No. 02-469

In The Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,

Petitioner,

v.

KENNETH L. NORD,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF OF THE NATIONAL ORGANIZATION OF SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES AS *AMICUS CURIAE* IN SUPPORT OF THE RESPONDENT

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INTEREST OF *AMICUS CURIAE* NOSSCR[1]

The National Organization of Social Security Claimants' Representatives (NOSSCR) is a non-profit corporation. NOSSCR members represent claimants in administrative proceedings for claims for federal benefits – primarily disability benefits – under Titles II and XVI of the Social Security Act, 42 U.S.C. §§ 401-434, 1381-1383f, and represent in civil litigation plaintiffs for Social Security benefits whose claims were denied administratively. NOSSCR members commonly represent claimants not only for Social Security benefits, but also for benefits under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq*. As *amicus curiae*, we present to the Court the interests both of our members who represent ERISA claimants and those ERISA claimants themselves. Our members and their clients have an interest in the full and fair review of claims for ERISA benefits. NOSSCR has filed *amicus* briefs in several prior cases to assist the Court by presenting the viewpoints of our members and their clients.

Additionally, NOSSCR members have vast experience with the well-established "treating physician rule" of Social Security law. This case involves the application of a treating physician rule in the ERISA context. We seek to assist the Court in its analysis of a treating physician rule

[1] The parties have consented to the filing of this *amicus* brief in support of Respondent. Counsel for a party did not author this brief in whole or in part. No person or entity, other than the *amicus curiae*, its members, or its counsel made a monetary contribution to the preparation or submission of this brief.

in the ERISA context based on our experience with the treating physician rule of Social Security law.

SUMMARY OF ARGUMENT

Judicial review of a plan administrator's denial of ERISA disability benefits typically involves consideration of medical opinions from treating and non-treating physicians. Neither the ERISA statute nor ERISA regulations explain how a court should consider various medical opinions when ruling on a challenge to a plan administrator's denial of ERISA disability benefits. Given this void and the necessity to consider medical opinions, the Ninth Circuit reasonably adopted the treating physician rule of Social Security law as part of the common law of ERISA. Social Security law has a mature, flexible treating physician rule well-suited to guide judicial review of a plan administrator's denial of ERISA disability benefits.

Petitioner purportedly identifies serious defects in Social Security's treating physician rule. For example, Petitioner contends that the rule does not take into account a physician's specialty. On the contrary, Social Security's treating physician rule requires consideration of a physician's specialty. Social Security's treating physician rule does not have the defects Petitioner alleges.

Petitioner maintains that Social Security's treating physician rule is inappropriate for ERISA because, unlike Petitioner's ERISA plan, Social Security does not define disability in terms of past work, and because, unlike ERISA, the burden of persuasion in Social Security cases is not on the claimant. Petitioner thereby mischaracterizes Social Security's definition of disability and burden of persuasion.

Petitioner also objects generally to a treating physician rule on the ground that it is incompatible with deferential judicial review, including deference to a factfinder's resolution of a conflict in the medical evidence. The experience of the lower courts reviewing administrative denials of Social Security disability benefits under 42 U.S.C. § 405(g) refutes this objection. For more than a decade, the lower courts have applied Social Security's treating physician rule when undertaking deferential substantial evidence review of administrative denials of Social Security disability benefits.

For these reasons, the Ninth Circuit correctly adopted Social Security's treating physician rule as the common law of ERISA for judicial review of a plan administrator's denial of ERISA disability benefits.

ARGUMENT

I. Instead Of Trying To Identify Anew In Each ERISA Case Principles To Guide The Consideration Of Medical Opinions, The Ninth Circuit Reasonably Adopted The Mature, Flexible Treating Physician Rule From Social Security Law

Respondent must satisfy the definition of disability set forth in the Black & Decker Disability Plan (Plan) in order to receive ERISA disability benefits. The Plan defines disability in terms of an employee's medical conditions and his ability to work. (L. 20.) Under the Plan, an employee is disabled during the first thirty months of disability if he cannot perform his regular occupation due to his mental and/or physical conditions. (L. 20.) Therefore, consideration of medical opinions is intrinsic both to the determination of disability by a plan administrator

and to judicial review of a plan administrator's denial of benefits. The same is true in the context of disability benefits under the Social Security Act. Consideration of medical opinions is intrinsic both to the administrative determination of claims for Social Security disability benefits, *see* 42 U.S.C. § 423(d), and to judicial review of administrative denials of claims for those benefits, *see* 42 U.S.C. § 405(g). Faced with the recurrent issue of how to consider medical opinions on judicial review of denials of ERISA disability benefits, the Ninth Circuit reasonably adopted the "treating physician rule" from Social Security law.

Although the ERISA statute does not address this recurrent issue, the Courts of Appeals are authorized to craft a common law for ERISA to fill the statutory void. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-11 (1989). Inasmuch as the Secretary of Labor did not anticipate in the 2000 regulations this recurrent issue of how to weigh conflicting medical opinions, it is necessary for the courts to provide a reasonable framework for dealing with this common situation. Nothing in the Secretary of Labor's implementing regulations (the current version of which does not specifically apply to the instant case, *see* 65 Fed. Reg. 70,246 (2000)) provides any guidance in this area.[2] Hence, contrary to the position of the Solicitor General, it cannot reasonably be argued that judicial imposition of a treating physician rule interferes with the "primary jurisdiction" of the Secretary of Labor. (U.S. Br. 11.) The Ninth Circuit reasonably filled the

[2] Addressing a different concern, the Department of Labor's 2000 regulations state that an ERISA plan administrator shall consult with a health care professional. 65 Fed. Reg. 70,269 (2000); 29 C.F.R. § 2560.503-1(h)(3)-(4) (2002).

statutory and regulatory void with the mature, flexible treating physician rule from Social Security law. (Petition App. 13.) *Cf. Halpin v. W.W. Grainger, Inc.*, 962 F.2d 685, 695 n.11 (7th Cir. 1992) ("Although the standards used in adjudicating social security cases are not applicable under ERISA, the guiding principles developed in those cases may be 'instructive' in ERISA cases."). By adopting the mature, flexible treating physician rule from Social Security law, the Ninth Circuit eliminated the need to decide anew in each case the appropriate rules for weighing medical opinions. Instead, guided by the treating physician rule, a court can focus on the facts of a particular ERISA case to determine on *de novo* or deferential judicial review whether the court should overturn the denial of disability benefits. Utilizing the treating physician rule from Social Security law for judicial review of denials of ERISA disability benefits thus promotes principled decisionmaking and judicial economy. Accordingly, this Court should approve of the application of a treating physician rule in ERISA cases without prejudice to the right of the Secretary of Labor to address this matter by regulation. *Cf. Schisler v. Sullivan*, 3 F.3d 563, 567-69 (2d Cir. 1993) (*Schisler III*) (holding that Social Security's new regulatory treating physician rule superseded prior Second Circuit treating physician caselaw).

