” from Dr. Lee, C.B.’s treating psychiatrist (ECF No. 12-8 at 31, 93, 99, ECF
7 No. 12-9 at 222, ECF No. 12-10 at 179), are in the context of their psychiatric sessions, where Dr.
8 Lee never purported to evaluate the severity of C.B.’s CFS or fibromyalgia.

9 **4. Drs. Hanna and Brodsky**

10 C.B. indirectly challenges the ALJ’s evaluation of the prior administrative medical
11 findings from Drs. Hanna and Brodsky, medical consultants for the SSA. C.B. argues that the
12 ALJ impermissibly “played doctor by relying on her own opinion,” in part because she rejected
13 almost all the medical opinions in the record regarding C.B.’s medically determinable
14 impairments. ECF No. 19 at 15. The only medical opinions credited by the ALJ were those of
15 Drs. Hanna and Brodsky, and even then, the ALJ only found the opinions persuasive through May
16 16, 2019, given that they had no knowledge of C.B.’s fibromyalgia and CFS diagnoses and the
17 October 2020 pacemaker implantation. ECF No. 12-3 at 30.

18 Dr. Hanna’s medical evaluation of C.B. occurred on December 24, 2018. ECF No. 12-4 at
19 6–7. Dr. Hanna found that C.B.’s “[s]ubjective limitations [are] not fully supported by
20 longitudinal objective [medical evidence of record]. After review of [medical evidence of record],
21 [client] capable of at least light [RFC]. Fatigue considered.” *Id.* at 7. Dr. Brodsky’s medical
22 evaluation of C.B. occurred on May 15, 2019. *Id.* at 22–24. Dr. Brodsky found that his review of
23 the prior and current medical evidence of record did not indicate any “significant changes” in her
24 condition since C.B. was evaluated by Dr. Hanna. *Id.* at 24.

25 According to the ALJ, the prior administrative medical findings of Drs. Hanna and
26 Brodsky are persuasive through May 2019 “as supported by the combination of medical signs and
27 findings for [C.B.’s] combination of severe and nonsevere physical and mental impairments.”
28 ECF No. 12-3 at 30. Once again, the ALJ did not explain how she considered the supportability

1 and consistency factors under 20 C.F.R. § 404.1520c(c)(1) and (c)(2). In fact, the ALJ provided
2 no more explanation than this one statement. This is not enough to support a finding of
3 persuasiveness. *Garrison*, 759 F.3d at 1012 (noting that the ALJ satisfies the “substantial
4 evidence” requirement by “setting out a detailed and thorough summary of the facts and
5 conflicting clinical evidence, stating his interpretation thereof, and making findings. The ALJ
6 must do more than state conclusions.”) (quoting *Reddick*, 157 F.3d at 725).

7 **C. Lay Witness Testimony**

8 C.B. argues that the ALJ also erred in rejecting the lay witness testimony of her partner,
9 Beth. ECF No. 19 at 15–16. The ALJ found that Beth’s testimony contained “sincere
10 observations” but did not “correlate with [the] contemporaneous medical record such that they
11 persuade as to more limitations than stated in the RFC.” ECF No. 12-3 at 33.

12 “Lay testimony as to a claimant’s symptoms is competent evidence that an ALJ must take
13 into account, unless he or she expressly determines to disregard such testimony and gives reasons
14 germane to each witness for doing so.” *Lewis v. Apfel*, 236 F.3d 503, 511 (9th Cir. 2001). “One
15 reason for which an ALJ may discount lay testimony is that it conflicts with medical evidence.”
16 *Id.* In addition, where the ALJ provides “clear and convincing reasons for rejecting [the
17 claimant’s] own subjective complaints,” and the lay witness testimony is “similar to such
18 complaints, it follows that the ALJ also gave germane reasons” for rejecting the lay witness
19 testimony. *Valentine v. Comm’r Soc. Sec. Admin.*, 574 F.3d 685, 694 (9th Cir. 2009).

20 The Commissioner notes how there is some uncertainty as to whether the “germane
21 reasons” standard survived the 2017 regulatory changes. ECF No. 24 at 20, n.3. Under the new
22 regulations, lay witness testimony falls under the category of “Evidence from nonmedical
23 sources.” 20 C.F.R. § 404.1513(a)(4). There is no regulatory requirement that the ALJs articulate
24 reasons for how they considered evidence from nonmedical sources. *See* 20 C.F.R.
25 § 404.1520c(d). Although the Ninth Circuit has not addressed the issue, in *Alice B. v. Kijakazi*,
26 No. 20-CV-05897-DMR, 2021 WL 6113000, (N.D. Cal. Dec. 27, 2021), the court held that the
27 “‘germane’ reasons requirement for evaluating lay witness testimony has always been a different
28 (and lower) standard than that required for evaluating medical opinions,” therefore, “[t]he new

1 regulations providing that lay opinions do not need to be evaluated under the same standards as
2 medical opinions is...consistent with the Ninth Circuit’s germane reasons standard.” *Id.* at *8.

