UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

NICOLE STRASSER,

Plaintiff(s),

v.

CAROLYN W. COLVIN,

Defendant(s).
_____/

No. C-12-05975 DMR

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

Pursuant to 42 U.S.C. § 405(g), Plaintiff Nicole Strasser ("Plaintiff") seeks judicial review of her application for supplemental security income ("SSI") benefits. Defendant Social Security Commissioner ("Defendant" or "Commissioner") denied her application after determining that Plaintiff was not disabled under XVI of the Social Security Act ("Act"), 42 U.S.C. § 1382c(a)(3)(A). Both parties filed motions for summary judgment. For the reasons stated below, the court grants Defendant's motion and denies Plaintiff's motion.

I. Procedural History

On March 26, 2009, Plaintiff filed an application for SSI benefits under Title XVI of the Act, alleging disability beginning August 1, 2003. Administrative Record ("A.R.") 158-64. The agency denied Plaintiff's claim, and subsequently denied it again upon reconsideration. A.R. 76-80, 82-86. On April 13, 2011, Administrative Law Judge (ALJ) Caroline H. Beers held a hearing at which Plaintiff was represented by counsel. A.R. 35-73. Plaintiff testified, as did Malcolm Brodzinsky, a

vocational expert ("VE Brodzinsky"). A.R. 20. On May 10, 2011, the ALJ issued a written decision denying Plaintiff's claim and holding that Plaintiff was not disabled. A.R. 20-29. The Appeals Council denied Plaintiff's request for review of the ALJ's decision, making the ALJ's decision the Commissioner's final decision. A.R. 1-4. Plaintiff then filed this action.

II. Factual Background

A. Background

The record contains the following information. Plaintiff is a 35 year-old woman. A.R. 154. As of the date of her application for benefits, Plaintiff was 30 years old. A.R. 28. Plaintiff had two years of college education and was able to read and write and do simple math. A.R. 45. Plaintiff also did vocational training as a emergency medical technician and became certified in 2003, although her license has since expired. A.R. 45. Plaintiff was last employed in 2006, when she worked for a nonprofit and was in charge of an education training program and fundraising. A.R. 45-46. That job required her to sit most of the time, answer phone calls, conduct outreach to donors via phone, use a computer, and lift 10-15 pounds. A.R. 46. Her previous employment has included work as an emergency medical technician, personal health attendant, secretary, lube technician, and ticket-seller at a movie theater. A.R. 45-48, 203. Plaintiff has not had significant paid or volunteer work since 2009. A.R. 48-49.

Plaintiff alleges that she suffers from lumbar disc disease, hepatitis C, liver disease, carpal tunnel syndrome, arthritis, edema, stress fractures, depression, insomnia, and panic attacks. A.R. 56, 75, Mot. for Summ. J. [Docket 20] at 2. She testified that she cannot work because she feels nauseous on a daily basis, "feel[s] like [she is] unreliable," "run[s] a constant fever," "[does not] feel like [she] can interact with other people," is "extremely emotional, sometimes irrational, impulsive, [and] extremely depressed," has panic attacks, has chronic, severe pain in her back that affects her legs, and pain and numbness in her hands and fingertips. A.R. 49, 61. Plaintiff testified that she was unable to stand for more than ten minutes with her cane before she needed to sit down, but could sit continuously for one or two hours. A.R. 54. She also testified that she had carpal tunnel syndrome in both hands and "trigger thumb" in her right thumb, which made it difficult for her to grasp objects like cups, door handles, and brooms, and open bottles. A.R. 55, 62.

With regard to her activities of daily living, Plaintiff typically woke irritable, depressed and nauseated. A.R. 58. Plaintiff lived with a roommate who assisted her with certain tasks, for example, feeding Plaintiff's dogs because the feed bag was too heavy for her to lift, walking the dogs, lifting wet laundry into the dryer, making her bed, and cleaning up around the house. A.R. 56, 58-59. Plaintiff was able to prepare microwave meals for herself. A.R. 58. Plaintiff was able to bathe only at a friend's house, where she had access to a bathroom with a bench and a detachable showerhead. A.R. 57. She did not do her own shopping; instead, her mother and roommate shopped for her because Plaintiff got panic attacks and could not last more than fifteen minutes in a supermarket. A.R. 59. However, Plaintiff was able to shop using her computer. A.R. 184. Prior to developing carpal tunnel syndrome, Plaintiff used to enjoy playing her keyboard and walking her dogs, but she testified that she no longer did either activity. A.R. 59. Some of Plaintiff's pastimes were reading books, writing poetry, watching television, singing, and using the computer. A.R. 58, 181, 185.

In a function report filled out by Plaintiff on April 13, 2009, Plaintiff noted that she spent time with other people by going to movies or theater, talking on the phone, cooking, going to the park with her dogs, or going out to coffee, for a maximum of 2-3 hours, about twice a month. A.R. 185. Plaintiff stated that she could count change, but could not pay bills, handle a savings account, or use a checkbook/money orders because she had no money to pay bills, had never used a money order, and did not have a savings account, but "[i]f I had those things I could use them." A.R. 184. In response to a question about how well she got along with authority figures, Plaintiff wrote, "Great!!" A.R. 187. In later reports, Plaintiff indicated that her condition had gotten worse. *See, e.g.* A.R. 251 (Disability Report dated March 20, 2010).

