IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

ROBIN CAROL JEWELL-GREENE, Plaintiff, v. **NANCY A. BERRYHILL**, Commissioner of Social Security, Defendant.	Case No. 6:16-cv-250-SI **OPINION AND ORDER**

Katherine L. Eitenmiller and Mark A. Manning, HARDER, WELLS, BARON & MANNING, P.C., 474 Willamette Street, Suite 200, Eugene, OR 97401. Of Attorneys for Plaintiff.

Billy J. Williams, United States Attorney, and Janice E. Hébert, Assistant United States Attorney, UNITED STATES ATTORNEY'S OFFICE, District of Oregon, 1000 S.W. Third Avenue, Suite 600, Portland, OR 97204; Sarah L. Martin, Special Assistant United States Attorney, OFFICE OF GENERAL COUNSEL, Social Security Administration, 701 Fifth Avenue, Suite 2900 M/S 221A, Seattle, WA 98104. Of Attorneys for Defendant.

Michael H. Simon, District Judge.

Robin Jewell-Greene ("Plaintiff") seeks judicial review of the final decision of the Commissioner of the Social Security Administration ("Commissioner") denying her applications for Supplemental Security Income ("SSI") and Disability Insurance Benefits ("DIB"). For the

reasons discussed below, the Commissioner's decision is REVERSED and REMANDED for further proceedings.

STANDARD OF REVIEW

The district court must affirm the Commissioner's decision if it is based on the proper legal standards and the findings are supported by substantial evidence. 42 U.S.C. § 405(g); see also Hammock v. Bowen, 879 F.2d 498, 501 (9th Cir. 1989). "Substantial evidence" means "more than a mere scintilla but less than a preponderance." Bray v. Comm'r of Soc. Sec. Admin., 554 F.3d 1219, 1222 (9th Cir. 2009) (quoting Andrews v. Shalala, 53 F.3d 1035, 1039 (9th Cir. 1995)). It means "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Id. (quoting Andrews, 53 F.3d at 1039).

Where the evidence is susceptible to more than one rational interpretation, the Commissioner's conclusion must be upheld. Burch v. Barnhart, 400 F.3d 676, 679 (9th Cir. 2005). Variable interpretations of the evidence are insignificant if the Commissioner's interpretation is a rational reading of the record, and this Court may not substitute its judgment for that of the Commissioner. See Batson v. Comm'r of Soc. Sec. Admin., 359 F.3d 1190, 1193, 1196 (9th Cir. 2004). "[A] reviewing court must consider the entire record as a whole and may not affirm simply by isolating a specific quantum of supporting evidence." Orn v. Astrue, 495 F.3d 625, 630 (9th Cir. 2007) (quoting Robbins v. Soc. Sec. Admin., 466 F.3d 880, 882 (9th Cir. 2006) (quotation marks omitted)). A reviewing court, however, may not affirm the Commissioner on a ground upon which the Commissioner did not rely. Id.; see also Bray, 554 F.3d at 1226.

BACKGROUND

A. Plaintiff's Application

Plaintiff protectively filed applications for DIB and SSI on May 2, 2013, alleging disability beginning on January 2, 2013. AR 95, 105. She was born on March 23, 1964, and was 49 years old at the time she filed her application. AR 94, 104. She alleged disability due to migraine headaches, fibromyalgia, and chronic fatigue syndrome. AR 95, 105. The Commissioner denied her applications both initially and upon reconsideration; thereafter, she requested a hearing before an Administrative Law Judge ("ALJ"). AR 102, 112, 123, 134, 138, 142, 148, 151, 153. An administrative hearing was held on May 12, 2015. AR 24. On June 24, 2015, the ALJ issued a decision finding that Plaintiff was not disabled under the Social Security Act for both DIB and SSI. AR 24-34. On July 7, 2015, Plaintiff requested a review of the ALJ decision by the Appeals Council, and on December 18, 2015, the appeals council denied her request for review and the ALJ's decision became final. AR 6-10, 18-19. Plaintiff now seeks judicial review of that decision.

B. The Sequential Analysis

A claimant is disabled if he or she is 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). "Social Security Regulations set out a five-step sequential process for determining whether an applicant is disabled within the meaning of the Social Security Act." Keyser v. Comm'r Soc. Sec. Admin., 648 F.3d 721, 724 (9th Cir. 2011); see also 20 C.F.R. §§ 404.1520 (DIB), 416.920 (SSI); Bowen v. Yuckert, 482 U.S. 137, 140 (1987). Each step is potentially dispositive. 20 C.F.R. §§ 404.1520(a)(4), 416.920(a)(4). The five-step sequential process asks the following series of questions:

1. Is the claimant performing "substantial gainful activity?" 20 C.F.R. §§ 404.1520(a)(4)(i), 416.920(a)(4)(i). This activity is work involving significant mental or physical duties done or intended to be done for pay or profit. 20 C.F.R. §§ 404.1510, 416.910. If the claimant is performing such work, she is not disabled within the meaning of the Act. 20 C.F.R. §§ 404.1520(a)(4)(i), 416.920(a)(4)(i). If the claimant is not performing substantial gainful activity, the analysis proceeds to step two.

2. Is the claimant's impairment "severe" under the Commissioner's regulations? 20 C.F.R. §§ 404.1520(a)(4)(ii), 416.920(a)(4)(ii). An impairment or combination of impairments is "severe" if it significantly limits the claimant's physical or mental ability to do basic work activities. 20 C.F.R. §§ 404.1521(a), 416.921(a). Unless expected to result in death, this impairment must have lasted or be expected to last for a continuous period of at least 12 months. 20 C.F.R. §§ 404.1509, 416.909. If the claimant does not have a severe impairment, the analysis ends. 20 C.F.R. §§ 404.1520(a)(4)(ii), 416.920(a)(4)(ii). If the claimant has a severe impairment, the analysis proceeds to step three.