II. Social Security's Treating Physician Rule Is A Response To The Need To Evaluate Medical Opinions When Deciding Disability Claims Administratively And When Undertaking Judicial Review Of Denied Claims

Because disability under the Social Security Act is based on a claimant's medical condition, *see* 42 U.S.C. § 423(d), Social Security Administration (SSA) adjudicators must

evaluate medical opinions from treating and non-treating physicians. For the same reason, federal courts must consider medical opinions when deciding whether to affirm or reverse administrative denials of Social Security disability benefits. *See* 42 U.S.C. § 405(g). By the mid-1980s, almost all of the Courts of Appeals had adopted a treating physician rule for Social Security cases. *See* Rachel Schneider, *A Role for the Courts: Treating Physician Evidence in Social Security Disability Determinations*, 3 U. Chi. L. Sch. Roundtable 391, 396-400 (1996) (surveying caselaw). Under the rule, more weight is generally owed to the opinion of a treating physician than a non-treating physician because a treating physician has more opportunity to observe and know his patient and because the treating physician is responsible for providing medical care. *See, e.g.*, *Murray v. Heckler*, 722 F.2d 499, 501-02 (9th Cir. 1983). Unlike other Circuits, the Second Circuit's rule in the 1980s was absolutist, stating that a treating physician's opinion was sometimes "binding." *Schisler v. Bowen*, 851 F.2d 43, 47 (2d Cir. 1988) (*Schisler II*). In 1991, the Agency issued a regulatory treating physician rule for three reasons: to announce that independent of caselaw a treating physician rule is appropriate; to summarize its agreement with caselaw principles; and to accept the Second Circuit's invitation to set forth a nationwide rule. *See* 56 Fed. Reg. 36,934 (1991); *see also* 20 C.F.R. § 404.1527 (2002)[3] (codifying as amended SSA's treating physician rule) (set forth in Appendix of this Brief).

[3] The regulations for claims under Title II of the Social Security Act are at 20 C.F.R. Part 404. We do not cite parallel regulations for claims under Title XVI of the Social Security Act at 20 C.F.R. Part 416.

In *Schisler III*, the Second Circuit held that the 1991 regulations superseded prior Second Circuit law. 3 F.3d at 569. Today, other Circuits cite interchangeably their caselaw and the 1991 regulations.[4] Petitioner argues that the Ninth Circuit "does not follow the SSA rule, even in SSA cases." (Pet. Br. 20 (*citing Morgan v. Commissioner of Social Security Admin.*, 169 F.3d 595, 600, 601 (9th Cir. 1999); *Lester v. Chater*, 81 F.3d 821, 831-32 (9th Cir. 1995); *Magallanes v. Bowen*, 881 F.2d 747, 750 (9th Cir. 1989)).) By this, Petitioner means that the Ninth Circuit utilizes its own caselaw treating physician rule instead of 20 C.F.R. § 404.1527 (2002). On the contrary, the Ninth Circuit follows 20 C.F.R. § 404.1527 (2002) as well as its caselaw. *See Edlund v. Massanari*, 253 F.3d 1152, 1157 (9th Cir. 2001) (*citing* 20 C.F.R. § 404.1527).[5] Because there is no substantive difference between Ninth Circuit caselaw and SSA regulations, the Ninth Circuit correctly

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[4] *See, e.g.*, *Plummer v. Apfel*, 186 F.3d 422, 429 (3d Cir. 1999) (citing caselaw and 1991 regulations); *Craig v. Chater*, 76 F.3d 585, 590 (4th Cir. 1996) (same); *Loza v. Apfel*, 219 F.3d 378, 395 (5th Cir. 2000) (same); *Walters v. Commissioner of Social Security*, 127 F.3d 525, 529-30 (6th Cir. 1997) (same); *Clifford v. Apfel*, 227 F.3d 863, 870 (7th Cir. 2000) (same); *Nelson v. Sullivan*, 966 F.2d 363, 367-68 (8th Cir. 1992) (same); *Castellano v. Secretary of Health and Human Servs.*, 26 F.3d 1027, 1029 (10th Cir. 1994) (same); *Lewis v. Callahan*, 125 F.3d 1436, 1440 (11th Cir. 1997) (same).

[5] *See also Holohan v. Massanari*, 246 F.3d 1195, 1202, 1205, 1207 (9th Cir. 2001) (*citing* 20 C.F.R. § 404.1527); *Regennitter v. Commissioner of Social Sec. Admin.*, 166 F.3d 1294, 1299 (9th Cir. 1999) (same); *Lester*, 81 F.3d at 832-33 (same); *Smolen v. Chater*, 80 F.3d 1273, 1285, 1288 (9th Cir. 1996); *Gomez v. Chater*, 74 F.3d 967, 971 (9th Cir. 1996) (same); *Andrews v. Shalala*, 53 F.3d 1035, 1041 (9th Cir. 1995) (*citing* 20 C.F.R. § 416.927).

cites interchangeably its own caselaw and SSA regulations.[6] Although Ninth Circuit caselaw and SSA's regulations are the same, we generally discuss below Ninth Circuit caselaw and SSA's regulations separately, demonstrating that there is no substantive difference between Ninth Circuit caselaw and SSA's regulations and that even if Ninth Circuit caselaw were different from SSA's regulations, both Ninth Circuit and SSA law meet Petitioner's objections to a treating physician rule.

III. The Mature, Flexible Treating Physician Rule Of Social Security Law Meets Petitioner's Objections

A. A Treating Physician Rule Accounts For Specialization, Training, And Experience

Petitioner objects to a treating physician rule because it places an "almost insurmountable burden on the plan administrator who believes that the treating physician's opinion is erroneous." (Pet. Br. 45.) As a main example arguing against a treating physician rule, Petitioner asserts that a plan administrator would have a great and difficult burden refuting a podiatrist's opinion that a claimant was disabled by throat cancer. (Pet. Br. 45; *see also id.* 14-15, 29 (stating that a treating physician rule does not take into account a physician's training and experience).) This example is not a serious challenge to a treating physician rule. Under the Ninth Circuit's treating physician rule, as well as SSA's treating physician rule, the specialty of a physician must be considered when

[6] The Solicitor General does not allege that any Ninth Circuit decision is inconsistent with the 1991 regulations.

evaluating the physician's opinion. *See Smolen*, 80 F.3d at 1285 ("the opinions of a specialist about medical issues related to his or her area of specialization are given more weight than the opinions of a nonspecialist."); 20 C.F.R. § 404.1527(d)(5) (2002) ("We generally give more weight to the opinion of a specialist about medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist.").[7] Similarly, under the Ninth Circuit's and SSA's treating physician rules, the nature of a podiatrist's treating relationship with a claimant as well as the podiatrist's clinical findings would be taken into account and would likely provide solid grounds to reject the podiatrist's opinion about throat cancer. *See Burkhart v. Bowen*, 856 F.2d 1335, 1139 (9th Cir. 1988) (ratifying rejection of treating physician's opinion unsupported by "medical findings, personal observations or test reports"); 20 C.F.R. § 404.1527(d)(2)(ii) (2002) ("For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck pain."); 20 C.F.R. § 404.1527(d)(3) (2002) ("The more a medical source presents relevant evidence to support an opinion, particularly medical signs and laboratory findings, the more weight we will give that opinion."). In fact, an ALJ or plan administrator would normally be justified in dismissing out of hand a podiatrist's opinion about a claimant's disability due to throat

[7] *See also Singh v. Apfel*, 222 F.3d 448, 452 (8th Cir. 2000) (specialist's opinion is generally owed more weight); *Mason v. Shalala*, 994 F.2d 1058, 1066-67 (3d Cir. 1993) (same); *Moore v. Sullivan*, 919 F.2d 901, 905 (5th Cir. 1990) (same).

cancer. *Cf.* 20 C.F.R. § 404.1513(a)(4) (2002) (acknowledging licensed podiatrists as "acceptable" medical sources only "for purposes of establishing impairments of the foot, or foot and ankle"); *Sobolewski v. Apfel*, 985 F. Supp. 300, 312 (E.D. N.Y. 1997) (similar).