B. Plaintiff's Relevant Medical History

1. Dr. Levine - Treating Psychiatrist

Plaintiff testified that she had been treated by Dr. Levine, a psychiatrist, for "maybe eight or ten years." A.R 52. However, the record from Dr. Levine is limited to three progress notes from February and September 2010 and January 2011, a letter dated March 18, 2011, and a residual functional capacity questionnaire.

Dr. Levine's notes are sparse and mostly seem to recite Plaintiff's complaints. For example, in the treatment notes dated September 2010, Dr. Levine states Plaintiff's "multiple complaints," including her herniated discs, hepatitis, depression and agoraphobia. A.R. 392. In the treatment notes dated January 2011, Dr. Levine noted that Plaintiff complained of longstanding back pain and anxiety. A.R. 391. The notes from January 2011 also include a mental status examination finding that Plaintiff was alert and coherent but complaining that her weight was making her miserable. A.R. 391. Dr. Levine diagnosed Plaintiff with chronic depression, opioid dependence in remission, and panic disorder NOS. A.R. 391.

In his March 2011 letter, Dr. Levine stated that Plaintiff "has suffered from a number of conditions which have made [sic] impeded her work for the past several years. She has a number of orthopedic problems which cause significant pain and disability . . . . Practically speaking, I do not think she is capable of gainful employment any time in the near future." A.R. 390. Dr. Levine also completed a residual functional capacity questionnaire and estimated moderate impairment in Plaintiff's ability to relate to other people, respond appropriately to co-workers, and perform varied tasks. He also found moderately severe difficulty in Plaintiff's ability to respond to customary work pressures and perform complex tasks, and severe restriction in Plaintiff's daily activities. A.R. 394.

2. Dr. Morse - Consultative Examining Psychologist

Dr. Roxanne Morse performed a psychological mental status evaluation on Plaintiff on July 7, 2009. A.R. 313-15. Dr. Morse noted that Plaintiff reported a long history of suicidal ideations as a result of depression and panic attacks, as well as history of abuse. A.R. 314. Plaintiff's performance on the objective mental status tests was satisfactory. A.R. 315. Her stream of mental activity and speech were normal, thought processes were linear, and her insight and judgment were fair. A.R. 314.

Dr. Morse listed the following diagnostic impressions: pain disorder associated with psychological features and a general medical condition, generalized anxiety disorder, panic disorder without agoraphobia, depressive disorder NOS, posttraumatic stress disorder, personality disorder NOS, isolation, pain, hypervigilance, anxiety, anergia, and anhedonia, and a global assessment of functioning score of 60. A.R. 315.

Dr. Morse found that Plaintiff could "relate to and interact with coworkers and supervisors" and "understand, remember, and carry out simple instructions." A.R. 315. She also found Plaintiff could carry out detailed and complex instructions with moderate difficulty, deal with the public with moderate difficulty, and maintain attention and concentration for two-hour increments. A.R. 315. Dr. Morse opined: "the claimant might function optimally in a work environment that required simple and repetitive tasks." A.R. 315. She further opined that Plaintiff's "ability to interact with the public, supervisors, and coworkers appears to be adequate," and that she would not require assistance in managing her own funds. A.R. 315. Dr. Morse also noted that "an additional obstacle to the claimant's work ability may be her medical conditions. This matter is beyond the scope of this evaluation and deferred to medical evaluation." A.R. 315.

3. Dr. Chen - Consultative Examining Physician

Dr. Frank Chen performed a comprehensive internal medicine evaluation on June 24, 2009. A.R. 306-07. He noted that Plaintiff's chief complaints were chronic low back pain and obesity. A.R. 306. Dr. Chen found that Plaintiff was in no acute distress, and that her extremities, coordination, station, and gait were "within normal limits." A.R. 307. Although Plaintiff used a cane (according to her reports "off and on for five months due to history of fracture of the left foot"), Dr. Chen observed that Plaintiff could walk normally without the device. A.R. 307. Dr. Chen found that the straight-leg raising test was negative in the seated and supine positions, muscle bulk and tone were normal, motor strength was 5/5 in all extremities, bilateral grip strength was 5/5, and sensory was intact in all extremities. A.R. 307. Dr. Chen diagnosed chronic low back pain due to degenerative disc disease and morbid obesity, and that found Plaintiff could lift and carry 20 pounds occasionally and 10 pounds frequently, stand and walk without a cane for about six hours in an eight-hour workday, and sit for six hours in an eight-hour workday. A.R. 307.

4. Dr. Shen - Treating Physician

The record contains a letter dated March 16, 2011 from Dr. Timothy Shen, Plaintiff's treating physician, specializing in physical medicine and rehabilitation. A.R. 389. The record does not contain any treatment notes or other medical records from Dr. Shen, but the letter indicates that

Plaintiff saw Dr. Shen at least four times: at some point in 2004; July 8, 2009; February 2010; and June 2010. A.R. 389.