3. Does the claimant's severe impairment "meet or equal" one or more of the impairments listed in 20 C.F.R. Part 404, Subpart P, Appendix 1? If so, then the claimant is disabled. 20 C.F.R. §§ 404.1520(a)(4)(iii), 416.920(a)(4)(iii). If the impairment does not meet or equal one or more of the listed impairments, the analysis continues. At that point, the ALJ must evaluate medical and other relevant evidence to assess and determine the claimant's "residual functional capacity" ("RFC"). This is an assessment of work-related activities that the claimant may still perform on a regular and continuing basis, despite any limitations imposed by his or her impairments. 20 C.F.R. §§ 404.1520(e), 404.1545(b)-(c), 416.920(e), 416.945(b)-(c). After the ALJ determines the claimant's RFC, the analysis proceeds to step four.

4. Can the claimant perform his or her "past relevant work" with this RFC assessment? If so, then the claimant is not disabled. 20 C.F.R. §§ 404.1520(a)(4)(iv), 416.920(a)(4)(iv). If the claimant cannot perform his or her past relevant work, the analysis proceeds to step five.

5. Considering the claimant's RFC and age, education, and work experience, is the claimant able to make an adjustment to other work that exists in significant numbers in the national economy? If so, then the claimant is not disabled. 20 C.F.R. §§ 404.1520(a)(4)(v), 416.920(a)(4)(v), 404.1560(c), 416.960(c). If the claimant cannot perform such work, he or she is disabled. Id.

See also Bustamante v. Massanari, 262 F.3d 949, 954 (9th Cir. 2001).

The claimant bears the burden of proof at steps one through four. Id. at 953; see also Tackett v. Apfel, 180 F.3d 1094, 1098 (9th Cir. 1999); Yuckert, 482 U.S. at 140-41. The Commissioner bears the burden of proof at step five. Tackett, 180 F.3d at 1100. At step five, the Commissioner must show that the claimant can perform other work that exists in significant numbers in the national economy, "taking into consideration the claimant's residual functional capacity, age, education, and work experience." Id.; see also 20 C.F.R. §§ 404.1566, 416.966 (describing "work which exists in the national economy"). If the Commissioner fails to meet this burden, the claimant is disabled. 20 C.F.R. §§ 404.1520(a)(4)(v), 416.920(a)(4)(v). If, however, the Commissioner proves that the claimant is able to perform other work existing in significant numbers in the national economy, the claimant is not disabled. Bustamante, 262 F.3d at 953-54; Tackett, 180 F.3d at 1099.

C. The ALJ's Decision

The ALJ found that Plaintiff met the insured status requirements of the Social Security Act through December 31, 2015. AR 26. He noted that Plaintiff must establish disability on or before that date in order to be entitled to DIB.[1] AR 24. The ALJ then applied the sequential analysis. AR 25-34.

At step one, the ALJ found that Plaintiff had not engaged in substantial gainful activity since January 2, 2013, the alleged onset date. AR 26. At step two, the ALJ found that Plaintiff's migraine headaches, fibromyalgia, and chronic fatigue syndrome all constituted severe impairments, meaning that they more than minimally affected her ability to perform basic work activities. Id. The ALJ also noted that the medical evidence indicated a history of depression and

[1] SSI benefits are not based on insured status.

anxiety; however, pursuant to the disability regulations for evaluating mental disorders, the ALJ found these mental impairments to be non-severe. AR 27. The ALJ further found that there was no indication that Plaintiff's history of other various health issues resulted in any functional limitations and found those to be non-severe as well. AR 28.

At step three, the ALJ found that Plaintiff did not have an impairment or combination of impairments that met or equaled the severity of one of the listed impairments in 20 C.F.R. Part 404, Subpart P, Appendix 1. AR 28-29. The ALJ next assessed Plaintiff's RFC as capable of performing light work as defined in 20 C.F.R. § 404.1567(b) and § 416.967(b), and he concluded that Plaintiff could stand or walk for only two hours out of an eight-hour work-day and any time spent off-task could be accompanied by normal breaks. AR 30. At step four, based on that determination and the recommendation of the vocational expert ("VE"), the ALJ found that after Plaintiff's alleged onset date of disability she was still capable of performing past relevant work ("PRW") as a data entry clerk, a bookkeeper, or an office manager, as those positions were generally performed. AR 33-34. Accordingly, the ALJ did not make a step five finding and ruled that Plaintiff was not under a disability from the alleged onset date through the date of the ALJ's decision. AR 34.

DISCUSSION

Plaintiff seeks review of the determination that she was not disabled. She argues that the ALJ erred by: (1) failing to provide clear and convincing reasons supported by substantial evidence when discounting Plaintiff's symptom testimony; (2) discrediting the opinion of Dr. Jotham Lefford, her treating physician, and instead assigning greater weight to the reviewing state agency physicians; and (3) assessing a flawed RFC, erroneously concluding that she retained the ability to perform the requirements of her PRW.

A. Credibility and Symptom Testimony

1. Applicable Law

To determine whether a claimant's testimony regarding subjective pain or symptoms is credible, an ALJ must perform two stages of analysis. 20 C.F.R. §§ 404.1529, 416.929. The first stage is a threshold test in which the claimant must present objective medical evidence of an underlying impairment that could reasonably be expected to produce the symptoms alleged. Molina v. Astrue, 674 F.3d 1104, 1112 (9th Cir. 2012); Tommasetti v. Astrue, 533 F.3d 1035, 1039 (9th Cir. 2008). When doing so, the claimant "need not show that her impairment could reasonably be expected to cause the severity of the symptom she has alleged; she need only show that it could reasonably have caused some degree of the symptom." Lingenfelter v. Astrue, 504 F.3d 1028, 1036 (9th Cir. 2007) (citing Smolen v. Chater, 80 F.3d 1273, 1282 (9th Cir. 1996)).