B. Treating Physicians Provide Opinions That Support And Detract From Claims Of Disability

Petitioner maintains that the Ninth Circuit's treating physician rule "effectively puts a 'thumb on the scale' in favor of the claimant. . . . " (Pet. Br. 47.) A treating physician rule is not a one-sided rule in favor of claimants. Treating physicians commonly provide opinions that are probative evidence that their patients do *not* satisfy the relevant legal standard of disability. *See Osenbrock v. Apfel*, 240 F.3d 1157, 1165 (9th Cir. 2001) (affirming denial of benefits based on treating physician's opinion); *Moncada v. Chater*, 60 F.3d 521, 523 (9th Cir. 1995) (same); *Matthews v. Shalala*, 10 F.3d 678, 680-81 (9th Cir. 1993) (same); *Curry v. Sullivan*, 925 F.2d 1127, 1129 (9th Cir. 1991) (same).[8]

Treating physicians routinely report not only that their patients can work – perhaps with restrictions such

[8] *See also Buxton v. Halter*, 246 F.3d 762, 775 (6th Cir. 2001) (affirming denial of benefits based on treating physician's opinion); *Shramek v. Apfel*, 226 F.3d 809, 814-15 (7th Cir. 2000) (same); *DeChirico v. Callahan*, 134 F.3d 1177, 1184 (2d Cir. 1998) (same); *Jones v. Department of Health and Human Servs.*, 941 F.2d 1529, 1533 (11th Cir. 1991) (same); *Griego v. Sullivan*, 940 F.2d 942, 945 (5th Cir. 1991) (same); *Davis v. Secretary of Health and Human Servs.*, 915 F.2d 186, 189 (6th Cir. 1990) (same); *Gossett v. Bowen*, 862 F.2d 802, 807 (10th Cir. 1988) (same).

as a limitation on lifting heavy objects – but also that their patients *should* work. *See, e.g.*, *Richardson v. Perales*, 402 U.S. 389, 391 (1971) (treating physician "advised that [the claimant] return to work"). In fact, the very purpose of much medical treatment is to restore a claimant's ability to work. Petitioner assumes without empirical or rational basis that treating physicians see themselves as protecting their patients from the workforce instead of helping their patients reach their maximum work capacities and continue or renew productive lives in the workforce.

Along the same lines, Petitioner asserts that the Ninth Circuit's treating physician rule "assumes that there is only one treating physician's opinion," (Pet. Br. 28), and cannot function reasonably if opinions from more than one treating physician conflict (Pet. Br. 29). Neither the Ninth Circuit's treating physician rule nor SSA's assumes that a claimant has only one treating physician. And both rules handle easily cases with opinions, including conflicting opinions, from more than one treating physician. *See Holohan*, 246 F.3d at 1201-05 (applying Ninth Circuit law and 20 C.F.R. § 404.1527 in case with more than one treating physician); *Magallanes*, 881 F.2d at 751-55 (applying Ninth Circuit law while resolving conflicting opinions from more than one treating physician).[9] In fact, in a *typical* disability case there are a series of opinions about various conditions from several treating physicians such as a treating orthopedist and a treating psychiatrist. *See, e.g.*, *Perales*, 402 U.S. at 390-408 (two

[9] *See also Buxton*, 246 F.3d at 773-75 (ALJ reasonably weighed the opinions of several treating sources); *Wolfe v. Shalala*, 997 F.2d 321, 325-26 (7th Cir. 1993) (same).

treating physicians, five one-time examining physicians, and one non-examining physician). If it were true that a treating physician rule cannot reasonably be applied when there is more than one treating physician, the Courts of Appeals and SSA would have abandoned the treating physician rule years ago.

C. A Treating Physician Rule Accounts For Differences Between Treating Physicians

In Petitioner's view, the Ninth Circuit's treating physician rule has serious infirmities. According to Petitioner, in the Ninth Circuit the opinion of a physician who "'treated' a patient one time is afforded the same weight as that of a physician who has been treating the patient through the entire course of his impairment." (Pet. Br. 28.) The Ninth Circuit's rule allegedly does not take into account "the length of time" a physician has treated a claimant. (Pet. Br. 14.) The Ninth Circuit's treating physician rule is not so simple-minded and irrational. Instead, the Ninth Circuit's treating physician rule permits reasoned evaluation of a treating physician's opinion based on the extent of the treating relationship. *See, e.g.*, *Lewis v. Apfel*, 236 F.3d 503, 517 (9th Cir. 2001) (addressing the precise extent of a treating physician's contact with a claimant); *Andrews*, 53 F.3d at 1040 (rejecting claimant's argument that a psychologist who examined him four times but did not treat his condition was a treating source); *Matney ex rel. Matney v. Sullivan*, 981 F.2d 1016, 1020 (9th Cir. 1992) (holding that ALJ properly gave less weight to opinion of a treating physician who examined

the claimant only once).[10] The regulations are no different. *See* 20 C.F.R. § 404.1527(d)(2) (2002) (evaluating treating physician opinions based on the "[l]ength of the treatment relationship," the "frequency of examination," and the "[n]ature and extent of the treatment relationship"); 20 C.F.R. § 404.1502 (2002) (defining "treating source" as a physician or psychologist who had or has an "ongoing treatment relationship" with a claimant).

D. A Treating Physician Rule Responds To Allegations Of Advocacy And Bias

Petitioner contends that a treating physician rule is unwarranted because the rule does not account for a treating physician's presumed advocacy for his patient (by falsifying medical records and opinions) and presumed bias against his patient working. (Pet. Br. 29-33.) But Petitioner fails to address how the treating physician rule actually deals with allegations of advocacy or bias.

