



Administrative Conference of the United States

SSA DISABILITY BENEFITS PROGRAMS: ASSESSING THE EFFICACY OF THE TREATING PHYSICIAN RULE

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INTRODUCTION

Consideration of medical opinions is intrinsic to both the administrative determination of claims for disability benefits under Social Security Disability Insurance (“SSDI”) and Supplemental Security Income (“SSI”), and to judicial review of administrative denials of benefit claims. The SSA Commissioner has “exceptionally broad”¹ statutory authority to establish rules for the receipt and assessment of proof—including medical evidence—in order to achieve efficiency and uniformity to the processing of over 3 million claims annually, 700,000 of which are heard by administrative law judges (“ALJs”). Given the nature of medical evidence, this is no easy task.

Just over twenty years ago, in 1991, the Social Security Administration (“SSA”) sought to bring greater clarity and uniformity to the assessment of medical evidence by establishing regulatory standards for such evaluations, particularly with respect to treating physicians.² The treating physician rule—which remains largely unchanged today—affords “controlling weight” to the opinions of the claimants’ treating physicians (or other acceptable medical sources) so long as their views are well-supported by medical evidence and do not conflict with other substantial evidence in the record.³ SSA gave treating physician opinions special deference based on the assumption that such individuals usually have the most knowledge about, and longitudinal insight into, their patients’ conditions.

Over the years, however, the treating physician rule has not brought this hoped-for uniformity and clarity to the adjudication of disability benefits. Decisions by ALJs involving the treating physician rule have been overturned at significant rates by the SSA Appeals Council (“Appeals Council”), as well as by federal courts. Analysis of data provided by SSA shows that, in recent years, the erroneous application of the treating source rule has been cited with a ten percent frequency rate as a reason for remand by the Appeals Council.⁴ At the district court level, the remand rate involving the treating physician rule is even higher—cited at about a thirty-five percent frequency rate.⁵ Indeed, of the bases for remand by federal courts that are tracked by SSA, the treating physician rule-based remands are the highest category of remands.⁶

¹ Heckler v. Campbell, 461 U.S. 458, 466 (1983).

² See Soc. Sec. Admin., Standards for Consultative Examinations and Existing Medical Evidence; Final Rules, 56 Fed. Reg. 36,932, 36,934 (Aug. 1, 1991) [hereinafter 1991 Final Rules] (“[J]udicial decisions in several circuits pointed to a need for a *clear policy statement* that would *encourage uniformity of adjudication* and provide the public and the courts with a definitive explanation of our policy on weighing treating source opinions.”) (emphasis added); see also Soc. Sec. Admin., Standards for Consultative Examinations and Existing Medical Evidence; Proposed Rules, 52 Fed. Reg. 13,014, 13,016 (Apr. 20, 1987) [hereinafter 1987 NPRM] (“[T]o clarify [SSA’s] existing policy with respect to the weight which [the agency] place[s] on opinions of treating sources and in response to certain Federal Circuit Court of Appeals decisions and other statements regarding [agency] policy, [SSA is] setting forth [its] policy with respect to opinions of treating sources.”) (emphasis added).

³ 20 C.F.R. §§ 404.1527(c), 416.927(c) (2012). For ease of reference, this report uses “treating physician” and “treating source” interchangeably; however, the treating physician rule also encompasses psychologists and “other acceptable medical sources.” See 20 C.F.R. §§ 404.1502, 416.902 (2012).

⁴ See Appendix (“App.”) B: Analysis of SSA Data on Remand Rates by Federal Courts and the Appeals Council, tbl. 9, p. A-8.

⁵ *Id.* at A-4 tbl.3.

⁶ *Id.* at A-3 - A-4 tbls. 2 & 3. Treating physician rule-related remands are a subcategory of the Opinion Evidence Evaluation & Residual Functional Capacity (“OEE & RFC”) classification and represent the highest percentage of remand frequency within that classification. The OEE & RFC classification is itself the most frequently cited remand category. See *id.* at A-3 tbl.2.

Additionally, dramatic changes in the American health care system over the past twenty years independently call into question the ongoing efficacy of the special deference afforded opinions by treating physicians. Long-term continuity of care between patient and physician is no longer the norm due to several interrelated factors, including: the rise of managed care and concomitant disruptions in continuity of care; changes in the practice of medicine (*i.e.*, increasing specialization and declining numbers of primary care physicians, as well as the rise of medical personnel, such as nurse practitioners (“NPs”), physician assistants (“PAs”), and licensed clinical social workers (“LCSWs”) acting as patients’ primary care providers); patient consumerism (largely through the Internet) leading to increasing voluntary changes in practice groups or physicians; and, other societal and demographic changes. As one scholar noted: “What was traditionally (and perhaps mythically) considered a dyadic relationship between the clinician and health care consumer has been potentially jeopardized by a new triangular interaction: the patient-provider-managed care/health insurance bureaucracy.”⁷ Thus, whatever may be said for the longevity of physician-patient relationships two decades ago, it is simply not the norm today.

SSA commissioned the Administrative Conference of the United States (“Administrative Conference” or “Conference”) to study and recommend improvements to adjudication of the SSDI and SSI programs, with a particular focus on exploring the high remand rates from federal courts under the treating physician rule.⁸ This report represents a collaborative effort between the Office of the Chairman of the Administrative Conference and the Conference’s consultants on this project, Dean Harold J. Krent and Professor Scott Morris. During the course of this study, we (1) reviewed statutes, regulations, and other publicly available information relating to SSA’s disability benefits programs that relate to the treating physician rule; (2) analyzed SSA-provided data in order to identify the impact of this rule at both the administrative level and in the federal courts; (3) reviewed federal case law, law review articles, and treatises addressing SSA’s treating physician rule; (4) documented the changing nature of the U.S. health care system through review of medical journals, federal and non-profit statistical resources, and other publicly available sources; and (5) conducted legal research on the evidentiary weight afforded the opinions of treating sources in other federal and state statutory disability benefits programs. Our review and research were supplemented by a questionnaire that was sent to both the National Organization of Social Security Claimants’ Representatives (“NOSSCR”) and the National Association of Disability Representatives (“NADR”), as well as by interviews of SSA officials, ALJs, decision writers, and attorneys.

This report provides background data and analysis to SSA should it choose to revisit the continued efficacy of the treating physician rule. Part I of this report begins with a brief description of the administrative process and legal standards governing the adjudication of Social Security disability benefits claims. This Part provides an overview of the origins of

⁷ Jeffrey M. Borhan, *Examining American Family Medicine in the New World Order – A Study of 5 Practices*, 48 J. FAM. PRAC. 620 (Aug. 1999).

⁸ As originally conceived, the Conference’s study of the treating physician rule was to be part of a broader study on the SSDI and SSI programs. *See, e.g.*, SSA Disability Administration: Disability Adjudication Project Outline, available at http://www.acus.gov/sites/default/files/documents/Final-SSA-Outline-Approv.-5_24_12.pdf (last accessed Feb. 7 2013). After the project started, however, it was decided that the treating physician rule aspect of the project would be addressed in this stand-alone report. Findings from the Conference’s broader SSA adjudication study will be discussed in a separate forthcoming report that is expected in early 2013 [hereinafter 2013 SSA Disability Adjudication Report].

the treating physician rule and the promulgation of regulatory standards in 1991. Part II then discusses the widely divergent standards used by federal courts in various circuits when reviewing cases involving the treating physician rule, with particular attention to the substantial evidence standard of review. Part III details the substantial changes in the delivery of health care in the United States over the last several decades and discusses how this evolution has largely undermined one of the primary assumptions underlying the treating physician rule. Part IV summarizes the results from an empirical analysis of SSA-provided data relating to the treating physician rule and remand rates with respect to both the Appeals Council and federal courts. Part V shows how the treating physician rule works in the context of other federal and state disability benefits programs, and discusses the perspective of claimant representative organizations. The report concludes with Part VI, which lays out guiding principles and options for SSA as it considers the continuing efficacy of the treating physician rule.

I. SSA DISABILITY BENEFITS PROGRAMS: ADJUDICATION PROCESS & LEGAL STANDARDS

A. Disability Claim Adjudication Process

The Social Security Act created two programs—SSDI and SSI—to provide monetary benefits to persons with disabilities who satisfy these programs’ requirements.⁹ Individuals may qualify for regular payments from the federal government if, among other things, they can show that they have an impairment that is disabling.¹⁰ The programs share the same definition of disability: the inability “to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.”¹¹ Every year, millions of people apply for these disability benefits,¹² and SSA has created what may be the world’s largest adjudicative system to process these claims.¹³

The disability benefits adjudication process begins with the filing of an application with a SSA field office, either in-person or online. Individuals seeking disability benefits may file (and pursue) their own claims or they may choose to enlist the assistance of a representative, who may or may not be an attorney. Once an application is received by the SSA field office, (in most instances) the case is sent to a federally funded state Disability Determination Service (“DDS”) for the initial steps in the adjudication process. In most states, a team consisting of a state disability examiner and a state agency medical and/or psychological consultant makes an initial determination of eligibility on behalf of SSA.¹⁴ The DDS team may gather medical documents and/or order an examination by a contracting

⁹ 42 U.S.C. §§ 401(b), 1381 (2012).

¹⁰ 42 U.S.C. § 423(d) (2012).

¹¹ 42 U.S.C §§ 423(d)(1)(A), 1382c(a)(3)(A) (2012).

¹² In fiscal year 2011, over 3.2 million people applied for disability benefits. SSA’S FY 2011 PERFORMANCE AND ACCOUNTABILITY REPORT 8 (2011), available at <http://www.ssa.gov/finance/2011/Full%20FY%202011%20PAR.pdf>.

¹³ *Securing the Future of the Disability Insurance Program: Hearing Before the Subcomm. on Soc. Sec. of the H. Comm. on Ways & Means*, 112th Cong. (June 27, 2012) (statement of Michael Astrue, Comm’r, Soc. Sec. Admin.) [hereinafter Astrue June 2012 Testimony], available at http://www.ssa.gov/legislation/testimony_062712.html; see also Heckler, 461 U.S. at 461 n.2 (quoting JERRY L. MASHAW ET AL., SOCIAL SECURITY HEARINGS AND APPEALS xi (1978)).

¹⁴ 42 U.S.C. §§ 405(b), 1383(c)(1) (2012).

physician or psychologist, termed a consultative examination, to make a decision regarding the claimant's disability status.¹⁵ If an individual's claim is denied, (in most states) the claimant may seek reconsideration¹⁶ by another DDS team, composed of a different examiner and medical or psychological consultant.¹⁷ As a whole, about forty percent of disability claims are allowed at the initial and reconsideration steps.¹⁸

If the claim is denied again, the individual may appeal his or her case to a SSA ALJ, and about forty percent of those whose claims were denied do in fact appeal.¹⁹ The ALJ reviews the case *de novo* and may either award benefits prior to the hearing, based on the record, or decide the claim after an adjudicative hearing.²⁰ For the first time in the process, an oral hearing is provided. No deference is afforded the DDS determination, and the ALJ may consider additional medical examinations, vocational or medical expert testimony, as well as question the claimant or other witnesses personally.²¹ In contrast to most administrative adjudications, the agency is not represented at the hearing,²² while the claimant is represented in roughly eighty percent of the cases at the ALJ hearing level, predominantly by attorneys. The percentage of cases in which claimants are represented has soared in the past thirty years,²³ though ALJs have the duty to develop the record where needed, irrespective of whether the claimant is represented.²⁴ ALJs currently determine that disability is warranted in roughly fifty percent of the cases decided.²⁵

A claimant may appeal an ALJ decision to the Appeals Council, which has

¹⁵ Charles H. Koch, Jr., *The Fourth Bite at the Apple: A Study of the Operation and Utility of the Social Security Administration's Appeals Council*, 17 FLA. ST. U. L. REV. 199, 219 (1990).

¹⁶ Astrue June 2012 Testimony, *supra* note 13; 20 C.F.R. §§ 404.907, 416.1407 (2012).

¹⁷ Astrue June 2012 Testimony, *supra* note 13; 20 C.F.R. §§ 404.909, 416.1409 (2012).

¹⁸ For more specific figures and differences in allowance rates among the states, see SOCIAL SECURITY ADVISORY BOARD, ASPECTS OF DISABILITY DECISION MAKING: DATA AND MATERIALS 44 fig. 39. (2012), available at http://www.ssab.gov/Publications/Disability/GPO_Chartbook_FINAL_06122012.pdf [hereinafter SSAB 2012 Report].

¹⁹ Astrue June 2012 Testimony, *supra* note 13; 42 U.S.C. §§ 405(b)(1), 1383(c)(1)(A) (2012); 20 C.F.R. §§ 404.929, 416.1429 (2012); see also RICHARD V. BURKHAUSER & MARY C. DALY, THE DECLINING WORK AND WELFARE OF PEOPLE WITH DISABILITIES: WHAT WENT WRONG AND A STRATEGY FOR CHANGE 50 (American Enterprise Institute 2011) (statistic based on 2000 data).

²⁰ Astrue June 2012 Testimony, *supra* note 13; 42 U.S.C. §§ 405(b), 1383(c) (2012); 20 C.F.R. §§ 404.929, 416.1429 (2012).

²¹ 20 C.F.R. §§ 404.929-404.965; 416.1429-416.1455 (2012).

²² The Veterans Administration is the other most notable example. See, e.g., *Hodge v. West*, 155 F.3d 1356, 1362 (Fed. Cir. 1998) (in discussing "the historically non-adversarial system of awarding benefits to veterans" stating that "[t]his court and the Supreme Court both have long recognized that the character of the veterans' benefits statutes is strongly and uniquely pro-claimant"); see also *Henderson v. Shinseki*, 131 S. Ct. 1197, 1200, 1206 (2011) (referring to proceedings before the VA as "ex parte," "informal[,] and nonadversarial").

²³ The percentage of claimants represented by attorneys at ALJ hearings has nearly doubled since 1977 (from about 35% to 76%), while the use of non-attorney representatives has also experienced a steady increase since 2007. SSAB 2012 Report, *supra* note 18, at 60 fig. 55.

²⁴ E.g., *Hildebrand v. Barnhart*, 302 F.3d 836, 838 (8th Cir. 2002) describing the duty of an ALJ to "fully and fairly develop[] the facts of the case"; *Byes v. Astrue*, 687 F.3d 913, 915-16 (8th Cir. 2012) (same); *Thornton v. Schweiker*, 663 F.2d 1312, 1316 (5th Cir. 1981) (same); see also *Richardson v. Perales*, 402 U.S. 389, 410 (1971) (noting ALJ duty to investigate facts and develop arguments both for and against granting benefits).

²⁵ Data provided by SSA show that fully favorable allowance rates have dropped to 50% (data on file with ACUS). This rate is down from 60%. See SSAB 2012 Report, *supra* note 18, at 12 fig. 7. There is no definitive way to measure whether ALJs or state DDS systems measure "disability" more accurately. For one intriguing study concluding that ALJs are more likely to get it "right," see Hugo Benitez-Silve, Moshe Buchinsky & John Rust, *How Large Are the Classification Errors in the Social Security Disability Award Process?* 33 (Nat'l Bureau of Econ. Research, Working Paper No. 10219, 2004).

discretionary authority to determine which cases to review.²⁶ The Appeals Council will review a case if: (1) the ALJ committed an abuse of discretion; (2) there is an error of law; (3) the ALJ's decision was not supported by substantial evidence; (4) there is a broad policy issue that might affect the public interest; or (5) new and material evidence is submitted and it relates to the period on or before the ALJ hearing decision and the record shows the ALJ's actions, findings, or conclusion are contrary to the weight of the evidence.²⁷ The Appeals Council may affirm, modify, reverse, or remand the ALJ's decision.²⁸ If the Appeals Council denies review, the ALJ's decision becomes the final agency action.²⁹

A claimant who is finally denied by SSA—either as a result of the denial of Appeals Council review or the affirmance of an adverse ALJ decision—may seek judicial review in a federal district court based on the full administrative record and subject to the substantial evidence review standard.³⁰ In the context of judicial review of Social Security disability benefits programs, the Supreme Court has explained that substantial evidence means “more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.”³¹ If the reviewing court determines that either substantial evidence does not support the agency's determination, or the court cannot determine whether substantial evidence even exists, it can reverse and remand the decision to the agency, either for an award of benefits, or for further proceedings.³²

B. Standards for Evaluating Medical Evidence

Consideration of medical opinions is intrinsic to the administrative determination of claims for SSDI or SSI disability benefits. During the claim adjudication process, claimants generally have the burden of proving that they qualify as disabled.³³ Part of this proof involves submission of medical “evidence that [SSA] can use to reach conclusions about [the claimant's] medical impairment(s)”³⁴ and includes laboratory findings, medical history, opinions, and statements about treatment received.³⁵ Normally, when evaluating this evidence, ALJs and other agency decision makers must give the treating physician's opinion

²⁶ 20 C.F.R. §§ 404.967-404.968, 416.1467-416.1468 (2012). The vast majority of these cases resulted from actions related to appeals by claimants, but a small percentage represent “own motion review” (*i.e.*, bureau protests and pre-effectuation review of fully favorable cases) of benefit grants. Data from SSA show that in FY2011, the Appeals Council processed 126,992 requests for review, whereas it processed 4351 cases under own motion review (data on file with ACUS). In FY2012, the Appeals Council processed 166,020 requests for review, while processing 7598 cases under own motion review (same).

²⁷ 20 C.F.R. §§ 404.970, 416.1470 (2012).

²⁸ 20 C.F.R. §§ 404.979, 416.1479 (2012).

²⁹ 20 C.F.R. §§ 404.966(b), 416.1466(b) (2012).

³⁰ 42 U.S.C. §§ 405(g), 1383(c)(3) (2012); 20 C.F.R. §§ 404.981, 416.1481 (2012). A claimant must exhaust all administrative remedies before appealing to federal court. The claim is appealable in federal court only after the Appeals Council has issued a decision or has refused to review the case.

³¹ *Richardson v. Perales*, 402 U.S. at 401 (quoting *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938)).

³² 42 U.S.C. § 405(g) (2012). Historically, federal district courts have reversed very few agency actions. In FY1995 – FY2010, the average reversal rate was just over 5%. *See* SSAB 2012 Report, *supra* note 18, at 70 fig. 65b. Of the remaining cases, district courts affirm about half of SSA's decisions, and remand the other half to the agency for further proceedings. *Id.*

³³ 20 C.F.R. §§ 404.1512(a), 416.912(a) (2012) (“In general, you have to prove to us that you are blind or disabled.”).

³⁴ *Id.*

³⁵ 20 C.F.R. §§ 404.1512(b)(1)-(2), (d)(2), 416.912(b)(1)-(2), (d)(2) (2012).

“controlling weight.”³⁶ What is “controlling weight”? How does SSA weigh evidence? The following part describes the existing statutory and regulatory standards governing these issues.

1. Social Security Act

The Social Security Act empowers SSA to “adopt reasonable and proper rules . . . to regulate and provide for the nature and extent of proofs and evidence” to establish entitlement to disability benefits.³⁷ As the Supreme Court has emphasized on several occasions, this statutory authority is “exceptionally broad.”³⁸ The Commissioner thus has wide latitude to issue regulations establishing the nature and extent of evidence, which form the basis for adjudicating disability claims.

Disability, in turn, is defined under the Act as the “inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.”³⁹ The claimant must prove his or her disability by “medical and other evidence . . . as the Commissioner . . . may require.”⁴⁰ Evidence includes:

medical signs and findings, established by medically acceptable clinical or laboratory diagnostic techniques, which show the existence of a medical impairment [and] . . . would lead to a conclusion that the individual is under a disability. Objective medical evidence of pain or other symptoms established by medically acceptable clinical or laboratory techniques . . . must be considered in reaching a conclusion as to whether the individual is under a disability.”⁴¹

The Act charges SSA with considering all of the medical evidence in the case record, and developing a complete medical history of the past year whenever it denies a disability claim.⁴² The statute further states that SSA must “make every reasonable effort to obtain from the individual’s treating physician (or other treating health care provider) all medical evidence” necessary to making a disability determination before evaluating medical evidence from a consultative source.⁴³ While the Act thus states that SSA must consider a treating physician’s evidence first, it does not mandate the weight that SSA must give to that evidence.⁴⁴

³⁶ 20 C.F.R. §§ 404.1527(c)(2), 416.927(c)(2) (2012).

³⁷ 42 U.S.C. § 405(a) (2012).

³⁸ *See, e.g.*, *Bowen v. Yuckert*, 482 U.S. 137, 145 (1987) (quoting *Heckler*, 461 U.S. at 466 (quoting *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981))).

³⁹ 42 U.S.C. §§ 416(i)(1)(A), 423(d)(1) (2012); *see also*, 42 U.S.C. § 1382c(a)(3)(A) (2012).

⁴⁰ 42 U.S.C. § 423(d)(5)(A) (2012).

⁴¹ *Id.*

⁴² *Id.*

⁴³ *Id.*

⁴⁴ When enacting legislation to amend the Act in 1984, Congress made clear “that it did not intend to alter in any way the relative weight that the Secretary places on reports received from treating physicians.” 1991 Final Rules, *supra* note 2, at 13,016 (citing S. REP. NO. 98-466 (1984)).

2. *Pre-1991: Federal “Common Law” Governs Evaluation of Treating Physician Opinions*

The treating physician rule traces its origins to the 1980s when SSA, the federal courts, and, to a lesser extent, Congress engaged in institutional battles over the proper evaluation and weight to afford different types of medical evidence. Several legal scholars have described SSA, in the early 1980s, as “adopting a series of controversial policies and practices to restrict benefits,”⁴⁵ one of which was to rely on the agency’s own consulting medical examiners, rather than the claimant’s treating physician.⁴⁶ Both the courts and Congress decided to step in—federal courts, by creating a treating physician rule, and Congress, by passing a law requiring SSA to establish standards governing the use of consulting examiners.⁴⁷

The treating physician rule thus began as a rule “developed by Courts of Appeals as a means to control disability determinations by [ALJs] under the Social Security Act.”⁴⁸ Nearly every federal circuit gave more weight to a treating physician than a non-treating source, although courts disagreed on precisely what was needed to refute a treating source’s opinion. For example, the Fifth, Ninth, Tenth, and Eleventh Circuits gave “substantial,” “great,” or “considerable” weight to the treating physician “unless good cause was shown to the contrary.”⁴⁹ Good cause existed when the medical testimony had been “brief, conclusory,

⁴⁵ Richard E. Levy & Robert L. Glicksman, *Agency-Specific Precedents*, 89 TEX. L. REV. 499, 544 (2011) [hereinafter, Levy, *Agency-Specific Precedents*].