At the second stage of the credibility analysis, absent affirmative evidence of malingering, the ALJ must provide clear and convincing reasons for discrediting the claimant's testimony regarding the severity of the symptoms. Id.; see also Brown-Hunter v. Colvin, 806 F.3d 487, 492-93 (9th Cir. 2015). It is "not sufficient for the ALJ to make only general findings; he must state which pain testimony is not credible and what evidence suggests the complaints are not credible." Dodrill v. Shalala, 12 F.3d 915, 918 (9th Cir. 1993). Finally, if the ALJ's credibility finding is specific, clear, and convincing, and supported by substantial evidence in the record, the court may not engage in second-guessing. See Thomas v. Barnhart, 278 F.3d 947, 959 (9th Cir. 2002); see also Kirkruff v. Berryhill, 2017 WL 1173910, at *2 (D. Or. March 28, 2017).

The ALJ's credibility decision may be upheld overall even if not all of the ALJ's reasons for rejecting the claimant's testimony are upheld. See Batson, 359 F.3d at 1197. The ALJ may not, however, make a negative credibility finding "solely because" the claimant's symptom

testimony "is not substantiated affirmatively by objective medical evidence." Robbins, 466 F.3d at 883.

2. Analysis

Plaintiff argues that the ALJ failed to provide clear and convincing reasons to support his adverse credibility determination as to Plaintiff's symptom testimony. The ALJ took issue with Plaintiff's allegations regarding the severity of her migraines, the severity of her fibromyalgia pain, as well as her overall credibility due to inconsistent statements and collecting unemployment benefits for a short period even after her alleged onset date of disability.

a. Migraine Allegations

In his decision, the ALJ first called into question Plaintiff's testimony regarding the severity of her migraines. The ALJ noted that Plaintiff was engaged in substantially gainful activity until 2006 despite receiving occasional emergency treatment for her migraines. The ALJ next asserted that during Plaintiff's alleged period of disability, she failed to seek migraine treatment for an extended period of time despite seeking treatment in that same period for other emergent medical issues. The ALJ concluded that the lack of similar treatment during that period discredited Plaintiff's claims that worsening migraines prevented her from working.

Plaintiff argues that although she has a history of suffering migraines while also maintaining employment, the record reflects that her migraines worsened in 2012, leading to the termination of her full-time work as a caregiver. This led to the loss of her health insurance, which she argues precluded her ability to afford further treatment. She argues the ALJ failed to weigh this consideration at all when making his findings. The Commissioner's brief cited cases asserting that a lack of treatment is powerful evidence and permits the inference that the symptoms were not as "all-disabling" as alleged. As further support, the Commissioner—as well as the ALJ in his decision—noted that Plaintiff sought treatment for other medical issues during

the same period in which she alleged she could not afford further treatment for her disabling symptoms. Plaintiff replies that the emergent issues for which she did seek treatment were not severe. Plaintiff also points to Dr. Morris's treatment recommendations in 2015 where he noted financial barriers to Plaintiff's useful treatment options.

The cases cited by the Commissioner are less persuasive in light of other Ninth Circuit precedent. A claimant's "failure to receive medical treatment during the period that he had no medical insurance cannot support an adverse credibility finding." Orn, 495 F.3d at 638. In Flaten v. Secretary of Health & Human Services, however, the Ninth Circuit allowed an ALJ to draw an adverse inference as to the claimant's symptom allegations where the claimant sought treatment for unrelated and non-disabling medical symptoms, despite alleging that she could not afford treatment for her disabling symptoms. 44 F.3d 1453, 1464 (9th Cir. 1995). The court in Flaten relied on another Ninth Circuit opinion, Fair v. Bowen, which held that an unexplained failure to seek treatment "can cast doubt on the sincerity of a claimant's pain testimony." 885 F.2d 597, 603 (9th Cir. 1989). The court in Fair, however, also noted that "there are any number of good reasons for not doing so." Id.

The Orn decision supports Plaintiff's position. Although Flaten permits a contrary inference, the facts of that case are distinguishable. Plaintiff's lack of treatment was not unreasonable, let alone "unexplained." In Flaten, the claimant went nearly ten years between back surgeries while seeking treatment only two times before a "recurrence" of back pain led to the second surgery. Here, Plaintiff lasted for much shorter periods of time without treatment for migraines, which the record suggests had worsened despite years of treatment. There is no

affirmative evidence to suggest Plaintiff's pain was subject to an extended period of dormancy followed by a recurrence of pain, as was the case in Flaten.[2]

As noted above, the ALJ asserted that Plaintiff only sought treatment for a contemporaneous migraine a single time—in May 2015—during the period at issue; however, the ALJ was mistaken. The record shows that Plaintiff sought emergency treatment for migraines in April 2015 as well. AR 495-99. Further, emergency treatment notes from September 2011 read:

> She states because of the migraine and the vomiting she has been unable to keep her pain medications down and therefore now feels that she is in narcotic withdrawal. She takes pain medications for fibromyalgia and her migraines. Robin actually contacted her dentist today and dentist decided that they could get her in. However, she decided her pain in her head was too severe and she needed to come to the emergency department instead.

AR 393. This is indicative of a contemporaneous migraine during the period at issue. Also of note, the ALJ referred to Plaintiff's August 2014 pain consultation only in the context her fibromyalgia pain. Although Plaintiff did not report a contemporaneous migraine, the first notes from that consultation report a "chief complaint of chronic headache pain." AR 423. Considering these instances, the ALJ's rationale on this point is not supported by substantial evidence in the record.