The Ninth Circuit has considered several times whether a treating physician's opinion may be rejected or given less weight on the ground that a claimant asked his treating physician to provide an opinion to obtain private

[10] *See also White v. Barnhart*, 287 F.3d 903, 908 (10th Cir. 2001) (approving giving less weight to the opinion of a treating physician whose treatment relationship was "relatively brief"); *Schaal v. Apfel*, 134 F.3d 496, 504 (2d Cir. 1998) (noting that the relevance of a treating physician's opinion depends on the length of the treatment); *Diaz v. Shalala*, 59 F.3d 307, 314-15 (2d Cir. 1995) (ALJ properly gave less weight to the opinion of a treating specialist who had only examined the claimant several times); *Mason*, 994 F.2d at 1067 (ALJ erroneously implied that a physician who examined the claimant once was a treating physician).

or public disability benefits. The Ninth Circuit's treating physician rule has evolved so that it is able to evaluate reasonably allegations of advocacy or bias based on facts in particular cases instead of assumptions that treating physicians are deceitful. In *Saelee v. Chater*, 94 F.3d 520 (9th Cir. 1996), the Ninth Circuit affirmed an ALJ's rejection of a treating physician's opinion on the ground that the treating physician attempted to assist the claimant "in obtaining social security benefits." *Id*. at 522. The ALJ correctly found that the treating physician relied too heavily on the claimant's subjective statements and that an objective basis for the treating physician's opinion was lacking. *Id.* at 523. Later, in *Reddick v. Chater*, 157 F.3d 715 (9th Cir. 1998), the Ninth Circuit clarified that a treating physician's opinion could not be dismissed merely because the physician was asked to provide an opinion: "[I]n the absence of other evidence to undermine the credibility of a medical report, the purpose for which the report was obtained does not provide a legitimate basis for rejecting it." *Id.* at 726. Petitioner thus could have challenged the opinions of Respondent's treating physicians *within the treating physician rule itself*. But within the treating physician rule, Petitioner needed *evidence*, not assumptions, to show that the opinions of Respondent's treating physicians were unsupported and incredible. *Id*.[11]

As a related matter, Petitioner seems to argue that the Seventh Circuit (correctly) presumes in Social Security cases that a claimant's treating physician is a partisan

[11] *See also Frey v. Bowen*, 816 F.2d 508, 515 (10th Cir. 1987) (finding that ALJ did not cite any evidence to support allegation that a family physician "naturally advocates his patient's cause").

advocate for finding his patient disabled: "'The patient's regular physician may want to do a favor for a friend and client, and so the treating physician may too quickly find disability.'" (Pet. Br. 32 (*quoting Stephens v. Heckler*, 766 F.2d 284, 289 (7th Cir. 1985)).) In *Micus v. Bowen*, 979 F.2d 602 (7th Cir. 1992), the Seventh Circuit clarified that its decisions in *Stephens* and another case[12] do "not create a presumption of bias in a treating physician's disability opinion; the cases recognize only the ALJ's ability as a trier of fact to consider a physician's possible bias." *Id.* at 609. Furthermore, the Seventh Circuit does not understand *Stephens* as inconsistent with a treating physician rule: the Seventh Circuit cites *Stephens* along with SSA's regulations when evaluating medical opinions. *See Dixon v. Massanari*, 270 F.3d 1171, 1177 (7th Cir. 2001) (*citing Stephens*, 766 F.2d at 289, *and* 20 C.F.R. § 404.1527); *Butera v. Apfel*, 173 F.3d 1049, 1056 (7th Cir. 1999) (same); *Books v. Chater*, 91 F.3d 972, 979 (7th Cir. 1996) (same).

E. A Treating Physician Rule Penalizes Malingering

Petitioner believes that the treating physician rule places an adjudicator, plan administrator, and reviewing court at the mercy of a malingering claimant and his corrupt treating physician conspiring with the malingerer to obtain undeserved benefits.[13] (Pet. Br. 25, 32.) Petitioner's belief is unfounded. The treating physician rule does not allow a malingering claimant to obtain benefits

[12] *Reynolds v. Bowen*, 844 F.2d 451 (7th Cir. 1988).

[13] Petitioner does not assert that Respondent himself is malingering. (Pet. Br. 1-48.)

by misleading his treating physician or conspiring with his treating physician to obtain benefits fraudulently. Instead, when there is evidence that a treating physician's opinion is not based on clinical findings but on a claimant's volitional misrepresentation, the treating physician's opinion should be discounted. *See Edlund*, 253 F.3d at 1157 (affirming rejection of treating physician's opinion when treating physician was unaware that the claimant exaggerated his complaints to seek pain medication); *Sandgathe v. Chater*, 108 F.3d 978, 980 (9th Cir. 1997) (affirming rejection of treating physician's opinion when claimant's "psychological problems may have been volitional"); *Brawner v. Secretary of Health and Human Servs.*, 839 F.2d 432, 433-34 (9th Cir. 1988) (affirming rejection of treating physician's opinion because it was based on claimant's unreliable statements); 20 C.F.R. § 404.1527(d)(3) (2002) ("The more a medical source presents relevant evidence to support an opinion, *particularly medical signs and laboratory findings*, the more weight we will give that opinion.") (emphasis added).[14]

F. Non-Lawyers And Lawyers Alike Can Apply A Treating Physician Rule

According to Petitioner, a treating physician rule should not be applied in the ERISA context because a "lay ERISA plan administrator" lacks the training of an SSA

[14] *See also Mastro v. Apfel*, 270 F.3d 171, 178 (4th Cir. 2001) (ALJ properly rejected treating physician's opinion when the treating physician's "diagnosis was based largely upon the claimant's self-reported symptoms"); *Craig*, 76 F.3d at 590 (ALJ properly rejected treating physician's conclusory opinion based on claimant's subjective complaints).

ALJ and thus, supposedly, lacks the training and ability to apply a treating physician rule. (Pet. Br. 21.) Petitioner misunderstands SSA's administrative process. The SSA uses a four-tier administrative process in which a *de novo* hearing before an ALJ is the third step. *See* 20 C.F.R. § 404.900 (2002) (describing four tiers); *Heckler v. Day*, 467 U.S. 104, 106-107 (1984) (same). At the first and second tiers of the administrative process, non-lawyer "disability examiners"[15] make disability determinations applying the same treating physician rule as ALJs at the third tier.[16] Just as non-lawyer SSA disability examiners can apply a treating physician rule, lay ERISA plan administrators can apply a treating physician rule.

For a similar reason, Petitioner's allegation that a treating physician rule would require plan administrators "to engage legal counsel to review their benefit denials" is baseless. (Pet. Br. 14.) Nothing in the Ninth Circuit's treating physician rule or SSA's treating physician rule is

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[15] Program Operations Manual System (POMS) DI 24501.005 (The Disability Determination Services (DDS) Disability Examiner's (DE's) Role In the Determination Process), *at* http://policy.ssa.gov/poms.nsf/poms?OpenView; *see also Washington State Dep't of Social and Health Servs. v. Guardianship Estate of Keffeler*, 123 S. Ct. 1017, 1025-26 (2003) (noting that the POMS warrants respect under *Skidmore v. Swift & Co.*, 323 U.S. 134, 139-140 (1944)).