In the letter, Dr. Shen noted that Plaintiff had a "longstanding history of low back pain related to an L5-S1 disc herniation," right-sided carpal tunnel syndrome causing numbness and tingling in both hands, and right-sided foot and knee pain. A.R. 389. Plaintiff's treatments included "physical therapy, lumbar epidural steroid injection and chronic pharmacologic pain medication (oxycodone)" for her back pain, unspecified "conservative[]" treatment for her knee pain, and a walking boot for her foot pain. A.R. 389. Dr. Shen stated that Plaintiff "was unable to tolerate" the walking boot and that, although he ordered a CT scan in June 2010, Plaintiff did not obtain that study. A.R. 389. X-rays of the foot were "unremarkable." A.R. 389. Dr. Shen also indicated that "the symptoms [of the carpal tunnel syndrome were] mostly stable" and that she need only follow up with a hand surgeon "if her symptoms progress." A.R. 389. Dr. Shen diagnosed "lumbar discogenic pain" with "radicular symptoms," "right-sided carpal tunnel syndrome," "right knee pain," and "persistent right greater than left foot pain." A.R. 389. Dr. Shen concluded his letter by stating, "Due to diffuse musculoskeletal pain that the patient experiences on a daily basis and her use of long-term pain medication, I believe that it would be difficult for the patient to continue working at her job on a regular basis." A.R. 389.

5. Dr. McCune - Treating Physician

The record contains two brief letters from Dr. Shannon McCune, a doctor affiliated with the Sutter East Bay Medical Foundation, "regarding [Plaintiff 's] ability to support herself financially." A.R. 363, 403.

In the first letter, dated March 4, 2010, Dr. McCune noted that Plaintiff had multiple medical and psychiatric problems, including chronic back pain followed by Dr. Shen, bilateral carpal tunnel syndrome followed by Dr. Cardon, nausea, hepatitis C infection, depression, and probable borderline personality disordered followed by Dr. Levine. Dr. McCune concluded that Plaintiff "is disabled from meaningful work at present, and likely for years to come." A.R. 363.

In the second letter, dated July 19, 2011, Dr. McCune stated that Plaintiff's medical issues "ha[d] not changed significantly." A.R. 403. Dr. McCune opined that Plaintiff's "most disabling

issue is her mental illness," because Plaintiff "continues [to be] depressed, anxious, and exhibits poor insight and judgement." A.R. 403. Dr. McCune noted that she "continue[d] to be of the opinion that [Plaintiff] is disabled from meaningful work at present, and likely for years to come. This opinion has been formed both by my visits with [Plaintiff] and through conversation with her psychiatrist, Dr. Richard Levine." A.R. 403. Dr. McCune's reference to "[her] visits with [Plaintiff]" is the only evidence in the record suggesting that Dr. McCune was Plaintiff's treating physician, as the record contains no treatment notes or other medical records from Dr. McCune. A.R. 403.

6. Dr. Cardon - Treating Physician

The record contains three treatment notes from Dr. Lamont Cardon, a hand surgeon who evaluated Plaintiff's right trigger thumb and bilateral carpal tunnel symptoms. A.R. 396-402. The treatment notes are dated May 2008; September 2008; and January 2010. Dr. Cardon's notes indicate that Plaintiff's carpal tunnel syndrome was "mild" and treated with a wrist splint to be worn at night. A.R. 397. Dr. Cardon indicated that Plaintiff should return for reevaluation if the symptoms did not improve, but there is no evidence of a return visit in the record. A.R. 397. Dr. Cardon also indicated that lidocaine injections "resulted in full resolution of her symptoms" in the thumb. A.R. 396, 398.

7. Testimony of Vocational Experts

At the administrative hearing, the ALJ presented two hypotheticals to VE Brodzinsky. A.R. 63-72. With respect to the first, VE Brodzinsky opined that someone able to perform light work; stand and walk six hours and sit six hours; perform simple repetitive tasks; have occasional contact with the public; make simple work related decisions with few workplace changes could not perform any of Plaintiff's past relevant work. A.R. 67-68. However, VE Brodzinsky testified that there were jobs in the regional and national economy that an individual with those limitations could perform, including small parts assembler, housekeeping/cleaner, small products assembler, bench hand assembler of electronic components. A.R. 68-70. The second hypothetical the ALJ presented to VE Brodzinsky assumed a person with the same limitations, but who could only be on task for 30

minutes out of each hour throughout an eight hour day. VE Brodzinsky testified that those limitations would preclude that person from all work. A.R. 70.

III. The Five-Step Sequential Evaluation Process

To qualify for disability benefits, a claimant must demonstrate a medically determinable physical or mental impairment that prevents her from engaging in substantial gainful activity[1] and that is expected to result in death or to last for a continuous period of at least twelve months. *Reddick v. Chater*, 157 F.3d 715, 721 (9th Cir. 1998) (citing 42 U.S.C. § 423(d)(1)(A)). The impairment must render the claimant incapable of performing the work she previously performed and incapable of performing any other substantial gainful employment that exists in the national economy. *Tackett v. Apfel*, 180 F.3d 1094, 1098 (9th Cir. 1999) (citing 42 U.S.C. § 423(d)(2)(A)).

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

1. At the first step, the ALJ considers the claimant's work activity, if any. If the claimant is doing substantial gainful activity, the ALJ will find that the claimant is not disabled.
2. At the second step, the ALJ considers the medical severity of the claimant's impairment(s). If the claimant does not have a severe medically determinable physical or mental impairment that meets the duration requirement in [20 C.F.R.] § 416.909, or a combination of impairments that is severe and meets the duration requirement, the ALJ will find that the claimant is not disabled
3. At the third step, the ALJ also considers the medical severity of the claimant's impairment(s). If the claimant has an impairment(s) that meets or equals one of the listings in 20 C.F.R., Pt. 404, Subpt. P, App. 1 [the "Listings"] and meets the duration requirement, the ALJ will find that the claimant is disabled.