⁴⁶ Richard E. Levy, *Social Security Disability Determinations: Recommendations for Reform*, 1990 BYU L. REV. 461, 501 (1990) [hereinafter Levy, *Disability Determinations*]; see also H. COMM. ON GOVERNMENT OPERATIONS, 99TH CONG., CONSULTATIVE EXAMINATIONS INVESTIGATION, H.R. REP. NO. 99-981, at 3 (1986) (noting SSA’s then-current practice of using of consultative examinations instead of original medical records).

⁴⁷ Social Security Disability Benefits Reform Act of 1984, Pub. L. No. 98-460, § 9, 98 Stat. 1794, 1804-05 (1984) (codified at 42 U.S.C. §§421(j), 423(d)(5)(b) (2012)) [hereinafter Disability Benefits Reform Act].

⁴⁸ *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 829 (2003) [hereinafter *Black & Decker*]. Once it is determined that “an impairment exists, the opinions of the treating physician are entitled to substantially greater weight than the impressions of a doctor who sees the claimant only once.” Rachel Schneider, *A Role for the Courts: Treating Physician Evidence in Social Security Disability Determinations*, 3 U. CHI. L. SCH. ROUNDTABLE 391, 396 n.31 (1996) (quoting *Selig v. Richardson*, 379 F. Supp. 594, 604 (E.D.N.Y. 1974)). Other cases dating from the late 1950s through early 1970s also afforded the treating physician’s opinions special weight. See *Floyd v. Finch*, 441 F.2d 73, 107 (6th Cir. 1971) (“[T]he evidence of a physician who has been treating such applicant over many years and whose conclusion is that he is totally incapacitated, is substantial evidence as compared with the evidence of physicians who have examined the claimant on *one* occasion, and whose reports are inconclusive and not contradictions of unqualified evidence that claimant is totally and permanently disabled.”) (emphasis added); *Branham v. Gardner*, 383 F.2d 614, 630 (6th Cir. 1967) (“The expert opinions of plaintiff’s treating physicians as to plaintiff’s disability and inability to engage in any substantial gainful employment are binding upon the referee if not controverted by substantial evidence to the contrary.”); *Heslep v. Celebrezze*, 356 F.2d 891, 894 (4th Cir. 1966) (“While the attending physician’s opinion that [the claimant] was disabled . . . may not be binding on the Secretary, [the court] think[s] it is entitled to substantial weight.”); *Celebrezze v. Walter*, 346 F.2d 156, 156 (5th Cir. 1965) (affirming a district court’s decision to set aside the Secretary’s finding of no disability because the claimant’s personal physician offered “ample positive proof of disability”); *Teeter v. Flemming*, 270 F.2d 871, 874 (7th Cir. 1959) (same).

⁴⁹ *Frey v. Bowen*, 816 F.2d 508, 513 (10th Cir. 1987) (citing *Turner v. Heckler*, 754 F.2d 326, 329 (10th Cir. 1985)) (giving substantial weight to the opinion); *Lamb v. Bowen*, 847 F.2d 698, 703 (11th Cir. 1988) (same); *Magallanes v. Bowen*, 881 F.2d 747, 751 (9th Cir. 1989) (giving “greater weight” to the opinion); *Floyd v. Bowen*, 833 F.2d 529, 531 (5th Cir. 1987) (“unless good cause can be shown to the contrary, a treating physician’s opinion is entitled to considerable weight”); *Scott v. Heckler*, 770 F.2d 482, 485 (5th Cir. 1985) (treating physician’s opinion is entitled to considerable weight, unless good cause is shown to the contrary; good cause can be shown by when the physician’s statements are brief and conclusory, or otherwise being unsupported by the evidence).

and unsupported by medical evidence,”⁵⁰ although specific reasons for ignoring the opinion had to be set forth. Similarly, the Eighth Circuit afforded substantial weight to the treating source opinion unless it was “unsupported by the evidence” or “merely conclusory.”⁵¹ The Fourth and Second Circuits’ formulation of the rule was even more deferential, essentially creating a rebuttable presumption in favor of the treating physician.⁵² On the other hand, the First and Seventh Circuits gave no greater weight to the opinions of treating physicians than those of other non-treating medical professionals.⁵³ Thus, while the circuits agreed in principle that the opinion of treating physicians was entitled to deference, the standard for weighing or measuring that deference varied substantially among the circuits.

Against this varied backdrop of judicially created “common law” on special preference for treating physician opinions, SSA frequently refused to acquiesce in specific judicial decisions—even on an intra-circuit basis—and continued to apply its own internal agency policies.⁵⁴ SSA justified its non-acquiescence by a need for national uniformity in carrying out the Social Security disability programs.⁵⁵ Federal courts reacted in two ways: first, by “holding that SSA decisions rejecting the treating physician’s opinion and relying on a consulting examiner were not supported by substantial evidence”⁵⁶ and, second, by chiding SSA for “its failure to seek a uniform national rule at the appellate level by seeking Supreme Court review.”⁵⁷

Schisler Cases

The problem of various circuit court standards, compounded by the absence of a national uniform regulation governing this area, came to a head in a series of Second Circuit cases—*Schisler v. Heckler* (“*Schisler I*”) and *Schisler v. Bowen* (“*Schisler II*”). *Schisler I* involved a state-wide (New York) class action challenging SSA’s benefits termination

⁵⁰ *Frey*, 816 F.2d at 513 (citing *Allison v. Heckler*, 711 F.2d 145, 148 (10th Cir. 1983)).

⁵¹ *Turpin v. Bowen*, 813 F.2d 165, 170-71 (8th Cir. 1987).

⁵² *Schisler v. Heckler*, 787 F.2d 76, 85 (2d Cir. 1986) (“a treating physician’s opinion on the subject of medical disability is binding on the factfinder unless contradicted by substantial evidence”) [hereinafter *Schisler I*]; *Coffman*, 829 F.2d at 517 (“[I]n the Fourth Circuit, [the] rule requires that the opinion of a claimant’s treating physician be given great weight and may be disregarded only if there is persuasive contradictory evidence.”); *Foster v. Heckler*, 780 F.2d 1125, 1130 (4th Cir. 1986) (“A treating physician’s testimony is ignored *only* if there is persuasive contradictory evidence.”); *Mitchell v. Schweiker*, 699 F.2d 185, 187 (4th Cir. 1983) (the opinion of the claimant’s treating physician “may be disregarded only if there is persuasive contradictory evidence”).

⁵³ *Pagan v. Sec’y of Health & Human Servs.*, 819 F.2d 1, 3 (1st Cir. 1987) (holding that opinions of the claimant’s physicians are “not entitled to greater weight merely because they were treating physicians”); *see also Stephens v. Heckler*, 766 F.2d 284 (7th Cir. 1985), which states:

Experience and knowledge of this case weigh on the side of the treating physician, expertise and knowledge of similar cases on the side of the consulting specialist. How these weigh in any particular case is a question for the Secretary’s delegate, subject only to the rule that the final decision must be supported by “substantial evidence.”

Id. at 289.

⁵⁴ *Levy, Disability Determinations*, *supra* note 46, at 503 (describing SSA’s policy of non-acquiescence); *see also Schisler v. Sullivan*, 3 F.3d 563, 565 (2d Cir. 1993) [hereinafter *Schisler III*] (“HHS chose not to acquiesce in [the court’s treating physician] rule.”).

⁵⁵ *See Levy, Disability Determinations*, *supra* note 46, at 504.

⁵⁶ *Levy, Agency-Specific Precedents*, *supra* note 45, at 545.

⁵⁷ *Schisler I*, 787 F.2d at 83; *see also Schisler v. Bowen*, 851 F.2d 43, 44 (2d Cir. 1988) [hereinafter *Schisler II*] (“[T]he Secretary had never sought to challenge this rule by petitioning for certiorari in the Supreme Court.”).

process and newly imposed “current disability” standard.⁵⁸ The district court had ordered that class members’ termination decisions be remanded to SSA for re-adjudication under the proper legal standard.⁵⁹

On appeal, the *Schisler I* class argued that the remand order should include an injunction compelling SSA to follow the Second Circuit’s treating physician rule when re-adjudicating their individual claims.⁶⁰ That rule, which had been the law of the circuit for five years, held that treating physician opinions were “binding on the fact-finder unless contradicted by substantial evidence,” and, even then, were still to be afforded “some extra weight because the treating physician is usually more familiar with a claimant’s medical condition than other physicians.”⁶¹ The court noted that, while SSA had not formally announced a policy of non-acquiescence toward the Second Circuit’s treating physician rule, cases reversing SSA benefits determinations at the district court and appellate level were nonetheless “almost legion.”⁶² Highlighting the institutional struggle at play, the Second Circuit chided SSA for its approach: “While SSA’s claim that non-acquiescence is often necessary in order to have a uniform national rule at the administrative level is understandable, its failure to seek a uniform national rule at the appellate level by seeking Supreme Court review is not.”⁶³

SSA argued that, while not set down in publications or instructions to ALJs, its informal policy on the evaluation of treating physician opinions was consistent with the Second Circuit’s formulation of the rule.⁶⁴ While accepting SSA’s representations “at face value,” the court noted “the historical record” of reversals in the circuit and “the failure of SSA to inform its adjudicators of its true policy.”⁶⁵ The court thus held that, on remand, the district court should issue an order compelling SSA to publish guidance for its adjudicators at all levels that instructed them to follow the Second Circuit’s treating physician rule.⁶⁶

Two years later, in *Schisler II*, the parties were back in the Second Circuit on appeal from remand proceedings. On remand, SSA proffered a draft Social Security Ruling (“SSR”) entitled “Development and Consideration of Medical Evidence” to the district court as a means of complying with *Schisler I*.⁶⁷ In this twelve-page SSR, SSA provided a section with background information (*i.e.*, legislative history and definitions), a section addressing consultative examinations, and, lastly, a section addressing the treating physician rule.⁶⁸ With respect to this rule, SSA proposed a formulation that made the weight afforded treating physician opinions contingent on consistency with other medical reports and clinical or laboratory diagnostic evidence.⁶⁹ The district court, however, largely rejected SSA’s draft

⁵⁸ *Schisler I*, 787 F.2d at 78.

⁵⁹ *Id.* at 79.

⁶⁰ *Id.* at 81.

⁶¹ *Id.*

⁶² *Id.* at 82 (internal quotations omitted).

⁶³ *Id.* at 82-83. SSA never sought review of the various circuits’ treating physician rules in the Supreme Court. See Levy, *Disability Determinations*, *supra* note 46, at 506 (“To some observers, it appeared that SSA chose [not to] risk an adverse decision by the Supreme Court.”)

⁶⁴ *Schisler I*, 787 F.2d at 83.

⁶⁵ *Id.* at 84. The court also noted: “Absent such instructions, the danger that those adjudicators will apply the wrong legal rule to the facts will be great.” *Id.*

⁶⁶ *Id.*

⁶⁷ *Schisler II*, 851 F.2d at 44.

⁶⁸ *Id.*

⁶⁹ *Id.*

SSR on the grounds that it was “rambling and ambiguous” and “fail[ed] to reflect, in significant respects, the treating physician rule recognized and effective here and to be in place nationwide.”⁷⁰ The district court then substantially rewrote the SSR—including, among other things, making treating physician opinions “binding” on adjudicators absent substantial contradictory evidence—and ordered SSA to comply with the revised version.⁷¹ On appeal, SSA argued that the district court exceeded its authority by failing to accord sufficient deference to the agency’s administrative ruling embodied in its draft SSR.⁷² The *Schisler II* panel disagreed, and affirmed the district court’s version of the SSR with only slight changes.⁷³ The court reasoned that its remand order in *Schisler I* was narrowly tailored and directed SSA to use administrative judgment only insofar as selecting the best method of informing ALJs and other adjudicators of its adoption of the Second Circuit’s treating physician rule.⁷⁴ Rulemaking, the court emphasized, was the more appropriate forum for modifying the contours of the treating physician rule:

[T]he remand in this case was not a proper occasion for the [Health and Human Services] Secretary to issue a regulation covering subjects not at issue in this litigation or to elaborate on the treating physician rule in ways not expressly authorized by our caselaw. To the extent the Secretary seeks to issue rulings covering such subjects or to elaborate on that rule, he should resort to the customary administrative processes.⁷⁵

The court then provided its own approved version of the SSR.⁷⁶ After *Schisler II*, SSA was left with the administrative choice of whether to simply publish the Second Circuit’s SSR on the treating physician or promulgate its own version of a uniform rule.

3. 1991 - Present: SSA’s Regulatory Approach to the Treating Physician Rule

As of the late 1980s, SSA was at a crossroads with respect to the evaluation of medical evidence when adjudicating Social Security disability benefits, particularly with respect to the opinions of treating physicians. The agency was buffeted by several competing institutional considerations. On one side were the federal courts. While compliance with the *Schisler II* order posed the most immediate issue, the varying federal “common law” versions of the treating physician rule among the circuits made uniform administration of a national program problematic. On another side was Congress. The Social Security Disability Benefits Reform Act of 1984 compelled SSA to issue regulations establishing standards for consultative examinations and revamping consideration of medical evidence.⁷⁷ The Senate Finance Committee, when it considered the bill requiring SSA to promulgate those regulations, stated “that it did not intend to alter in any way the relative weight that the Secretary places on reports received from treating physicians”⁷⁸; however, it was clear that

⁷⁰ *Id.* at 44-45.

⁷¹ *Id.*

⁷² *Id.* at 45.

⁷³ *Id.* at 45-46.

⁷⁴ *Id.* at 45.

⁷⁵ *Id.*

⁷⁶ *Id.* at 46-47.

⁷⁷ Disability Benefits Reform Act, *supra* note 47.

⁷⁸ 1987 NPRM, *supra* note 2, at 13,016 (citing S. REP. NO. 98-466, at 26 (1984)).

Congress generally did not approve of SSA's non-acquiescence policy.⁷⁹

Against this backdrop, in April 1987, SSA issued a notice of proposed rulemaking ("NPRM") on various aspects of evaluation of medical evidence, including consultative examinations and treating physicians.⁸⁰ With respect to the treating physician rule, SSA characterized the proposed rule as having a dual purpose: (1) "to clarify [its] existing policy with respect to the weight which [it] place[s] on opinions of treating sources," and (2) to "respon[d] to certain Federal Circuit Court of Appeals decisions[, including *Schisler I*,] and other statements regarding [SSA's] policy."⁸¹ In terms of regulatory substance, SSA proposed "to revise [20 C.F.R.] §§ 404.1527 and 416.927 to clearly indicate those instances when a treating source opinion will be conclusive, when it will be given preference, and when neither conclusiveness nor preference will be granted."⁸² Opinions of treating physicians, under the proposed rule, would be "conclusive" on medical disability issues so long as "fully supported" by medically acceptable laboratory or diagnostic findings and "not inconsistent with the other substantial medical evidence of record."⁸³ And, if the treating source's opinions were inconsistent with other medical evidence, SSA nonetheless proposed to afford "some extra weight" to that treating opinion in resolving such inconsistency.⁸⁴ No mention was made in the text of the proposed rule (or elsewhere in the NPRM) to giving special preference to treating physician opinions because of their presumed longitudinal perspective on claimants' medical impairments.

Four years later, in August 1991, SSA issued final rules entitled, "Standards for Consultative Examination and Existing Medical Evidence."⁸⁵ The preamble discussion of the treating physician rule in the 1991 Final Rules is notable in several respects. First, SSA reiterated that judicial decisions from various circuits (including, by that point, *Schisler II*) "pointed to a need for a clear policy statement that would encourage uniformity of adjudication and provide the public and the courts with a definitive explanation of our policy on weighing treating source opinions."⁸⁶ SSA observed that, while circuit courts varied in their approaches to judicially created treating physician rules, the majority of courts agreed on two fundamental principles: (1) treating source opinions have "special intrinsic value" because of the relationship the source has with the claimant; and (2) if the opinion is rejected, good reasons should be provided for doing so.⁸⁷ SSA stated that the final rules had been drafted with these principles in mind.⁸⁸

⁷⁹ The 1984 legislation originally required SSA to comply with judicial decisions on the treating physician rule, but that provision was withdrawn from the final bill when SSA indicated that it would abandon its non-acquiescence policy. See Levy, *Disability Determinations*, *supra* note 46, at 506 n.249; H.R. CONF. REP. NO. 98-1039, at 36-38 (1984), *reprinted in* 1984 U.S.C.C.A.N. 3080, 3094-96 (conferees noted that, while the provision prohibiting non-acquiescence had been dropped, they still had constitutional objections and urged SSA to confine such practice to limited circumstances).

⁸⁰ 1987 NPRM, *supra* note 2, at 13,016; see also 1991 Final Rules, *supra* note 2, at 36,934 ("[J]udicial decisions in several circuits pointed to a need for a clear policy statement that would encourage uniformity of adjudication and provide the public and the courts with a definitive explanation of our policy on weighing treating source opinions.").

⁸¹ 1987 NPRM, *supra* note 2, at 13,016.

⁸² *Id.*

⁸³ *Id.* at 13,022, 13,030.

⁸⁴ *Id.*

⁸⁵ 1991 Final Rules, *supra* note 2.

⁸⁶ *Id.* at 36,934.

⁸⁷ *Id.*

⁸⁸ *Id.*

Second, unlike the 1987 NPRM, SSA emphasized in the preamble to the final rules that treating source opinions warranted controlling weight because such medical professionals typically have detailed, long-term perspectives on their patient-claimants' medical impairments.⁸⁹ Sections 404.1527 and 416.927 of the final rule read as follows, in pertinent part:

Generally, we give more weight to opinions from [the claimant's] 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 [SSA] find[s] 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 [the claimant's] case record, [SSA] will give it controlling weight. . . . [SSA] will always give good reasons in [its] notice of determination or decision for the weight [it] give[s] the claimant's] treating source's opinion.⁹⁰

As SSA emphasized when describing this provision: “Essentially, once [the agency] ha[s] determined that an opinion is from a treating source, it is entitled to special deference.”⁹¹

Third, SSA noted that many commenters were critical of certain aspects of the approach SSA took in the 1987 NPRM concerning evaluation of treating physician opinions.⁹² As a result, SSA noted that it had revised and expanded §§ 404.1527 and 416.927 of the final rules to clarify its policy on weighing treating physician evidence and to respond to such comments. For example, one of the main concerns was that SSA's “proposed rules did not require adjudicators to articulate reasons for rejecting any treating source opinions.”⁹³ SSA responded by noting that “unsupported opinions cannot be determinative. However, [SSA] will never disregard a treating source's opinion . . . [and will] accord their opinions greater weight—even when they are unsupported or contradicted—than such opinions would otherwise be entitled to if they came from a nontreating source.”⁹⁴ In the final rule, SSA therefore directed its ALJs to give “good reasons” when the treating source opinion is not ascribed “controlling weight.”⁹⁵ The final rule also laid out five factors (and one catch-all factor)—such as length and nature of treatment relationship, area of specialization, supportability of opinion—for adjudicators to use when weighing treating source opinions that are not given controlling weight.⁹⁶

⁸⁹ *Id.* at 36,935.

⁹⁰ *Id.* at 36,961, 36,969 (emphasis added) (codified at 20 C.F.R. §§ 404.1527(d)(2), 416.927(d)(2) (1991)).

⁹¹ *Id.* at 36,937.

⁹² *Id.* at 36,934.

⁹³ *Id.* at 36,950.

⁹⁴ *Id.*

⁹⁵ *Id.*; *see also id.* at 36,951 (SSA “will always provide an explanation in [its] notice of determination or decision of [the agency's] reason why [it] ha[s] not adopted a treating source's opinion.”).

⁹⁶ *Id.* at 36,961, 36,969 (codified at 20 C.F.R. §§ 404.1527(d)(2)-(6), 416.927(d)(2)-(6) (1991)). Specifically, these factors are: (1) “length of the treatment relationship and the frequency of examination;” (2) “nature and extent of the treatment relationship;” (3) “supportability” of the opinion by other evidence, particularly medical

Another concern raised by commenters involved SSA's original proposal to give treating physician opinions "some extra weight" when they conflict with other medical evidence.⁹⁷ Although SSA had adopted that language directly from *Schisler I*, the agency decided in the final rule to eliminate that language and to articulate the specific process by which ALJs would evaluate and weigh medical opinions instead.⁹⁸ The final rule thus describes a hierarchy of opinions—treating source opinions being given the most deference, non-treating, examining sources being given less deference, and non-treating, non-examining sources being given the least deference.⁹⁹

Lastly, several commenters suggested that the definition of "treating source" in the 1987 NPRM was unclear and overly restrictive.¹⁰⁰ SSA, in the final rules, thus modified the language in the definition of "treating source."¹⁰¹ The final regulation provides that a "treating source" means a claimant's "own physician or psychologist who has provided [him or her] with medical treatment or evaluation and who has or has had an ongoing treatment relationship with [him or her]."¹⁰² The definition goes on to clarify an ongoing relationship with an accepted source: one whom the claimant sees or has seen "with a frequency consistent with accepted medical practice for the type of treatment and evaluation required for [the claimant's] medical condition(s)."¹⁰³

While the substance of the treating physician rule has remained unchanged following promulgation of the 1991 final rules, there have been several administrative-type revisions over the intervening years.¹⁰⁴ Most notably, in March 2000, the phrase "acceptable medical source" was added to the definition of "treating source" to simplify and clarify terms for medical used across all regulatory provisions.¹⁰⁵ The revised definition provided, in pertinent part: "Treating source means your own physician, psychologist, or other acceptable medical source who provides you with . . . medical treatment or evaluation and who has, or has had, an ongoing treatment relationship with you." "Acceptable medical sources," in turn, referred to the limited set of medical professionals who could provide evidence of a medically determinable impairment; in addition to physicians and psychologists, "accepted" medical

signs and laboratory findings; (4) "consistency" of the opinion with the rest of the record; (5) "specialization" of the medical source; and (6) any other relevant factors. *Id.*

⁹⁷ *Id.* at 36,951.

⁹⁸ *See generally, id.*

⁹⁹ *Id.* at 36,953.

¹⁰⁰ *Id.* at 36,938.

¹⁰¹ *Id.*

¹⁰² *Id.* at 36,954, 36,963 (codified at 20 C.F.R. §§ 404.1502, 416.902 (1991)).