[16] *See* 20 C.F.R. § 404.1502 (2002) (regulations apply to all levels of adjudication); 20 C.F.R. § 404.985(a) (2002) (adverse caselaw applies to all levels of adjudication); POMS DI 24515 (Specific Medical Evaluation Instructions) (instructions to disability examiners to follow the regulatory treating physician rule).

In Fiscal Year 2000, disability examiners made 1,988,425 determinations. Social Security Advisory Bd., *Disability Decision Making: Data and Materials* (Jan. 2001), at Chart 67, *at* http://www.ssab.gov/chartbookB.pdf.

so arcane or technical that it cannot be readily mastered by a plan administrator. Any plan administrator with the ability to understand and effectuate an ERISA benefits plan surely has the ability to understand and apply a treating physician rule. (*See* L. 15-30 (Black & Decker's sixteen-page disability plan).)

G. Petitioner Mischaracterizes SSA's Disability Programs

As justification for not applying in the ERISA context the Ninth Circuit's treating physician rule from Social Security law, Petitioner purports to identify major differences between SSA's definition of disability and Petitioner's definition of disability in its ERISA plan. (Pet. Br. 23.) Petitioner's argument is based on a mischaracterization or misunderstanding of SSA's disability program.

1. The Plan *And* SSA Define Disability In Terms of Past Work

Petitioner argues that a "decision by a plan administrator that an employee is disabled from *his own occupation* is entirely different than an ALJ's decision in an SSA case that a person is disabled from 'any substantial gainful activity.'" (Pet. Br. 22-23 (emphasis in original) (*quoting* 20 C.F.R. § 416.927(a)(1) (2002)).) This is incorrect. The Black & Decker Disability Plan has two definitions of disability. For the first thirty months, a claimant is disabled if he cannot perform his "regular occupation." (Petition App. 3; L. 20.) Beginning with the thirty-first month, disability is defined as the "complete inability (whether physical and/or mental) of a participant to engage in any gainful occupation." (Petition App. 3; L. 20.) This case involves a claim of disability during the first thirty months. (Pet. Br. 3.) The

plan's definition of disability during the first thirty months as a claimant's inability to perform his "regular occupation" is virtually identical to step four of SSA's well-known five-step sequential evaluation, for which the test is whether a claimant can do his "past relevant work":

> Your impairment(s) must prevent you from doing past relevant work. If we cannot make a decision based on your current work activity or on medical facts alone, and you have a severe impairment(s), we then review your residual functional capacity and the physical and mental demands of the work you have done in the past. If you can still do this kind of work, we will find that you are not disabled.

20 C.F.R. § 404.1520(e) (2002) (step four);[17] *see also Bowen v. Yuckert*, 482 U.S. 137, 141-42 (1987) (summarizing sequential evaluation). Step four is the regulatory expression of the Social Security Act's provision that a claimant is not disabled if he can perform his "previous work." 42 U.S.C. § 423(d)(2)(A).

Petitioner argues that the "own occupation," i.e., regular occupation, disability test of the Black & Decker Disability Plan "requires knowledge and information about that occupation," while SSA's test does not. (Pet. Br. 23.) On the contrary, when SSA determines at step four whether a claimant can do his past relevant work, SSA gathers information about the mental and physical demands of that occupation. *See* Social Security Ruling (SSR)

[17] The Court granted this Term the Solicitor General's petition for a writ of certiorari to review the Third Circuit's construction of step four. *Thomas v. Commissioner of Social Security*, 294 F.3d 568 (3d Cir. 2002), *cert. granted*, 71 U.S.L.W. 3390 (U.S. Feb. 24, 2003) (No. 02-763).

82-62;[18] *see also Pinto v. Massanari*, 249 F.3d 840, 845 (9th Cir. 2001) (applying SSR 82-62); *Winfrey v. Chater*, 92 F.3d 1017, 1024 (10th Cir. 1996) (same). Determining whether a claimant can do his past relevant work at step four necessarily requires knowledge of the demands of that past work.

Petitioner's underlying contention based on a plan administrator's need to know about the demands of a claimant's regular occupation – and an SSA adjudicator's supposed lack of need to know about demands of past work – appears to be that a treating physician's opinion is worthless because the treating physician is unfamiliar with the demands of the claimant's regular occupation. (Pet. Br. 23.) Petitioner's argument is ill-founded.

First, a claimant or plan administrator would simply need to provide a treating physician with relevant facts about a claimant's regular occupation to ensure that the treating physician addressed the claimant's ability to do his regular occupation. Petitioner assumes that the treating physician not only lacks relevant information about the claimant's regular occupation, but also that he cannot be provided with and assimilate that information. Petitioner's argument is not an argument against a treating physician rule. It is merely a good reason to provide the treating physician with the relevant information and to ask the treating physician relevant questions.

Second and more significantly, a treating physician can provide an opinion relevant to a determination of

[18] At http://www.ssa.gov/OP_Home/rulings/. Social Security Rulings announce agency-wide policy, and are binding on agency adjudicators. 20 C.F.R. § 402.35(b) (2002).

whether the claimant can do his regular occupation (past work) even if the treating physician knows nothing about the claimant's regular occupation. For example, if a treating physician opines that a claimant cannot lift more than five pounds and if the claimant's regular occupation requires lifting more than five pounds, the treating physician's opinion is evidence that the claimant cannot do the lifting that his regular occupation requires. Here, Respondent's treating physician Dr. Hartman opined that Respondent could not lift more than five pounds (L. 53), and Respondent's regular occupation as a material planner required lifting up to twenty pounds (L. 143). Therefore, Dr. Hartman's opinion was evidence that Respondent could not do the lifting that his regular occupation of material planner required. Thus, Petitioner's criticism of Dr. Hartman as not knowing "the essential functions of the position of a material planner" misses the point. (Pet. Br. 35.) Once Dr. Hartman specified Respondent's functional limitations (L. 53), it became a straightforward task to compare those limitations to the known requirements of Respondent's regular occupation as a material planner (L. 143). For the same reason, Petitioner's allegation that Dr. Hartman's opinions were not relevant to ascertaining whether Petitioner could work as a material planner has no basis in fact or logic. (Pet. Br. 45.) Petitioner's objections to the treating physician rule do not withstand even superficial review.[19]

[19] Petitioner suggests, "Some persons with limited physical capacity outperform persons with no limitations; there is no direct relationship between a person's physical capacity and a person's work capacity." (Pet. Br. 36.) This is a non sequitur. What Petitioner apparently is trying to say is that there is no absolute relationship between

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2. SSA's Treating Physician Rule Does Not Place The Burden Of Persuasion On SSA

A claimant for ERISA disability benefits bears "the burden of proving that he is entitled to a benefit under 29 U.S.C. § 1132(a)(1)(B)." (Pet. Br. 39 (*citing Horton v. Reliance Standard Life Ins. Co.*, 141 F.3d 1038, 1040 (11th Cir. 1998); *Fuja v. Benefit Trust Life Ins. Co.*, 18 F.3d 1405, 1408 (7th Cir. 1994)).) Petitioner relies on a supposed difference in the burden of proof between claims for ERISA and Social Security disability benefits as reason not to utilize a treating physician rule in the judicial review of denials of ERISA benefits. (Pet. Br. 23; *see also id.* 15, 45.) Petitioner's argument rests on an erroneous evaluation of the burden of proof in SSA proceedings. According to Petitioner, a treating physician rule *is* compatible with SSA proceedings because in those proceedings the "burden is ultimately on the SSA, and not the claimant, to prove

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the severity of a claimant's medical diagnosis and a claimant's functional limitations. If true, this basic proposition is reason *for* a treating physician rule because a treating physician is best situated to assess how an individual claimant's medical diagnosis actually affects the claimant's ability to function. In contrast, an examining physician or non-examining physician might consider every claimant as an average or typical case. A treating physician is best suited to know whether a medical diagnosis of a specific severity has more or less impact on an individual claimant than in the average case.

