IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

MELISSA H.,[1]

Plaintiff,

v.

COMMISSIONER, SOCIAL SECURITY ADMINISTRATION,

Defendant.

No. 1:19-cv-01412-HZ

OPINION & ORDER

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[1] In the interest of privacy, this Opinion uses only the first name and the initial of the last name of the non-governmental party or parties in this case.

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HERNÁNDEZ, District Judge:

Plaintiff Melissa H. brings this action seeking judicial review of the Commissioner's final decision to deny disability insurance benefits ("DIB") under Title II of the Social Security Act. This Court has jurisdiction pursuant to 42 U.S.C. § 405(g). For the reasons below, the Court reverses the Commissioner's decision and remands this case for further administrative proceedings.

PROCEDURAL BACKGROUND

Plaintiff applied for DIB on July 7, 2016, alleging an onset date of February 4, 2015. Tr. 60.[2] Plaintiff's date last insured date is March 31, 2017. Tr. 60. Her application was denied initially and on reconsideration. Tr. 74–78.

On August 20, 2018, Plaintiff appeared with counsel for a hearing before an Administrative Law Judge ("ALJ"). Tr. 32. On September 25, 2018, the ALJ found Plaintiff not disabled. Tr. 25. The Appeals Council denied review. Tr. 1.

FACTUAL BACKGROUND

Plaintiff alleges disability due to panic disorder, anxiety disorder, and attention deficit hyperactivity disorder ("ADHD"). Tr. 167. At the time of her alleged onset date, she was twenty-seven years old. Tr. 62. She has a limited education and no past relevant work experience. Tr. 24.

[2] Citations to "Tr." refer to the page(s) indicated in the official transcript of the administrative record, filed herein as Docket No. 7.

SEQUENTIAL DISABILITY EVALUATION

A claimant is disabled if they are unable to "engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which . . . has lasted or can be expected to last for a continuous period of not less than 12 months[.]" 42 U.S.C. §§ 423(d)(1)(A), 1382c(a)(3)(A). Disability claims are evaluated according to a five-step procedure. *See Valentine v. Comm'r*, 574 F.3d 685, 689 (9th Cir. 2009) (in social security cases, agency uses five-step procedure to determine disability). The claimant bears the ultimate burden of proving disability. *Id.*

In the first step, the Commissioner determines whether a claimant is engaged in "substantial gainful activity." If so, the claimant is not disabled. *Bowen v. Yuckert*, 482 U.S. 137, 140 (1987); 20 C.F.R. §§ 404.1520(b), 416.920(b). In step two, the Commissioner determines whether the claimant has a "medically severe impairment or combination of impairments." *Yuckert*, 482 U.S. at 140–41; 20 C.F.R. §§ 404.1520(c), 416.920(c). If not, the claimant is not disabled. *Id.*

In step three, the Commissioner determines whether the claimant's impairments, singly or in combination, meet or equal "one of a number of listed impairments that the [Commissioner] acknowledges are so severe as to preclude substantial gainful activity." *Yuckert*, 482 U.S. at 141; 20 C.F.R. §§ 404.1520(d), 416.920(d). If so, the claimant is conclusively presumed disabled; if not, the Commissioner proceeds to step four. *Yuckert*, 482 U.S. at 141.

In step four, the Commissioner determines whether the claimant, despite any impairment(s), has the residual functional capacity (RFC) to perform their "past relevant work." 20 C.F.R. §§ 404.1520(e), 416.920(e). If the claimant can perform past relevant work, the claimant is not disabled. If the claimant cannot perform past relevant work, the burden shifts to

the Commissioner. In step five, the Commissioner must establish that the claimant can perform other work. *Yuckert*, 482 U.S. at 141–42; 20 C.F.R. §§ 404.1520(e)–(f), 416.920(e)–(f). If the Commissioner meets his burden and proves that the claimant can perform other work that exists in the national economy, then the claimant is not disabled. 20 C.F.R. §§ 404.1566, 416.966.