¹⁰³ *Id.* The final rule did not establish any standard for the frequency with which a claimant must see his or her physician for that physician to be considered a treating source—the visits may be few or have happened with long intervals in between. *See id.*

¹⁰⁴ For a comparison between the regulations as they originally existed and how they exist today, *see* App. C: Comparison Between Selected Provisions of the 1991 and Current Regulations Relating to the Treating Physician Rule, pp. A-12 - A-13.

¹⁰⁵ *See* Soc. Sec. Admin., Federal Old-Age Survivors, and Disability Insurance and Supplemental Security Income for the Aged, Blind, and Disabled; Evaluating Opinion Evidence; Final Rules, 65 Fed. Reg. 11,866, 11,867 (Mar. 7, 2000) (codified at 20 C.F.R. §§ 404.1502, 416.902 (2000)) [hereinafter 2000 Final Rule]. The term "acceptable medical source" had been used for years in 20 C.F.R. §§ 404.1513(a), 416.913(a). *Id.* The purpose of the phrase's inclusion in the definition section of the treating physician rule was simply to facilitate the application of the rules both "establish[ing] the existence of a medically determinable impairment" and assigning controlling weight to the treating physician. *Id.*

sources included osteopaths and optometrists (for the measurement of visual acuity).¹⁰⁶ In subsequent rulemakings, SSA added podiatrists and speech-language pathologists to the list of “acceptable medical sources” (2000), and expanded the situations in which optometrists would be considered an “accepted” source of medical evidence (2007).¹⁰⁷

In retrospect, while the *Schisler II* decision encouraged creation of the 1991 regulation,¹⁰⁸ SSA believed that articulation of a formal rule would help ALJs structure their decisions, especially in a circuit court environment replete with varying standards. Given that ALJs often confront a file abounding with reports and testimony from many different physicians, focusing on a treating physician’s report or testimony would provide ALJs not only with a starting place for analysis, but an end point as well if nothing else in the file outweighed the treating physician’s opinion.

II. DISTORTIONS IN APPLYING THE TREATING PHYSICIAN RULE

Even if the strong presumption afforded treating physician opinions was still justified, application of the controlling weight formulation has resulted in skewed decision-making by both courts and ALJs. If SSA thought the treating physician rule would simplify ALJ decision-making, it was mistaken. ALJs have struggled to determine what evidence justifies disregarding a treating source’s opinion, and reviewing courts have imposed high barriers. As a result, ALJ decisions have become increasingly vulnerable to challenge.

A. The Sheer Number of Findings Required

An initial difficulty faced by ALJs is the number of discrete findings required in the large volume of cases they adjudicate. Given the goal to complete between 500 and 700 hearings a year and then issue decisions, ALJs must assess and describe to reviewing courts’ satisfaction the weight of each medical opinion.¹⁰⁹ Files often contain information from a great number of medical sources. For instance, in *Mitchell v. Commissioner of Social Security*,¹¹⁰ the ALJ considered: (1) the claimant’s testimony that he was in extreme pain; (2) the opinion of one physician who administered a series of tests, concluding that the claimant had an IQ score of eighty-six and only had moderate impairment, but “lacked ‘the skills and coping mechanism[s]’ to sustain occupational pressure; (3) the opinion of another physician who reviewed the first physician’s conclusions and agreed with most of his findings except for his conclusion that the claimant lacked the capacity to work; (4) a third medical opinion that evaluated the claimant and found a lower IQ score of sixty-one and found the claimant to be severely impaired; (5) a fourth opinion which suggested that the author of the third opinion had no medical basis for his conclusions; (6) a vocational expert who found a hypothetical person matching the claimant’s qualifications and medical condition to have the

¹⁰⁶ *Id.* at 11,867; *see also* 20 C.F.R. §§ 1502, 416.902 (Apr. 1, 2000).

¹⁰⁷ *See* Medical and Other Evidence of Your Impairments and Definition of Medical Consultant, 65 Fed. Reg. 34952 (June 1, 2000); Optometrists as “Accepted Medical Sources” to Establish a Medically Determinable Impairment, 72 Fed. Reg. 9239 (March 1, 2007) (providing that licensed optometrists would be deemed accepted medical sources “for purposes of establishing visual acuity”).

¹⁰⁸ *Schisler II*, 851 F.2d at 45. The regulations note that the Second Circuit “expressly invited the Secretary” to promulgate an extensive policy. 1991 Final Rules, *supra* note 2, at 36,934.

¹⁰⁹ In 2007, SSA established guidelines suggesting that each ALJ issue 500 to 700 hearing decisions annually. SSAB 2012 Report, *supra* note 18, at 57. In FY2010, about 28% of ALJs met the 500-decision goal, and about 3% of ALJS issued in excess of 700 decisions. *Id.* at 57 & fig. 52.

¹¹⁰ 330 Fed. Appx. 563 (6th Cir. 2009).

ability to engage in entry-level, unskilled jobs.¹¹¹ To describe the weight afforded each medical opinion in depth imposes a high burden on ALJs—perhaps surprisingly, the ALJ’s decision was upheld in this case.

In contrast, in *Newsome v. Astrue*,¹¹² the ALJ faced the task of weighing the following medical evidence: (1) three different physicians’ reports dated between 2004 and 2007 from the same hospital, all conflicting in their diagnoses of a seizure disorder; (2) a 2006 diagnosis of alcoholic pancreatitis; (3) a physical therapist’s 2007 report declaring that the claimant was “independent in his ambulation[,] that he never showed impaired judgment or confusion[,] and was sociable and had no difficulty adjusting to his surroundings;” (4) a sixth medical opinion, from 2005, diagnosing the claimant with seizure disorder, polyneuropathy, but only accompanied by a normal CT scan and a MRI scan showing no abnormalities; (5) a neurologist’s opinion noting no neuropathy and no abnormalities from the MRI, but later diagnosing the claimant with (alcohol-related) seizure disorder, (sensory) polyneuropathy, and headaches; (6) a 2006 Physical Residual Functional Capacity Assessment (“RFC”) report diagnosing the claimant with alcohol-induced seizures, noting he could do light work, not involving dangerous machinery; (7) a 2006 opinion from a NP stating that the claimant could not work but then also indicating that the claimant could work at a sedentary level; (8) a 2006 diagnosis of a seizure disorder along with an opinion that the claimant had the ability to concentrate long enough to complete a work task; (9) an eleventh opinion stating that the claimant was indefinitely unemployable because of seizures, neuropathy, and abdominal pain; and (10) a twelfth opinion stating that the claimant was not employable due to his “abdominal pain, seizures, hip fracture, and alcohol abuse treatment.”¹¹³ The above list does not even include the non-medical social worker’s opinion and the claimant’s subjective testimony—all pieces of the record that the ALJ had to evaluate.¹¹⁴ The reviewing court remanded for failure to weigh properly one of the above twelve medical opinions.¹¹⁵ Thus, aside from the questionable efficacy of the treating physician rule, ALJs are faced with great challenges in evaluating, weighing, and assessing the medical evidence in the record.¹¹⁶

B. Difficulty in Meeting Threshold to Reject Treating Source Opinion

ALJs face additional challenges when attempting to articulate reasons for discrediting the treating source opinion. If a treating source’s opinion on the issue of the nature and severity of an impairment “is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in [the claimant’s] case record, [it is given] controlling weight” under SSA’s regulations.¹¹⁷ ALJs must provide specific, non-conclusory reasons for rejecting a treating physician’s opinion. In at least one circuit, an ALJ must give “clear and convincing” reasons for rejecting the

¹¹¹ *Id.* at 565-66.

¹¹² 817 F. Supp. 2d 111 (E.D.N.Y. 2011).

¹¹³ *Id.* at 117-22.

¹¹⁴ *Id.* at 117, 122.

¹¹⁵ *Id.* at 128, 140.

¹¹⁶ For an assessment of certain ALJ shortcomings in writing decisions, see STAFF OF S. COMM. ON HOMELAND SEC. & GOVERNMENTAL AFFAIRS, PERMANENT SUBCOMM. ON INVESTIGATIONS, 112TH CONG., SOCIAL SECURITY DISABILITY PROGRAMS: IMPROVING THE QUALITY OF BENEFIT AWARD DECISIONS, UNITED STATES SENATE PERMANENT SUBCOMMITTEE ON INVESTIGATIONS (2012), available at <http://www.hsgac.senate.gov/subcommittees/investigations/hearings/social-security-administrations-disability-programs> [hereinafter *Minority Staff Report 2012*]; see also 2013 SSA Disability Adjudication Report, *supra* note 8.

¹¹⁷ See 20 C.F.R. §§ 404.1527(c)(2), 416.927(c)(2) (2012).

uncontroverted opinion of a claimant’s treating physician; if the treating physician’s opinion is controverted, the ALJ’s reasons need only be “specific and legitimate.”¹¹⁸ Sometimes the “controverting” opinion in and of itself serves as the specific and legitimate reason for rejecting the treating source’s opinions.¹¹⁹ However, an ALJ more often will articulate other “specific” reasons for rejecting a treating source—such as a claimant’s testimony or work history—beyond a mere conflict in medical opinions.

The controlling weight test can deflect courts’ focus from the claimant’s medical condition. Instead, reviewing courts seemingly review ALJ decisions to assess whether ALJs have been sufficiently careful in discrediting treating source opinions. We trace below a sampling of contexts in which courts have rejected ALJs’ justifications for withholding controlling weight from evidence supplied by treating physicians.

For one example, ALJ reliance on other medical evidence in the record has been deemed insufficient if the treating physician evidence is more recent. In *Winters v. Barnhart*,¹²⁰ the claimant submitted a report from her treating psychologist in June 2002 and then was evaluated by an agency psychologist that October.¹²¹ Subsequently, the claimant submitted an additional report from her treating psychologist in March 2003.¹²² The examining psychologist’s mental assessment indicated that the claimant was “alert, fully oriented, appropriately responsive, [and] able to understand and follow instructions [and] to work within a set schedule.”¹²³ The examining psychologist further acknowledged that the claimant was “poorly tolerant of adult stress, pressure and responsibility and seems to relate to others in an overly-dependent manner,” but concluded that the claimant was not disabled.¹²⁴ In the March 2003 report, the claimant’s treating physician indicated that the claimant’s diagnoses were unchanged and her condition was “chronic and only partially responsive to current treatment,” and opined that the claimant was unable to work in any capacity because of her depression and anxiety.¹²⁵ The ALJ cited the examining report as a reason not to afford controlling weight to the treating physician.¹²⁶ The court disagreed, finding that “[b]ecause [the treating source’s] detailed report was the most recent medical evidence concerning [the claimant’s] psychiatric status in the record and was not contradicted, it should not have been discounted by the ALJ.”¹²⁷ Although the examining physician’s report may have been sufficient to discredit the treating physician’s initial report, it evidently was not sufficient to counteract the treating physician’s second report several months later, which was nearly identical.

¹¹⁸ See, e.g., *Hiler v. Astrue*, 687 F.3d 1208, 1212 (9th Cir. 2012); *Bray v. Comm’r of Soc. Sec. Admin.*, 554 F.3d 1219, 1228 n.8 (9th Cir. 2009); *Connett v. Barnhart*, 340 F.3d 871, 874 (9th Cir. 2003); *Thomas v. Barnhart*, 278 F.3d 947, 956-57 (9th Cir. 2002); *Andrews v. Shalala*, 53 F.3d 1035, 1041 (9th Cir. 1995); *Rodriguez v. Bowen*, 876 F.2d 759, 762-63 (9th Cir. 1989).

¹¹⁹ *Lemmon v. Astrue*, No. CV-11-1808-PHX-GMS, 2012 WL 3778280, at *4 (D. Ariz. 2012) (concluding that the examining physician’s “detailed examination qualifies as substantial evidence in the record, and the ALJ did not err by assigning significant weight to his report given ‘his medical specialty and extensive examination.’”); see also *Nelson v. Comm’r of Soc. Sec. Admin.*, 252 F. Supp. 2d 1148, 1160 (D. Kan. 2003) (concluding that an ALJ “may reject a treating physician’s opinion outright only on the basis of contradictory medical evidence”).

¹²⁰ 153 Fed. Appx. 846 (3d Cir. 2005).

¹²¹ *Id.* at 846-47.

¹²² *Id.* at 847-48.

¹²³ *Id.* at 847.

¹²⁴ *Id.*

¹²⁵ *Id.* at 847-48.

¹²⁶ *Id.* at 848.

¹²⁷ *Id.* at 849.

One of the cases studied in the recent Senate Permanent Subcommittee on Investigations Report also highlights the tendency to reconcile conflicting medical evidence based on which opinion is most recent.¹²⁸ The patient's rheumatologist discharged the patient for not following his directions in treating her back pain.¹²⁹ He believed that she had recovered from back surgery sufficiently to the point that she was no longer disabled.¹³⁰ A new rheumatologist, however, just saw her once.¹³¹ The claimant asserted that this new physician's report was entitled to controlling weight given its status as a treating physician finding.¹³² A SSA attorney advisor, who had been delegated the case, apparently determined that the claimant was disabled without addressing the conflict between the two rheumatologists' evidence.¹³³ Again, the most recent physician report prevailed, even though no change in condition was noted. Placing greater weight on the more recent medical evidence makes sense, but only when it is based on changed circumstances.

ALJs can also overcome treating physician opinions by finding that the testimony or behavior of the claimant is not credible. Reviewing courts, however, have been reluctant at times to accept the credibility determinations made by an ALJ. For example, in the Eighth Circuit, an ALJ must discuss a claimant's pain complaints in light of six factors.¹³⁴ Some circuits require a showing of malingering or clear and convincing evidence¹³⁵ (or substantial evidence)¹³⁶ to discredit a claimant. Therefore, it has become more difficult for an ALJ to reject a treating source's opinion based on a claimant's pain complaints.

Moreover, in some settings an ALJ should be able to rely on a history of conservative treatment prescribed to impeach the treating physician's conclusion of total or permanent disability.¹³⁷ ALJs logically have questioned why, if the claimant is disabled, the treating physician did not prescribe a more aggressive treatment regimen. However, an ALJ's finding of conservative treatment is not always convincing to the reviewing court. For example, in *Santiago v. Barnhart*,¹³⁸ the court expressly denounced an ALJ's use of this justification to

¹²⁸ See Minority Staff Report 2012, *supra* note 116, at 69-70.

¹²⁹ *Id.* at 70.

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² *Id.*

¹³³ *Id.*

¹³⁴ When there is no objective medical basis to corroborate subjective complaints, the following should be considered in evaluating the complaints: "the claimant's prior work record[;] observations by third parties and treating and examining physicians relating to such matters as: 1. the claimant's daily activities; 2. the duration, frequency and intensity of the pain; 3. precipitating and aggravating factors; 4. dosage, effectiveness and side effects of medication; 5. functional restrictions." *Polaski v. Heckler*, 739 F.2d 1320, 1322 (8th Cir. 1984).

¹³⁵ See, e.g., *Smolen v. Chater*, 80 F.3d 1273, 1281 (9th Cir. 1996).

¹³⁶ See, e.g., *Mendez v. Comm'r of Soc. Sec.*, 300 F. Supp. 2d 317, 320 (D.P.R. 2003); *Clark v. Astrue*, 844 F. Supp. 2d 532, 544, 549 (D. Del. 2012).

¹³⁷ See, e.g., *Johnson v. Shalala*, 60 F.3d 1428, 1433 (9th Cir. 1995) (concluding the ALJ can properly reject the treating physician's opinion where the claimant only needs conservative care); see also *Castellano v. Sec'y of Health & Human Servs.*, 26 F.3d 1027, 1029 (10th Cir. 1994) (affirming the impeachment of a treating physician's conclusion that the claimant could not return to work where the physician had not treated for deterioration of the claimant's condition but stated on a prior occasion the claimant could complete light or sedentary work).

¹³⁸ 386 F. Supp. 2d 20 (D.P.R. 2005).

reject a treating physician's conclusions.¹³⁹ The physician prescribed only limited treatment for the claimant's nervous condition, but the reviewing court was not persuaded.¹⁴⁰

In *Guttilla v. Astrue*,¹⁴¹ one reason the ALJ gave for partially rejecting the treating psychiatrist's testimony was the mild medication prescribed and the infrequent follow-up visits scheduled, which appeared to conflict with the treating psychiatrist's relatively low Global Assessment of Functioning ("GAF") Score.¹⁴² The court rejected the use of this justification for two reasons: (1) the GAF evaluation occurred before the alleged onset of the disability, and (2) the findings in the psychiatrist's progress notes were "mixed."¹⁴³ Thus, the relevant mental evaluation "contain[ed] facts that support[ed] and contradict[ed] the ALJ's] decision."¹⁴⁴ Moreover, the court still found the conservative treatment not dispositive as to the psychiatrist's credibility, even though the mental status evaluation seemingly supported the ALJ's finding, at least in part.¹⁴⁵

Thus, the controlling weight formulation has engendered unexpected consequences. ALJs have struggled to assign the proper weight to each medical opinion offered, and courts have scrutinized excessively the justifications that ALJs proffer to discredit the treating physician opinion. Too little of the analysis has centered on the pivotal issue of disability itself.

Part of the problem may arise from the fact that district courts review only ALJ decisions that discredit as opposed to credit the treating source opinion. Even if the decision-maker at the DDS level rejects claims for disability, ALJs grant disability in almost fifty percent of the cases appealed,¹⁴⁶ largely following the recommendation of the treating physician. Perhaps if the district courts were exposed to those determinations, they would not be as demanding in the comparatively fewer cases in which ALJs discredit the treating source opinion. The asymmetrical nature of the SSDI and SSI adjudication system, under which claimants but not the agency can appeal adverse ALJ decisions, may lead to excessively strict district court review of the many ALJ decisions that reject treating physician opinions.

Finally, the treating source rule provides a hook on which the courts can rest a remand order reached out of sympathy for a claimant who may be sick but not necessarily disabled under the Act. For example, in *McPherson v. Barnhart*,¹⁴⁷ the ALJ denied the claimant benefits because a vocational expert testified that she could at least perform sedentary, unskilled jobs despite her treating physician opining that she was "markedly limited."¹⁴⁸ The district court described the claimant's struggles at length, including her father's death, her mother's diabetes and multiple sclerosis, and her eviction from her apartment.¹⁴⁹ The court

¹³⁹ *Id.* at 23.

¹⁴⁰ *Id.*

¹⁴¹ No. 09CV2259 MMA RBB, 2010 WL 5313318 (S.D. Cal. 2010).

¹⁴² *Id.* at *15.

¹⁴³ *Id.* at *13.

¹⁴⁴ *Id.*

¹⁴⁵ *Id.* at *15.

¹⁴⁶ Data provided by SSA show that fully favorable allowance rates have dropped to 50% (data on file with ACUS). This rate is down from 60%. See SSAB 2012 Report, *supra* note 18, at 12 fig. 7.

¹⁴⁷ 356 F. Supp. 2d 953 (S.D. Iowa 2005).

¹⁴⁸ *Id.* at 958.

¹⁴⁹ *Id.* at 955.

placed particular emphasis on the claimant's poor financial state.¹⁵⁰ The court held that the ALJ did not give enough weight to the treating physician's opinion and reversed the ALJ's decision.¹⁵¹ Yet, the ALJ specifically had determined that the treating physician's opinion was "inconsistent with [his] treatment notes and a GA[F] of 65," which indicates a relatively high-level of function.¹⁵²

For another example, consider *Schaal v. Apfel*.¹⁵³ There, the claimant asserted that she was disabled as a result of a combination of painful varicose veins and severe allergies that led to pulmonary problems.¹⁵⁴ Physician reports from 1990 and 1991 noted only modest restrictions, and the SSA medical examiner in 1993 detected no structural impairments and concluded that the claimant enjoyed the capacity for gainful work.¹⁵⁵ The claimant submitted a form from yet another physician whom she saw starting in 1992, who checked several boxes on the form indicating, without explanation, that in his view, the claimant should be considered disabled.¹⁵⁶ The ALJ did not defer to that opinion, both because there was no elaboration of clinical findings and because there was nothing introduced in the record as to the duration of the claimant's relationship to this new physician.¹⁵⁷ The ALJ cited the conflicting evidence presented by several other physicians as well.¹⁵⁸ The Second Circuit, however, remanded, finding that the ALJ had insufficiently explained why it was not affording "controlling weight" to the treating physician's evidence: "[w]e hold that the Commissioner's failure to provide 'good reasons' for apparently affording no weight to the opinion of plaintiff's treating physician constituted legal error."¹⁵⁹ Given the presence of other medical evidence to the contrary, the court's opinion is less than persuasive.

Similarly, in *Wiltz v. Barnhart*,¹⁶⁰ the ALJ determined that the claimant exaggerated the side effects of his migraines because, among other reasons, the claimant testified to doing schoolwork, homework, shopping, driving occasionally, playing video games, playing on the basketball and football teams at school, and performing some household chores.¹⁶¹ However, the reviewing court found this credibility finding (and therefore rejection of the treating source opinion) inadequate because the ALJ independently asserted that the treating physician report was insufficiently supported by objective evidence, a result with which the court disagreed.¹⁶² The adverse credibility finding was apparently reversed, therefore,

¹⁵⁰ *Id.* at 960-61. ("Plaintiff is a young woman with numerous physical and mental problems all of which are amplified by poverty which makes it more difficult for her to see her doctors and obtain treatment than if she were a person of financial means.").

¹⁵¹ *Id.* at 961.

¹⁵² *Id.* at 960; *see also* *Nguyen v. Chater*, 100 F.3d 1462, 1463 (9th Cir. 1996) (In finding disability based largely on mental impairment, stressing that the claimant was "shot in both legs by the Communists in 1970 when he was a soldier in the South Vietnamese army.").

¹⁵³ 134 F.3d 496 (2d Cir. 1998).

¹⁵⁴ *Id.* at 498-99.

¹⁵⁵ *Id.* at 499.

¹⁵⁶ *Id.* at 499-500.

¹⁵⁷ *Id.* at 504.

¹⁵⁸ *Id.* at 499.

¹⁵⁹ *Id.* at 505. After the ALJ determination, the claimant furnished additional information to the Appeals Council showing that she had seen the treating physician a number of times and that his opinion had some basis in clinical findings. *Id.* at 500. Perhaps the court would have been on sounder footing to remand for insufficient consideration of the new evidence rather than for the ALJ's insufficient deference to the treating physician.

¹⁶⁰ 484 F. Supp. 2d 524 (W.D. La. 2006).

¹⁶¹ *Id.* at 533-34.