Further, contrary to the Commissioner's contentions, the limited treatment Plaintiff received during the time she did not have insurance was for significant issues. For example, as Plaintiff points out in her reply brief, her dental problem was, in fact, severe. It is not

[2] Even if the ALJ believed that Plaintiff's failure to seek treatment for short periods of time is evidence of brief improvement, "[c]ycles of improvement and debilitating symptoms are a common occurrence, and in such circumstances it is error for an ALJ to pick out a few isolated instances of improvement over a period of months or years and to treat them as a basis for concluding a claimant is capable of working." Garrison v. Colvin, 759 F.3d 995, 1017 (9th Cir. 2014) (citing Holohan v. Massanari, 246 F.3d 1195, 1205 (9th Cir. 2001)).

unreasonable that, even without insurance, Plaintiff would seek medical treatment for newly emergent significant health concerns before paying out-of-pocket to seek more aggressive treatment for a chronic illness that she had been treating for years without much success. Looking at the record as a whole, Plaintiff's lack of treatment during the period at issue is not a clear and convincing reason to discount her migraine symptom testimony.

The ALJ next noted that on an occasion when Plaintiff sought treatment for her migraines in 2015, she claimed that the migraines were worse as a result of being involved in a motor vehicle accident. The ALJ inferred from this that the worsened symptom was "non-representative" of her symptom severity overall. The Commissioner also argues that Plaintiff reported pain at inconsistent levels. In 2012, however, Plaintiff reported having several migraines a week—some lasting several days without subsiding—and her hearing testimony is consistent with that report. She testified that her migraines worsened toward the end of her work as a caregiver, in roughly 2012, which was the reason for ultimately being let go. Merely because Plaintiff experienced worsening migraines as a result of an accident in 2015 does not undermine the credibility of her allegations and testimony as to the increased severity of her migraines beginning in 2012.

b. Fibromyalgia Pain and Chronic Fatigue Allegations

The ALJ next found suspect Plaintiff's allegations regarding the severity of her pain associated with her fibromyalgia and chronic fatigue syndrome. The ALJ concluded that the medical treatment notes from 2013 and 2014 contradict Plaintiff's symptom allegations. First, the ALJ referenced a July 2013 medical appointment, the notes for which demonstrate that Plaintiff had non-tender extremities and a normal range of motion. Second, the ALJ referenced the pain management consultation with Dr. Morris in August 2014. At that appointment, Dr. Morris noted that Plaintiff's standing and walking were stable and functional and he assessed

good mobility in numerous areas of the body. The ALJ concluded from this that Plaintiff's pain did not affect her ability to ambulate and found further support in Plaintiff's report to Dr. Morris that Plaintiff was walking on a treadmill on a daily basis.

Plaintiff cites cases in her brief concluding that "the ALJ may not reject subjective symptom testimony . . . simply because there is no showing that the impairment can reasonably produce the degree of the symptom alleged." Lingenfelter, 504 F.3d at 1036 (emphasis removed) (citing Smolen, 80 F.3d at 1282). Nevertheless, the ALJ is permitted to reject symptom testimony by "offering specific, clear and convincing reasons for doing so." Brown-Hunter, 806 F.3d at 493.

Here, the inconsistencies raised by the ALJ—the doctors' impressions as to Plaintiff's mobility—are negligible. The ALJ infers from the medical notes that Plaintiff had some heightened level of mobility above what she claimed; however, the statements are conclusory and provide virtually no explanation. The medical notations reflecting non-tender extremities and normal range of motion from the July 2013 appointment were memorialized only by a single checked box. AR 401. Similarly, in the report from the August 2014 pain management consultation, Dr. Morris merely repeats, "range of motion shows mobility is good." AR 428. These conclusions are nondescript and are not further supported by any description, commentary or justification; thus, they are not substantial evidence in the record serving as clear and convincing reasons to discount Plaintiff's subjective testimony regarding her pain and fatigue. Additionally, as Plaintiff argues in her brief, her report that she was walking on a treadmill for exercise is entirely consistent with her testimony that she was encouraged to walk as much as possible and that her ability to do so varies. Plaintiff testified, "[s]ome days I can get down the steps and some days I can go clear to the end of the driveway." AR 78. The ALJ's reasoning as

to these appointment notes does not rise to the level of clear and convincing evidence sufficient to render Plaintiff's testimony not credible.

Also stemming from the 2014 pain consultation, the ALJ suggested that Plaintiff rated her pain level as a three out of ten "over the past week," suggesting that the record is inconsistent with her testimony reporting an average pain level of seven or eight out of ten. AR 31. This assertion was inaccurate. The record instead reflects that her pain was three out of ten only at that time of evaluation, and she in fact reported pain at a level of ten out of ten within the past week. Contrary to the ALJ's subsequent conclusion, this is consistent with Plaintiff's testimony that her pain level varies from day to day, typically experiencing pain at a seven or eight out of ten. The ALJ's rationale again fails to meet the high bar set by the "clear and convincing" standard.

The ALJ next relied on the same lack-of-treatment rationale the Court rejected relating to Plaintiff's migraine testimony. As with Plaintiff's migraines, the Court will not fault Plaintiff for seeking treatment—even without insurance—for allegedly acute and emergent medical issues that, in her judgment, required immediate medical attention, while not seeking treatment for her chronic conditions of fibromyalgia and fatigue.