But Petitioner does not consistently suggest or argue that there is *no* correlation between the severity of a claimant's medical diagnosis and the claimant's functional limitations. In fact, Petitioner apparently argues for reliance on Dr. Mitri's independent medical examination precisely because Dr. Mitri supposedly could deduce from the severity of Petitioner's medical diagnoses Respondent's functional limitations. (Pet. Br. 33, 44.)

that the claimant is not totally disabled from any substantial gainful activity." (Pet. Br. 23.) Petitioner cites a footnote in *Yuckert*, which refers to the "burden of proof" in SSA proceedings as shifting to SSA at step five. (Pet. Br. 23 (*citing Yuckert*, 482 U.S. at 146 n.5).) But it is settled law that a claimant for Social Security benefits has the burden of persuasion through step four in SSA proceedings, the analogous step of SSA's five-step sequential evaluation to Petitioner's "regular occupation" ERISA disability standard relevant to this case. *See Pinto*, 249 F.3d at 844 ("At step four, claimants have the burden of showing that they can no longer perform their past relevant work."). Because SSA applies its treating physician rule at step four when determining a claimant's residual functional capacity, *see* 20 C.F.R. § 404.1527 (2002); SSR 96-5p,[20] it cannot be true that a treating physician rule shifts the burden of persuasion to the adjudicator or plan administrator. There is no tension between SSA's treating physician rule and an SSA claimant's burden at step four to persuade SSA that he cannot do his past relevant work. Although there has been a treating physician rule in Social Security law for decades, Petitioner does not cite a single case holding that SSA's treating physician rule cannot be applied at step four of the five-step sequential evaluation because at step four the claimant, not SSA, has the burden of persuasion.[21]

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[20] *At* http://www.ssa.gov/OP_Home/rulings/.

[21] The burden of proof includes the burden of production of evidence and the burden of persuasion. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). In *Yuckert*, this Court recognized that SSA has the authority to define through regulation the burden of proof in Social Security disability proceedings. *Yuckert*, 482 U.S. at 146 n.5

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H. A Treating Physician Rule Considers Whether A Treating Physician Responds To A Request For More Information

Petitioner sets forth as an objection to a treating physician rule that the Ninth Circuit below did not consider that Respondent did not provide additional information from a treating physician when the plan administrator asked Respondent to submit examining physician Dr. Mitri's report to a treating physician for comment. (Pet. Br. 44.) This is no defect in the treating physician rule. Under that rule, an adjudicator, plan administrator, and court may consider the fact that a claimant did not respond to a request to provide additional information from a treating physician. *See Tidwell v. Apfel*, 161 F.3d 599, 602 (9th Cir. 1998) (approving an ALJ's rejection of a treating physician's opinion because the treating physician gave an inadequate response to a request for additional information); 20 C.F.R.

(*citing Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981)). In footnote five of *Yuckert*, this Court did not distinguish between the burdens of production and persuasion, stating broadly that the Agency "is required to bear this burden [of proof] only if the sequential evaluation process proceeds to the fifth step." *Yuckert*, 482 U.S. at 146 n.5. This Court referred to the shifting burden *of production* of *vocational* evidence from the claimant to the Agency at step five. *Id.*; *see also Heckler v. Campbell*, 461 U.S. 458 (1983) (describing the Agency's burden to provide evidence of jobs at step five); *Tackett v. Apfel*, 180 F.3d 1094, 1098 n.3 (9th Cir. 1999) (describing "elusive" nature of shifting burden of proof in SSA proceedings). This Court in *Yuckert* did not reach the issue of whether a claimant or SSA has the burden *of persuasion* at step five. On this issue, the Circuits are split. *Compare Curry v. Apfel*, 209 F.3d 117, 122-23 (2d Cir. 2000) (placing burden of persuasion on SSA at step five); Acquiescence Ruling 00-4(2), 65 Fed. Reg. 54,879 (2000) (SSA disagreement with *Curry*), *with Her v. Commissioner of Social Security*, 203 F.3d 388, 391 (6th Cir. 1999) (placing burden of persuasion on claimant at step five). There is no need to reach the issue in this case.

§§ 404.1512(e), 404.1527(c)(3) (2002) (regulatory procedure for recontacting a treating physician).

IV. A Treating Physician Rule Is Compatible With Deferential Judicial Review

A. Petitioner Seeks Review Significantly More Deferential Than Even Substantial Evidence Review

Petitioner erroneously asserts that application of a treating physician rule is incompatible with deferential judicial review such as abuse of discretion review or substantial evidence review. (Pet. Br. 24-25.) For example, Petitioner protests that the Ninth Circuit's treating physician rule is inconsistent with deferential substantial evidence review because the Ninth Circuit requires either clear and convincing reasons or specific and legitimate reasons to justify rejection of a treating physician's opinion. (Pet. Br. 24.) Neither the Ninth Circuit nor any other Circuit has understood the application of a treating physician rule to require more than substantial evidence in order to justify affirmance of an administrative denial of Social Security benefits. Nor could it, given the Social Security Act. *See* 42 U.S.C. § 405(g) ("The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive"). And the Ninth Circuit's treating physician rule does not require more than substantial evidence to support a denial of benefits: it requires exactly "substantial evidence" to support a denial of benefits. *See, e.g.*, *Smolen*, 80 F.3d at 1286. The Ninth Circuit correctly does not understand its treating physician rule in the Social Security context as overriding the statutorily prescribed substantial evidence standard of review. 42 U.S.C. § 405(g).

In support of its argument that the Ninth Circuit's treating physician rule is incompatible with substantial evidence review, Petitioner seems to rely on Richard J. Pierce's *Administrative Law Treatise* (2002), in which Pierce supposedly criticizes the Second Circuit's treating physician rule. (Pet. Br. 28 n.12, 41 (*citing Administrative Law Treatise*, §§ 9.10, 11.3).) Pierce objects in part to the Second Circuit's rule described in *Stieberger v. Bowen*, 801 F.2d 29, 31 (2d Cir. 1986). *See Administrative Law Treatise* §§ 9.10, 11.3. This is no longer the Second Circuit's rule. In *Schisler III*, the Second Circuit held that its prior treating physician caselaw was superseded by SSA's regulations promulgated in 1991. 3 F.3d at 569. The Second Circuit now has a mature, flexible treating physician rule that aids judicial review under the substantial evidence standard. *Id.* (*following* 20 C.F.R. § 404.1527 (2002)).