[1] Substantial gainful activity means work that involves doing significant and productive physical or mental duties and is done for pay or profit. 20 C.F.R. §§ 404.1510, 416.910.

4. At the fourth step, the ALJ considers an assessment of the claimant's residual functional capacity ("RFC") and the claimant's past relevant work. If the claimant can still do his or her past relevant work, the ALJ will find that the claimant is not disabled.

5. At the fifth and last step, the ALJ considers the assessment of the claimant's RFC and age, education, and work experience to see if the claimant can make an adjustment to other work. If the claimant can make an adjustment to other work, the ALJ will find that the claimant is not disabled. If the claimant cannot make an adjustment to other work, the ALJ will find that the claimant is disabled.

20 C.F.R. § 416.920(a)(4); 20 C.F.R. §§ 404.1520; *Tackett*, 180 F.3d at 1098-99.

IV. The May 10, 2011 Decision By the ALJ

In the May 10, 2011 decision, the ALJ applied the five-step sequential evaluation to determine whether Plaintiff was disabled. A.R. 20-29. At Step One, the ALJ found that Plaintiff had not engaged in substantial gainful activity since March 19, 2009, the day she applied for disability benefits. A.R. 22. At Step Two, the ALJ found that Plaintiff had the following severe impairments: lumbar pain with radicular symptoms; right-sided carpal tunnel syndrome; right knee and foot pain; hepatitis C; arthritis; pain medication addiction; trigger finger; obesity; pain disorder; anxiety; panic disorder; depression; posttramatic stress disorder; and personality disorder. A.R. 22.

At Step Three, the ALJ found that Plaintiff's impairment did not meet or equal a presumptively disabling impairment in the Listings. A.R. 22. The ALJ found that Plaintiff had the residual functional capacity to "lift and carry 20 pounds occasionally and 10 pounds frequently, sit 6 hours in an 8-hour workday, stand and walk about 6 hours in an 8-hour workday, and perform simple repetitive tasks." A.R. 23-24. In addition, the ALJ found that Plaintiff could "maintain occasional contact with the public and coworkers and make simple work-related decisions with few workplace changes." A.R. 24. At Step Four, the ALJ found that Plaintiff was "unable to perform any past relevant work." A.R. 28. At Step Five, the ALJ determined that Plaintiff was not disabled because there were a significant number of jobs in the national economy that Plaintiff could perform, considering her age, education, work experience, and RFC. A.R. 28.

V. Issues Presented

Plaintiff contends that the ALJ erred at Steps Two, Three, and Five of the sequential evaluation process. Specifically, the court will consider the following issues:

1. Whether the ALJ erred in failing to give controlling weight to the opinions of Plaintiff's treating physicians;
2. Whether the ALJ erred in failing to consider Plaintiff's longitudinal history of mental impairments;
3. Whether the ALJ erred in determining Plaintiff's RFC;
4. Whether the ALJ erred by failing to include all of Plaintiff's non-exertional limitations in the hypotheticals to VE Brodzinsky.

VI. Standard of Review

The ALJ's underlying determination "will be disturbed only if it is not supported by substantial evidence or it is based on legal error." *Magallanes v. Bowen*, 881 F.2d 747, 750 (9th Cir. 1989) (internal quotation marks omitted). "Substantial evidence" is evidence within the record that could lead a reasonable mind to accept a conclusion regarding disability status. *See Richardson v. Perales*, 402 U.S. 389, 401 (1971). It is "more than a mere scintilla" but less than a preponderance. *Id*. If the evidence reasonably could support two conclusions, the court "may not substitute its judgment for that of the Commissioner" and must affirm the decision. *Jamerson v. Chater*, 112 F.3d 1064, 1066 (9th Cir. 1997) (citation omitted). The ALJ is responsible for determining credibility and resolving conflicts in medical testimony, resolving ambiguities, and drawing inferences logically flowing from the evidence. *Allen v. Heckler*, 749 F.2d 577, 579 (9th Cir. 1984); *Sample v. Schweiker*, 694 F.2d 639, 642 (9th Cir.1982); *Vincent ex. rel. Vincent v. Heckler*, 739 F.2d 1393, 1394-95 (9th Cir. 1984). "Finally, the court will not reverse an ALJ's decision for harmless error, which exists when it is clear from the record that the ALJ's error was inconsequential to the ultimate nondisability determination." *Tommasetti v. Astrue*, 533 F.3d 1035, 1038 (9th Cir. 2008) (citations and internal quotation marks omitted); *Ludwig v. Astrue*, 681 F.3d 1047, 1054 (9th Cir. 2012) ("Reversal on account of error is not automatic, but requires a determination of prejudice.").

VII. Discussion

A. . Evaluation of the Medical Evidence

Plaintiff contends that the ALJ erred by failing to give adequate weight to the opinions of Drs. Levine, Shen, and McCune, who were Plaintiff's treating psychiatrist and physicians.