THE ALJ'S DECISION

At step one, the ALJ determined that Plaintiff had not engaged in substantial gainful activity after her alleged onset date through her date last insured. Tr. 17. Next, at steps two and three, the ALJ determined that Plaintiff has the following severe impairments: "generalized anxiety disorder, panic disorder, and attention deficit hyperactivity disorder (ADHD)." Tr. 17. However, the ALJ determined that Plaintiff's impairments did not meet or medically equal the severity of a listed impairment. Tr. 18. At step four, the ALJ concluded that Plaintiff has the RFC to perform a full range of work at all exertional levels. Tr. 20. At step five, the ALJ found that there are jobs that exist in significant numbers in the national economy that Plaintiff can perform, such as "Kitchen helper[,] Meat clerk[,] and Addresser." Tr. 25. Thus, the ALJ concluded that Plaintiff is not disabled. Tr. 25.

STANDARD OF REVIEW

A court may set aside the Commissioner's denial of benefits only when the Commissioner's findings "are based on legal error or are not supported by substantial evidence in the record as a whole." *Vasquez v. Astrue*, 572 F.3d 586, 591 (9th Cir. 2009) (internal quotation marks omitted). "Substantial evidence means more than a mere scintilla but less than a preponderance; it is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Id.* (internal quotation marks omitted). The court considers the record as a whole, including both the evidence that supports and detracts from the Commissioner's decision.

Id.; *Lingenfelter v. Astrue*, 504 F.3d 1028, 1035 (9th Cir. 2007). "Where the evidence is susceptible to more than one rational interpretation, the ALJ's decision must be affirmed." *Vasquez*, 572 F.3d at 591 (internal quotation marks and brackets omitted); *see also Massachi v. Astrue*, 486 F.3d 1149, 1152 (9th Cir. 2007) ("Where the evidence as a whole can support either a grant or a denial, [the court] may not substitute [its] judgment for the ALJ's") (internal quotation marks omitted).

DISCUSSION

Plaintiff argues the ALJ erred in two ways. First, Plaintiff argues the ALJ erred by improperly considering medical evidence from Plaintiff's date last insured ("DLI"), March 31, 2017. Pl. Op. Br. 9, ECF 8. Second, Plaintiff argues the ALJ erred by giving partial weight to the medical opinion of her treating physician, Alden B. Glidden, M.D. *Id.* at 12. Because Plaintiff's objections to the ALJ's decision relate to conditions that developed just before and after Plaintiff's DLI, a preliminary discussion of the facts surrounding these conditions is warranted.

On January 31, 2017, Plaintiff saw Dr. Glidden for an ankle injury that resulted from a fall ten days prior. Tr. 332. In addition to symptoms related to Plaintiff's fall, she also expressed worry over her "tight and tense" abdomen and pain in her lower back. Tr. 333–34. On March 27, 2017, Plaintiff went to the emergency room reporting chronic full-body and epigastric pain that worsened with movement and "never goes away." Tr. 335. An ultrasound revealed cholelithiasis, and her labs revealed an obstructive pattern of the liver. Tr. 340–41. The next day, Plaintiff had a follow-up appointment with Dr. Glidden, in which he diagnosed Plaintiff with calculus of the gallbladder with acute cholecystitis. Tr. 351. Plaintiff underwent a laparoscopic cholecystectomy on March 29, 2017. Tr. 385.

Following her laparoscopic cholecystectomy surgery, Plaintiff experienced acute respiratory failure and septic shock and was transferred from Sky Lakes Medical to Legacy Emanuel Medical Center ("LEMC") in order to begin ECMO. Tr. 354–55, 510, 563. When she arrived at LEMC on March 31, 2017, Plaintiff had, among other liver and kidney conditions, septic shock, severe adult respiratory distress syndrome, and coagulopathy. Tr. 353. Stanton Smith, M.D., suspected Plaintiff's condition was "a progression of the patient's initial disease process on admission[,]" and that "she has been brewing a progressive liver disease [that] may be affecting metabolism of other drugs leading to her current situation." Tr. 446. Her "prognosis [was] guarded" at that time. Tr. 446.