The ALJ next discussed Dr. Morris's directive to Plaintiff to seek follow-up care with her primary care provider following the 2014 pain consultation. The ALJ inferred that because Plaintiff's primary care physician never re-referred Plaintiff to Dr. Morris for additional pain consultation, that must mean Plaintiff's pain was not so severe as to require any further consultation, and thus was not disabling. The Commissioner argues in her brief that this was a reasonable interpretation by the ALJ and as such the Court should not substitute its judgment for that of the ALJ's. The Court is not persuaded that the ALJ's conclusion here was reasonable; rather, the inference was made without any explicit support from the record. There is no

evidence in the record that Plaintiff's primary care physician found Plaintiff's symptoms to not be "of such severity that they required re-referral to a pain specialist." AR 31. Thus, the ALJ only relied on Plaintiff's physician's silence to support that conclusion.

Plaintiff argues that a physician's silence on an issue is not sufficient to satisfy the Commissioner's burden to support a decision with clear and convincing reasons. Plaintiff does not cite to, and the Court was unable to find, any Ninth Circuit precedent to support that assertion. Other circuits, however, have expressly held that a doctor's silence on an issue should not permit an inference one way or another and is not substantial evidence. See Pate-Fires v. Astrue, 564 F.3d 935, 943 (8th Cir. 2009) (collecting Eighth Circuit precedent for the assertion that a doctor's silence on an issue cannot be used as substantial evidence that the claimant is not disabled); Rosa v. Callahan, 168 F.3d 72, 81 (2d Cir. 1999) (finding that because the physician's reports did not set out an express opinion on the subject, the Commissioner was precluded from relying on the physician's omissions as primary evidence supporting denial of benefits); Mason v. Shalala, 994 F.2d 1058, 1068 n.15 (3d Cir. 1993) ("It would not seem appropriate to construe a physician's silence as to a patient's pain as an affirmative statement that the patient is not in pain."); Lamb v. Bowen, 847 F.2d 698, 703 (11th Cir. 1988) (holding that no inference may be taken from a physician's silence). Though not controlling, the Court finds this out-of-circuit authority persuasive, just as other district courts within this Circuit have similarly found. See Brown v. Comm'r, Soc. Sec. Admin., 2016 WL 184424, at *8 (D. Or. Jan. 15, 2016); Betancourt v. Colvin, 2016 WL 1178309, at *7 (D. Ariz. Mar. 28, 2016); Valenzuela v. Colvin, 2015 WL 2228074, at *5 (C.D. Cal. May 8, 2015). The ALJ's reliance on the silence of Plaintiff's physician—the lack of a re-referral to a pain specialist—is not substantial evidence. It does not reasonably support an inference that Plaintiff's doctor found Plaintiff's symptoms to be so mild

as to not require further pain consultation. Such an inferential leap does not satisfy the clear and convincing evidence standard.

Finally, when Plaintiff sought treatment in March 2015, Dr. Lefford took note that, at least in part, the reason for her visit was to fill out paperwork related to her disability claims. The ALJ suggested that this reflected unfavorably upon the alleged severity of Plaintiff's symptoms at the time. At that March 2015 appointment, Plaintiff presented with profuse sweating, fibromyalgia pain and frequent migraines; she had been struggling with her symptoms for more than a decade at that point. It is not reasonable to discount her long-standing symptom allegations because she sought to have her physician help her fill out necessary paperwork. This rationale does not clearly and convincingly support discounting Plaintiff's testimony regarding her symptoms.

c. General Inconsistencies and Overall Credibility

Next, the ALJ noted his concern with general inconsistencies in Plaintiff's testimony as well as her actions. AR 31-32. First, the ALJ questioned the reasons offered by Plaintiff as the cause for an automobile accident in which she was involved. Plaintiff testified that she hit a mailbox with her car and went into the bushes. Though the police believed her to be under the influence of alcohol, she testified that she does not drink and that she thought the likely cause of the accident was a bad reaction to both her allergy medication and the dental substance given to her at the dentist the day before. She clearly was uncertain as to the exact cause, but she testified, "I think between the two it just wasn't very good." AR 52.

The week after the accident and upon reporting suicidality, Plaintiff was brought to the hospital by police for a mental health evaluation. Notes from that evaluation reveal that Plaintiff claimed her suicidal thoughts resulted from frustration with her chronic pain and migraines, the treatment of which—including narcotics and other prescription medications—provided "no

relief." AR 476. Roughly consistent with her testimony, the evaluation notes also show that she attributed the automobile accident to taking too much allergy medication; however, in that instance she did not mention the substance given to her at the dentist the day prior to the accident. The ALJ relied on these notes, asserting that they were inconsistent with her testimony regarding the reason for her accident. The Court is not persuaded by the ALJ's rationale. Taking too much allergy medication versus having a bad reaction to it are not facially inconsistent; they are not mutually exclusive and it is entirely plausible that both happened. Additionally, failing to mention the dental substance would seem irrelevant given that Plaintiff could only tentatively speculate as to the cause of her accident. This incident is virtually unrelated to her disability allegations, and on this point, the ALJ's reasoning is far from clear and convincing.

The ALJ also attributed to Plaintiff a general "lack of candor" based on inconsistent claims regarding when she became unable to care for her two grandchildren any longer. In her August 2014 pain consultation with Dr. Morris, he took note that "[p]atient raised them until July." AR 427. Though the doctor did not provide the associated year in his notes, it would be reasonable for the ALJ to assume that the doctor was referring to July of that same year, 2014. Plaintiff's testimony, however, demonstrates that she was trying very hard to remember the date she stopped caring for her grandchildren, considering specific aspects of her life such as whether she was living in a house or her trailer and whether she was still working as a caregiver, to help her recollection. AR 71-74. She surmised that her reference to July must have been to 2013 and not 2014. AR 71-72.