3 In *S.M. v. Saul*, No. 20-CV-05304-SVK, 2022 WL 958379, (N.D. Cal. Mar. 30, 2022), the
4 court cited *Alice B.* favorably, but ultimately did not “resolve any latent disagreement on this
5 point” because “the Commissioner has briefed this case under the assumption that the germane
6 reasons case law continues to apply.” *Id.* at *7. Despite the footnote, the Commissioner also
7 briefs the issue of Beth’s lay witness testimony under the “germane reasons” standard. ECF No.
8 24 at 19-20. Because the Ninth Circuit’s “germane reasons” standard is not inconsistent with the
9 revised 2017 regulatory scheme, and the Commissioner has briefed the issue applying that
10 standard, the Court will proceed in evaluating the issue of Beth’s testimony under the “germane
11 reasons” framework.

12 The Commissioner argues that “the ALJ provided proper reasons for discounting [C.B.’s]
13 own testimony, thus providing a sufficient basis for rejecting third-party statements from her
14 partner as well.” ECF No. 24 at 19 (citing *Valentine*, 574 F.3d at 694). However, the ALJ did not
15 cite to C.B.’s symptom testimony as a reason for rejecting Beth’s testimony. ECF No. 12-3 at 33.
16 Even if she had, the Court already held that the ALJ did not provide “clear and convincing
17 reasons” for rejecting C.B.’s symptom testimony. Accordingly, those reasons cannot be a
18 “sufficient basis” for rejecting Beth’s testimony as well. *See Alice B.*, 2021 WL 6113000, at *8
19 (“Because the court finds that the ALJ’s reasons for rejecting [the p]laintiff’s testimony were not
20 supported by substantial evidence, the court cannot apply those reasons to [the p]laintiff’s
21 mother’s testimony to find the error harmless.”) The ALJ simply stated that Beth’s “statements do
22 not correlate with the contemporaneous medical record...” ECF No. 12-3 at 33. But she did not
23 cite to any medical record evidence or explain where the inconsistency lies. *See Stout v. Comm’r,*
24 *Soc. Sec. Admin.*, 454 F.3d 1050, 1054 (9th Cir. 2006) (“[T]he ALJ...is required to provide
25 specific reasons for rejecting lay testimony.”) Therefore, the ALJ did not otherwise provide any
26 other “germane” reason for discounting Beth’s testimony.

27 **D. Step Five Findings**

28 At step five of the five-step sequential evaluation process, the burden shifts to the

1 Commissioner to show that the claimant has the residual functional capacity (RFC) to perform
 2 other work that exists in significant numbers in the national economy. *Hoopai*, 499 F.3d at 1074.
 3 The Commissioner can meet this burden “by the testimony of a vocational expert...” *Tackett v.*
 4 *Apfel*, 180 F.3d 1094, 1101 (9th Cir. 1999). “At step five, the ALJ can call upon a vocational
 5 expert to testify as to: (1) what jobs the claimant, given his or her [RFC], would be able to do; and
 6 (2) the availability of such jobs in the national economy. At the hearing, the ALJ poses
 7 hypothetical questions to the vocational expert that ‘set out all of the claimant’s impairments’ for
 8 the vocational expert’s consideration.” *Id.* An ALJ is “only required to accept those limitations
 9 she decide[s] are applicable,” and she is “free to accept or reject restrictions in a hypothetical
 10 question that are not supported by substantial evidence.” *Denman Thompson v. Colvin*, No. 13-
 11 CV-04242-NJV, 2014 WL 12487664, at *10 (N.D. Cal. Apr. 29, 2014) (quoting *Osenbrock v.*
 12 *Apfel*, 240 F.3d 1157, 1164–65 (9th Cir. 2001)).