¹⁶² *Id.* at 534-35.

because the court did not agree with *an independent* justification offered by the ALJ to discredit the treating source opinion. Sympathy for the claimant may have factored into the result.¹⁶³

C. Application of the Ninth Circuit’s Credit-As-True Rule

The challenge posed by the treating physician rule is far greater in the circuits that embrace the “credit-as-true” rule. In the Ninth Circuit, for instance, courts combine the treating physician rule with the circuit’s credit-as-true rule to remand for a court-ordered award of benefits when the ALJ’s effort to discredit the treating source is deemed insufficient.¹⁶⁴ Ninth Circuit courts credit treating source testimony and remand for an award of benefits where:

(1) the ALJ has failed to provide legally sufficient reasons for rejecting such testimony, (2) there are no outstanding issues that must be resolved before a determination of disability can be made, and (3) it is clear from the record that the ALJ would be required to find the claimant disabled were the testimony credited.¹⁶⁵

In effect, the credit-as-true rule deprives an ALJ of a second opportunity to reweigh testimonial evidence or correct any errors in his or her initial opinion with respect to the treating source rule. As a result, claimants who are not disabled may receive benefits.

The Ninth Circuit borrowed the credit-as-true rule from the Eleventh Circuit’s practice of crediting a claimant’s subjective pain testimony as true if the ALJ articulated insufficient reasons for rejecting it.¹⁶⁶ In *Varney v. Secretary of Health & Human Services*,¹⁶⁷ the Ninth Circuit addressed the rights of claimants, some of whom “experienc[ed] unwarranted difficulties in the application process.”¹⁶⁸ Five years had passed since Varney first applied for benefits and the court noted that “her situation is not atypical.”¹⁶⁹ The court also expressed concern over ALJs’ alleged tendencies to “reach a

¹⁶³ *Id.* at 533.

¹⁶⁴ *Benecke v. Barnhart*, 379 F.3d 587, 594 (9th Cir. 2004) (“Because the ALJ failed to provide legally sufficient reasons for rejecting [the claimant’s] . . . treating physicians’ opinions, we credit the evidence as true.”).

¹⁶⁵ *Smolen v. Chater*, 80 F.3d 1273,1292 (9th Cir. 1996); *see also Brewes v. Comm’r of Soc. Sec. Admin.*, 682 F.3d 1157, 1164-65 (9th Cir. 2012) (concluding that further proceedings were not necessary and remanding for an award of benefits where “[t]he complete record show[ed] that [the claimant was] likely to miss multiple days of work per month [and] [t]he vocational expert testified that a person with [the claimant’s] characteristics who would miss that much work was not employable”).

¹⁶⁶ The rule in the Eleventh Circuit does not involve treating physician testimony, but only credits claimants’ subjective pain testimony where “the Secretary fails to articulate reasons for refusing to credit a claimant’s subjective pain testimony.” *Hale v. Bowen*, 831 F.2d 1007, 1012 (11th Cir. 1987); *see also MacGregor v. Bowen*, 786 F.2d 1050, 1054 (11th Cir. 1986) (“If the secretary refuses to credit [a claimant’s subjective pain] testimony he must do so explicitly and give reasons for that decision. . . . Where he fails to do so we hold as a matter of law that he has accepted the testimony as true.”).

¹⁶⁷ 859 F.2d 1396 (9th Cir. 1988).

¹⁶⁸ *Id.* at 1398.

¹⁶⁹ *Id.* at 1399 (“Applicants for disability benefits generally suffer from crippling conditions that preclude them from earning a living wage; they often have no other source of income and can experience tremendous financial difficulties while awaiting the outcome of their appeals and proceedings on remand.”) (citing *Lopez v. Heckler*, 713 F.2d 1432, 1437 (9th Cir.1983)).

conclusion first, and then attempt to justify it by ignoring competent evidence in the record that suggests an opposite result.”¹⁷⁰

The Ninth Circuit extended the credit-as-true rule to treating physician testimony. A reviewing court may credit the treating source’s opinion and remand for a calculation of benefits if the ALJ has not sufficiently explained why the treating source opinion does not merit controlling weight.¹⁷¹

For example, in *Folio v. Astrue*,¹⁷² the district court reversed and remanded for an award of benefits because the treating physician’s opinion stated that [the claimant] was “permanent[ly] disab[led].”¹⁷³ However, the same source opinion asserted that the claimant’s “medical problems are stable”; that [the claimant] is “fully aware of medication side effects”; and that “[h]is prognosis is fair to good, depending largely on how he controls his [d]iabetes.”¹⁷⁴

Alongside the treating physician’s ambiguous opinion, the record contained two examining, non-treating opinions that were inconsistent with a conclusion of “permanent disability,” and so the ALJ relied on those opinions to contravene the treating source opinion.¹⁷⁵ The ALJ also determined that the claimant had exaggerated his symptoms both in the hearing and to the treating physician.¹⁷⁶ Upon finding that the ALJ did not adequately articulate a rejection of the claimant’s treating physician’s opinion, *inter alia*, the district court ordered an award of benefits relying on the treating source’s conclusion that the claimant was permanently disabled.¹⁷⁷ The court order awarding benefits deprived the ALJ of an opportunity to provide additional articulation of the reasons that the judge denied “controlling weight” to the treating physician’s opinion.

In *Young v. Commissioner of Social Security*,¹⁷⁸ the Commissioner conceded that the ALJ improperly discredited a treating source, but sought remand for further proceedings to permit the ALJ to make additional findings with respect to the disabling effects of the claimant’s mental condition.¹⁷⁹ The claimant’s physician opined that the claimant had “‘marked’ [limitation] in maintaining concentration, persistence and pace.”¹⁸⁰ If the medical evidence were credited as true, it would have pointed to an emotional disorder.¹⁸¹ However, establishing an emotional disorder or a dysthymic disorder generally is not “per se disabling.”¹⁸² Instead of remanding for a determination of the disabling effects of the claimant’s impairment, however, the court remanded for a calculation of benefits.¹⁸³

¹⁷⁰ *Id.* (citing *Gallant v. Heckler*, 753 F.2d 1450, 1456 (9th Cir. 1984)).

¹⁷¹ *See, e.g., Benecke*, 379 F.3d at 594-95 (concluding that the vocational expert’s testimony established no need to remand for further proceedings where the vocational expert concluded that the claimant could not work if her treating physician’s testimony were credited).

¹⁷² No. CV06-2700-PHX-EHC, 2008 WL 3982972 (D. Ariz. 2008).

¹⁷³ *Id.* at *4.

¹⁷⁴ *Id.*

¹⁷⁵ *Id.* at *6.

¹⁷⁶ *Id.* at *4.

¹⁷⁷ *Id.* at *8.

¹⁷⁸ No. CV09-744-KI, 2010 WL 3607766 (D. Ore. 2010).

¹⁷⁹ *Id.* at *1, *3.

¹⁸⁰ *Id.* at *1.

¹⁸¹ *Id.* at *3.

¹⁸² *See Sample v. Schweiker*, 694 F.2d 639, 642 (9th Cir. 1982).

¹⁸³ *Young*, *supra* note 178, at *4.

Application of the credit-as-true rule, where evidence might support either outcome, effectively supplants the judgment of the ALJ for that of the reviewing court.¹⁸⁴

The Ninth Circuit has not clarified whether the credit-as-true rule is mandatory, but even if discretion remains, the rule may bestow a windfall upon some claimants. ALJs can only circumvent the consequences of a court-ordered award of benefits in the Ninth Circuit by satisfying the court initially that they are correctly withholding “controlling weight” from the treating physician’s testimony. This task is far from simple. As discussed, the improper rejection of treating source opinions remains the most frequently cited basis for remands of ALJ decisions.¹⁸⁵

The credit-as-true rule also makes it easier for reviewing courts to grant claimant-friendly orders for reasons irrelevant to the determination of disability. One judge opened her opinion by noting that “[t]his matter is now nearly fifteen years old and has a record that is nearly 1,000 pages.”¹⁸⁶ The opinion continued by elaborating upon the long procedural history of the case before beginning any analysis of the issues. The court ultimately found that the ALJ erred by discrediting three treating source opinions without clear and, convincing reasons.¹⁸⁷ Given the Ninth Circuit’s credit-as-true precedent, the judge terminated the proceedings and ordered an immediate payment of benefits.¹⁸⁸ An understandable frustration with delay may sway judges to award immediate benefits rather than remanding for further fact-finding. At the end of a separate opinion, a judge concluded, “[i]n light of the extensive delay in Plaintiff’s application for benefits, the Court invokes its discretion and remands this case for the payment of benefits. . . . Further delays at this point would be unduly burdensome on Plaintiff.”¹⁸⁹ The focus was not on disability per se. The credit-as-true rule exacerbates rather than clarifies the problems faced by ALJs in overcoming the controlling weight formulation.

D. Inversion and Subversion of Substantial Evidence Review

The preceding analysis suggests that court application of SSA’s controlling weight formulation has distorted substantial evidence in the record review.¹⁹⁰ Substantial evidence on the record as a whole under the Administrative Procedure Act (“APA”) is meant to be a highly deferential standard.¹⁹¹ Reviewing courts too often focus on the weight to be ascribed various physicians’ opinions and the amount of evidence needed to discredit the treating physician as opposed to assessing whether, based on all of the medical evidence and

¹⁸⁴ See *Matney v. Sullivan*, 981 F. 2d 1016, 1019 (9th Cir. 1992) (“The trier of fact and not the reviewing court must resolve conflicts in the evidence, and if the evidence can support either outcome, the court may not substitute its judgment for that of the ALJ.”) (citing *Richardson v. Perales*, 402 U.S. at 400; *Allen v. Heckler*, 749 F.2d 577, 579 (9th Cir. 1984)).

¹⁸⁵ See App. B, at A-1.

¹⁸⁶ *Feskens v. Astrue*, 804 F. Supp. 2d 1105, 1111 (D. Ore. 2011).

¹⁸⁷ *Id.* at 1115-22.

¹⁸⁸ *Id.* at 1123.

¹⁸⁹ *D’Angel’o v. Astrue*, No. CV06-03055-PHX-EHC, 2007 WL 4617186 at *9 (D. Ariz. 2007).

¹⁹⁰ See RICHARD J. PIERCE, JR., *ADMINISTRATIVE LAW TREATISE* 1015 (Wolters Kluwer 2010) (“Circuit courts sometimes adopt modifications to the APA substantial evidence standard, though the legitimacy of such judicial modifications is doubtful.”).

¹⁹¹ See 42 U.S.C. §§ 405(g), 1383(c)(3) (2012); 5 U.S.C. § 706(2)(E) (2012); Paul R. Verkuil, *An Outcomes Analysis of Scope of Review Standards*, 44 WM. & MARY L. REV. 679 (2002).

testimony, substantial evidence in the record supports the agency's determination.¹⁹² Instead of engaging in judicial review within specifically defined parameters, courts have exercised broad judicial discretion.¹⁹³

To be sure, if the agency's decision is unclear, or if the decision misstates law or SSA policy, then remand is appropriate. And the courts, Appeals Council, and SSA General Counsel's Office agree that there are ALJ decisions that fall short in explaining why particular medical evidence is more probative than other evidence. Indeed, the Appeals Council has documented that with a five percent cited reason for remand frequency rate, ALJs do not even express why they have discredited the treating physician's opinion.¹⁹⁴ But, many remands flow from district court disagreement over the weight afforded one or more physician opinions even when many other opinions exist in the record. Other remands stem from judicial reluctance to deem ALJ credibility determinations sufficient to overcome the strong presumption for the treating physician's opinion.

Seeds for the inversion in review can be found in SSA's 1991 regulation itself. The regulation provides that as long as the treating source's opinion "is not inconsistent with the other substantial evidence in [the claimant's] case record, [SSA] will give it controlling weight."¹⁹⁵ The regulation, in other words, shifts the focus from whether there is substantial evidence in the record as to disability—a familiar APA inquiry—to whether there is substantial evidence to overcome the treating physician's opinion. When the question is relatively close, there may be substantial evidence in the record as a whole to support an agency decision pointing in either direction, but an ALJ may be hard pressed to convince a reviewing court that substantial evidence exists to discredit the treating physician opinion. In essence, a reviewing court today typically does not ask whether there is substantial evidence to justify a finding as to disability—a highly deferential standard¹⁹⁶—but rather whether the ALJ properly found that substantial evidence exists to justify rejection of the treating physician opinion—a much less deferential stance. Although the term "substantial evidence" is used in both contexts, the substantial evidence needed to override a treating physician's opinion is more demanding. Instead of deferring to the ALJ's determination unless clearly wrong, the regulation asks the reviewing court to ensure that the ALJ has met his or her burden of finding that the great weight of the evidence in the record justifies discrediting the treating source's opinion.

¹⁹² SSA's explanations accompanying the regulations acknowledge the tension that exists when making disability determinations: the desire to objectively identify disability coupled with "subjectivity and individualization" that accompanies the decision-making process. *Schneider, supra* note 48, at 402 (citing 1991 Final Rules at 36,934-35, which discuss the uniqueness of each case and the inability to define the weight to be given to every piece of evidence in every case).

¹⁹³ *Id.* at 399-400 ("[C]ourts introduce flexibility into the substantial evidence standard by using the treating physician rule to define the relevant evidence that a reasonable mind would accept as sufficient.").

¹⁹⁴ *See* App. B at A-9 tbl. 10.

¹⁹⁵ 20 C.F.R. §§ 404.1527(c)(2); 416.927(c)(2) (2012); *see also* 42 U.S.C. §§ 405(g), 1383(c)(3) (2012) (describing judicial review of agency action according to the substantial evidence review standard).

¹⁹⁶ In *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951), the Supreme Court explained that the substantial evidence standard requires reviewing courts to consider the entire record and "take into account whatever in the record fairly detracts from its weight." The Court continued that the standard was not "intended to negative the function of the [agency] presumably equipped or informed by experience to deal with a specialized field of knowledge, whose findings within that field carry the authority of an expertness which courts do not possess and therefore must respect." *Id.* In the SSA context, the Supreme Court has explained that substantial evidence means "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. at 401.

The deference implied by the substantial evidence test is often overlooked by courts for two reasons: first, it is difficult for courts to accept that a person may be denied disability benefits so long as a job theoretically exists in the national economy, even if practically, the person would not be able to engage in that work (*e.g.*, the individual would have to move across the country).¹⁹⁷ Second, courts have a long tradition of substituting their own judgment for that of SSA in the treating physician context, based both on pre-1991 regulation case law and enduring application of that case law.¹⁹⁸

In short, the controlling weight formulation turns the familiar agency/court relationship on its head: the agency must demonstrate to the court's satisfaction that its disavowal of the treating physician rule was appropriate as opposed to the court deferentially reviewing the entire record to ensure that the agency's determination can be supported. This distortion of the substantial evidence review standard "effectively . . . override[s] the congressionally chosen scope of review standard."¹⁹⁹

III. EROSION OF BASES FOR THE TREATING PHYSICIAN RULE

Health care (and the practice of medicine) in the United States has undergone dramatic changes over the course of the last several decades. Factors underlying this transformation include: restructuring of financial and organizational models for health care delivery; greater specialization of medical professionals (and concomitant shortage of primary care physicians); and rising incidence of chronic diseases and disability. As a result, the paradigmatic long-term doctor-patient relationship is largely extinct. Individuals now typically visit multiple medical professionals (*e.g.*, primary physicians, specialists, NPs, PAs, LCSWs) in a variety of settings (*e.g.*, private group or solo practices, managed care clinics, hospitals, ambulatory care centers, specialty clinics, public health care centers, community mental health clinics) for their health care needs, and less frequently develop a sustained relationship with one physician. Erosion of some of the distinctions between treating physicians and other physicians (such as examining physicians) suggests there is currently less reason to presumptively deem treating source opinions to be of "special intrinsic value." Moreover, difficulty in determining who among a wide range of medical professionals should be considered a treating source has bedeviled ALJs and reviewing courts, resulting in high remand rates and perhaps even allowance of claims by individuals who were not disabled. These factors, addressed in more detail below, raise fundamental questions about the continuing efficacy of the treating physician rule.

A. The Changing Nature of the United States' Health Care System

As SSA noted in 1991 when promulgating the treating physician rule, the presumptive weight afforded the opinions of these medical professionals is based on the following central premise: that treating physicians generally have longitudinal knowledge and unique

¹⁹⁷ Verkuil, *supra* note 191, at 707.

¹⁹⁸ See *supra* Part I.B.2 and Part II (discussion and analysis of the treating physician rule as applied by federal court case law both before and after the 1991 regulations).

¹⁹⁹ Verkuil, *supra* note 191, at 709. SSA data reveal that disparity relating to the treating physician rule exists among the circuits. See App. B at A-11 tbl. 12. As demonstrated by the varying frequency with which the treating physician rule is cited as a reason for remand, federal courts are not free from confusion about the treating physician rule.

perspectives concerning their patients' physical or mental impairments that cannot be gleaned from medical records or test results alone.²⁰⁰ In this special valuation of continuity in the physician-patient relationship, SSA is not alone. Embedded in both American medicine and culture is the notion that longevity enhances the relationship between doctor and patient and leads to better medical outcomes. Medical studies are replete with references to continuity of care as a central tenet of medical practice, particularly in primary care.²⁰¹ An idealized vision of enduring doctor-patient relationships is a fixture in American society, as well.²⁰² For example, early television series in the 1960s, such as *Ben Casey*, *Dr. Kildare*, and *Marcus Welby, M.D.*, featured story lines of doctors who had long-term relationships with their patients and treated each with a personal touch—portrayals which “helped turn the American doctor into a cultural hero vying in popularity with the ubiquitous cowboy.”²⁰³ As of the 1980s, physician autonomy in practice management and patients' ability to choose—and stay with—their choice of clinician remained the dominant health care model.²⁰⁴

Over the last several decades, however, health care systems in the United States have undergone tremendous changes, primarily—though not exclusively—due to the rise of managed care.²⁰⁵ Foremost among these changes has been the considerable financial and organizational restructuring of the health care delivery system. Health care has evolved from

²⁰⁰ 20 C.F.R. §§ 404.1527(c)(2), 416.927(c) (2012); see also discussion *supra* Part I.B.3.

²⁰¹ E.g., Matthew Ridd et al., *The Patient-Doctor Relationship: A Synthesis of the Qualitative Literature on Patients' Perspectives*, 59 BRIT. J. OF GEN. PRAC. e116, e119-21 (April 2009); John W. Saultz, *Defining and Measuring Interpersonal Continuity of Care*, 1 ANNALS OF FAM. MED. 134, 134-35 (Sept./Oct. 2003) [hereinafter Saultz, *Defining and Measuring Continuity*]; Susan A. Flocke et al., *The Impact of Insurance Type and Forced Discontinuity on the Delivery of Primary Care*, 45 J. FAM. PRAC. 129 (Aug. 1997) [hereinafter Flocke, *Impact of Insurance Type*]; Institute of Medicine, National Academy of Science, PRIMARY CARE: AMERICAN'S HEALTH IN A NEW ERA 31-32, 43-44, 56-57 (1996) (defining “primary care” by, among other essential attributes, continuity of care over time by a single individual or team of health professionals) [hereinafter PRIMARY CARE].

²⁰² Sharyn J. Potter & John B. McKinlay, *From a Relationship to Encounter: An Examination of Longitudinal and Lateral Dimensions in the Doctor-Patient Relationship*, 61 SOC. SCI. & MED. 465, 466 (2005).

²⁰³ *Id.* (internal quotation omitted).

²⁰⁴ As of 1988, nearly 75% of employees were enrolled in traditional indemnity (fee-for-service) plans. See App. G at A-32. Government health insurance programs (*i.e.*, Medicare and Medicaid) also featured fee-for-service plans from their inception in 1965 until adoption of the prospective payment system in 1982. Laura D. Hermer, *Private Health Insurance in the United States: A Proposal for a More Functional System*, 6 HOUS. J. HEALTH L. & POL'Y 1, 13-14 (2005). Under fee-for-service plans, “physicians operated autonomously, making patient care decisions based solely on what they deemed to be in the patient's best interest.” Julia A. Martin & Lisa K. Bjerknes, *The Legal and Ethical Implications of Gag Clauses in Physician Contracts*, 22 AM. J. L. AND MED. 433, 440 (1996); see also, Peter D. Jacobson, *Who Killed Managed Care? A Policy Whodunit*, 47 ST. LOUIS U. L.J. 365, 368 (2003) (“In the fee-for-service model, there was very little interference on physician autonomy from payers, hospital administrators, or patients.”).

²⁰⁵ Rhodes Adler et al., *The Relationship Between Continuity and Patient Satisfaction: A Systematic Review*, 27 FAM. PRAC. 171, 177 (2010) (“Changes in health care over the past 25 years have been perceived as leading to decreased continuity, and have actually decreased continuity for patients.”); Potter, *supra* note 202, at 466-70 (describing longitudinal changes to doctor-patient relationship in latter decades of 20th century as corporatist model of health care took hold, due largely to “exponential growth of managed health care in the 1980s and 1990s [that] drastically changed the roles of both physicians and patients”); Saultz, *Defining and Measuring Continuity*, *supra* note 201, at 134 (observing that “[c]hanges in American health care during the past 2 decades have undermined the ability of patients to choose and remain with an individual physician”); see also Eva Kahana et al., *Forced Disruption in Continuity of Primary Care: The Patients' Perspective*, 30 SOCIOLOGICAL FOCUS 177, 183 (1997) (“The role of ‘medico-administrative forces’ in disrupting continuity of patient care and adverse effects of social disruption have been widely lamented by clinicians . . . [and] the vast majority of patients report dismay, dissatisfaction and anger as they attempt to cope with administratively mandated disruption of their customary medical care.”).

a largely unorganized collection of interactions between individual doctors and patients, to a highly interconnected system involving many corporate entities.²⁰⁶

In the 1990s, spiraling health care costs under traditional indemnity (fee-for-service) plans led to the rise of managed care organizations (“MCOs”).²⁰⁷ Managed care, in its broadest sense, represents “a system that closely monitors the medical care provided by health care providers and the treatment patients receive in an effort to control health care spending.”²⁰⁸ MCOs employ a variety of restrictions (or cost-control incentives) to influence physicians’ practice behavior and to promote patient-enrollees’ efficient use of health care services.²⁰⁹ Under some MCOs, such as health maintenance organizations, subscribers must choose a primary care physician who acts as a “gatekeeper” for other medical services, such as referral to an approved in-network specialist or laboratory tests.²¹⁰ Other MCOs, such as preferred provider organizations (“PPOs”), are networks of health care providers who agree to discount their fee-for-service rates in exchange for incentives offered by the insurer to patients to use in-network providers.²¹¹ PPO plans thus encourage use of preferred, in-network providers by offering subscribers discounted rates, so long as they see providers

²⁰⁶ E.g., John W. Saultz & Waleed Albedaiwi, *Interpersonal Continuity of Care and Patient Satisfaction: A Critical Review*, 2 ANNALS OF FAM. MED. 445, 445 (Sept./Oct. 2004) [hereinafter Saultz, *Interpersonal Continuity*] (“Changes in the American healthcare system during the past decade have made it increasingly difficult to establish such long-term trusting relationships between physicians and patients. Some authors have questioned whether a personal model of care is feasible, as health plans increasingly have required provider changes for economic reasons.”); Borkan, *supra* note 7 (“What was traditionally (and perhaps mythically) considered a dyadic relationship between clinician and the health care consumer has been potentially jeopardized by a new triangular interaction: the patient-provider-managed care/health insurance bureaucracy.”).