Deferential judicial review such as substantial evidence review is based on the "whole" evidentiary record. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 481-89 (1951). Petitioner attacks the treating physician rule as inconsistent with deferential review of the "entire medical record." (Pet. Br. 24.) On the contrary, a treating physician rule neither prevents nor discourages reasoned consideration of the whole record. The treating physician rule itself emphasizes consideration of the whole record. *See* 20 C.F.R. § 404.1527(d)(4) (2002) ("Generally, the more consistent an opinion is *with the record as a whole*, the more weight we will give to that opinion.") (emphasis added). In order to assess whether an adjudicator or plan administrator properly accepted *or* rejected a treating physician's opinion, it is necessary to review the treating physician's opinion in the context of the other record evidence, including the treating physician's clinical findings, other medical opinions and findings, and non-medical

facts. *See Magallanes*, 881 F.2d at 751-55 (affirming denial of benefits after review of the "whole" record, including multiple medical opinions and findings from various physicians).[22]

Instead of inhibiting consideration of the whole record on deferential judicial review, a treating physician rule focuses the court's attention on important evidence: treating physician opinions. In almost all cases involving a determination of disability based on a medical condition, a claimant's treating physician's opinion deserves thoughtful consideration even if the court's ultimate conclusion is to ratify the adjudicator's or plan administrator's rejection or endorsement of the treating physician's opinion. The mature, flexible treating physician rule as set forth in Ninth Circuit caselaw and SSA regulations aids a court's review of the whole record because it identifies for the court important evidence. This rule neither requires nor implies that evidence other than a treating physician's opinion must or should be ignored.

In any case, Petitioner does not welcome deferential review based on the whole record. Petitioner is hostile to deferential review based on the whole record. As the Ninth Circuit described in its decision below, Petitioner maintains that a plan administrator need not consider *any* evidence contrary to the plan administrator's chosen result:

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[22] *See also Clifford*, 227 F.3d at 871 (medical opinions are evaluated with "*all* relevant evidence") (emphasis in original); *Prosch v. Apfel*, 201 F.3d 1010, 1013 (8th Cir. 2000) (a treating physician's opinion is evaluated "in light of the record as a whole").

> Because the issue of an apparent conflict of interest was litigated below, Black & Decker received ample opportunity to demonstrate that its termination of Nord's benefits was free from conflict by advancing sound reasons for its denial of benefits. It has provided none. *Rather, it has simply asserted at every turn, and again before this Court, that it was under no duty to consider evidence that was unfavorable to its determination, whether coming from Nord's physicians or from its own human resources representative*. . . .

(Petition App. 14 (emphasis added).) This position is unreasonable and a breach of a plan administrator's fiduciary duty to provide "full and fair" review. 29 U.S.C. § 1133(2). Moreover, it is inconsistent with this Court's jurisprudence of deferential judicial review emphasizing consideration of the "whole" record, including evidence that "detracts" from the disputed finding. *Universal Camera Corp.*, 340 U.S. at 488.

B. A Court Can Apply A Treating Physician Rule And Respect A Factfinder's Responsibility To Resolve Evidentiary Conflicts

Petitioner contends that the Ninth Circuit's treating physician rule impedes or prevents a plan administrator from weighing conflicting evidence. (Pet. Br. 47.) This is not an argument against the Ninth Circuit's treating physician rule. The Ninth Circuit's treating physician rule neither impedes nor prevents the weighing of conflicting evidence, but rather requires the reasonable resolution of evidentiary conflicts. *See Thomas v. Barnhart*, 278 F.3d 947, 956-57 (9th Cir. 2002) (affirming finding of non-disability based on the reasonable resolution of conflicting medical opinions); *Tonapetyan v. Halter*, 242 F.3d 1144, 1149 (9th

Cir. 2001) (holding that ALJ properly resolved a conflict among medical opinions when rejecting a claimant's allegations); *Magallanes*, 881 F.2d at 751-55 (affirming finding of non-disability based on the reasonable resolution of conflicting medical opinions); *Allen v. Heckler*, 749 F.2d 577, 579 (9th Cir. 1984) (same).[23]

Petitioner's argument if correct would be astonishing. There are more than 15,000 civil actions annually challenging SSA's administrative decisions denying claims of disability.[24] *See* 42 U.S.C. § 405(g). If Petitioner were correct, the lower courts could not both enforce SSA's treating physician rule, *see* 20 C.F.R. § 404.1527 (2002), *and* respect a factfinder's responsibility to weigh conflicting evidence, *see Perales*, 402 U.S. at 399 ("We therefore are presented with the not uncommon situation of conflicting medical evidence. The trier of fact has the duty to resolve that conflict."). But the lower courts discharge both duties every day.

[23] *See also Mastro*, 270 F.3d at 179 (affirming ALJ's rejection of treating physician's opinion given conflicting evidence); *Stanley v. Secretary of Health and Human Servs.*, 39 F.3d 115, 118 (6th Cir. 1994) (ALJ reasonably resolved conflict among a treating physician's opinions); *Williams v. Shalala*, 997 F.2d 1494, 1499 (D.C. Cir. 1993) (affirming rejection of treating physician's opinion given "contradictory" evidence).

[24] Office of Human Resources and Statistics, Admin. Office of the U.S. Courts, *Federal Judicial Caseload Statistics* (Mar. 2002), Table C3, *at* http://www.uscourts.gov/caseload2002/contents.html. About 700 district-court dispositions under 42 U.S.C. § 405(g) annually are appealed to the Courts of Appeals. *Id.* at Table B7.

CONCLUSION

The judgment of the Court of Appeals for the Ninth Circuit should be affirmed.

Respectfully submitted,

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APPENDIX

20 C.F.R. § 404.1527 (2002), provides in full:

(a) *General*.

(1) You can only be found disabled if you are unable to do 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 12 months. See § 404.1505. Your impairment must result from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. See § 404.1508.

(2) Evidence that you submit or that we obtain may contain medical opinions. Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of your impairment(s), including your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions.

(b) *How we consider medical opinions*. In deciding whether you are disabled, we will always consider the medical opinions in your case record together with the rest of the relevant evidence we receive.

(c) *Making disability determinations*. After we review all of the evidence relevant to your claim, including medical opinions, we make findings about what the evidence shows.

(1) If all of the evidence we receive, including all medical opinion(s), is consistent, and there is sufficient evidence for us to decide whether you are disabled, we will make our determination or decision based on that evidence.

(2) If any of the evidence in your case record, including any medical opinion(s), is inconsistent with other evidence or is internally inconsistent, we will weigh all of the evidence and see whether we can decide whether you are disabled based on the evidence we have.