13 Here, C.B. challenges the ALJ’s determination at step five that she can perform sedentary,
 14 unskilled work. ECF No. 19 at 22–23. The ALJ refused to adopt in her RFC finding the work
 15 restrictions proposed by Drs. Bonilla, Harris, Snell, and Sugden, specifically, their opinion that
 16 C.B. cannot engage in regular and sustained work activity because her post-exertional malaise
 17 would require her to be frequently off task. ECF No. 12-3 at 29–31, 82. Instead, the ALJ found
 18 that C.B. has the RFC to perform unskilled, “sedentary” work, consisting in part of “the ability to
 19 lift/carry up to 10 pounds occasionally, and 5 pounds frequently,” “stand and walk up to 2 hours
 20 cumulatively in an 8-hour workday,” and “understand, remember, and complete 3-4 step, routine,
 21 but not complex tasks.” *Id.* at 25–26. At the hearing, the ALJ posed three hypothetical questions
 22 to the vocational expert. ECF No. 12-3 at 73–79. The second hypothetical question concerned the
 23 jobs available to an individual with all the limitations from C.B.’s RFC. *Id.* at 78. The vocational
 24 expert testified that such a person can perform the requirements of “unskilled” and “sedentary”
 25 occupations including lens gauger, addresser, and circuit board assembler. *Id.* The third
 26 hypothetical question concerned the jobs available to an individual with C.B.’s RFC with the
 27 additional limitation that the individual would be off task 20 percent of the workday, a restriction
 28 detailed in the medical source opinions provided by C.B. *Id.* at 79. The vocational expert testified

1 that such an individual would be unemployable. *Id.*

2 C.B. argues that “Drs. Bonilla, Harris, Snell, and Sugden all opined that [she] could not
3 complete a normal workday or workweek” and that the vocational expert “testified that a person
4 who would be off task 20% of the workday would be unemployable.” ECF No. 19 at 23. The
5 Commissioner’s response to this argument is that the hypothetical question which was ultimately
6 credited and accepted as true by the ALJ, hypothetical question number two, only included
7 “limitations that the ALJ found were supported by substantial evidence.” ECF No. 24 at 21. That
8 is to say, the ALJ was not required to accept the vocational expert’s testimony in response to
9 hypothetical question number three, since the ALJ determined that the additional limitation of
10 being off task 20 percent of the workday was not supported for C.B. by the medical evidence of
11 record. *Id.*

12 As detailed above, the Court found that the ALJ’s refusal to credit the medical opinions of
13 Drs. Bonilla, Harris, Snell, and Sugden was not supported by substantial evidence. It is because of
14 the ALJ’s rejection of these medical opinions that she accepted the vocational expert’s testimony
15 in response to hypothetical number two as to an individual with C.B.’s RFC being able to perform
16 sedentary, unskilled work, over his testimony in response to hypothetical number three that an off-
17 task individual for up to 20 percent of the workday would be unemployable “[I]f an ALJ’s
18 hypothetical is based on a [RFC] assessment that does not include some of the claimant’s
19 limitations, the vocational expert’s testimony has no evidentiary value.” *Ghanim v. Colvin*, 763
20 F.3d 1154, 1166 (9th Cir. 2014) (internal quotation marks and citation omitted); *see also Embrey*
21 *v. Bowen*, 849 F.2d 418, 422 (9th Cir. 1988) (“Hypothetical questions posed to the vocational
22 expert must set out all the limitations and restrictions of the particular claimant.”) Given the
23 ALJ’s error as to the medical opinion evidence, it is possible that hypothetical question number
24 two, the hypothetical with C.B.’s RFC and the one ultimately accepted by the ALJ, did not include
25 all of C.B.’s limitations.

26 In *Ruben A. v. Saul*, No. 19-CV-03893-EMC, 2020 WL 1897578 (N.D. Cal. Apr. 16,
27 2020), the court found that the ALJ erred in discounting a treating doctor’s medical opinion, which
28 in turn had a “material impact on the [vocational expert]’s testimony.” *Id.* at *6. The treating

1 doctor opined that the plaintiff could sit with appropriate breaks for four hours during an eight-
2 hour workday, while the ALJ’s hypothetical involved an individual who could sit six hours in an
3 eight-hour workday. *Id.* at *5–6. The court held that it could not “confidently conclude that the
4 outcome would have been the same absent this error because the ALJ’s determination was based
5 on the [vocational expert]’s testimony, which in turn was based on the incomplete hypothetical.”
6 *Id.* at *6 (quoting *Brown v. Berryhill*, No. 16-CV-04022-EMC, 2017 WL 4417516, at *9 (N.D.
7 Cal. Oct. 4, 2017)). Because the ALJ’s findings as to the medical opinions of Drs. Bonilla, Harris,
8 Snell, and Sugden were not supported by substantial evidence, the Court cannot confidently
9 conclude that the vocational expert testimony in response to hypothetical question number two,
10 which did not include the limitations these doctors opined, is not likewise incomplete. Given all
11 the above, the Court finds that remand is appropriate on these grounds for the ALJ to make her
12 step-five determination after properly evaluating the medical opinion evidence in the record.