²⁰⁷ Hermer, *supra* note 204, at 14-15, 22-23; Potter, *supra* note 202, at 468-69; see also Russell Korobkin, *The Failed Jurisprudence of Managed Care, and How to Fix It: Reinterpreting ERISA Preemption*, 51 UCLA L. REV. 457, 462 (2003) (“[E]mployers began to look for healthcare options that could rein in expenses.”). Under the traditional fee-for-service model, an individual can visit a health care provider of their choosing, with the insurer reimbursing most of the cost (typically, 80%). See Hermer, *supra* note 204, at 21-22. Fee-for-service models thus separate delivery of health care from payment, and have few cost control measures. MCOs, by comparison, integrate care delivery and reimbursement through a variety of contractual, organizational, and administrative arrangements in order to control costs and health care utilization. *Id.*

²⁰⁸ Potter, *supra* note 202, at 468; see also Susan A. Flocke, *Does Managed Care Restrictiveness Affect the Perceived Quality of Primary Care? A Report from ASPN*, 48 J. FAM. PRAC. 762 (Oct. 1999) [hereinafter Flocke, *Managed Care Restrictiveness*]; Hermer, *supra* note 204, at 22; Korobkin, *supra* note 207, at 462 (managed care constitutes “an institutional arrangement in which one company provides an insurance function or arranged with subcontractors for the provision of healthcare services”); PRIMARY CARE, *supra* note 201, at 105 (defining managed care as “health plans that have a selective list of providers, both professionals and hospitals, and that include mechanisms for influencing the nature, quantity, and site of services delivered”). Common managed care plans or arrangements include: health maintenance organizations (“HMOs”), Point of Service (“POS”) plans, preferred provider organizations (“PPOs”), and independent practice associations (“IPAs”). Hermer, *supra* note 204, at 22-26. For cogent descriptions of the various types of managed care, see *id.* and Kaiser Family Foundation, *How Private Health Coverage Works: A Primer (2008 Update)* 2-5 (2008), available at <http://www.kff.org/insurance/upload/7766.pdf>.

²⁰⁹ Hermer, *supra* note 204, at 23-25; Flocke, *Managed Care Restrictiveness*, *supra* note 208. Typical managed care restrictions/incentives relating to physicians include capitation arrangements, utilization reviews, prescription formulary, and clinician-withhold or incentive-bonus funds. *Id.* With respect to insured enrollees, managed care plans often use some combination of preauthorization for diagnostic or treatment procedures, referral requirements, specialty networks, or carve-outs/annual limits for particular treatments or conditions. *Id.*

²¹⁰ Hermer, *supra* note 204, at 24; Martin, *supra* note 204, at 437; see also Sandra J. Carnahan, *Law, Medicine, and Wealth: Does Concierge Medicine Promote Health Care Choice, Or Is It a Barrier to Access?*, 17 STAN. L. & POL’Y REV. 121, 124 n. 12 (2006) (the primary care physician “acts as the ‘gatekeeper’ for access to hospital and specialty services”).

²¹¹ Hermer, *supra* note 204, at 25.

within the network; on the other hand, financial “penalties” are typically imposed on subscribers—in the form of higher copayments or other out-of-pocket costs—for visiting out-of-network providers.²¹²

Managed care now dominates the United States’ health care marketplace. Today, 210 million Americans are enrolled in some form of managed care plan.²¹³ Traditional fee-for-service plans are largely non-existent: while 73% of individuals covered by employer-sponsored health plans were enrolled in fee-for-service plans in 1988, enrollment in such plans had dwindled to less than 1% as of 2012.²¹⁴ By contrast, as of 2012, 99% of enrollees in employer-sponsored private insurance subscribed to some form of managed care plan.²¹⁵

The increased corporatization of health care spurred by managed care has also led to wholesale (and ongoing) changes in business relationships between physicians, other health care providers (such as hospitals), MCOs, and employers.²¹⁶ Indeed, the last several decades have been described as the “era of Brownian motion in health care” in which “mergers, acquisitions and affiliations have been commonplace within the health plan, hospital, and physician practice sectors.”²¹⁷ These shifting business alliances often cause discontinuities in professional relationships (for providers) or treating relationships (for health care consumers).²¹⁸

The rise of managed care, in its many forms, has had profound effects on the doctor-patient relationship. Most notably, the long-term doctor-patient relationship—which Commissioner Michael Astrue has called the “Marcus Welby” model²¹⁹—has been rendered virtually obsolete. A robust body of scholarly medical literature has documented the deleterious effect of managed care on the continuity of care.²²⁰ Notably, in several studies,

²¹² *Id.*

²¹³ See *Current National Managed Care Enrollment*, MCOL.COM, http://www.mcol.com/current_enrollment (last visited Jan. 25, 2013).

²¹⁴ See App. G at A-32 (citing Kaiser Family Foundation/Health Research & Educational Trust, *2012 Employer Benefits Health Survey* 67 ex. 5.1 (2012), available at <http://ehbs.kff.org/pdf/2012/8345.pdf>).

²¹⁵ *Id.*

²¹⁶ Flocke, *Managed Care Restrictiveness*, *supra* note 208, at; Institute of Medicine, National Academy of Science, *CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY* 3-4 (2001) [hereinafter *CROSSING THE CHASM*]; Saultz & Albedaiwi, *Interpersonal Continuity*, *supra* note 206, at 245 (observing that, not only has managed care come to dominate the health care delivery market, but “health plans increasingly have required provider changes for economic reasons”).

²¹⁷ *CROSSING THE CHASM*, *supra* note 216, at 3.

²¹⁸ *E.g.*, Borkan, *supra* note 206.

²¹⁹ As Commissioner Astrue noted in his congressional testimony in June 2012: “I think that the treating physician rule historically . . . relied on [a] different paradigm. . . . [T]here was a time when we all had a Marcus Welby as a personal physician and that’s not true anymore.” Astrue June 2012 Testimony, *supra* note 13. *Marcus Welby, M.D.* was an American medical television program in the 1970s that featured two general practitioners, Dr. Welby and his young assistant, who provided individualized care to patients. See *Marcus Welby, M.D.*, IMDB.COM, http://www.imdb.com/title/tt0063927/?ref=sr_1 (last visited Jan. 25, 2013)

²²⁰ Paul Nutting et al., *Continuity of Primary Care: To Whom Does it Matter and When?*, 1 ANNALS OF FAM. MED. 149, 154 (Nov. 2003) (“The current organizational and financial restructuring of the health care system creates strong pressures against continuity with employers changing plans, and plans changing providers. Forced disruption in continuity of care is common, particularly for those with a managed care type of insurance.”); Borkan, *supra* note 206 (based on case studies of five Midwestern family practice groups, the authors found that managed care disrupted long-term relationships between medical providers and patients, and noted: “[T]hough some exceptional patients chos[e] to stick with their providers under any circumstances, both parties seem[ed] to be aware that those bonds m[ight] be severed at any time.”); Kahana, *supra* note 205, at 183-84 (observing that “vast majority of patients report dismay, dissatisfaction, and anger” when coping with

about fifty percent of managed care subscribers reported they had changed their usual physicians over the studied period (typically, several years), with even higher rates of discontinuity of care for elderly, minority, or other disadvantaged patients.²²¹ Forced disruption of doctor-patient relationships is frequently due to shifting business alliances—such as annual re-bidding of insurance contracts or provider networks—which result in a subscriber’s formerly in-network primary care physician or specialist getting dropped from the plan’s preferred network, or an employer dropping an insurance plan entirely.²²² Researchers have also found higher rates of *voluntary* physician-switching by managed care patients.²²³ Simply put, under MCOs, relationships between doctors and patients tend to be relatively short term whether due to administrative changes in insurance or network coverage (forced disruption) or patient choice (voluntary switching physicians).

The doctor-patient relationship has also undergone significant *qualitative* changes over the last several decades—some attributable to managed care, some not. Under the new managed care paradigm, both physicians and patients frequently feel time-pressured.²²⁴ Physicians state that they do not have sufficient time to diagnose their patients, while patients

managed care-related forced disruption of medical care, and that “patients with recent or acute health problems are at particularly high risk in instances of formal care discontinuity”); Flocke, *Impact of Insurance Type*, *supra* note 301 (patients with IPA/PPO type of managed care were four times more likely to report forced change of doctors compared to patients with fee-for-service plans); Karen Davis et al., *Choice Matters: Enrollees’ Views of Their Health Plans*, 14 HEALTH AFF. 99, 103, 111 (May 1995) (advent of restricted-network managed care plans introduced inherent instability to employment-linked health care coverage, and “this instability may undermine continuity of patient care”).

²²¹ See Nutting, *supra* note 220, at 154 (summarizing studies showing that only about 50% of surveyed patients reported continuity of regular physician, and rates were lower for elderly or minority patients and those without medical insurance); Davis et al., *supra* note 220, at 103-04 (1995) (finding, based on random telephone survey of working class families with employment-based health insurance, that almost half of the respondents had changed plans in the past three years, with one in three reporting that change was involuntary); see also George E. Kikano et al., ‘My Insurance Changed’: *The Negative Effects of Forced Discontinuity of Care*, 7 FAM. PRAC. MGMT. 44 (Nov./Dec. 2000) (in study of 1,800 primary care patients in Midwest, 24% had been forced to change family doctors in previous three years due to insurance change); L.J. Cornelius, *The Degree of Usual Provider Continuity for African and Latino Americans*, 8 J. HEALTH CARE FOR POOR AND UNDERSERVED 170 (1997).

²²² Nutting, *supra* note 220, at 154 (describing forced disruptions in care from MCOs as “common”); see also Borkan, *supra* note 206 (chronic shifting in contracts and relationships among employers, managed care organizations, medical groups, health plans, hospitals and providers due to managed care has disrupted long-term relationships between medical providers and patients, and surveyed providers felt that such disruptions cause “splintering” of continuity of care and an “endless” number of new patients); Flocke, *Impact of Insurance Type*, *supra* note 201 (25% of surveyed medical practices had experienced a recent professional merger, and 33% had undergone a recent buyout).

²²³ Dana Gelb Safran et al., *Switching Doctors: Predictors of Voluntary Disenrollment from a Primary Physician’s Practice*, 50 J. FAM. MED., *2-3 (Dec. 2000) (about 25% of studied patients enrolled in MCOs voluntarily changed physicians during the three-year study period (1996 – 1999), with perceived quality of the physician-patient relationship as the leading determinant in patient loyalty or disenrollment).

²²⁴ See Susan Door Goold & Mack Lipkin, *The Doctor-Patient Relationship Challenges, Opportunities, and Strategies*, 14 JGIM (Supp. 1) S24, S29 (Jan. 1999) (examining effects of managed care on visit time); Carnahan, *supra* note 210, at 129-30 (citing research from Center for Studying Health System Change that, as of 2001, “34% of physicians reported that they ha[d] inadequate time to spend with their patients, [which was] up from 28% in 1997”); see also David C. Dugdale, Ronald Epstein & Steven Z. Pantilat, *Time and the Patient-Physician Relationship*, 45 J. GEN. INTERN. MED. (Supp. 1) S34, S34 (Jan. 1999) (citing results from 1995 survey by Commonwealth Fund that “physicians with at least half of their patients in managed care were nearly twice as likely to be dissatisfied with the amount of time spent with patients (38% vs. 18%)”).

say that they do not have sufficient time to communicate their thoughts to their physicians.²²⁵ Financial considerations also drive increased patient loads for many physicians, particularly primary care doctors. “Family physicians average twenty to thirty patient visits per day, with a weekly average of 127.7 patient contacts in various settings, including office, hospital, and nursing home visits, and supervision of home health, nursing home, and hospice patients.”²²⁶ Managed care has also been linked to decreased duration of patient visits to medical specialists.²²⁷ Indeed, the time and other pressures that now encroach on the doctor-patient relationship have prompted one scholar to observe: “What happens between a doctor and patient might more aptly be termed an ‘encounter’ rather than a relationship . . . [it] is becoming increasingly similar to the ‘fleeting relationship’ between a cab driver and his fare.”²²⁸

To be sure, other forces over the course of the last twenty years have also effected qualitative changes in the doctor-patient relationship. One factor—of particular salience here—is an epidemiological shift in the medical needs of the American public from predominantly acute care, to episodic care for chronic conditions.²²⁹ Chronic conditions are now the leading cause of illness, disability, and death in this country; they affect about half of

²²⁵ E.g., Richard J. Baron, *New Pathways for Primary Care: An Update on Primary Care Programs From the Innovation Center at CMS*, 10 ANNALS OF FAM. MED. 152, 152 (Mar./Apr. 2012) (“[M]any [physicians] feel frustrated by constraints of time . . . as they struggle to incorporate burgeoning responsibilities.”); Kevin Grumbach et al., *Primary Care Physicians’ Experience of Financial Incentives in Managed-Care Systems*, 339 NEW ENG. J. MED. 1516, 1519 (1998) (analysis of survey data from California-based primary care physicians with at least one managed care contract found that 75% felt pressure to see more patients per day, and nearly one-third of these doctors believed such pressure compromised patient care); see also Cynthia A. Smith, *A Legislative Solution to the Problem of Concierge Care*, 30 SETON HALL LEGIS. J. 145, 146 (2005); Julia Murphy et al., *The Quality of the Physician-Patient Relationship*, 50 J. FAM. PRAC. 123, 126-27 (Feb. 2001) (observational study of patients under continuing care of primary physician from 1996 to 1999 found significant declines in indicators of relationship quality relating to interpersonal treatment, quality of communication, and trust).

²²⁶ See Carnahan, *supra* note 210, at 128; Smith, *supra* note 225, at 147 (primary care providers reported needing to see at least 30 patients per day).

²²⁷ Gery P. Guy, Jr. et al., *Visit Duration for Outpatient Physician Office Visits Among Patients With Cancer*, 8 J. ONCOLOGY PRAC. 2s, 4s (Supp. May 2012) (study of mean duration of ambulatory visits for cancer patients showed that “physician reimbursement mechanisms affected visit duration . . . higher rates of performance-based compensation and capitation were associated with shorter visit times”).

²²⁸ Potter, *supra* note 202, at 465, 476. Other researchers have characterized U.S. health care in the 21st century in similar fashion. For example, one author likened health care delivery to a production line:

Physicians have become a constantly hurried and harried group of “pieceworkers.” Because [they] are paid per visit or procedure, the only way to maintain income in the face of rising costs is to increase the volume of services provided. Patients have become [their] means of production. Because each “piece” of work has become devalued, physicians must perform higher volumes to meet their budgets. For example, if a primary care physician does not make twenty-four to thirty billable visits per day, he [or she] may not be able to meet his [or her] overhead expenses. The non-reimbursed aspects of care, such as case management and communication, fall by the wayside. . . . Because medicine has become commodified, there is less emphasis on doctor-patient relationships.

Rebecca D. Elon, *The Ethics of Health Care Reform: Unintended Consequences of Payment Schemes and Regulatory Mandates*, 12 J. HEALTH CARE L. & POL’Y 63, 66 (2009); see also Goold & Lipkin, *supra* note 224, at S29 (analogizing time constraints on visits to patients “being on a conveyor belt with a production-line-oriented doctor”).

²²⁹ CROSSING THE CHASM, *supra* note 216, at 3-4, 9, 26-27; see also Thomas Bodenheimer, *Primary Care—Will It Survive?*, 355 NEW ENG. J. MED. 861, 861-62 (Aug. 2006) [Bodenheimer, *Will It Survive?*].

the U.S. population and account for the majority of health care expenditures.²³⁰ Moreover, nearly half (44%) of persons with chronic illnesses have more than one such condition.²³¹ Medical care for chronic, comorbid conditions is often complex and calls for a collaborative, multidisciplinary approach among a variety of medical disciplines.²³² Patients with chronic illnesses thus tend to have multidisciplinary treatment teams of medical professionals, rather than a singular treating physician.

Additionally, over the last two decades, the trend toward specialization in American medical education—and concomitant shortage in primary care physicians—has accelerated significantly. Since 1998, medical school graduates entering specialty (or subspecialty) fields have far outpaced those selecting primary care.²³³ Indeed, during this period, the number of graduates from U.S. medical schools entering primary care dropped by fifty percent.²³⁴ The net result is a shortage of primary care physicians. Studies published in the last ten years document a shortage of primary care physicians.²³⁵ The American College of Physicians, for example, has warned: “The primary care system, the backbone of the nation’s health system, is at grave risk of collapse.”²³⁶ Gaps in the primary care workforce are expected to widen further when, as a result of health care reform, an estimated thirty million or more newly insured individuals will enter the health care system.²³⁷

To help fill this void, nonphysician clinicians—such as NPs, PAs, and LCSWs—have been shouldering a steadily increasing share of the primary care workload.²³⁸ As of 2010,

²³⁰ *Id.* at 3-4, 26-27; *see also* Potter, *supra* note 220, at 470. Chronic conditions are defined as “illnesses that last longer than three months and are not self-limiting.” CROSSING THE CHASM, *supra* note 216, at 27.

²³¹ CROSSING THE CHASM, *supra* note 216, at 27.

²³² *Id.* at 9, 26-27.

²³³ Bodenheimer, *Will It Survive?*, *supra* note 229, at 862; U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-09-438R, GRADUATE MEDICAL EDUCATION 3 & encl. I (2009).

²³⁴ *See* Bodenheimer, *Will It Survive?*, *supra* note 229, at 862-63; *see also* American College of Physicians, *The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation’s Health Care: A Report from the American College of Physicians* 3 (Jan. 30, 2006) [hereinafter *ACOP Report*] (collecting studies noting “dramatic decline” in the number of graduating medical students entering primary care), available at http://www.acponline.org/advocacy/events/state_of_healthcare/statehc06_1.pdf.

²³⁵ *E.g.*, Kaiser Commission on Medicaid and the Uninsured, *Improving Access to Adult Primary Care in Medicaid: Exploring the Potential Role of Nurse Practitioners and Physician Assistants* 1 (2011) (citing reports showing that, by 2020, the estimated shortage of primary care physicians will be about 45,000); Thomas Bodenheimer and Hoangmai H. Pham, *Primary Care: Current Problems and Proposed Solutions*, 5 HEALTH AFFAIRS 799, 801 (2010) [hereinafter Bodenheimer, *Primary Care Problems and Solutions*] (projected shortage of 35,000 - 44,000 adult primary care practitioners by 2025); *but see* Catherine Dower and Edward O’Neil, *Primary Care Health Workforce in the United States (Research Synthesis Report No. 22)* 9-10 (July 2011) (arguing that maldistribution of primary care providers represents more significant problem than shortage), available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf402104/subassets/rwjf402104_1.

²³⁶ *ACOP REPORT*, *supra* note 234, at 1.

²³⁷ Kaiser Commission, *supra* note 235, at 1, 6-7; Dower, *supra* note 235, at 9-10.

²³⁸ HEALTH RESOURCES AND SERVICES ADMINISTRATION, U.S. DEPT. OF HEALTH AND HUMAN SERVICES, THE PHYSICIAN WORKFORCE: PROJECTIONS AND RESEARCH INTO CURRENT ISSUES AFFECTING SUPPLY AND DEMAND 50 (Dec. 2008) (finding significant growth in nonphysician clinician workforce in recent years and projecting continuation of “rapid growth”); Kaiser Commission, *supra* note 235, at 3 (observing that NPs are “by far, the fastest growing segment of the primary care workforce”); Benjamin G. Dross et al., *Trends in Care by Nonphysician Clinicians in the United States*, NEW ENG. J. MED. 130-31 (2003) (analysis of survey data showed “rapid[] increase[e]” in outpatient care provided by nonphysician clinicians between 1987 and 1997); *see also* Roderick S. Hooker & Linda E. Berlin, *Trends in the Supply of Physicians and Nurse Practitioners in the United States*, 21 HEALTH AFFAIRS, 174, 179 (Sept. 2002) (noting 50% increase in PA and NP graduates since 1996).

NPs and PAs collectively made up about thirty percent of the primary care workforce nationally,²³⁹ and an even higher proportion in rural and other medically underserved areas.²⁴⁰ NPs and PAs also tend to have proportionally higher caseloads of minority and uninsured patients relative to primary care physicians.²⁴¹ The ranks of NPs and PAs engaged in primary care are projected to continue rising due, in large part, to financial incentives and other provisions in the Patient Protection and Affordable Care Act (“ACA”) designed to spur growth in the nonphysician primary care workforce to care for an expanded patient population.²⁴²

NPs and PAs, moreover, are not just increasing in numbers, but also in comprehensiveness of care provided. Over the last several decades, state-based scope of practice rules for NPs and PAs have expanded, providing them with increased authority to practice independently and provide comprehensive primary care.²⁴³ A robust body of literature has found that NPs and PAs in primary care settings provide care that is comparable to physicians in terms of types of patients, prescribing behavior, treatment complexity,

²³⁹ Agency for Health Care Policy and Research, U.S. Dept. of Health and Human Services, *Primary Care Workforce Facts and Stats No. 3: Distribution of the U.S. Primary Care Workforce*, AHRQ Publication No. 12-P001-4-EF (Jan. 2012) (based on statistics from 2010 National Provider Identifier dataset, AHRQ calculated that the primary care workforce was comprised as follows: physicians – 208,807 (71%); NPs – 55,625 (19%); and PAs – 30,402 (10%)), available at <http://www.ahrq.gov/research/pcwork3.htm> (last visited Jan. 25, 2013); see also Kaiser Commission, *supra* note 235, at 1 (as of 2009, NPs accounted for 27% of primary care providers, nationally and PAs accounted for 15%); Institute of Medicine, National Academy of Science, *THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH* 88 (2011) [hereinafter *FUTURE OF NURSING*] (citing studies showing that, as of 2008, there were 83,000 NPs and 23,000 PAs which respectively represented 21% and 6% of the primary care workforce).