The ALJ also characterized Plaintiff as having "simultaneously reported that she stopped caring for her grandchildren in 2013 and when she started working as a home caregiver," and concluded that both cannot be true because Plaintiff started working as a caregiver in 2008. The

ALJ misstates Plaintiff's testimony. Although Plaintiff mentioned that she "stopped" caring for her grandchildren when she started working as a caregiver for her patient "Ethyl," she later provided a more detailed explanation. She explained that her first patient as a caregiver through Senior Disabled Services was her own daughter, during which time she continued to care for her grandchildren, and that Ethyl was her second patient. AR 74. During the time she worked as a caregiver for Ethyl, she still sometimes took care of her grandchildren—on the weekends, on some days when she would take them to Ethyl's house, and on some days when Ethyl's granddaughter would care for Ethyl and Plaintiff would care for her grandchildren. AR 73-74. Thus, while Plaintiff's full time caregiving for her grandchildren "stopped" when she began caring for Ethyl, her caregiving for her grandchildren did not stop in its entirety. Although Plaintiff's testimony demonstrates that she does not have perfect recollection—which is consistent with her alleged symptom of being in a "fog" from her fibromyalgia and migraines—her testimony on this point is not necessarily inconsistent and does not support an inference of an overall lack of candor.

Finally, the ALJ discredited Plaintiff's alleged functional limitations because she was collecting unemployment benefits through 2013. He found this to be inconsistent with her representation that she was disabled beginning in January 2013. The ALJ relied on the fact that, while allegedly disabled, Plaintiff was actively seeking part-time caregiver positions by completing applications online in order to collect unemployment. The Ninth Circuit has spoken directly on this issue. "[W]hile receipt of unemployment benefits can undermine a claimant's alleged inability to work fulltime, the record here does not establish whether [Claimant] held himself out as available for full-time or part-time work. Only the former is inconsistent with his disability allegations." Carmickle v. Comm*'r*, 533 F.3d 1155, 1161-62 (9th Cir. 2008) (citations

omitted); see also Cullen v. Colvin, 2016 WL 706232, at *5 (D. Or. 2016) ("A claimant's receipt of unemployment benefits is an improper reason to discredit a claimant's testimony, unless the record establishes that the claimant held himself out as being available for full-time work." (citing Carmickle, 533 F.3d at 1162)).

Here, Plaintiff availed herself of only part-time work. Further, Plaintiff argues that Oregon law permits a person with a disability to apply for unemployment benefits so long as he or she is able to perform "some work." The Oregon Administrative Rules support her argument:

> An individual with a permanent or long-term "physical or mental impairment" (as defined at 29 CFR 1630.2(h)) which prevents the individual from working full time or during particular shifts shall not be deemed unable to work solely on that basis so long as the individual remains available for some work.

Or. Admin. R. 471-030-0036(2)(b) (2017). Because Plaintiff sought only part-time work, the ALJ erred by discrediting her alleged "functional limitations attributable to her symptoms." Under these circumstances, the fact that Plaintiff received unemployment benefits while applying for disability does not support discounting Plaintiff's symptom testimony.

B. Medical Opinion Evidence

1. Applicable Law

"In disability benefits cases . . . physicians may render medical, clinical opinions, or they may render opinions on the ultimate issue of disability—the claimant's ability to perform work." Garrison v. Colvin, 759 F.3d 995, 1012 (9th Cir. 2014) (citing Reddick v. Chater, 157 F.3d 715, 725 (9th Cir. 1998)). "There are three types of medical opinions in [S]ocial [S]ecurity cases: those from treating physicians, examining physicians, and non-examining physicians." Valentine v. Comm'r Soc. Sec. Admin., 574 F.3d 685, 692 (9th Cir. 2009) (citing Lester v. Chater, 81 F.3d 821, 830 (9th Cir. 1995)). Generally, more weight will be given to opinions from treating sources than non-treating sources, because they are likely to be able to provide a "longitudinal

picture" of impairments, and "bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone" or from one-time evaluations from consultative examinations. 20 C.F.R. §§ 404.1527(c)(2), 416.927(c)(2); see also Lester, 81 F.3d at 830. Nevertheless, "[t]he ALJ need not accept the opinion of any physician, including a treating physician, if that opinion is brief, conclusory, and inadequately supported by clinical findings." Bray, 554 F.3d at 1228.

In the event that "a treating or examining physician's opinion is contradicted by another doctor, the ALJ must determine credibility and resolve the conflict." Valentine, 574 F.3d at 692 (quoting Thomas, 278 F.3d at 956-57). However, "even when contradicted, a treating or examining physician's opinion is still owed deference and will often be 'entitled to the greatest weight . . . even if it does not meet the test for controlling weight.'" Garrison, 759 F.3d at 1012 (quoting Orn, 495 F.3d at 633). Further, an ALJ may only reject a contradicted opinion "by providing specific and legitimate reasons that are supported by substantial evidence." Ghanim v. Colvin, 763 F.3d 1154, 1161 (9th Cir. 2014) (quoting Ryan v. Comm'r of Soc. Sec., 528 F.3d 1194, 1198 (9th Cir. 2008)).

"An ALJ can satisfy the 'substantial evidence' requirement by setting out a detailed and thorough summary of the facts and conflicting clinical evidence, stating his interpretation thereof, and making findings." Garrison, 759 F.3d at 1012 (quoting Reddick, 157 F.3d at 725). A specific and legitimate reason for rejecting a treating physician's opinion is that the opinion is premised on a claimant's subjective complaints, which the ALJ had properly discounted. Fair, 885 F.2d at 605; Morgan v. Comm'r Soc. Sec. Admin., 169 F.3d 595, 602 (9th Cir. 1999); Batson, 359 F.3d at 1195; but see Ryan, 528 F.3d at 1199-200 ("[A]n ALJ does not provide clear and convincing reasons for rejecting an examining physician's opinion by questioning the

credibility of the patient's complaints where the doctor does not discredit those complaints and supports his ultimate opinion with his own observations.").