Plaintiff also experienced an "arterial insufficiency of her right lower extremity" following her laparoscopic cholecystectomy surgery, respiratory distress, and ECMO. Tr. 502; *see also* tr. 503 (hypercoagulable state related to critical illness, ECMO cannulation and immobility). Sometime in the afternoon of March 31, 2017, a doppler exam revealed an absence of doppler signals in Plaintiff's right ankle. Tr. 557–58. On April 1, 2017, Marcos Barnatan, M.D., performed another doppler exam and noted, "[d]oppler signals remain absent in the foot, suggesting distal microembolization to the foot vessels[.]" Tr. 559. Dr. Barnatan diagnosed Plaintiff with right leg ischemia, and Plaintiff received an embolectomy and four compartment fasciotomy that day. Tr. 557.

On April 13, 2017, Dr. Barnatan amputated Plaintiff's right foot. Tr. 547 (describing amputation procedure). Following her right below the knee amputation ("BKA"), Plaintiff received psychological support while in the hospital to better manage her physical illness and activities of daily living. Tr. 567. Plaintiff was taken off ECMO three days after her amputation.

Tr. 530. She was discharged from the hospital just over two months after her illness began, on June 7, 2017. Tr. 500.

On July 19, 2017, Plaintiff reported ongoing pain from the stump of her right BKA to Dr. Glidden. Tr. 1444. Dr. Glidden noted that her BKA prevented her from ambulating effectively and that she was confined to a wheelchair full-time, but that the amputation was otherwise healing nicely. Tr. 1445. Plaintiff expressed a desire to learn to function with a prosthesis so that she could fully participate in activities with her child. Tr. 1445.

On October 4, 2017, Plaintiff returned to Dr. Glidden, reporting pain from wearing her prosthetic leg and that she was only able to wear it once a day after taking pain medication. Tr. 1451. She further stated that she recently developed a cold that was causing her increased shortness of breath, coughing, vomiting, and diarrhea. Tr. 1451. Dr. Glidden diagnosed Plaintiff with pneumonia. Tr. 1452.

Three days later, Plaintiff was admitted to the ICU with worsening symptoms. Tr. 1177, 1454. Lindsey Burwell, M.D., diagnosed Plaintiff with pneumonia, acute respiratory failure with hypoxia, sepsis, and chronic pain syndrome. Tr. 1176. Dr. Burwell suspected that her sepsis was likely the result of a "superinfection of bacteria." Tr. 1177. Plaintiff also tested positive for C. difficile enteritis, and Dr. Burwell noted that Plaintiff "has a history of C. diff. with her prior prolonged hospitalization." Tr. 1178. Plaintiff was discharged five days later and placed on antibiotics and a tapering course of prednisone. Tr. 1176–77.

I. Consideration of Medical Evidence at Step Two

Plaintiff argues the ALJ improperly considered medical evidence from Plaintiff's DLI in making his step-two finding. Pl. Op. Br. 9. At step two of the five-step evaluation, the Commissioner determines whether the claimant has a "medically severe impairment or

combination of impairments." *Yuckert*, 482 U.S. at 140–41. A severe impairment is one which significantly limits the claimant's physical or mental ability to do basic work activities. 20 C.F.R. §§ 404.1520(c), 416.920(c). "Basic work activities" are the "abilities and aptitudes necessary to do most jobs," including physical functions such as walking, standing, sitting, and lifting, and mental functions such as understanding, carrying out, and remembering simple instructions. 20 C.F.R. §§ 404.1522(b), 416.922(b). Pursuant to Social Security Ruling ("SSR") 85–28 (available at 1985 WL 56856, at *3), an impairment "is not severe" if it has "no more than a minimal effect on [an individual's] physical or mental ability(ies) to do basic work activities."