When reviewing an ALJ's medical opinion determinations, courts distinguish between three types of physicians: those who treat the claimant ("treating physicians"); and two categories of "nontreating physicians," those who examine but do not treat the claimant ("examining physicians") and those who neither examine nor treat the claimant ("nonexamining physicians"). *See Lester*, 81 F.3d at 830. A treating physician's opinion is entitled to more weight than an examining physician's opinion, and an examining physician's opinion is entitled to more weight than a nonexamining physician's opinion. *Id.*

The ALJ is entitled to resolve conflicts in the medical evidence. *Sprague v. Bowen*, 812 F.2d 1226, 1230 (9th Cir. 1987). However, to reject the opinion of an uncontradicted treating or examining physician, an ALJ must provide "clear and convincing reasons." *Lester*, 81 F.3d at 830; *see also* § 416.927(d)(2); SSR 96-2p, 1996 WL 374186. If another doctor contradicts a treating or examining physician, the ALJ must provide "specific and legitimate reasons" supported by substantial evidence to discount the treating or examining physician's opinion. *Lester*, 81 F.3d at 830-31. The ALJ meets this burden "by setting out a detailed and thorough summary of the facts and conflicting clinical evidence, stating his interpretation thereof, and making findings." *Reddick*, 157 F.3d at 725. A nonexamining physician's opinion alone cannot constitute substantial evidence to reject the opinion of an examining or treating physician, *Pitzer v. Sullivan*, 908 F.2d 502, 506 n.4 (9th Cir. 1990), though it may be persuasive when supported by other factors. *See Tonapetyan v. Halter*, 242 F.3d 1144, 1149 (9th Cir. 2001); *Magallanes*, 881 F.2d at 751-55 (upholding rejection of treating physician's opinion given contradictory laboratory test results, reports from examining physicians, and testimony from claimant). An opinion more consistent with the record as a whole generally carries more persuasiveness. *See* §416.927(d)(4).

1. Dr. Levine

The ALJ noted that "[t]he evidence concerning mental health treatment is sparse, limited to three progress notes from February and September 2010 and January 2011 with Dr. Levine." A.R. 26. The ALJ described the progress notes as follows:

> Those notes reflect complaints of depressed mood, anxiety, lethargy, and agoraphobia, and diagnoses of chronic depression, opioid dependence in remission,[2] and panic disorder NOS. [In a letter dated March 18, 2011,] Dr. Levine stated that he felt that the claimant was not capable of gainful employment. Dr. Levine completed a questionnaire and estimated moderate impairment in the ability to relate to other people, respond appropriately to co-workers, and perform varied tasks. He found moderately severe difficulty in the ability to respond to customary work pressures and perform complex tasks, and severe restriction in daily activities.

A.R. 26. The ALJ also noted that "there is only one mental status examination [in the medical record], which only indicates the claimant was alert and coherent but that her weight was making her miserable." A.R. 27.

The ALJ gave specific and legitimate reasons for giving "little weight" to the opinion of Dr. Levine. First, the ALJ gave "great weight" to the opinion of Dr. Morse, whose conclusions are inconsistent with Dr. Levine's opinion that Plaintiff was incapable of gainful employment. As discussed above, Dr. Morse found that Plaintiff's objective mental status test results were satisfactory, that Plaintiff's stream of mental activity and speech were normal, that Plaintiff's thought processes were linear and that her insight and judgment were fair, and that Plaintiff was able to interact with others, carry out simple tasks, and manage her own funds.[3] A.R. 314-315.

Second, the ALJ noted that she gave little weight to the opinions of Dr. Levine because his "treatment records do not support his conclusions. The three progress notes from February 2010, September 2010, and January 2011, are sparse and appear to merely recite the claimant's reports of

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[2] Plaintiff has a history of intravenous drug use with heroin and was on methadone maintenance for two years. A.R. 382.

[3] Plaintiff argues that Dr. Morse's "serious mental diagnoses" indicated that Dr. Morse thought that "Plaintiff had very severe mental impairments and life stressors, which make [Dr. Morse's] functional capacity assessment inconsistent with her own findings and diagnoses." Mot. Summ. J. at 10. For this reason, Plaintiff urges the court to find that the ALJ erred in giving great weight to Dr. Morse's opinion. However, what Plaintiff calls "serious mental diagnoses" are actually Dr. Morse's "diagnostic impressions" of Plaintiff. *See* A.R. 315. These diagnostic impressions indicate various possibilities for rather than a definitive diagnosis of any particular impairment, do not include any findings on the severity of those diagnostic possibilities, and are not at odds with Dr. Morse's separate assessment of Plaintiff's functional abilities. The court thus finds that the ALJ did not err by giving great weight to Dr. Morse's report.

depressed mood, anxiety, lethargy, and agoraphobia." A.R. 27. Despite Plaintiff's testimony that she had been treated by Dr. Levine for "maybe eight or ten years," A.R 52, the record contains only these three progress notes covering a span of 13 months. A letter from Plaintiff's mother indicates that Plaintiff discontinued her psychotherapy around 2003. A.R. 199. These three treatment records say little about Plaintiff's mental health other than what Plaintiff reported to Dr. Levine, and do not support Dr. Levine's conclusion that Plaintiff was not capable of gainful employment. *See Tonapetyan*, 242 F.3d at 1149 (ALJ properly rejected treating doctor's opinion that the claimant could not perform even sedentary work because "it was unsupported by rationale or treatment notes, and offered no objective medical findings to support the existence of [the claimant's] alleged conditions"). With respect to Dr. Levine's residual functional questionnaire, Dr. Levine indicated on the questionnaire that he had not obtained a psychological evaluation of Plaintiff. A.R. 395. He did not provide any objective support for his opinions and provided no comments in the space provided on the form. A.R. 394-95. It was permissible for the ALJ to give little weight to Dr. Levine's unsupported opinions. 20 C.F.R. § 416.927 (ALJ is not allowed to adopt the opinion of a treating physician as controlling if it is not "well-supported by medically acceptable clinical and laboratory diagnostic techniques" or if it is "inconsistent with other substantial evidence in the individual case record)"; SSR 96-2p at *1 (same); *see also Molina v. Astrue*, 674 F.3d 1104, 1111-12 (9th Cir. 2012) ("We have held that the ALJ may 'permissibly reject[ ] . . . check-off reports that [do] not contain any explanation of the bases of their conclusions'") (citations omitted).