²⁴⁰ See Kaiser Commission, *supra* note 235, at 3 (discussing studies showing that NPs and PAs make up a greater share of the primary care workforce in lower income and medically underserved areas); Kevin Grumbach et al., *Who Is Caring for the Underserved? A Comparison of Primary Care Physicians and Nonphysician Clinicians in California and Washington*, 1 *ANNALS FAM. MED.* 97, 101 (July/Aug. 2003) (higher proportion of nonphysician clinicians, as compared to physicians, provide primary care in underserved areas in two studied states); Agency for Health Care Policy and Research, U.S. Dept. of Health and Human Services, *Primary Care Workforce Facts and Stats No. 2: The Number of Nurse Practitioners and Physician Assistants Practicing Primary Care in the United States*, AHRQ Publication No. 12-P001-3-EF (Oct. 2011) [hereinafter *AHCPR, Workforce Facts No. 2*], available at <http://www.ahrq.gov/research/pcwork2.htm> (last visited Jan. 25, 2013).

²⁴¹ See Kaiser Commission, *supra* note 235, at 3 (NPs and PAs provide medical care for large numbers of minority or uninsured patients); Grumbach, *supra* note 240, at 101 (higher proportion of nonphysician clinicians, as compared to physicians, provide primary care to uninsured and minority patients in two studied states); *AHCPR, Workforce Facts No. 2*, *supra* note 240, at 1.

²⁴² Kaiser Commission, *supra* note 235, at 1, 6-7 (summarizing ACA provisions supporting expansion of nonphysician clinician workforce, including: \$31 million in grants to nursing schools to increase enrollment in primary care programs through student stipends; \$30 million in grants to PA schools for stipends to students in primary care programs; and \$15 million for a demonstration project to fund 10 new nurse-managed health clinics (“NMHCs”) for three years that will provide primary care in medically underserved areas and assist in training NPs); *FUTURE OF NURSING*, *supra* note 239, at 131-36; Mary D. Naylor & Ellen T. Kurtzman, *The Role of Nurse Practitioners in Reinventing Primary Care*, 29 *HEALTH AFFAIRS* 893, 897 (May 2010). Several states, spurred by the ACA, are also considering expanding the roles of NPs and PAs in primary care. See Kevin Murphy, *Advanced Practice Nurses: Prime Candidates to Become Primary Caregivers in Relation to Increasing Physician Shortages Due to Health Care Reform*, 14 *J. NURSING L.* 117 (2011); Carla K. Johnson, *Facing Doctor Shortage, 28 States May Expand Nurses’ Role*, *USA TODAY*, April 16, 2010.

²⁴³ *FUTURE OF NURSING*, *supra* note 239, at 97-98; Dower, *supra* note 235, at 13 & App. IV; Christine M. Everett et al., *Physician Assistants and Nurse Practitioners as Usual Source of Care*, 25 *J. RURAL HEALTH* 407 (2009); Ann Ritter & Tine Hansen-Turton, *The Primary Care Paradigm Shift*, 20 *HEALTH LAW.* 21, 23-25 (April 2008); see also Potter, *supra* note 202, at 468.

quality of care, and patient outcomes.²⁴⁴ Today, though there are some variations among states, NPs and PAs in primary care settings generally provide services that are similar to those provided by physicians—namely, taking medical histories, diagnosing and treating acute and chronic illnesses, prescribing and managing medications, ordering and interpreting lab tests and x-rays, and educating and counseling patients.²⁴⁵ As one 2008 study concluded:

Evidence increasingly demonstrates PA/NPs have expanding practice autonomy and scope of practice, are treating similar patients in a similar fashion to doctors and producing equivalent outcomes, and are currently recognized by some patients as their primary source of care, suggesting that the role of PA/NPs in primary care may be progressing toward that of a substitute.²⁴⁶

Similar dramatic changes have been observed in the mental health system. Managed behavioral health organizations (“MBHOs”), as with MCOs for general medicine, became dominant in the 1990s.²⁴⁷ Almost all mental health care in both public and private sectors is now overseen by MBHOs.²⁴⁸ Indeed, according to at least one study, “[m]ental health services appear to be managed even more rigorously than most medical and surgical services.”²⁴⁹ Perhaps nowhere has that management rigor been felt as keenly as the within the cadre of mental health professionals. MBHOs have sought, in large part, to reduce costs by substituting other mental health professionals—chiefly, LCSWs—for psychiatrists. As a result, since 1990, the number of LCSWs (relative to psychiatrists) has risen dramatically.²⁵⁰ This growth trend in LCSWs is expected to continue—and perhaps accelerate—in future years.²⁵¹ Today, LCSWs represent the largest segment of the mental health care workforce

²⁴⁴ E.g., Robin P. Newhouse et al., *Advanced Practice Nurse Outcomes 1990-2008: A Systematic Review*, 29 NURSING ECON. 230, 248 (Sept./Oct. 2011) (systematic review of published literature comparing the processes and outcomes of care delivered by advance practice nurses (which encompasses NPs) and finding that review “supports a high level of evidence that such nurses provide safe, effective, quality care to a number of specific populations in a variety of settings”); Kaiser Commission, *supra* note 235, at 3; Mary D. Naylor & Ellen T. Kurtzman, *The Role of Nurse Practitioners in Reinventing Primary Care*, 29 HEALTH AFFAIRS 893, 894-95 (May 2010); Benjamin G. Druss et al., *Trends in Care by Nonphysician Clinicians*, 34 NEW ENG. J. MED. 130, 136 (Jan. 2003) (finding that physicians and nonphysician clinicians treated similar types of patients).

²⁴⁵ E.g., Kaiser Commission, *supra* note 235, at 1-2; Ritter, *supra* note 245, at 23-25; Everett, *supra* note 243.

²⁴⁶ Everett, *supra* note 243.

²⁴⁷ David Mechanic, *Mental Health Services Then and Now*, 26 HEALTH AFFAIRS 2548, 1549 (2007) [hereinafter Mechanic, *Mental Health Services*]; Richard G. Frank & Sherry Glied, *Changes in Mental Health Financing Since 1971: Implications for Policy Makers and Patients*, 25 HEALTH AFFAIRS 601, 603 (May/June 2006).

²⁴⁸ Mechanic, *Mental Health Services*, *supra* note 247.

²⁴⁹ Mechanic, *Mental Health Services*, *supra* note 247, at 1549.

²⁵⁰ Richard M. Scheffler & Paul B. Kirby, *The Occupational Transformation of the Mental Health System*, 22 HEALTH AFFAIRS 177, 178-79 (Sept. 2003); *see also* Frank, *supra* note 247, at 604 (noting that “mental health care system has undergone remarkable changes during past three decades,” including significant increase in nonphysician providers such as social workers); David Mechanic & Scott Bilder, *Treatment of People with Mental Illness: A Decade-Long Perspective*, 23 HEALTH AFFAIRS 84, 86 (July 2004) [hereinafter Mechanic, *Treatment of Mental Illness*] (“Although the supply of traditional mental health providers such as psychiatrists and psychiatric nurses ha[d] increased only modestly [from 1992 to 2000], there [were] larger increases in psychology and social work.”).

²⁵¹ *See* Scheffler & Kirby, *supra* note 250, at 185; Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2012-13 Edition*, Social Workers (predicting that employment of social workers will grow by 25% from 2010 to 2020), available at <http://www.bls.gov/ooh/community-and-social-service/social-workers.htm>.

(45%), followed by psychologists (36%) and psychiatrists (19%).²⁵² Some studies estimate that LCSWs provide up to 65% of all mental health services.²⁵³ LCSWs spend the majority of their time providing direct services to clients.²⁵⁴ These services generally include (with some state-to-state variation): intake and assessment of client histories; diagnosis of psychiatric disorders; development of treatment plans; provision of direct psychotherapy or individual counseling; and provision of crisis and case management services.²⁵⁵ In their evolving role in the mental health system, LCSWs are thus providing the bulk of frontline mental health services, and are expected to continue doing so in future years.

Taken together, the effects of managed care and other forces that have dramatically reshaped the American health care system over the past two decades call into question the ongoing efficacy of the treating physicians rule. Development of a sustained “Marcus Welby”-type relationship between a single physician and patient is now rare. Instead, care for medical and mental health conditions is generally discontinuous and fragmented between multiple providers—including, primary physicians, specialists, NPs, PAs, and LCSWs—who work in a variety of clinical settings.

B. Difficulty Ascertaining Treating Physician Status

Although “[t]he doctor-patient relationship is critical for vulnerable patients as they experience a heightened reliance on the physician’s competence, skills, and good will,”²⁵⁶ the question remains on which physician or non-physician do patients rely and to what extent do they rely on a particular opinion? The shift in health care delivery challenges the treating physician paradigm. Are the primary care physicians who serve as gatekeepers in HMO-style MCOs (or MBHOs) the treating physician or should that designation be reserved for the specialists to whom they refer their patients? What about the physicians who serve in a supervisory capacity? Are they treating physicians, or should other medical professionals who personally interact with the patients on a regular basis be considered treating sources instead?

²⁵² Scheffler & Kirby, *supra* note 250, at 185. Though not reflected in the cited figures, there are a relatively small number of advanced practice psychiatric nurses (“AAPNs”) in the mental health workforce. See Nancy P. Hanrahan et al., *Health Care Reform and the Federal Transformation Initiatives: Capitalizing on the Potential of Advanced Practice Psychiatric Nurses*, 11 POL’Y POLIT. NURSING PRAC. 235 (Aug. 2010) (as of mid-2000s, there were about 8700 certified APPNs, representing about 2% of the mental health workforce).

²⁵³ Scheffler & Kirby, *supra* note 250, at 185; see also *Specialization and Integration in Mental Health Care*, 25 HEALTH AFFAIRS 647, 647 (May/June 2006) (characterizing the current mental health care system as encompassing a “riotously pluralistic provider universe”).

²⁵⁴ NASW Center for Workforce Studies, *Assuring the Sufficiency of a Frontline Workforce: A National Study of Licensed Social Workers (Executive Summary)* 18-19 (2006), available at http://workforce.socialworkers.org/studies/nasw_06_execsummary.pdf.

²⁵⁵ See NASW Center for Workforce Studies, *Social Workers in Mental Health Clinics & Outpatient Facilities 1* (2011), available at <http://workforce.socialworkers.org/studies/profiles/Mental%20Health%20Clinics.pdf>. LCSWs, however, cannot directly prescribe or dispense medications. See App. I at A-38 tbl. 17. Other nonphysician clinicians may have prescribing privileges depending on state scope of practice laws. See Hanrahan, *supra* note 252 (In a 2007 practice survey, “[n]early 66.5% of [certified] AAPNs who treat adults prescribe psychotropic medications and reported that one third of their week is spent either prescribing/managing medication regimens alone or in combination with psychotherapy.”); Carolyne Krupa, *Psychologists seek prescribing rights in 6 states*, AM. MED. NEWS, March 7, 2011, <http://www.ama-assn.org/amednews/m/2011/03/07/pl20307.htm> (last visited Jan. 27, 2013).

²⁵⁶ Goold & Lipkin, *supra* note 224, at S27.

Judicial Responses

Courts have reacted to the change in the health care system in different ways, often by expanding the concept of a treating source. If physicians other than traditional family physicians or specialists warrant treating physician status, the dichotomy between treating physicians and all other medical personnel that underlies the SSA treating physician rule has been compromised. If more physicians contribute to the care decisions, is there reason to privilege one opinion at the expense of others?

A sampling of cases shows that courts recently have considered physicians with relatively sporadic treatment relationships to patients to be treating sources. For example, where a physician treated a patient three times in three-month intervals, an ALJ gave little weight to the physician's opinion because of the relatively short period of time that the physician treated the patient.²⁵⁷ However, the First Circuit reversed the ALJ's decision because the ALJ did not explain or provide a "citation in support of[] her belief that [the physician's] treatment relationship with the claimant [was] too abbreviated."²⁵⁸

Courts have also determined that treating physician status can be shared among a practice group—a significant departure from the original model. For instance, in *Shontos v. Barnhart*, the Eighth Circuit determined that all members of a team of mental health professionals, who rotated in evaluating the claimant, could be considered treating sources.²⁵⁹ This relationship is far more attenuated than the original treating physician model contemplated.

To further confuse the standards regarding what weight is accorded to which opinion, the Ninth Circuit has held that a physician who is informed, but does not examine the patient personally, is not quite a treating physician, but is entitled to greater weight than an examining physician. In *Ratto v. Secretary, Department of Health & Human Services*, a district court determined that a physician who did not personally treat the claimant for four years prior to the ALJ's hearing, but continued to receive updates of the claimant's medical records, was not entitled to treating source deference.²⁶⁰ This opinion concluded nonetheless that physicians in such circumstances were entitled to more weight than an examining physician, but less than another treating physician.²⁶¹ Later, in *Benton v. Barnhart*,²⁶² the Ninth Circuit debated whether a psychiatrist who managed the provision of the claimant's medication and received reports from other medical sources without seeing the claimant regularly, was a treating source.²⁶³ The court relied on *Ratto* and found that the psychiatrist's opinion was entitled to greater weight than an examining physician because, unlike physicians who evaluate a claimant's condition based on "the cold record," his opinion was based on direct communication with his treatment team.²⁶⁴ The court noted that the psychiatrist "had examined [the claimant] not much more than a year before his report, and was still employed to cure" the claimant.²⁶⁵ The court went on to say, "[W]hile [the

²⁵⁷ *Johnson v. Astrue*, 597 F.3d 409, 411 (1st Cir. 2009).

²⁵⁸ *Id.*

²⁵⁹ *Shontos v. Barnhart*, 328 F.3d 418, 426 (8th Cir. 2003).

²⁶⁰ *Ratto v. Sec'y, Dept. of Health & Human Servs.*, 839 F. Supp. 1415, 1425 (D. Or. 1993).

²⁶¹ *Id.*

²⁶² 331 F.3d 1030 (9th Cir. 2003).

²⁶³ *Id.* at 1035-39.

²⁶⁴ *Id.* at 1039.

²⁶⁵ *Id.* at 1038.

psychiatrist] may be placed relatively low on the continuum of treating physicians in this respect, he would still fall into the treating physician category. His opinion would be entitled to greater weight than that of an examining or reviewing physician.”²⁶⁶

These cases reveal that, from the courts’ perspective, the distinction between treating and other physicians has blurred. The expansion of treating physician status runs the risk of undermining the rule itself. The original idea that the persuasiveness of medical opinion should turn more on the frequency of visits and depth of professional judgment underlying the medical opinion has gotten lost.

This blurring of professional lines—between treating physicians and other medical professionals—is, moreover, increasingly reflected not just in judicial opinions, but in medical offices as well. Indeed, the treating physician business has expanded with new services to include doctors who see patients in high volume.²⁶⁷ Some evidence suggests that many of these “high volume” doctors also serve as treating physicians for SSA disability benefits claimants.²⁶⁸ This “devaluation” of the physician-patient relationship calls into further question whether any deference—let alone “controlling weight”—should be afforded to the opinions of this type of medical practitioner.

Other Considerations

To be sure, the rationale for the treating physician rule stems not only from what was considered to be the special relationship between patient and treating physician, but also from the *mistrust* of consulting and examining physicians who are paid by SSA. Arguably, even if

²⁶⁶ *Id.* at 1039; *see also* Nyberg v. Commissioner of Social Security, 179 Fed. Appx. 589 (11th Cir. 2006) (according treating physician status even when physician was not employed to treat the condition that caused the disability).

²⁶⁷ As Commissioner Astrue noted in the following colloquy with Representative Brady during a recent congressional hearing on the Social Security appeals process:

BRADY: How about on the front end into the process not just those who are having assets but those end providers who are enabling those to try to defraud the system with medical disabilities. [¶] What percentage of applicants are we now identifying through the process on the front end, you know, who are attempting to defraud the system?

ASTRUE: It's relatively small but the Disability Examiners are quite good about being alert on these things . . . Some of our administrative law judges have been very sharp about this, too. One of the more spectacular ones that we're working on now can because of the very alert ALJ. [¶] I would say if you're going to see on one thing. I think that the treating physician rule historically, you know, relied on the different paradigm. You know there was a time when we all had a Marcus Welby as a personal physician and that's not true anymore. In fact, we're increasingly seeing physicians who are essentially extensions of the lawyers doing the representation. I mean, often sometimes physically housed within those complexes.

Disability Insurance Appeals Process: Hearing Before the Subcomm. on Soc. Sec. of the H. Comm. on Ways & Means, 112th Cong. *10-11 (2012).

²⁶⁸ For example, in August 2012, the United States Attorney in San Diego secured a guilty plea from a psychologist on fraud charges after he falsified medical reports for Social Security disability benefits claimants; that scheme had led to improper payments totaling \$1.5 million from 2006 to 2012. Greg Moran, *Psychologist Pleads Guilty to Fraud Counts*, SAN DIEGO UNION-TRIBUNE, Aug. 3, 2012, at B-2. For a similar fraudulent scheme in the railroad industry, see William K. Rashbaum & Mosi Secret, *Charges for 11 in Disability Fraud Plot at L.I.R.R.*, N.Y. TIMES, Oct. 27, 2011, A-1 (reporting that “sampling of hundreds of cases approved by two doctors showed that \$121 million had been paid to workers whose disabilities were either fabricated or exaggerated, according to court papers, though the total was quite likely more”).

the treating physician does not have better knowledge about claimants, he or she might be considered by some to be more objective and independent.

The objectivity argument cuts both ways of course. First, given that physicians have a fiduciary duty to those they examine,²⁶⁹ drawing such a marked distinction between the weights afforded treating and all other physicians, including those paid by SSA, is not fully persuasive since the Hippocratic Oath covers all physicians equally.

Second, as Judge Richard Posner has observed, the treating physician may show more sympathy for patients who, even if not disabled under the statute, often have limited ability to find gainful employment in this economy.²⁷⁰ Representatives of claimants often provide questionnaires for treating physicians to fill out in ways that make a finding of disability much easier to defend, a problem that courts have noted.²⁷¹

Consider the Seventh Circuit's comments in *Butera v. Apfel*.²⁷² There, the ALJ discounted the treating physician's assessments, which were largely based on the claimant's subjective complaints of pain, and relied instead on the opinion of consulting orthopedists. In upholding the ALJ's decision, the court noted that it had "repeatedly stressed that 'a claimant's treating physician may be biased in favor of the claimant; bias that a consulting physician may not share.'"²⁷³ The court added that "[t]he 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."²⁷⁴ This sympathy factor supports diminishing reliance on the opinions of treating physicians in some cases.

This is not to suggest that a treating physician's assessment should be disregarded. Far from it. Even aside from the treating source rule, SSA's regulations, 20 C.F.R. §§ 404.1527 and 416.927, specify that ALJs should consider the duration of a patient's relationship with the physician and the amount of time that a patient has spent face-to-face with the physician. Thus, the testimony of a treating source receives far greater deference than a physician who examines the patient only once, much less a consulting physician who assesses only the medical files. Those aspects of the treating physician's role should still entitle physician opinions to considerable deference on a case-by-case basis. However, the

²⁶⁹ Goold & Lipkin, *supra* note 224, at S27.

²⁷⁰ *E.g.*, *Hofslein v. Barnhart*, 439 F.3d 375, 376 (7th Cir. 2006). As Judge Posner observed: "[T]he fact that the [SSI or SSDI] claimant is the treating physician's patient also detracts from the weight of that physician's testimony, since, as well known, many physicians (including those most likely to attract patients who are thinking of seeking disability benefits) will often bend over backwards to assist a patient in obtaining benefits." *Id.*; see also *Black & Decker*, 538 U.S. 822, 832 (observing that "a treating physician, in a close case, may favor a finding of 'disabled'"); *Hawkins v. First Union Corp. Long-Term Benefit Plan*, 326 F.3d 914, 817 (7th Cir. 2003) (collecting cases); *Flynn v. Astrue*, 563 F. Supp. 2d 932, 944-45 (N.D. Ill. 2008). Other social science research also points to potential bias by treating physicians in the context of state worker's compensation claims. See Seth Seabury, Robert Reville & Frank Neuhauser, *Physician Shopping in Workers' Compensation: Evidence from California*, 3 J. OF EMPIRICAL L. STUD. 47 (2006); K. Folley, *Physician Advocacy and Doctor Deception*, 48 FED. LAWYER 25, 25 (2001); V. Freeman, et. al., *Lying for Patients: Physician Deception of Third-Party Payers*, 159 ARCHIVES OF ENVTL. MED. 2263, 2263 (1999).

²⁷¹ *Dixon v. Masanari*, 270 F.3d 1171, 1177 (7th Cir. 2001).

²⁷² 173 F.3d 1049 (7th Cir. 1999).

²⁷³ *Id.* at 1056.

²⁷⁴ *Id.*; see also *Dixon*, 270 F.3d at 1177 (noting that "the claimant's regular physician may not appreciate how her patient's case compares to other similar cases, and therefore that a consulting physician's opinion might have the advantages of both impartiality and expertise.").

controlling weight formulation, by ascribing talismanic force to one of perhaps many medical opinions in the file, focuses the search on someone who, in this evolving world of medical practice, may no longer exist. In short, changes in the health care system have eroded the distinction between treating physicians and all other medical personnel.

IV. EMPIRICAL ANALYSIS OF SSA DATA: TREATING PHYSICIAN RULE AND REMAND RATES

SSA has developed databases which track cases that are remanded both by courts to the agency, and by the Appeals Council to ALJs. This Part offers a summary and an analysis of remands in both contexts, with particular focus on the treating physician rule.