To obtain disability benefits, a claimant must demonstrate that the severe impairment(s) existed prior to the claimant's DLI. The claimant bears the burden of proof and must prove that she was "either permanently disabled or subject to a condition which became so severe as to disable [the claimant] prior to the date upon which [the claimant's] disability insured status expire[d]." *Anderson ex rel. Anderson v. Apfel*, No. CIV. 98-1405-HA, 2000 WL 913666, at *4 (D. Or. Mar. 25, 2000) (quoting *Johnson v. Shalala*, 60 F.3d 1428, 1432 (9th Cir. 1995)). The significant date for disability determination is the date of onset of the disability, rather than the date of diagnosis. *Morgan v. Sullivan*, 945 F.2d 1079, 1080–81 (9th Cir. 1991). For disabilities of traumatic origin, "onset is the day of the injury if the individual is thereafter expected to die as a result or is expected to be unable to engage in substantial gainful activity . . . for a continuous period of at least 12 months." SSR 83–20 (available at 1983 WL 31249, at *2).[3] When determining the onset of a nontraumatic disability, an ALJ must consider three factors: (1) the claimant's alleged onset date; (2) the date the impairment caused the claimant to stop working; and (3) medical evidence. *Id.*; *Morgan*, 945 F.2d at 1082. Where a case involves a progressing

[3] SSR 83-20 was rescinded and replaced by SSR 18-1p and 18-2p on October 2, 2018.

impairment, determining the proper onset date may be difficult. *Anderson ex rel. Anderson,* 2000 WL 913666 at *5. Accordingly, the ALJ must "infer the onset date from the medical and other evidence that describe the history and symptomatology of the disease process." *Id.*

Generally, "[a]ny deterioration in [Plaintiff's] condition subsequent to [the DLI] is . . . irrelevant [to the ALJ's decision]." *Waters v. Gardner*, 452 F.2d 855, 858 (9th Cir. 1971). But evidence such as "retrospective diagnoses by treating physicians and medical experts, contemporaneous medical records, and testimony from family, friends, and neighbors are all relevant to the determination of a continuously existing disability with onset prior to the expiration of insured status." *Flaten v. Sec'y of Health & Hum. Services*, 44 F.3d 1453, 1461 n.5 (9th Cir. 1995). In seeking to establish a continuously existing disability, "two separate disability causes ordinarily cannot be tacked to equal 12 months." *Ratto v. Sec'y*, 839 F. Supp. 1415, 1427 (D. Or. 1993) (citing former 20 C.F.R. § 404.1522(a)); *but see Smolen*, 80 F.3d at 1284 (declining to resolve the question of whether a claimant can tack unrelated impairments to meet the duration and onset requirement but noting that SSR 82–52 allows tacking for re-entitlement purposes). However, "a different rule applies where the first disability is related to the second." *Ratto*, 839 F. Supp. at 1427 (citing *Lichter v. Bowen*, 814 F.2d 430, 436 (7th Cir. 1987)) ("Where an emerging mental impairment overlaps in time with a triggering but diminishing physical impairment, the combined effect of the impairments should be considered to the extent it might bear on the onset date of disability.").

Here, the ALJ found that Plaintiff's generalized anxiety disorder, panic disorder, and ADHD constituted severe impairments, whereas her physical impairments did not. Tr. 18. The ALJ acknowledged that Plaintiff was treated for sepsis and arterial insufficiency of her right lower extremity, ultimately resulting in a BKA. Tr. 18. But the ALJ rejected counsel's argument

that "the overall medical condition that eventually led to this result occurred on March 31, 2017, such that it was established prior to the expiration of the claimant's insured status." Tr. 18. Instead, the ALJ found, without elaboration, that "the evidence does not establish a reasonable inference of onset prior to the claimant's date last insured." Tr. 18.