In any event, Dr. Levine's opinion that Plaintiff is not "capable of gainful employment any time in the near future" is not a "medical opinion." "Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of [a claimant's] impairment(s), including [a claimant's] symptoms, diagnosis and prognosis, what [a claimant] can still do despite impairment(s), and [the claimant's] physical or mental restrictions." 20 C.F.R. § 416.926(a)(2). Instead, it is a conclusory statement on an issue that is reserved to determination of the agency. 20 C.F.R. § 416.927(e) ("We will not give any special significance to the source of an opinion on issues reserved to the Commissioner."). A conclusory

statement by a medical source that a claimant "is 'disabled' or 'unable to work' does not mean that [the agency] will determine that [the claimant is] disabled." *Id.*

2. Drs. Shen, McCune, and Cardon

In assessing Plaintiff's RFC, the ALJ "accord[ed] great weight to the opinion of Dr. Chen based on his examining relationship and because his opinion is consistent with the totality of the treatment notes and radiographic reports," and gave "little weight to the opinions of Dr. Shen and Dr. McCune" for the following reasons:

> While [Dr. Shen and Dr. McCune] are treating sources, their conclusions are not consistent with medical evidence. The claimant has been treated very conservatively for her physical conditions. She has only received physical therapy, steroid injections, and pain medication for the back. Imaging evidence from November 2009 demonstrates degenerative changes at multiple levels resulting in only mild foraminal narrowing. [Citation.] Additionally, nerve condition studies of the upper extremities reveal only mild right carpal tunnel syndrome that was treated with a splint at night. Dr. Cardon's most recent note from January 2010 shows negative Tinel's, Froment's, and Wartenberg's signs bilaterally, no significant swelling in either hand, full range of motion, and no atrophy. Dr. Cardon also indicated that the claimant's right trigger thumb resolved following the second cortisone injection in September 2008. [Citation.]

A.R. 26-27. The ALJ also summarized the medical evidence concerning Plaintiff's physical condition at length, including the results of the Plaintiff's MRIs and other hospital records. A.R. 25-26. The ALJ found that the medical record showed that (1) in 2004, an MRI showed that Plaintiff had a slight protrusion at one spot in her spine, degenerative disc disease with mild annular disc bulge and a probable small annular tear at another, and mild degenerative disc disease with mild annular bulge at a third; (2) between August 2004 and May 2008 there was no evidence of further treatment; (3) in May 2008, Plaintiff saw Dr. Cardon, who diagnosed mild carpal tunnel syndrome and trigger finger, the latter of which Dr. Cardon notes was fully resolved in 2010 through cortisone injections; (4) in 2009, another lumbar spine MRI showed degenerative changes at multiple levels resulting in mild neural foraminal narrowing, but that there was no significant central canal stenoisis at any level imaged. A.R. 25 (citing A.R. 306-307, 364-365, 368-369, 396-402).

The ALJ gave specific and legitimate reasons for discounting the opinions of Dr. Shen and Dr. McCune. The ALJ pointed to contradictory medical evidence, which generally shows mild ailments and conservative treatment. Even Dr. Shen's letter describes fairly conservative treatment of Plaintiff's back, hand, and foot and knee pain, which is inconsistent with his later conclusion that

"it would be difficult for [Plaintiff] to continue working at her job on a regular basis."[4] Evidence of conservative treatment only is inconsistent with a finding of disabling pain. *See Tommasetti*, 533 F.3d at 1039 (ALJ permissibly inferred that claimant's pain was "not as all-disabling as he reported" because he did not seek an aggressive, alternative, or more-tailored treatment program); *Parra v. Astrue*, 481 F.3d 742 (9th Cir. 2007) ("We have previously indicated that evidence of 'conservative treatment' is sufficient to discount a claimant's testimony regarding severity of an impairment.") (citation omitted). The ALJ also pointed to contradictory opinions from an examining physician (Dr. Shen) and Plaintiff's treating physician (Dr. Cardon). In addition, with respect to Dr. McCune, the record contains no treatment notes or other medical records from Dr. McCune, and only contains two brief letters regarding "[Plaintiff's] ability to support herself financially." A.R. 363, 403. Dr. McCune's reference to "[her] visits with [Plaintiff]" is the only evidence in the record suggesting that Dr. McCune was Plaintiff's treating physician. A.R. 403. This sparse treatment record is inconsistent with Dr. McCune's statement that Plaintiff "is disabled from meaningful work at present, and likely for years to come." A.R. 363.

Furthermore, just as with Dr. Levine's opinion that Plaintiff was disabled, neither Dr. Shen's opinion that "it would be difficult for [Plaintiff] to continue working at her job on a regular basis" nor Dr. McCune's opinion that Plaintiff was "disabled from meaningful work at present, and likely for years to come" are "medical opinions" that may be given controlling weight.