Social Security regulations provide that, when a treating source's opinions are not given controlling weight, an ALJ must apply the factors set forth in 20 C.F.R. § 404.1527(c)(2)(i-ii) and (c)(3–6) in determining how much weight to give each opinion. These factors are the length of the treatment relationship and the frequency of examination, § 404.1527(c)(2)(i), the nature and extent of the treatment relationship, § 404.1527(c)(2)(ii), "supportability," § 404.1527(c)(3), consistency, § 404.1527(c)(4), specialization, § 404.1527(c)(5), and other factors that tend to support or contradict the opinion, § 404.1527(c)(6).

2. Analysis

Plaintiff argues that the ALJ improperly assigned controlling weight to the medical opinions of the reviewing state agency physicians over the medical opinion of Dr. Lefford, her treating and primary care physician. The ALJ's decision expressly accorded "great weight" to the reviewing physicians while only according "little weight" to Dr. Lefford. The reasons given by the ALJ in support of his decision included: (1) the limited extent of Dr. Lefford's treating relationship with Plaintiff; (2) the brief and conclusory nature of his medical opinion, lacking adequate explanation; and (3) that the first two reasons permit the inference that Dr. Lefford relied heavily on Plaintiff's subjective complaints which the ALJ concluded were not sufficiently credible.

Because Dr. Lefford's opinion was not given controlling weight, the ALJ was required to consider the factors under 20 C.F.R. § 404.1527(c)(2)(i-ii) and (c)(3–6) in determining how much weight to give each opinion. Regarding the limited nature of treatment, the ALJ cited to the record to establish that Plaintiff received treatment from Dr. Lefford on only three occasions. As an initial matter, there is evidence in the record to suggest that there were in fact four

occasions of treatment. Although treatment notes from the purported first visit are missing from the record, Dr. Lefford's notes from the February 2014 visit allude to treatment beginning the month prior. Regardless of whether Dr. Lefford saw Plaintiff three or four times, the ALJ's weight balancing ultimately fails. The state physicians never visited with Plaintiff on even a single occasion.

The Commissioner argues that, despite this fact, the state physicians based their opinions on all of the medical records, whereas Dr. Lefford based his opinion primarily on his limited treatment relationship with Plaintiff. The Court does not find this to be persuasive in light of the considerations raised by Plaintiff in her reply brief. Notably, the state physicians based their opinions on past treatment records that Plaintiff argues were limited due to her lack of insurance, which affected her ability to seek more regular or aggressive treatment. The Commissioner and the ALJ explicitly relied on that fact in discounting Plaintiff's symptom testimony. The Court finds it was not reasonable for the ALJ to give controlling weight to the opinions of the non-examining medical providers that were based solely on treatment records that grew sparser following Plaintiff's loss of insurance, which also coincided with when Plaintiff alleged her symptoms began to worsen. The treatment records on which the reviewing physicians relied were bereft of notes covering Plaintiff's symptoms at their worst and thus, most relevant. Considering all the evidence, the ALJ's first reason is thus unpersuasive, and is not sufficiently specific and legitimate to justify deferral to the state physicians' opinions and rejection of Plaintiff's treating physician.

In addition, the ALJ gave less weight to Dr. Lefford's opinion due to its conclusory nature, asserting that it provided no explanations. The conclusions of the reviewing state agency physicians, however, also lack adequate explanations. Thus, this is not a specific and legitimate

reason to afford the state agency opinions more weight than Dr. Lefford's. Given that the reviewing physicians did not actually examine Plaintiff in person, there would seem to be a greater need for them adequately to explain their conclusions with support from the record. In each of the four opinions—comprising the DIB and SSI decisions on both initial consideration and reconsideration—the standardized opinion form provides a space for the reviewing physician to explain the evidence that supports the functional limitation findings. In fact, the form expressly urges physicians to "[c]ite specific facts upon which your conclusions are based." AR 101. Nevertheless, each of the explanations provided by both state agency physicians was identical and stated "[l]imits to lifting and standing due to fibromyalgia and CFS." AR 100-01, 110-11, 121, 132. Although the reviewing opinions included a brief outline of Plaintiff's recorded medical history, the ultimate functional limitation findings were not expressly supported by any valuable explanation—let alone by "specific facts." It is unreasonable to afford those opinions more weight when they suffer from the same defects on which the ALJ relied to justify affording Dr. Lefford's opinion less weight.

Finally, the ALJ found that the above issues "strongly suggest[]" that Dr. Lefford's opinion relied heavily on Plaintiff's subjective complaints, and because the ALJ discounted Plaintiff's testimony, he similarly discounted Dr. Lefford's opinion relying on that testimony. Because the Court has rejected the ALJ's assessment of Plaintiff's testimony, this is not a specific and legitimate reason to discount Dr. Lefford's opinion.

Looking at the factors assessed under 20 C.F.R. § 404.1527(c)(2)(i-ii) and (c)(3–6), the ALJ erred by affording more weight to the state reviewing physicians' opinions than to Dr. Lefford's opinion. The purported deficiencies on which the ALJ relied as justification for refusing to give controlling weight to Dr. Lefford's opinion are not persuasive in light of the

identical deficiencies in the state physicians' opinions. "The opinion of a nonexamining physician cannot by itself constitute substantial evidence that justifies the rejection of the opinion of either an examining physician or a treating physician." Morgan, 169 F.3d at 602. Thus, because the ALJ's alternative reasons for rejecting Dr. Lefford's opinion each fail, the opinions of the nonexamining state agency physicians alone do not constitute the requisite specific and legitimate reasons supported by substantial evidence sufficient to reject Dr. Lefford's contradicted opinion.