A. The Federal Courts

Over the period from 2009 to 2011, courts remanded cases back to SSA forty-five percent of the time.²⁷⁵ SSA tracks these remands by grouping them into categories and subcategories. SSA first divides the cases into ten different categories, according to the reason or reasons a case was remanded.²⁷⁶ While any one case may list up to three remand reasons, the category Opinion Evidence Evaluation & Residual Functional Capacity (“OEE & RFC”) (of which treating source is a part) was listed with the most frequency at 54%.²⁷⁷ In fact, Credibility Evaluation—the category with second highest percentage—at 19%, did not come close to OEE & RFC’s frequency rate.²⁷⁸

SSA then divides the ten categories further; OEE & RFC itself contains five different remand classifications.²⁷⁹ The remand reason with the highest frequency percentage by far was the treating source.²⁸⁰ Out of the 14,571 cases that cited remand reasons, 5138 cases cited the treating source as a reason for remand—a citation frequency rate of thirty-five percent. The category with the second highest frequency percentage, RFC, trailed the treating source percentage by twenty percent.²⁸¹ The treating source category is also divided into five subcategories²⁸²:

- ***Opinion Not Identified or Discussed:*** SSA either did not identify or evaluate the treating source’s opinion.
- ***Opinion Rejected Without Adequate Articulation:*** SSA discredited the treating source’s opinion without adequately explaining why the agency took such action.
- ***Weight Accorded Opinion Not Specified:*** SSA failed to clearly articulate the weight it assigned to the treating source’s opinion.
- ***Opinion on Issue Reserved to Agency:*** SSA adopted the treating source’s opinion that a claimant is disabled without an independent finding from the agency.

²⁷⁵ See App. B at A-2 tbl. 1.

²⁷⁶ For a list of the ten categories, see App. B at A-3 tbl. 2.

²⁷⁷ See *id.* This percentage remained relatively unchanged during the 2009 – 2011 observation period. See App. B at A-6 tbl. 5.

²⁷⁸ See *id.* at A-3 tbl. 2.

²⁷⁹ For a list of the five classifications, see App. B at A-4 tbl. 3.

²⁸⁰ See *id.* This percentage remained relatively unchanged during the 2009 – 2011 observation period. See App. B at A-6 tbl. 5.

²⁸¹ See *id.* at A-4 tbl. 3.

²⁸² See *id.* at A-5 tbl. 4.

- **Recontact Necessary:** SSA failed to re-contact the treating source when clarification was necessary.

Four of the five subcategories combined accounted for approximately thirteen out of the thirty-five percent remand frequency rate.²⁸³ A full twenty-two percent of the cases included the remand reason “Opinion Rejected Without Adequate Articulation.”²⁸⁴ This percentage is particularly significant.

Apparently, courts often do not believe that SSA adequately explained why it discredited the treating source’s opinion. It is plausible that SSA has in fact failed properly to articulate its reasons. However, in light of this report’s previous discussion,²⁸⁵ it is also quite plausible that courts have distorted the application of the treating physician rule. Federal courts have applied different standards when assessing whether SSA has been sufficiently careful in discrediting treating source opinions.²⁸⁶ These varying standards make it difficult for SSA to know when it has attained the threshold required to reject an opinion.²⁸⁷ Moreover, federal courts (perhaps at the regulation’s invitation) turn the substantial evidence review standard on its head. Instead of focusing on whether substantial evidence exists in the record to support SSA’s disability finding, federal courts often focus on whether SSA found that substantial evidence exists to justifiably discredit the treating physician’s opinion.²⁸⁸ In any event, the high remand frequency percentage rate calls into question the efficacy of the current treating physician rule.

B. The Appeals Council

Over the period from 2009 to 2011, the Appeals Council remanded cases back to ALJs twenty-four percent of the time.²⁸⁹ The OEE & RFC category (of which treating source is a part) was the most frequently cited reason for remand at thirty-five percent. Within the OEE & RFC category, treating source—at ten percent—was the second-most frequently coded basis (after RFC) for remand back to ALJs.²⁹⁰ SSA further divides the treating source classification into four subcategories—which is similar to the coding used for remands from federal courts.²⁹¹ Unlike the court data, however, not as much disparity exists among the percentages. The two subcategories with the highest percentages are “Opinion Not Identified or Discussed” (approximately five percent) and “Opinion Rejected Without Adequate Articulation” (approximately three percent).²⁹²

²⁸³ *See id.* This percentage has remained relatively unchanged during the 2009 – 2011 observation period. *See* App. B at A-6 tbl. 6.

²⁸⁴ *See id.* at A-5 tbl.4. This percentage has remained relatively unchanged during the 2009 – 2011 observation period. *See id.* at A-6 tbl. 5.

²⁸⁵ *See supra* Part II.

²⁸⁶ These varying standards may be reflected in the varying remand rates across district courts. *See* App. B at A-11 tbl.12.

²⁸⁷ *See supra* Part II.B.

²⁸⁸ *See supra* Part II.D.

²⁸⁹ *See* App. B at A-7 tbl. 7.

²⁹⁰ *See id.* at A-9 tbl. 10.

²⁹¹ For a list of the four subcategories, see App. B at A-8 tbl. 8. Except for “Opinion on Issue Reserved to Agency,” SSA uses the same subcategories when the Appeals Council remands a case as when a court remands a case.

²⁹² *See id.*

Although there is certainly room for improvement in either context, the differences in remand rates between the federal courts and the Appeals Council are telling. The treating source is cited with a thirty-five percent frequency rate in cases remanded by the federal courts, but is only cited with a ten percent frequency rate in remands from the Appeals Council. Furthermore, as previously stated, the remand reason “Opinion Rejected Without Adequate Articulation” is cited with a twenty-two percent frequency rate in cases remanded by the federal courts, but is only cited with an approximately three percent frequency rate in remands from the Appeals Council. The Appeals Council is an expert body, which not only sees well over 100,000 disability cases a year, but is also involved in quality review and policy interpretations. If ALJs were in fact significantly failing to comply with SSA’s treating physician rule, one would expect to see a higher remand rate from the Appeals Council.²⁹³ As it stands, the high judicial remand rate lends support to the courts’ misinterpretation of the rule²⁹⁴ and the agency’s need to revisit it.

Observation on the Use of Medical Experts

It is also interesting to note the impact (or rather, lack of impact) of the presence of a medical expert (“ME”) in the outcome of dispositions. Across the board, the presence of MEs did not affect the disposition rate, whether fully favorable, partially favorable, or unfavorable.²⁹⁵ This non-impact existed even before adjusting for the likelihood that a ME was not present in cases that resulted in dismissal. In fact, before that adjustment, the presence of a ME was associated with a higher fully favorable rate and a lower dismissal rate.²⁹⁶ This is an important point given the context in which the treating physician rule was first introduced by courts.²⁹⁷ Courts sought to shield claimants from SSA’s practice of using its own examiners, rather than relying on claimants’ physicians. Since the presence of a ME does not affect a case’s disposition, it appears that this protection is no longer necessary.

V. PERSPECTIVES ON THE TREATING PHYSICIAN RULE

The treating physician rule, as the Supreme Court recently observed, “has not attracted universal adherence outside the Social Security context.”²⁹⁸ Only one other agency—the Department of Labor (“DOL”)—has promulgated a regulatory standard for a federal disability program that embraces the notion of giving special weight to opinions of treating physicians. Indeed, several federal courts have called into question the ongoing efficacy of a treating physician rule.²⁹⁹ While this reality could be a reflection of the

²⁹³ On the other hand, time pressures from the Appeals Council’s high caseload may prevent it from giving close review to the record of each case on appeal.

²⁹⁴ This misinterpretation may stem from both the courts’ distortions in applying the rule and in the rule’s lack of clarity.

²⁹⁵ *See id.*

²⁹⁶ *See id.*

²⁹⁷ *See infra*, notes 45-47 and accompanying text.

²⁹⁸ *Black & Decker*, 538 U.S. 822, 829, n.3; *see also* Levy, *Agency-Specific Precedents*, *supra* note 45, at 546 (noting that federal courts have, as a general matter, “explicitly declined to extend the treating physician rule beyond the Social Security disability context”).

²⁹⁹ *E.g.*, *Benton v. Barnhart*, 331 F.3d 1030, 1038 (9th Cir. 2003) (quoting *Rodriguez v. Bowen*, 876 F.2d 759, 761 (9th Cir. 1989) (“It is not necessary, or even practical, to draw a bright line distinguishing a treating physician from a non-treating physician. Rather, the relationship is better viewed as a series of points on a continuum reflecting the duration of the treatment relationship and the frequency and nature of the contact.”); *Hofslien v. Barnhart*, 439 F.3d 375, 376 (7th Cir. 2006) (“It is time that the Social Security Administration reexamined the [treating physician] rule.”).

differences in various agencies' statutory and regulatory programs, some scholars have also opined that "the substantial evidence standard of review should mean the same thing under the Social Security Act as it does under the APA or other organic statutes."³⁰⁰ Representative organizations, too, have strong opinions about the treating physician rule, and relatedly, about the classification of "acceptable medical sources."

A. Other Federal and State Disability Benefits Programs

1. *Minority Approach: Programs With a Treating Physician Rule*

Among the agencies surveyed by this report, the Department of Labor is the only agency, outside of SSA, to have promulgated a treating physician rule applicable to a federal disability program, specifically in its Black Lung benefits program.³⁰¹ The treating physician rule for the Black Lung program was fashioned by drawing on principles set forth in case law, as well as on SSA's treating physician regulation.³⁰² DOL's regulations guide how the adjudication officer should weigh the opinion of a miner's treating physician. The adjudication officer must take the following factors into account: (1) nature of the treating relationship; (2) duration of the relationship; (3) frequency of the treatment; and the (4) extent of the treatment.³⁰³ When no "probative," contrary evidence exists, the regulations compel the adjudication officer to accept the treating physician's statement according to the aforementioned factors.³⁰⁴ In some cases, the relationship between the treating physician and the miner may be such that the relationship should be accorded "controlling weight."³⁰⁵ Controlling weight, however, is only ascribed to the physician's opinion after the adjudication officer assesses its credibility according to the record as a whole.³⁰⁶ Indeed, as DOL emphasized when promulgating the rule, it is not outcome-determinative because it permits the adjudicator to "consider[] the credibility of the [treating] physician's opinion in light of its documentation and reasoning and the relative merits of the other relevant medical evidence of record."³⁰⁷

While some scholars note that confusion marred the weighing of opinion evidence from a miner's treating physician prior to the promulgation of DOL's 2000 final rules, since that time,³⁰⁸ circuit court cases interpreting DOL's treating physician rule have consistently affirmed the rule's regulatory approach for medical opinion evidence.³⁰⁹ While disavowing

³⁰⁰ Levy, *Agency-Specific Precedents*, *supra* note 45, at 546.

³⁰¹ For the treating physician rule applicable in the Black Lung program, see 20 C.F.R. § 718.104(d) (2012); *see also* 30 U.S.C. § 901 et seq. (2012) for the establishment of benefits to certain coal miners and their families in the event of the miner's death or complete disability related to pneumoconiosis.

³⁰² Dept. of Labor, Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, As Amended; Proposed Rule, 64 Fed. Reg. 54,966, 54,969 (Oct. 8, 1999) [hereinafter 1999 DOL Proposed Rules].

³⁰³ 20 C.F.R. § 718.104(d)(1)-(4) (2012).

³⁰⁴ 20 C.F.R. § 718.104(d)(5) (2012).

³⁰⁵ *Id.*

³⁰⁶ *Id.*

³⁰⁷ Dept. of Labor, Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, As Amended; Final Rules, 65 Fed. Reg. 79,920, 79,923, 79,931-32 (Dec. 20, 2000).

³⁰⁸ *See, e.g.*, Brian C. Murchison, *Due Process, Black Lung, and the Shaping of Administrative Justice*, 54 ADMIN. L. REV. 1025, 1094 (2002).

³⁰⁹ *E.g.*, *Eastover Mining Co. v. Williams*, 338 F.3d 501, 512-13 (6th Cir. 2003) (discussing and applying with approval the treating physician rule embodied in DOL's 2000 final rules); William S. Mattingly, *If Due Process Is a Big Tent, Why Do Some Feel Excluded from the Big Top?*, 105 W.VA. L. REV. 791, 810 (2003) (collecting cases).

any “mechanical rule that the views of a treating physician prevail,”³¹⁰ circuit courts reviewing Black Lung decisions affirm the rule’s basic approach—namely, that the “opinions of treating physicians are entitled to greater weight than those of non-treating physicians,”³¹¹ so long as opinions from treating sources are “properly credited and weighed.”³¹²

DOL’s Black Lung regulation, however, defines neither “treating physician” nor “controlling weight.” By declining to define these terms, DOL intended to “require the factfinder to recognize the additional weight to which a physician’s opinion may be entitled, in light of all of the other relevant evidence [in the] record,” rather than to predetermine “the outcome of a factfinder’s evaluation.”³¹³ In some ways, then, DOL’s rule affords greater flexibility than SSA’s rule. Another key difference between DOL and SSA is that DOL’s regulations govern one medical issue—pneumoconiosis—that involves respiratory and pulmonary conditions. SSA, on the other hand, may see any medical issue or combination of medical issues resulting in full disability.

Additionally, while DOL has not promulgated regulations establishing a treating physician rule with respect to the adjudication of benefits under the Longshore and Harbor Workers’ Compensation Act (“LHWCA”),³¹⁴ some federal courts have nonetheless engrafted a judicially created treating physician rule into this program.³¹⁵ Courts have asserted that an ALJ is “bound by the expert opinion of a treating physician as to the existence of a disability ‘unless contradicted by substantial evidence to the contrary.’”³¹⁶

Outside these two contexts, however, our research did not reveal any federal disability benefits programs apart from the Social Security Act in which adjudicators were governed by a treating physician rule, either by regulation or federal case law.

³¹⁰ *Ziegler Coal Co. v. OWCP*, 490 F.3d 609, 616 (7th Cir. 2007) (internal quotations omitted); *see also* *Peabody Coal Co., v. Groves*, 277 F.3d 829, 834 (6th Cir. 2002).

³¹¹ *Peabody Coal*, 277 F.3d at 834 (quoting *Tussey v. Island Creek Coal Co.*, 982 F.2d 1036, 1042 (6th Cir. 1993)).

³¹² *Id.*; *see also* *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 441 (4th Cir. 1997) (noting that a treating physician’s opinion may be “deserving of especial consideration,” but that consideration is not bestowed automatically).

³¹³ 1999 DOL Proposed Rules, *supra* note 302, at 54,977; *see also* *Eastover*, 338 F.3d at 512-13 (“The [treating physician] regulation [in the 2000 final rules] says nothing about prioritizing a treating physician’s perspective; rather, the regulation expects ALJs to analyze the nature and duration of the doctor-patient relationship along with the frequency and extent of treatment.”); *Mattingly*, *supra* note 309, at 810 (observing that, by declining to define the term “treating physician,” DOL’s 2000 final rule leaves open the issue of how such a relationship may be established: “Whether such a treating relationship is established on one occasion or over a course of years goes unaddressed and will be left for practitioners and ALJs to iron out.”).

³¹⁴ *See* 33 U.S.C. § 901 et seq. (2012) for the establishment of benefits to certain employees and their families in the event of the employee’s death or complete disability occurring upon or related to the navigable waters.

³¹⁵ This engrafting was prior to *Black & Decker*, 538 U.S. 822 (2003). *See infra*, Part V.A.2.

³¹⁶ *See* *Pietrunti v. Director, OWCP*, 119 F.3d 1035, 1042 (2d Cir. 1997) (citing *Alston v. Sullivan*, 904 F.2d 122, 126 (2d Cir. 1990)); *see also* *Bath Iron Works Corp. v. Preston*, 380 F.3d 597, 609 (1st Cir. 2004) (ALJ based his finding of total disability on, among other evidence, the uncontroverted opinion of the claimant’s treating physicians); *Amos v. Director, OWCP*, No. 96-70988, 1998 U.S. App. LEXIS 33883, *9 (9th Cir. 1998) (“Where an injured employee seeks benefits under the LHWCA, a treating physician’s opinion is entitled to special weight.”).

2. Majority Approach: No Treating Physician Rule

By far, the majority approach for adjudications under disability benefits programs—in both federal and state contexts—is not to afford special weight to the opinions of treating sources through either regulatory standards (by agencies) or case law (by courts). Most prominently, in the context of Employee Retiree Income Security Act of 1974 (“ERISA”),³¹⁷ the Supreme Court rejected the Ninth Circuit’s attempt to impose a treating physician rule—patterned after SSA’s rule—on ERISA plan administrators when making benefits determinations under private employer-sponsored disability plans.³¹⁸ At issue in *Black & Decker* was the denial of a disability benefits claim by an employee with degenerative disc disease by the plan administrator of Black & Decker Corporation’s ERISA-covered employee welfare benefit plan. The employee then filed suit, challenging the Black & Decker Disability Plan in federal court.³¹⁹ The employee’s principle argument was that the plan administrator improvidently credited the opinion of an independent (*i.e.*, consulting) neurologist over his treating physicians. The district court rejected the employee’s argument and granted summary judgment to the plan administrator.³²⁰

On appeal, the Ninth Circuit summarily reversed and held that the employee was entitled to summary judgment. The Ninth Circuit emphasized that, under controlling circuit precedent, ERISA plan administrators are bound to follow the same treating physician rule applied to adjudication of claims arising under Social Security’s disability benefits programs.³²¹ As applied in the ERISA context, the Ninth Circuit characterized SSA’s rule as requiring a plan administrator to “reject the conclusions of the treating physicians only if the administrator ‘gives specific, legitimate reasons for doing so that are based on substantial evidence in the record.’”³²² Because the defendant plan administrator had failed to do so, the Ninth Circuit found an abuse of discretion.³²³

The Supreme Court not only unanimously rebuffed the Ninth Circuit’s attempt to judicially impose a treating physician rule in the ERISA context,³²⁴ but also called into question the efficacy of the treating physician rule generally. The Court based its decision on several considerations. The Court noted that neither ERISA, nor the Secretary of Labor’s implementing regulations, imposed a heightened burden of explanation on administrators when they reject a treating physician’s opinion.³²⁵ In the absence of such a statutory or regulatory mandate, judicial imposition of a treating physician rule was wholly inappropriate. Additionally, and perhaps most important here, the Court questioned the efficacy of the treating physician rule as a means of increasing the accuracy of disability determinations.³²⁶ Various classes of medical professionals, the Court noted, have comparative pluses and

³¹⁷ See 29 U.S.C. § 1002 et seq. (2012) for the establishment of minimum standards for pension plans in private industry.

³¹⁸ See generally, *Black & Decker*, 538 U.S. 822 (2003).

³¹⁹ *Nord v. The Black & Decker Disability Plan*, No. CV 99-0408 CM, 2000 U.S. Dist LEXIS 22824 (C.D. Cal. 2000) [hereinafter *Nord I*].

³²⁰ *Nord I*, 2000 U.S. Dist LEXIS at *26-27.

³²¹ *Nord v. The Black & Decker Disability Plan*, 296 F.3d 823, 830-31 (9th Cir. 2002) [hereinafter *Nord III*].

³²² *Id.* at 831.

³²³ *Id.* at 831-32.

³²⁴ *Black & Decker*, at 825 (holding that “the Ninth Circuit erroneously applied a ‘treating physician rule’ to a disability plan governed by ERISA”).

³²⁵ *Id.* at 831.

³²⁶ *Id.* at 832.

minuses depending on the particular case—treating physicians may (or may not) have a better longitudinal perspective on their patients’ conditions, consulting physicians repeatedly hired by benefit plans may (or may not) be more prone to bias in favor of the plan, and specialists may (or may not) enjoy a greater depth of knowledge.³²⁷ In this light, the Court cautioned that the treating physician rule’s built-in evidentiary bias in favor of treating physicians might prove improvident in some cases and suggested further empirical study of the rule:

But the assumption that the opinions of a treating physician warrant greater credit than the opinions of plan consultants may make scant sense when, for example, the relationship between the claimant and the treating physician has been of short duration, or when a specialist engaged by the plan has expertise the treating physician lacks. And if a consultant engaged by a plan may have an “incentive” to make a finding of “not disabled,” so a treating physician, in a close case, may favor a finding of “disabled.” *Intelligent resolution of the question whether routine deference to the opinion of a claimant’s treating physician would yield more accurate disability determinations, it thus appears, might be aided by empirical investigation of the kind courts are ill equipped to conduct.*³²⁸

The cautionary note sounded by the Supreme Court in *Black & Decker* applies as well, it would seem, to Social Security’s disability benefits programs. Indeed, as detailed in earlier parts of this report, our legal and empirical assessment of SSA’s treating physician rule suggests that the rule’s “routine deference” to treating physicians may no longer be warranted.

Federal courts have also refused to impose a treating physician rule with respect to several other statutory disability programs when the responsible federal entity—the Department of Veterans Affairs’ (“VA”) Board of Veterans Appeals, Railroad Retirement Board, and the Department of Health and Human Services’ (“HHS”) Departmental Appeals Board (“DAB”)—declined to adopt such a rule. In summary, these cases held as follows:

- ***Board of Veterans Appeals:*** In *White v. Principi*,³²⁹ the Federal Circuit held that the Board of Veterans Appeals need not afford special weight to treating physician opinions in determining entitlement to veterans’ benefits for service-connected disabilities.³³⁰ The court found that the VA’s statute and regulations not only failed to provide a basis for judicial adoption of a treating physician rule, but also, “in fact, appear to conflict with such a rule.”³³¹ The court concluded: “[G]iven the comprehensive statutory and regulatory scheme for the award of veterans’ benefits, it would not be appropriate for this court to impose the ‘treating physician rule’ on the VA.”³³²

³²⁷ *Id.*

³²⁸ *Id.* at 832 (emphasis added).

³²⁹ 243 F.3d 1378 (Fed. Cir. 2001).

³³⁰ *Id.* at 1381-82.

³³¹ *Id.* at 1381 (“[T]he VA benefits statutes and regulations do not provide any basis for the ‘treating physician rule’ and, in fact, appear to conflict with such a rule.”).

³³² *Id.*

- **Railroad Retirement Board:** Similarly, in *Dray v. Railroad Retirement Board*,³³³ the Seventh Circuit rejected importation of a treating physician rule for disability determinations under the Railroad Retirement Act of 1974. The court reasoned that in the case of multiple physicians, “it remains the province of the hearing officer to decide whom to believe—a treating doctor whose experience and knowledge about the case may (or may not) be relevant to understanding the claimant’s condition or a consulting specialist who may bring expertise and knowledge about similar cases.”³³⁴
- **Departmental Appeals Board:** The DAB provides independent review of disputed decisions in a wide range of HHS programs under more than sixty statutory provisions.³³⁵ Part of its job includes overseeing nursing facilities that participate in the Medicare and Medicaid programs.³³⁶ In *Golden Living Center v. Secretary of Health & Human Services*,³³⁷ the Sixth Circuit affirmed the DAB’s imposition of a civil penalty on the plaintiff’s nursing home for failure to provide adequate care for a patient. Citing SSA’s treating physician rule, the nursing home claimed that the DAB (and ALJ) erred by failing to defer to its treating physicians. The Sixth Circuit rejected application of the treating physician rule, noting that it had “no applicability” to nursing facility enforcement cases.³³⁸ In addition, in the Medicare reimbursement context, a treating physician rule has also been rejected.³³⁹

A majority of state courts have likewise refused to import a treating physician rule into state worker’s compensation programs.³⁴⁰ Some courts rejecting a treating physician rule have reasoned that it would unduly interfere with discretion accorded the finder of fact to weigh conflicting medical opinions.³⁴¹ Other courts have questioned the wisdom of

³³³ 10 F.3d 1306 (7th Cir. 1993).