For these reasons, the court finds that the ALJ did not err by giving little weight to the opinions of Dr. Levine, Dr. Shen, and Dr. McCune.[5]

B. Plaintiff's Longitudinal History of Mental Impairments

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[4] Dr. Shen's statement that "it would be difficult for [Plaintiff] to continue working at her job on a regular basis" is puzzling, considering that Plaintiff had not worked for nearly two years at the time Dr. Shen wrote this letter.

[5] Plaintiff states that Dr. Cardon is a "[t]reating [s]ource [w]hose [o]pinions [m]ust [b]e [g]iven [c]ontrolling [w]eight," Mot. Summ. J. at 5, but does not actually argue that the ALJ failed to accord proper weight to Dr. Cardon. In fact, the ALJ appeared to accept Dr. Cardon's opinion, as she relied on Dr. Cardon's notes on Plaintiff's mild and resolved physical symptoms to contradict the opinions of Dr. Shen and Dr. McCune.

Plaintiff argues that the ALJ erred by not giving weight to two documents in the record: (1) a "Psycho-Educational Assessment" from the school psychologist at Plaintiff's high school, dated January 1994, and (2) an individualized education plan ("IEP") dated May 1996. A.R. 275-292. Plaintiff contends that these documents show that Plaintiff has had numerous mental problems during her younger years—for example, depression, isolation, poor social skills, and difficulty coping with changes—many of which continued into adulthood without evidence of improvement.

The educational assessment states that Plaintiff "is being assessed at the request of her parent, Ms. Strasser, to determine her eligibility for special education services." A.R. 275. The assessment describes Plaintiff as "a troubled adolescent who is clearly conduct disordered," and describes her problems with truancy, recreational drug usage, and other risk-taking behavior. A.R. 282-283. The assessment notes that Plaintiff refused to complete several tests administered by the psychologist and "exhibited a tendency to be provocative." A.R. 281. While Plaintiff "present[ed] herself as a young adolescent with clear anti-social tendencies . . . clearly more interested in immediate gratification and 'partying' with her peer group," she "exhibited no signs of poor reality testing or thought disorder" and the psychologist found it "impossible to state whether [Plaintiff] is indeed depressed." A.R. 281-282. Instead of admitting Plaintiff to the school's special education program, the psychologist recommended a "program designed to work with adolescents who have engaged in extensive and varied recreational drug use," therapy, adult supervision at home, and possibly a vocational based educational program. A.R. 283.

The IEP contains a listing of Plaintiff's strengths and weakness in cognition, social/emotional/adaptive behavior, physical/motor condition, educational performance, and social skills. A.R. 287-289. The document notes that Plaintiff "has a variety of supportive people in her life," is "friendly and fun to be with," "has the ability to be insightful," has a "good sense of humor" and a "large vocabulary," is "very personable and charming, creative, intuitive . . . [and] able to bounce back from incidents of anger and frustration and move on," and is "capable of exceptional work." A.R. 287-288. It also notes that Plaintiff "reacts impulsively when frustrated and depressed," has "low self-esteem," has depression but denies it and lacks "willingness to desire to take medication for depression," has "'roller coaster' mood swings," has "poor social skills, and

"few positive peer relationships," and could be "gamey and manipulative in stressful situations." A.R. 287-288. The IEP also notes that Plaintiff had completed her GED, was applying for college, and held two jobs. A.R. 288.

Plaintiff argues that the ALJ did not comply with 20 C.F.R. 416.920a(c), which states that the agency will consider "all relevant evidence to obtain a longitudinal picture" of Plaintiff's alleged mental impairments. Although the ALJ did not specifically discuss either the educational assessment or the IEP, the ALJ noted that she had considered the entire record, A.R. 22, including Plaintiff's report to the consultative examining psychologist that she had "a history of mental impairment since childhood with at least 20 involuntary psychiatric holds due to suicidal ideations." A.R. 26. In any event, even if the ALJ erred in not considering the educational assessment and IEP, such error was harmless because neither document supports a finding of disability. The documents do not suggest that Plaintiff was "unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." 42 U.S.C. § 1382c(a)(3)(A). Her educational documents paint a picture of a troubled teenager but offer few conclusions and details about any mental impairment. Plaintiff engaged in substantial gainful activity for some years following high school. Given Plaintiff's sparse adult medical records, the ALJ was not required to make inferential leaps to conclude that Plaintiff suffered from early mental impairments that persisted into adulthood and became disabling.

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C. Plaintiff's RFC

At Step 3 of the five-step sequential evaluation process,[6] the ALJ found that Plaintiff had mild restriction in activities of daily living. A.R. 23. The ALJ made this conclusion based on Plaintiff's "admissions that she is able to walk her pet (when she feels ok), perform limited housework, and prepare simple meals." A.R. 23. The ALJ noted that her assessment of Plaintiff's limitations in activities of daily living was consistent with an April 2009 function report by James Avant, Plaintiff's roommate, A.R. 189-202, and was also supported by Dr. Chen's evaluation, during which Plaintiff "stated that she was able to do some housework, buy groceries, do laundry, watch television, and use a computer." A.R. 23.

Plaintiff does not dispute that the ALJ accurately described Plaintiff's admissions, Mr. Avant's function report, and Dr. Chen's evaluation. Nor does Plaintiff challenge the ALJ's determination at Step 3 that Plaintiff's activities of daily living are only mildly restricted, and that Plaintiff does not have an impairment or combination of impairments that meets or equals one of the Listings.