The Court finds that the ALJ erred at step two of his analysis when he concluded that Plaintiff did not have a medically determinable physical impairment prior to her DLI. The record shows that as of Plaintiff's DLI, Plaintiff had been diagnosed with, among other conditions, severe sepsis, acute respiratory failure, and arterial insufficiency. Tr. 353, 557–58. These impairments had more than a minimal effect on Plaintiff's ability to perform basic work activities. *See, e.g.*, *John J. v. Comm'r of Soc. Sec.*, 2020 WL 525968, *2–3 (W.D. Wash. Feb. 3, 2020) ("[i]t is difficult to read the ALJ's description of Plaintiff's [septic shock, acute renal failure, septic right knee, large right atrial thrombus, and pneumonia] and imagine that Plaintiff's impairments did not seriously affect his ability to function in a workplace."). And, contrary to the ALJ's conclusion, the record supports an inference of a relationship between these conditions and Plaintiff's BKA, suggesting the onset of a severe impairment lasting or expecting to last twelve months prior to her DLI. *See, e.g.*, tr. 1348 ("The patient had a below the knee amputation as a consequence of her episode of respiratory failure [during her surgery.]"). In addition, the ALJ did not address SSR 83–20 or whether Plaintiff's physical conditions were traumatic or nontraumatic in determining the onset date. *See, e.g.*, *Lichter v. Bowen,* 814 F.2d 430, 436 (7th Cir. 1987) (remanding to the ALJ to consider SSR 83–20 in determining the onset date of the claimant's disability where there was medical evidence that the claimant's worsening mental impairment was directly related to his earlier automobile accident); *Burrell v. Astrue*, No. 11-0141-N, 2012 WL 3817788, *5 (S. D. Ala. Aug. 31, 2012) (citing *Ratto* and finding claimant's

plantar fibromatosis, the two surgeries for that condition, and resulting foot pain from the surgeries constituted a single impairment for purposes of 12-month duration requirement).

The ALJ's error at step two was not harmless. *See Stout v. Comm'r, Soc. Sec. Admin.*, 454 F.3d 1050, 1054 (9th Cir. 2006) ("We recognize harmless error applies in the Social Security context."). If the ALJ identifies at least one severe impairment at step two, the ALJ must consider all of the claimant's limitations at subsequent steps of his evaluation, regardless of whether they are severe or non-severe. *Howard ex. rel Wolff v. Barnhart*, 341 F.3d 1006, 1012 (9th Cir. 2003) (citing 20 C.F.R. § 416.923); *Lewis v. Astrue*, 498 F.3d 909, 911 (9th Cir. 2007). In formulating his RFC at step four, the ALJ failed to discuss any of Plaintiff's limitations stemming from her right BKA and the conditions that led to Plaintiff's hospitalization. The ALJ also failed to consider whether any of these impairments satisfied a listed impairment at step three, presumptively establishing disability. In sum, the ALJ erred in his consideration of medical evidence at step two of his analysis, and this error was not harmless.

II. Medical Opinion from Dr. Glidden

Plaintiff argues the ALJ improperly assigned partial weight to the medical opinion of Plaintiff's treating physician, Dr. Glidden. Pl. Op. Br. 12. Social security law recognizes three types of physicians: (1) treating, (2) examining, and (3) non-examining. *Garrison v. Colvin*, 759 F.3d 995, 1012 (9th Cir. 2014). Generally, more weight is given to the opinion of a treating physician than to the opinion of those who do not treat the claimant. *Id.*; 20 C.F.R. §§ 404.1527(c)(1)–(2), 416.927(c)(1)–(2). More weight is also given to an examining physician than to a non-examining physician. *Garrison*, 759 F.3d at 1012. If a treating physician's medical opinion is supported by medically acceptable diagnostic techniques and is not inconsistent with other substantial evidence in the record, the treating physician's opinion is