(3) If the evidence is consistent but we do not have sufficient evidence to decide whether you are disabled, or if after weighing the evidence we decide we cannot reach a conclusion about whether you are disabled, we will try to obtain additional evidence under the provisions of §§ 404.1512 and 404.1519 through 404.1519h. We will request additional existing records, recontact your treating sources or any other examining sources, ask you to undergo a consultative examination at our expense, or ask you or others for more information. We will consider any additional evidence we receive together with the evidence we already have.

(4) When there are inconsistencies in the evidence that cannot be resolved, or when despite efforts to obtain additional evidence the evidence is not complete, we will make a determination or decision based on the evidence we have.

(d) *How we weigh medical opinions*. Regardless of its source, we will evaluate every medical opinion we receive. Unless we give a treating source's opinion controlling weight under paragraph (d)(2) of this section, we consider

all of the following factors in deciding the weight we give to any medical opinion.

(1) *Examining relationship*. Generally, we give more weight to the opinion of a source who has examined you than to the opinion of a source who has not examined you.

(2) *Treatment relationship*. Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source's opinion controlling weight, we apply the factors listed in paragraphs (d)(2)(i) and (d)(2)(ii) of this section, as well as the factors in paragraphs (d)(3) through (d)(6) of this section in determining the weight to give the opinion. We will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion.

(i) *Length of the treatment relationship and the frequency of examination*. Generally, the longer a treating source has treated you and the more times you have been seen by a treating source, the more weight we will give to the source's medical opinion. When the treating source has seen you a number of times and long enough to have

obtained a longitudinal picture of your impairment, we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(ii) *Nature and extent of the treatment relationship*. Generally, the more knowledge a treating source has about your impairment(s) the more weight we will give to the source's medical opinion. We will look at the treatment the source has provided and at the kinds and extent of examinations and testing the source has performed or ordered from specialists and independent laboratories. For example, if your ophthalmologist notices that you have complained of neck pain during your eye examinations, we will consider his or her opinion with respect to your neck pain, but we will give it less weight than that of another physician who has treated you for the neck pain. When the treating source has reasonable knowledge of your impairment(s), we will give the source's opinion more weight than we would give it if it were from a nontreating source.

(3) *Supportability*. The more a medical source presents relevant evidence to support an opinion, particularly medical signs and laboratory findings, the more weight we will give that opinion. The better an explanation a source provides for an opinion, the more weight we will give that opinion. Furthermore, because nonexamining sources have no examining or treating relationship with you, the weight we will give their opinions will depend on the degree to which they provide supporting explanations for their opinions. We will evaluate the degree to which these opinions consider all of the pertinent evidence in your claim, including opinions of treating and other examining sources.

(4) *Consistency*. Generally, the more consistent an opinion is with the record as a whole, the more weight we will give to that opinion.

(5) *Specialization*. We generally give more weight to the opinion of a specialist about medical issues related to his or her area of specialty than to the opinion of a source who is not a specialist.

(6) *Other factors*. When we consider how much weight to give to a medical opinion, we will also consider any factors you or others bring to our attention, or of which we are aware, which tend to support or contradict the opinion. For example, the amount of understanding of our disability programs and their evidentiary requirements that an acceptable medical source has, regardless of the source of that understanding, and the extent to which an acceptable medical source is familiar with the other information in your case record are relevant factors that we will consider in deciding the weight to give to a medical opinion.

(e) *Medical source opinions on issues reserved to the Commissioner*. Opinions on some issues, such as the examples that follow, are not medical opinions, as described in paragraph (a)(2) of this section, but are, instead, opinions on issues reserved to the Commissioner because they are administrative findings that are dispositive of a case; i.e., that would direct the determination or decision of disability.

(1) *Opinions that you are disabled*. We are responsible for making the determination or decision about whether you meet the statutory definition of disability. In so doing, we review all of the medical findings and other evidence that support a medical source's statement that

you are disabled. A statement by a medical source that you are "disabled" or "unable to work" does not mean that we will determine that you are disabled.

(2) *Other opinions on issues reserved to the Commissioner*. We use medical sources, including your treating source, to provide evidence, including opinions, on the nature and severity of your impairment(s). Although we consider opinions from medical sources on issues such as whether your impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments in appendix 1 to this subpart, your residual functional capacity (see §§ 404.1545 and 404.1546), or the application of vocational factors, the final responsibility for deciding these issues is reserved to the Commissioner.

(3) We will not give any special significance to the source of an opinion on issues reserved to the Commissioner described in paragraphs (e)(1) and (e)(2) of this section.

(f) *Opinions of nonexamining sources*. We consider all evidence from nonexamining sources to be opinion evidence. When we consider the opinions of nonexamining sources, we apply the rules in paragraphs (a) through (e) of this section. In addition, the following rules apply to State agency medical and psychological consultants, other program physicians and psychologists, and medical experts we consult in connection with administrative law judge hearings and Appeals Council review:

(1) At the initial and reconsideration steps in the administrative review process, except in disability hearings, State agency medical and psychological consultants are members of the teams that make the determinations of disability. A State agency medical or psychological consultant

will consider the evidence in your case record and make findings of fact about the medical issues, including, but not limited to, the existence and severity of your impairment(s), the existence and severity of your symptoms, whether your impairment(s) meets or equals the requirements for any impairment listed in Appendix 1 to this subpart, and your residual functional capacity. These administrative findings of fact are based on the evidence in your case record but are not themselves evidence at these steps.

(2) Administrative law judges are responsible for reviewing the evidence and making findings of fact and conclusions of law. They will consider opinions of State agency medical or psychological consultants, other program physicians and psychologists, and medical experts as follows:

(i) Administrative law judges are not bound by any findings made by State agency medical or psychological consultants, or other program physicians or psychologists. However, State agency medical and psychological consultants and other program physicians and psychologists are highly qualified physicians and psychologists who are also experts in Social Security disability evaluation. Therefore, administrative law judges must consider findings of State agency medical and psychological consultants or other program physicians or psychologists as opinion evidence, except for the ultimate determination about whether you are disabled. See § 404.1512(b)(6).

(ii) When an administrative law judge considers findings of a State agency medical or psychological consultant or other program physician or psychologist, the administrative law judge will evaluate the findings using

relevant factors in paragraphs (a) through (e) of this section, such as the physician's or psychologist's medical specialty and expertise in our rules, the supporting evidence in the case record, supporting explanations provided by the physician or psychologist, and any other factors relevant to the weighing of the opinions. Unless the treating source's opinion is given controlling weight, the administrative law judge must explain in the decision the weight given to the opinions of a State agency medical or psychological consultant or other program physician or psychologist, as the administrative law judge must do for any opinions from treating sources, nontreating sources, and other nonexamining sources who do not work for us.

(iii) Administrative law judges may also ask for and consider opinions from medical experts on the nature and severity of your impairment(s) and on whether your impairment(s) equals the requirements of any impairment listed in appendix 1 to this subpart. When administrative law judges consider these opinions, they will evaluate them using the rules in paragraphs (a) through (e) of this section.

(3) When the Appeals Council makes a decision, it will follow the same rules for considering opinion evidence as administrative law judges follow.