Instead, Plaintiff argues that the ALJ erred in determining Plaintiff's RFC, specifically by failing "to articulate which of the aforementioned activities could actually be translated into substantial gainful activity or is inconsistent with Plaintiff's disability claim." Mot. Summ. J. at 8. Plaintiff cites *Fair v. Bowen* in support of this argument, for the proposition that "[t]he Social Security Act does not require that claimants be utterly incapacitated to be eligible for benefits, and many home activities are not easily transferable to what may be the more grueling environment of

[6] At Step 3, the ALJ must determine whether Plaintiff has an impairment or combination of impairments that meets or equals one of the Listings. In order to make that determination, an ALJ must consider whether Plaintiff has demonstrated that she meets at least two of the four so-called "paragraph B criteria": (1) marked restriction of activities of daily living; (2) marked difficulties in maintaining social functioning; (3) marked difficulties in maintaining concentration, persistence, or pace; or (4) repeated episodes of decompensation. 20 C.F.R. Pt. 404, Subpt. P, App. 1, § 12.06; *see also* 20 C.F.R. § 1520a; 20 C.F.R. § 416.920(a)(4)(iii). As the ALJ noted, the limitations identified at this step in the sequential evaluation process "are not a residual functional capacity assessment." A.R. 23. Rather, "the mental residual functional capacity assessment used at steps 4 and 5 of the sequential evaluation process required a more detailed assessment by itemizing various functions contained in the broad categories found in paragraph B." A.R. 23.

the workplace, where it might be impossible to periodically rest or take medication." 885 F.2d 597, 603 (9th Cir. 1989).

Plaintiff's citation takes the Ninth Circuit's holding out of context. The *Fair* court was considering "what sorts of specific findings would be sufficient to discredit . . . [a claimant's] allegation of pain," and found that an ALJ could rely on evidence of the claimant's daily activities. *Id.* ("[I]f a claimant is able to spend a substantial part of his day engaged in pursuits involving the performance of physical functions that *are* transferable to a work setting, a specific finding as to this fact may be sufficient to discredit an allegation of disabling excess pain."). In reaching this conclusion, the Ninth Circuit stated that "[t]his line of reasoning clearly has its limits." *Id.* It was in this context that the Ninth Circuit noted that simply because a claimant could conduct some activities of daily living did not mean that she could not also be disabled (i.e., a claimant need not be "utterly incapacitated to be eligible for benefits"). *Id.*

This court agrees that a claimant need not be utterly incapacitated to be eligible for benefits. Plaintiff's argument nonetheless fails because substantial evidence supports the ALJ's determination that Plaintiff's functional capacity was at a level that did not render her disabled. At Step 4, the ALJ found that Plaintiff's RFC included the ability to "lift and carry 20 pounds occasionally and 10 pounds frequently, sit 6 hours in an 8-hour workday, stand and walk about 6 hours in an 8-hour workday, and perform simple repetitive tasks," and also found that Plaintiff could "maintain occasional contact with the public and coworkers and make simple work-related decisions with few workplace changes." A.R. 24. The ALJ noted that this RFC assessment "reflects the degree of limitation the undersigned has found in the 'paragraph B' mental function analysis." A.R. 23. In making this determination about Plaintiff's RFC, the ALJ "considered all symptoms and the extent to which these symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence . . . ." A.R. 24. The ALJ gave weight to the opinions of Drs. Chen and Morse, and gave little weight to the opinions of Drs. Levine, Shen, and McCune, which was appropriate for the reasons discussed above. The ALJ's assessment of Plaintiff's RFC is supported by substantial evidence and consistent with the record as a whole, including the elements of the record that demonstrate Plaintiff's mild restrictions in her activities of daily living. A.R. 23-27.

The court therefore finds that the ALJ did not err in assessing Plaintiff's RFC or by failing to articulate which of Plaintiff's activities of daily living "could actually be translated into substantial gainful activity or is inconsistent with Plaintiff's disability claim."

D. Plaintiff's Exertional Limitations

Plaintiff contends that the ALJ erred by failing to include all of Plaintiff's non-exertional limitations in the hypotheticals to VE Brodzinsky. Specifically, Plaintiff argues that the ALJ failed to give weight to the non-exertional limitations endorsed by Dr. Levine, and erred by giving weight to the functional capacity assessment of Dr. Morse. Plaintiff's argument amounts to a restatement of her contention that the ALJ improperly weighed the opinions of Dr. Levine and Dr. Morse in her determination of Plaintiff's RFC. For the reasons stated above, the court finds that the ALJ did not err in weighing the opinions of Dr. Levine and Dr. Morse when determining Plaintiff's RFC, and therefore also did not err in presenting hypotheticals that tracked the limitations in that RFC to VE Brodzinsky. *See Stubbs-Danielson v. Astrue*, 539 F.3d 1169, 1175-76 (9th Cir. 2008) ("In arguing theALJ's hypothetical was incomplete, [the claimant] simply restates her argument that the ALJ's RFC finding did not account for all her limitations because the ALJ improperly discounted her testimony and the testimony of medical experts. As discussed above, we conclude the ALJ did not.").

VIII. Conclusion

Based on the foregoing reasons, the court finds that the ALJ's decision that Plaintiff was not disabled was supported by substantial evidence in the record and in accordance with law. Accordingly, the court grants Defendant's motion for summary judgment and denies Plaintiff's motion for summary judgment.

IT IS SO ORDERED.

Dated: February 5, 2014

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
IT IS SO ORDERED

DONNA M. RYU
United States Magistrate Judge