given controlling weight. *Ghanim v. Colvin*, 763 F.3d 1154, 1160 (9th Cir. 2014); *Orn v. Astrue*, 495 F.3d 625, 631 (9th Cir. 2007). If the treating physician's opinion is not contradicted by another doctor, the ALJ may reject it only for "clear and convincing" reasons supported by substantial evidence in the record. *Ghanim*, 763 F.3d at 1160–61. Even if the treating physician's opinion is contradicted by another doctor, the ALJ may not reject the treating physician's opinion without providing "specific and legitimate reasons" which are supported by substantial evidence in the record. *Id.* at 1161; *Bayliss*, 427 F.3d at 1216.

On April 11, 2018, Dr. Glidden completed two questionnaires evaluating Plaintiff's physical and mental abilities and resulting limitations. Tr. 1489, 1494. In his treating source statement, Dr. Glidden stated he had been treating Plaintiff monthly for five years. Tr. 1489. Dr. Glidden diagnosed Plaintiff with panic disorder, agoraphobia, a history of renal failure and hepatic failure, and right BKA. Tr. 1489. Of these conditions, Dr. Glidden specified that he expected Plaintiff's panic disorder, agoraphobia, and right BKA to last at least twelve months. Tr. 1489. Listed symptoms of Plaintiff's conditions include "[right] stump pain" and an inability to "go out in public places[.]" Tr. 1490. As part of Plaintiff's treatment, Dr. Glidden prescribed her Trazodone, Oxycodone, Celexa, and Gabapentin. Tr. 1491. Dr. Glidden stated that Plaintiff would need a job which permits shifting positions at will from sitting, standing, or walking, and she cannot stand or walk for more than ten minutes at a time or three hours total in an eight-hour workday. Tr. 1491. She cannot walk a single city block without rest or pain. Tr. 1491. Dr. Glidden opined that Plaintiff could occasionally lift no more than 20 lbs. Tr. 1492. He also specified that Plaintiff's medical conditions would cause her to miss work more than four days per month. Tr. 1493.

In his medical source statement evaluating Plaintiff's mental capabilities, Dr. Glidden stated that Plaintiff's ability to understand, remember, and carry out instructions was not affected by her impairment "in a restricted environment." Tr. 1495. Dr. Glidden indicated that Plaintiff's ability to interact appropriately with supervisors, co-workers, and the public, as well as respond to changes in the routine setting was "extreme[ly]" affected by her agoraphobia. Tr. 1495. He also noted that Plaintiff is "unable to go out of the home except for medical visits" and that her "[h]usband does all of the shopping." Tr. 1496. Dr. Glidden estimated that Plaintiff began experiencing symptoms of her mental health conditions five years before his evaluation. Tr. 1496.

The ALJ assigned Dr. Glidden's treating source statement partial weight. Tr. 24. The ALJ found Dr. Glidden's opinion of Plaintiff's physical functioning was well supported by the record, but he nevertheless concluded that it was only supported after May 15, 2017, after Plaintiff's DLI.[4] Tr. 24. The ALJ gave partial weight to Dr. Glidden's opinion of Plaintiff's mental functioning because he "is a family practitioner and has no specialized qualifications for assessing psychiatric illness." Tr. 24. He also noted "[Dr. Glidden] had not conducted any psychiatric tests" to support his assessment of Plaintiff's RFC. Tr. 24.

The ALJ erred in assigning partial weight to Dr. Glidden's opinion of Plaintiff's mental functioning. Dr. Glidden diagnosed and treated Plaintiff's mental conditions with psychotherapeutic drugs during the relevant period, and he was qualified to do so as Plaintiff's primary care provider. Tr. 1491; *see Sprague v. Bowen*, 812 F.2d 1226, 1232 (9th Cir. 1987) (finding general practitioners are qualified to provide mental health opinions and that

[4] The ALJ incorrectly states throughout his decision that Plaintiff's amputation occurred on May 15, 2017. The correct date is April 13, 2017. Tr. 547.

prescription of psychotherapeutic drugs by general practitioners is medically acceptable evidence).