13 **E. Appeals Council’s Consideration of the September 2020 Letter from Dr. Snell**

14 Finally, C.B. argues that “[t]he Appeals Council’s failure to consider the new and material
15 evidence submitted in accordance with 20 C.F.R § 404.970(b) constituted legal error.” ECF No.
16 19 at 21. The “new and material evidence” is a letter from Dr. Snell, dated September 14, 2020,
17 written in response to an “inaccurate” medical review performed by Dr. Kristal Bright, M.D. for
18 C.B.’s long-term disability insurance carrier. *Id.* When the Appeals Council denied review, on
19 August 19, 2022, it found that the letter did not “show a reasonable probability that it would
20 change the outcome of the decision.” ECF No. 12-3 at 3. The Appeals Council did “not exhibit
21 this evidence,” meaning that Dr. Snell’s letter is not part of the administrative record lodged by the
22 Commissioner in this case.⁵ *Id.*

23 The Appeals Council “will review a case if ... [it] receives additional evidence that is new,
24

25 ⁵ C.B. informed the Court that the Dr. Snell letter was not part of the administrative record in her
26 Motion for Summary Judgment when she attached a “Motion to Supplement the Record” along
27 with the only copy of the letter on the Court’s docket. ECF No. 19-1. The Court denied the
28 “motion” without prejudice because of C.B.’s failure to file it as a separate motion, as well as her
failure to attach a proposed order and proper supporting declaration as required by the Local
Rules. ECF No. 20. The Court gave C.B. another opportunity to file her “motion,” but she chose
to not renew her request to supplement the record.

1 material, and relates to the period on or before the date of the hearing decision, [] there is a
 2 reasonable probability that the additional evidence would change the outcome of the decision,”
 3 and there is “good cause” for not submitting the new evidence earlier. 20 C.F.R. § 404.970(a)(5),
 4 (b). “Where the Appeals Council was required to consider additional evidence, but failed to do so,
 5 remand to the ALJ is appropriate so that the ALJ can reconsider its decision in light of the
 6 additional evidence.” *Taylor v. Comm’r of Soc. Sec. Admin.*, 659 F.3d 1228, 1233 (9th Cir. 2011).
 7 “A claimant has the burden to demonstrate the evidence should have been considered by the
 8 Appeals Council” under the SSA’s regulations. *Garcia v. Saul*, No. 1:19-CV-1103-JLT, 2021 WL
 9 223205, at *4 (E.D. Cal. Jan. 22, 2021). However, if the Appeals Council does consider new
 10 evidence submitted by the claimant in denying review of the ALJ’s decision, “the new evidence is
 11 part of the administrative record, which the district court must consider in determining whether the
 12 Commissioner’s decision is supported by substantial evidence.” *Brewes v. Comm’r of Soc. Sec.*
 13 *Admin.*, 682 F.3d 1157, 1159–60 (9th Cir. 2012).

14 C.B.’s challenge assumes that the Appeals Council did not consider the September 2020
 15 letter from Dr. Snell. However, courts in the Ninth Circuit have recognized a difference between
 16 evidence that the Appeals Council “considered” and evidence the Appeals Council merely “looked
 17 at,” in determining whether the additional evidence should be incorporated into the administrative
 18 record and be subject to judicial review. *See, e.g., Victor A. v. Kijakazi*, No. 2:21-CV-07482-GJS,
 19 2023 WL 2614510, at *3 (C.D. Cal. Mar. 23, 2023). “[I]f ‘the Appeals Council only looked at the
 20 evidence ... the new evidence [does] not become part of the record’ and the Court ‘may not
 21 consider it.’” *Id.* (quoting *Amor v. Berryhill*, 743 F. App’x 145, 146 (9th Cir. 2018)).