C. RFC and the Ability to Perform PRW

The RFC is the most a person can do, despite his physical or mental impairments. 20 C.F.R. §§ 404.1545, 416.945. In formulating an RFC, the ALJ must consider all medically determinable impairments, including those that are not "severe," and evaluate "all of the relevant medical and other evidence," including the claimant's testimony. Id.; see also SSR 96-8p, 1996 WL 374184, at *5 (July 2, 1996). In determining a claimant's RFC, the ALJ is responsible for resolving conflicts in the medical testimony and translating the claimant's impairments into concrete functional limitations in the RFC. Stubbs-Danielson v. Astrue, 539 F.3d 1169, 1174 (9th Cir. 2008). Only limitations supported by substantial evidence must be incorporated into the RFC and, by extension, the dispositive hypothetical question posed to the VE. Osenbrock v. Apfel, 240 F.3d 1157, 1163-65 (9th Cir. 2001).

Based on the RFC determination, the ALJ must then determine at step four of the sequential analysis whether the claimant can perform any PRW. Pinto v. Massanari, 249 F.3d 840, 844 (9th Cir. 2001). Adjudicators begin with the Dictionary of Occupational Titles ("DOT") in order to determine how PRW is generally performed, and how it was specifically performed by the claimant. 20 C.F.R. §§ 404.1560(b), 416.960(b); Pinto, 249 F.3d at 845-46. After the DOT, a VE may provide additional expert opinion testimony. Additionally,

adjudicators may seek information from other sources, including prior supervisors, co-workers, or family members. Id. Although the burden of proof at step four falls on the claimant to show that she cannot perform PRW, the ALJ nonetheless has a duty to support the conclusion that the claimant retains the RFC to: (1) perform PRW as actually previously performed; or (2) perform PRW as performed generally in the national economy. Id. at 845-46; SSR 96-8p, 1996 WL 374184, at *4.

The ALJ assessed an RFC and certain functional limitations, concluding that Plaintiff was capable of performing her PRW. Because the ALJ improperly rejected Plaintiff's symptom testimony and Dr. Lefford's medical opinion, the RFC assessed by the ALJ was not adequately supported by substantial evidence, thus tainting the subsequent determination as to Plaintiff's ability to perform her PRW.

D. Remand

Within the Court's discretion under 42 U.S.C. § 405(g) is the "decision whether to remand for further proceedings or for an award of benefits." Holohan v. Massanari, 246 F.3d 1195, 1210 (9th Cir. 2001) (citation omitted). Although a court should generally remand to the agency for additional investigation or explanation, a court has discretion to remand for immediate payment of benefits. Treichler v. Comm'r of Soc. Sec. Admin., 775 F.3d 1090, 1099-1100 (9th Cir. 2014). The issue turns on the utility of further proceedings. A remand for an award of benefits is appropriate when no useful purpose would be served by further administrative proceedings or when the record has been fully developed and the evidence is insufficient to support the Commissioner's decision. Id. at 1100. A court may not award benefits punitively and must conduct a "credit-as-true" analysis on evidence that has been improperly rejected by the ALJ to determine if a claimant is disabled under the Act. Strauss v. Comm'r of the Soc. Sec. Admin., 635 F.3d 1135, 1138 (9th Cir. 2011).

In the Ninth Circuit, the "credit-as-true" doctrine is "settled" and binding on this Court. Garrison, 759 F.3d at 999. The United States Court of Appeals for the Ninth Circuit articulates the rule as follows:

> The district court must first determine that the ALJ made a legal error, such as failing to provide legally sufficient reasons for rejecting evidence. If the court finds such an error, it must next review the record as a whole and determine whether it is fully developed, is free from conflicts and ambiguities, and all essential factual matters have been resolved. In conducting this review, the district court must consider whether there are inconsistencies between the claimant's testimony and the medical evidence in the record, or whether the government has pointed to evidence in the record that the ALJ overlooked and explained how that evidence casts into serious doubt the claimant's claim to be disabled. Unless the district court concludes that further administrative proceedings would serve no useful purpose, it may not remand with a direction to provide benefits.
>
> If the district court does determine that the record has been fully developed and there are no outstanding issues left to be resolved, the district court must next consider whether the ALJ would be required to find the claimant disabled on remand if the improperly discredited evidence were credited as true. Said otherwise, the district court must consider the testimony or opinion that the ALJ improperly rejected, in the context of the otherwise undisputed record, and determine whether the ALJ would necessarily have to conclude that the claimant were disabled if that testimony or opinion were deemed true. If so, the district court may exercise its discretion to remand the case for an award of benefits. A district court is generally not required to exercise such discretion, however. District courts retain flexibility in determining the appropriate remedy and a reviewing court is not required to credit claimants' allegations regarding the extent of their impairments as true merely because the ALJ made a legal error in discrediting their testimony.

Dominguez v. Colvin, 808 F.3d 403, 407-08 (9th Cir. 2015) (citations and quotation marks omitted).

Here, the ALJ did not provide sufficient reasons for discounting Plaintiff's symptom testimony and Dr. Lefford's medical opinion. The record is not, however, free from all conflicts

and ambiguities. Thus, the matter is remanded for further proceedings so that the ALJ properly can consider Plaintiff's symptom testimony and Dr. Lefford's opinion, assess Plaintiff's RFC, and consider step four and, if necessary, step five.

CONCLUSION

The Commissioner's decision that Plaintiff is not disabled is REVERSED, and this case is REMANDED for further proceedings consistent with this opinion.

IT IS SO ORDERED.

DATED this 18th day of July, 2017.

/s/ Michael H. Simon
Michael H. Simon
United States District Judge