The ALJ also erred by not considering Dr. Glidden's medical opinion as it relates to the days before and on Plaintiff's DLI. As stated above, "later objective medical evidence of disability may provide evidence to support a finding of disability before the date last insured." *Simpson v. Colvin*, No. 3:13-cv-00584-SI, 2014 WL 5791566, at *5 (D. Or. Nov. 6, 2014). While Dr. Glidden completed his medical evaluation for Plaintiff approximately one year after her DLI, he listed conditions that were diagnosed before and on Plaintiff's DLI, including Plaintiff's history of renal failure and hepatic failure. Tr. 1489. Along with the in-office care he provided to Plaintiff, Dr. Glidden was regularly in contact with other doctors treating Plaintiff throughout the relevant period, including on Plaintiff's DLI when Plaintiff was hospitalized for the conditions that lead to her BKA. *See, e.g.*, tr. 473 (reporting that Dr. Glidden had multiple updates as to Plaintiff's condition). Thus, Dr. Glidden was familiar with Plaintiff's conditions during the relevant period, and the ALJ erred in not considering his medical opinion about Plaintiff's physical functioning on and preceding her DLI.

III. Remand for Benefits/Further Proceedings

The decision whether to remand for further proceedings or for immediate payment of benefits is within the Court's discretion. *Harman v. Apfel*, 211 F.3d 1172, 1178 (9th Cir. 2000). To determine which type of remand is appropriate, the Ninth Circuit uses a three-part test. *Garrison v. Colvin*, 759 F.3d 995, 1020 (9th Cir. 2014); *see also Treichler v. Comm'r*, 775 F.3d 1090, 1100 (9th Cir. 2014) ("credit-as-true" rule has three steps). First, the ALJ must fail to provide legally sufficient reasons for rejecting evidence, whether claimant testimony or medical opinion. *Garrison*, 759 F.3d at 1020. Second, the record must be fully developed, and further

administrative proceedings would serve no useful purpose. *Id.* Third, if the case is remanded and the improperly discredited evidence is credited as true, the ALJ would be required to find the claimant disabled. *Id.* To remand for an award of benefits, each part must be satisfied. *Id.*; *see also Treichler*, 775 F.3d at 1101 (when all three elements are met, "a case raises the 'rare circumstances' that allow us to exercise our discretion to depart from the ordinary remand rule" of remanding to the agency). Even if those requirements have been met, the district court retains the flexibility to remand the case for further proceedings, particularly where the record as a whole creates serious doubts that the claimant is disabled. *Burrell v. Colvin*, 775 F.3d 1133, 1141 (9th Cir. 2014).

The Court finds that the ordinary remand rule is the proper course in this case. The ALJ failed to adequately address whether Plaintiff's physical impairments were related impairments and ascertain their onset date under the appliable social security rulings at step two of the sequential analysis. *See, e.g.*, *Lichter,* 814 F.2d at 436; *Ratto*, 839 F. Supp. at 1427. If there is ambiguity as to the relationship between and onset of Plaintiff's conditions, the ALJ should call on the expertise of a medical expert. *See Simpson*, 2014 WL 5791566, at *4 (citing *Armstrong v. Comm'r of Soc. Sec. Admin.*, 160 F.3d 587, 590 (9th Cir. 1998)) (The ALJ has a "responsibility, under [SSR] 83–20 and Ninth Circuit case law, to resolve an ambiguous onset date by calling on a medical expert."). Accordingly, the Court remands this case for further administrative proceedings.

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CONCLUSION

Based on the foregoing, the Commissioner's decision is REVERSED and REMANDED for administrative proceedings.

IT IS SO ORDERED.

DATED: April 26, 2021.

Marco Hernández

MARCO A. HERNÁNDEZ
United States District Judge