22 In *Victor*, the Appeals Council used the exact same language it used in this case when
 23 denying the plaintiff’s request for review based on new medical records submitted. 2023 WL
 24 2614510, at *3 (“We find this evidence does not show a reasonable probability that it would
 25 change the outcome of the decision. We did not exhibit this evidence.”) The district court held
 26 that the Appeals Council had “looked” at but not “consider[ed]” the new medical records. *Id.*; *see*
 27 *also Guzman v. Kijakazi*, No. 1:20-CV-0514 JLT, 2021 WL 6062645, at *3 (E.D. Cal. Dec. 22,
 28 2021) (interpreting Appeals Council statement that it “did not exhibit this evidence” to mean it

1 “did not consider the evidence but merely looked at it.”) The Ninth Circuit in *Amor* also found
2 that the Appeals Council only “looked” at the new evidence in part because it determined that the
3 evidence did not meet the standard for consideration, therefore, “the new evidence did not become
4 part of the record, and we may not consider it.” 743 F. App’x. at 146.

5 On the other hand, *Amor* is an unpublished Ninth Circuit case, and courts in this District
6 have previously held that new evidence before the Appeals Council “is part of the record the Court
7 must consider in determining whether the ALJ’s decision is supported by substantial evidence.”
8 *Linnehan v. Berryhill*, No. 17-CV-04146-JSC, 2018 WL 6267846, at *8 (N.D. Cal. July 31, 2018).
9 In *Linnehan*, the plaintiff submitted several documents, including medical records, to the Appeals
10 Council, and the Appeals Council decision likewise stated, “[w]e find this evidence does not show
11 a reasonable probability that it would change the outcome of the decision. We did not consider and
12 exhibit this evidence.” *Id.* at *7. The court cited *Brewes* in support of the proposition that “the
13 Appeals Council cannot consider the evidence to conclude that it ‘does not show a reasonable
14 probability that it would change the outcome of the decision’ and then exclude the evidence from
15 the record based on the illogical conclusion that ‘[w]e did not consider and exhibit this evidence.’”
16 *Id.* at *8 (citation omitted).

17 Neither the Commissioner nor C.B. address the issue of whether it was proper for the
18 Appeals Council to forego exhibiting Dr. Snell’s September 2020 letter or whether the Appeals
19 Council did in fact “consider” the letter as required by SSA regulations. Because the Appeals
20 Council concluded that Dr. Snell’s letter did not “show a reasonable probability that it would
21 change the outcome” of the ALJ’s decision, and denied review, the Court finds that the Appeals
22 Council did “consider” the letter. *See Linnehan*, 2018 WL 6267846, at *8. Thus, the Court
23 incorporates Dr. Snell’s letter into the administrative record and is bound to consider it in
24 determining whether the Commissioner’s decision is supported by substantial evidence. *See*
25 *Brewes*, 682 F.3d at 1159–60.

26 In terms of the substance of the letter, C.B. argues that Dr. Snell “explains in detail why a
27 2-day [CPET] could indicate significant functional impairments while a single treadmill test
28 would not.” ECF No. 19 at 22. Dr. Snell also explains “the nature of [postexertional] malaise,”

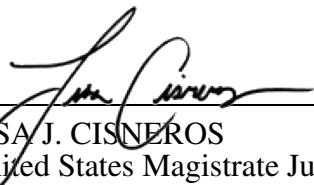
1 how it makes CFS difficult to diagnose, and how following the 2-day [CPET], C.B. “experienced
2 profound fatigue despite significant rest,” “widespread aches and pain,” and “was not recovered 7
3 days post-testing.” *Id.* The Commissioner notes that all these findings are covered in Dr. Snell’s
4 January 2021 letter and the CPET Evaluation Report, both of which were in the record before the
5 ALJ. ECF No. 24 at 23; *see* ECF No. 12-16 at 22–33. That is, Dr. Snell compares the CPET to an
6 exercise treadmill test (ECF No. 12-16 at 22–23), explains how some patients with CFS may not
7 be “obviously ill-appearing during clinical evaluations,” (*id.* at 24) and makes the exact same
8 findings as to C.B.’s symptoms post-testing in the CPET Evaluation Report. *Id.* at 30. The Court
9 held above that the ALJ’s findings as to Dr. Snell’s January 2021 letter and CPET Evaluation
10 Report are not supported by substantial evidence in part because of the ALJ’s failure to address
11 these exact points when evaluating their consistency with the rest of the medical evidence of
12 record. Dr. Snell’s September 2020 letter does not affect the Court’s determination either way.

13 **IV. CONCLUSION**

14 For the reasons stated above, the Court **GRANTS** Plaintiff’s Motion for Summary
15 Judgment and **DENIES** Defendant’s Cross-Motion for Summary Judgment, and **REMANDS** for
16 further proceedings consistent with this Order.

17 **IT IS SO ORDERED.**

18 Dated: March 27, 2024

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22 LISA J. CISNEROS
23 United States Magistrate Judge
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