³³⁴ *Dray*, 10 F.3d at 1311.

³³⁵ For additional information about the DAB and its adjudicatory responsibilities, see the explanation provided by the Dept. of Health & Human Servs. on its website, *available at* <http://www.hhs.gov/dab/>.

³³⁶ See 42 U.S.C. § 1395i-3 (2012); 42 C.F.R. § 483.1 et seq. (2012).

³³⁷ 656 F.3d 421 (6th Cir. 2011).

³³⁸ *Id.* at 426 n.3. A district court in another circuit, the Second Circuit, has similarly refused to hold the treating physician rule to apply to Medicare cases. *Murphy v. Sec’y of Health & Human Servs.*, 62 F. Supp. 2d 1104, 1107 (S.D.N.Y. 1999); see also *Hosp. Serv. Dist. No. 1 of Lafourche v. Thompson*, 343 F. Supp. 2d 515, 524 (E.D. La. 2004) (same).

³³⁹ *Renzio v. Sec’y of Health, Education & Welfare*, 403 F. Supp. 917, 919 (E.D. Mich. 1975) (“the plaintiff’s physician is entitled to be weighed along with the other evidence, it should not be given additional weight”). The opinion even notes that according treating physicians special weight in Medicare cases may invite “substantial abuses in the program.” *Id.* (quoting *Weir v. Richardson*, 343 F. Supp. 353, 357 (S.D. Iowa 1972)).

³⁴⁰ See *Conradt v. Mt. Carmel Sch.*, 539 N.W.2d 713, 717 (Wis. Ct. App. 1995) (noting majority rule and observing that “[a] handful of states allow trial courts to give greater deference to the testimony of an attending physician, yet without creating a presumption that this is so”) (emphasis removed); see also 8 ARTHUR LARSON & LEX K. LARSON, *LARSON’S WORKERS’ COMPENSATION LAW* § 130.05D[4][b] (2002) (discussing state court decisions).

³⁴¹ *E.g.*, *Doyle v. Public Employees’ Retirement Sys.*, 808 So. 2d 902, 907 (Miss. 2002) (“The law contains no such duty of deference [to the treating physician], and . . . this Court cannot reweigh the facts.”); *Dillon v. Whirlpool Corp.*, 19 P.3d 951, 953-954 (Or. Ct. App. 2001) (“[D]ivided medical opinion leaves the Board in the position of evaluating the evidence.”); *Conradt*, 539 N.W.2d at 716 (“[I]t is for [the state commission] to decide if one expert’s testimony is more persuasive than another’s.”); *Ashe v. Workmen’s Comp. Appeal Bd.*, 648 A.2d 1306, 1308 (Pa. Commw. Ct. 1994) (“[T]he weighing of testimony is solely within the province of the referee, and his decision to accept testimony of one competent witness over another will not be disturbed on appeal.”); *Gibson v. City of Lincoln*, 376 N.W.2d 785, 791 (Neb. 1985) (“[T]he ‘trier of fact’ remains the sole judge of a witness’ credibility and the testimony’s weight.”).

categorically deferring to the opinions of treating physicians.³⁴² For similar reasons, New York courts have rejected the treating physician rule for disability determinations under the State's employee retirement system.³⁴³

B. Views of Claimant Representative Organizations

In an effort to represent and understand different perspectives on the treating physician rule, we contacted both NOSSCR and NADR,³⁴⁴ two of the most prominent claimant representative organizations. Both organizations believe “that the current regulations and polices provide detailed guidance for adjudicators and the public.”³⁴⁵

While the organizations do not take issue with the content of the treating physician rule itself, they do harbor serious reservations about its application. One of the main concerns both NOSSCR and NADR discuss is their belief that SSA often fails to provide adequate reasons when it discredits a treating source's opinion.³⁴⁶ NOSSCR notes that members of its organization review hundreds of federal court cases involving SSDI and SSI disability claims each year.³⁴⁷ Many of those cases result in remand, and many of those remands occur because SSA has not sufficiently supported its reasons for discounting and even rejecting the treating source's opinion.³⁴⁸ NADR compounds NOSSCR's concern by claiming that SSA fails to apply its rulings.³⁴⁹ Those rulings explain how SSA should evaluate a treating physician's opinion, particularly explaining when the agency should give the opinion controlling weight and how the agency should explain its decision when it does not.³⁵⁰

When asked whether the organizations would have any concern if SSA weighed all evidence under the same standards, regardless of the source of evidence, NOSSCR and

³⁴² *E.g.*, *McClanahan v. Raley's Inc.*, 34 P.3d 573, 577 (Nev. 2001) (“We do not agree that because a physician has a duty to cure a patient that the physician will necessarily be more familiar with an issue.”); *Gibson*, 376 N.W.2d at 791 (“Generally, an expert witness' firsthand knowledge is a factor which may affect such witness' credibility and weight given to the testimony from that expert, but presence or absence of firsthand knowledge does not, by itself, necessarily establish preference or priority in evidentiary value.”).

³⁴³ *E.g.*, *Irish v. McCall*, 747 N.Y.S.2d 610, 611 (App. Div. 2002) (“We have adhered to the view that the Comptroller is vested with the authority to resolve conflicts in medical opinion and credit the testimony of one medical expert over another.”).

³⁴⁴ See Letter from Nancy G. Shor, Exec. Dir. Nat'l Org. of Soc. Sec. Claimants' Reps., to Amber Williams, Att'y Advisor Admin. Conf. of the U.S. (Dec. 19, 2012) (copy attached App. E: Letter from Nat'l Org. of Soc. Sec. Claimants' Reps., p. A-19) [hereinafter NOSSCR 2012 Letter]; Letter from Trisha Cardillo, Pres. Nat'l Ass'n of Disability Reps., to Amber Williams, Att'y Advisor Admin. Conf. of the U.S. (Dec. 28, 2012) (copy attached App. F: Letter from Nat'l Ass'n of Disability Reps., p. A-24) [hereinafter NADR 2012 Letter].

³⁴⁵ NOSSCR 2012 Letter, *supra* note 344, at A-20; see also NADR 2012 Letter, *supra* note 344, at A-25. However, NADR, in particular, believes that adjudicators at the DDS level could benefit from further training about how to apply the rule. See NADR 2012 Letter, *supra* note 344, at A-26. NADR also expresses the view that both ALJs and DDS adjudicators would benefit from reinforcement of the rule requiring them “to recontact the treating physician when additional information or clarification is needed, before ordering a consultative examination.” *Id.*

³⁴⁶ See NOSSCR 2012 Letter, *supra* note 344, at A-22; NADR 2012 Letter, *supra* note 344, at A-30.

³⁴⁷ See NOSSCR 2012 Letter, *supra* note 344, at A-22.

³⁴⁸ *Id.*

³⁴⁹ See NADR 2012 Letter, *supra* note 344, at A-30.

³⁵⁰ *Id.* The rulings also explain how to consider medical source opinions on issues reserved for the Commissioner. *Id.*

NADR expressed similar views.³⁵¹ Both organizations oppose weighing all evidence under the same standard. NOSSCR emphasized that treating source opinions are (and should be) afforded controlling weight so long as well-supported and consistent as set forth in the current regulations (*see* §§ 404.1527(c)(2) and 426.927(c)(2)); only if treating source opinions do not meet these standards should they be weighed just like other medical evidence.³⁵² NADR, as well, stated that it “would strongly oppose a change in existing policy to allow SSA to weigh all evidence under the same standards.”³⁵³ NADR supports SSA’s hierarchy of medical sources and fears that if different medical sources are weighed according to the same standards, they would in fact receive the same weight.³⁵⁴

Although both NOSSCR and NADR support the treating physician rule, they do suggest that it be revised in one respect. Currently, only a specific subset of medical professionals—namely, physicians, psychologists, optometrists, and speech-language pathologists—are considered “acceptable medical sources” that may be considered treating sources.³⁵⁵ Given changes in the health care system over the last several decades, NOSSCR and NADR recommend that SSA expand the definition of “acceptable medical sources” to include NPs, PAs, and clinical social workers.³⁵⁶ NOSSCR and NADR suggest broadening the regulatory scope of “acceptable medical sources” to include these nonphysician clinicians for three reasons: (1) these clinicians increasingly serve as primary providers of physical and mental health care, yet their opinions—despite guidance provided by SSA in SSR 06-03p—are often ignored or downplayed in the adjudication process; (2) their inclusion as “acceptable medical sources” would streamline the disability claims process since consultative examinations would no longer be needed to confirm their diagnoses or opinions about the severity of impairments;³⁵⁷ and (3) each of these three professions are licensed and credentialed under state law.³⁵⁸

³⁵¹ In a prior draft of this report, we characterized NOSSCR’s letter as expressing the view that the organization did “not seem to harbor any concern” should all medical opinion evidence be evaluated under the same standards, regardless of source. *See* SSA DISABILITY BENEFITS PROGRAMS: ASSESSING THE EFFICACY OF THE TREATING PHYSICIAN RULE 45-46 (Feb. 22, 2013) (draft report). Subsequently, NOSSCR representatives informed the Administrative Conference that this statement did not accurately reflect the organization’s position. *See* Letter from Nancy G. Shor, Executive Director, NOSSCR & Ethel Zelenske, Director of Government Affairs, NOSSCR to Amber Williams, Att’y Advisor, Admin. Conf. of the U.S. (Mar. 1, 2013) (on file with ACUS). The description of NOSSCR’s position on this point has, accordingly, been modified and is reflected herein.

³⁵² *See* NOSSCR 2012 Letter, *supra* note 344, at A-22.

³⁵³ *See* NADR 2012 Letter, *supra* note 344, at A-30.

³⁵⁴ *Id.*

³⁵⁵ *See* 20 C.F.R. §§ 404.1502, 404.1513(a), 404.1513(d), 404.1527(c) (2012); *see also* 20 C.F.R. §§ 416.902, 416.913 416.917 (2012).

³⁵⁶ *See* NOSSCR 2012 Letter, *supra* note 344, at A-21 - A-23; NADR 2012 Letter, *supra* note 344, at A-26 - A-27.

³⁵⁷ Because there is insufficient publicly available information relating to the use of consultative examinations in situations noted by NOSSCR and NADR, we did not assess this claim. As a general matter, however, SSA has noted in the past that use of consultative examinations, when needed, adds time and expense to the disability adjudication process. *See* Optometrists as “Acceptable Medical Sources” To Establish a Medically Determinable Impairment, 72 Fed. Reg. 9239, 9239 (Mar. 1, 2007) (noting, in final rule amending list of “acceptable medical sources” to include licensed optometrists, that revised regulation “will allow us to make more decisions based on medical evidence supplied to us solely from optometrists, rather than having to purchase time-consuming and expensive consultative examinations”).

³⁵⁸ *Id.*; *see also* Social Security Ruling 06-03p, Titles II and IVI: Considering Opinions and Other Evidence from Sources Who Are Not “Acceptable Medical Sources” in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies (2006), *reprinted in* 71 Fed. Reg. 45,593 (Aug. 9, 2006); Nat’l Law Center on Homelessness and Poverty, *Improving Access: Expanding Acceptable*

While SSA did not specifically task the Conference with examining the regulatory definition of “acceptable medical source” as it relates to the treating physician rule, the comments from NOSSCR and NADR prompted us to do so in order to assess their suggested regulatory revision and to explore the efficacy of the existing evidentiary framework for “other” medical sources (*i.e.*, those falling outside the scope of “acceptable medical sources”) in light of SSR 06-03p. Our study of this issue included: research in medical journals and related literature; review of federal court opinions (primarily, from district courts) applying SSR 06-03p; and review of publicly available information on state license and credential requirements for NPs, PAs, and LCSWs. Our findings follow below.

1. Evaluation of Call for Expansion of Definition of “Acceptable Medical Sources”

As an initial matter, NOSSCR and NADR rightly note that, over the last two (or more) decades, PAs, NPs, and LCSWs have shouldered an ever-increasing share of the primary care workload due to the rise of managed care and other factors. As detailed earlier in this report, NPs and PAs now make up about one-third of primary care providers nationally, with a higher proportion (relative to primary care physicians) practicing in rural or medically underserved areas or serving minority, low income, or uninsured patients.³⁵⁹ A large body of medical and other literature demonstrates that PAs and NPs have expanded practice autonomy and scope of practice as compared to twenty years ago, and are providing care in primary care settings comparable to physicians; for many patients, these clinicians are their usual provider of care.³⁶⁰ Moreover, with respect to the provision mental health services, LCSWs now represent the single largest segment of the mental health workforce.³⁶¹ Today, LCSWs are providing the bulk of frontline mental health services, and are projected to continue doing so in coming years.³⁶²

One of the practical effects of the changed medical landscape is significant dissonance between the existing regulatory scheme for medical evidence (which assigns second-tier evidentiary value to the opinions of NPs, PAs, and LCSWs because they are not granted “treating source” status) and the realities of the current health care system (*i.e.*, for many claimants, these medical professionals *are* their usual, treating sources).³⁶³ This “regulatory

Medical Sources for the Social Security Disability Determination Process (2012) [hereinafter NLCHP, *Improving Access: Expanding Acceptable Medical Sources*] (study cited by NOSSCR that recommends expansion of “acceptable medical sources” given import of this definition to homeless disability claimants), available at <http://www.nlchp.org/content/pubs/5.14.12%20Improving%20Access,%20FINAL.pdf>.

³⁵⁹ See *supra* Part III.A. SSA, too, has acknowledged the rise of managed care in the preamble to SSR 06-03p. See *infra* Part V.B.2.

³⁶⁰ *Id.*

³⁶¹ *Id.*

³⁶² *Id.*

³⁶³ For examples of these nonphysician clinicians serving as treating providers, see, e.g., *Bowman v. Astrue*, 511 F.3d 1270, 1273-74 (10th Cir. 2008) (NP treated claimant as primary medical provider for various conditions, including asthma, arthritis, tuberculosis, post-surgical wrist problems, anxiety and depression); *Frantz v. Astrue*, 509 F.3d 1299, 1300 (10th Cir. 2007) (claimant treated at VA hospital for bipolar disorder and anxiety never had treating physician; mental health services provided by clinical nurse specialist instead); *Dixon v. Astrue*, 2011 U.S. Dist. LEXIS 37518 (D. Kan. 2011) (claimant treated for mental impairments by NP and LCSW, no treating sources); *Hoy v. Astrue*, 2011 U.D. Dist. LEXIS 61181 (W.D. Va. 2011) (NP was claimant’s primary treating mental health provider); *White v. Comm’r of Soc. Sec.*, 302 F. Supp.2d 170 (W.D.N.Y. 2004) (LCSW served as “sole source who had treating relationship” with claimant for treatment of mental impairment and alcohol dependence); *White v. Comm’r of Soc. Sec.*, 302 F. Supp. 2d 170, 175-76 (W.D.N.Y. 2004) (LCSW

lag” raises two distinct problems. First, in this era of managed care, if long-term treating relationships with medical professionals are to be had, such relationships tend to be with NPs, PAs, or LCSWs, rather than physicians.³⁶⁴ By categorically excluding these medical professional clinicians from the definition of “acceptable medical source,” the current regulations may impede due consideration (and weighing) of the very sort of “detailed, longitudinal”³⁶⁵ medical perspectives that served as the touchstone for the treating source rule when promulgated in 1991. For example, in *Sloan v. Astrue*, the claimant had a five-year treating relationship with a LCSW from whom she sought treatment for mental illness because she could not afford the out-of-pocket costs of a psychiatrist.³⁶⁶ The ALJ, after noting the report of a DDS examining psychologist, flatly rejected the treating LCSW’s assessment of the severity of claimant’s mental impairment and his RFC simply because she was not a psychiatrist:

So, I don’t have any other opinions, I guess, from well, I have the counseling opinion, from the social worker, but as I said, we don’t get real excited about social workers just because it’s sort of a pecking order of authority, and usually in a mental case a person is seen by a psychiatrist.³⁶⁷

The Eight Circuit held that the ALJ’s summary dismissal of the treating LCSW’s opinions constituted reversible error and remanded the case back to SSA for administrative rehearing.³⁶⁸

Second, blanket exclusion of these nonphysician providers from “acceptable medical source”/“treating source” status creates inequities for disability claimants who, because of where they live, their insurance coverage (or lack thereof), or their financial situation, may have no choice but to use NPs, PAs, or LCSWs as their usual source of medical or mental health care.³⁶⁹ Indeed, for this reason, at least one district court has called on SSA to revise

was “sole source that had treating relationship with [claimant]”); NLCHP, *Improving Access: Expanding Acceptable Medical Sources*, *supra* note 357, at 4, 6-7; Yvonne Perret et al./National Academy of Social Insurance, *Improving Social Security Disability Programs for Adults Experiencing Long-Term Homelessness* 8-10 (Nov. 2008) [hereinafter Perret/NASI, *Improving Social Security Disability for Homeless Adults*], available at http://www.nasi.org/usr_doc/Perret_and_Dennis_January_2009_Rockefeller.pdf.

³⁶⁴ *E.g.*, *Bowman*, 511 F.3d at 1273-74 (13-year treating relationship between NP and claimant); *Sloan v. Astrue*, 499 F.3d 883, 885-86 (8th Cir. 2007) (LCSW treated claimant’s mental impairments for 5 years, including monthly counseling sessions); *Shadwick v. Astrue*, 2011 U.S. Dist. LEXIS 24220 (N.D. Okla. Jan. 24, 2011) (NP treated complainant “on a regular basis” for 2 years); *Tracey v. Astrue*, 2011 U.S. Dist. LEXIS 31410 (E.D. Cal. 2011) (NP provided long-term treatment for chronic pain syndrome); *Albert v. Astrue*, 2011 U.S. Dist. LEXIS 62993 (D. Ariz. April 4, 2011) (treating NP saw claimant on a consistent basis for 3 years); *Hoy*, 2011 U.D. Dist. LEXIS at *9-12 (NP saw claimant on bi-weekly basis for 5 years to adjust medications, monitor mental status, and make clinical assessment of level of functioning); *Foster v. Astrue*, 826 F. Supp.2d 884, 886 (W.D.N.C. 2011) (finding that LCSW had a “lengthy [treating] relationship” with claimant and worked with him “on a consistent and regular basis”).

³⁶⁵ 1991 Final Rules, *supra* note 2, at 36,961, 36,969.

³⁶⁶ *Sloan v. Astrue*, 499 F.3d 883 (8th Cir. 2007).

³⁶⁷ *Id.* at 886.

³⁶⁸ *Id.* For other examples of ALJs rejecting the opinions of NPs or LCSWs simply because they were not “acceptable medical sources,” see *Canales v. Astrue*, 698 F. Supp.2d 335, 344 (E.D.N.Y. Mar. 26, 2010); *White*, 302 F. Supp. 2d at 175-76; *Bailey v. Astrue*, 725 F. Supp.2d 1244, 1255-56 (E.D. Wash. 2010); *Vasquez v. Astrue*, 2009 U.S. Dist. LEXIS 28337 (E.D. Wash. April 3, 2009).

³⁶⁹ *Kohler v. Astrue*, 546 F.3d 260, 262, 268 (2d Cir. 2008) (ALJ erred when failing to consider opinion of treating NP “particularly because [she] was the only medical professional available to [claimant] for long stretches of time in the very rural ‘North Country’ of New York State”); *Sloan*, 499 F.3d at 885-86, 889

its regulation. At issue in *Richard v. Astrue*³⁷⁰ was the plaintiff's contention that the ALJ failed to give proper weight to the opinions of his treating medical providers, including a LCSW who had treated his mental impairment for several years. The court examined SSA's regulatory scheme for "acceptable medical sources" and concluded that, under these rules, the ALJ did not err when declining to give controlling weight to the opinions of the plaintiff's treating LCSW. Nonetheless, the court went on to note the inequities caused by exclusion of LCSWs from "accepted" medical sources and called on SSA's to consider revising its rules:

This disparaging designation of social workers [as outside the list of "acceptable" medical sources] is probably unjustified and certainly should be reconsidered. Clinical social workers are often the applicant's primary clinician, see the applicant the most often, and have the professional training and experience to offer assessments fully equal to those of other clinicians currently deemed "acceptable."³⁷¹

While the court in *Richard* ended up affirming SSA's denial of disability benefits, the court's views on "acceptable medical sources" nonetheless highlight the fact that the current regulatory scheme which assigns second-tier evidentiary status to LCSWs (and other nonphysician clinicians) conflicts with the practical realities of managed care and may cause inequities for some disadvantaged claimants.

To be sure, there are countervailing considerations when evaluating the expansion of "acceptable medical sources" to include these categories of medical professionals, including the need for sufficient uniformity of state law-based educational and professional requirements given the nationwide scope of SSA's disability benefit program. SSA last addressed this issue in 2000, when it issued a final rule adding licensed or certified school psychologists, licensed podiatrists, and qualified speech-language pathologists to the list of "acceptable medical sources."³⁷² SSA, in response to a commenter's recommendation that NPs also be included as acceptable medical sources, declined such an expansion and stated:

We have . . . provided in these final rules that podiatrists and speech-language pathologists may be acceptable medical sources, not only because of their unique qualifications, but because we have determined that there is sufficient standardization of their qualifications across States for us to provide rules for their general use in claims. *We have not determined this for other specialties*

(remanding case to SSA based on ALJ failure to consider opinions of treating LCSWs, noting that claimant was "a seriously ill person of very limited means who lack[ed] the ability to afford a psychiatrist"); *Frantz*, 509 F.3d at 1300 (claimant-veteran treated at VA hospital assigned NP for treatment of mental illness, rather than physician); *Tracey*, 2011 U.S. Dist. LEXIS at *21-23 (holding that ALJ erred by failing to provide specific reasons for rejecting opinions of treating NP, and noting that "reliance on paraprofessionals such as NPs may be greater in rural or other areas of low population such as Lone Pine, California . . . where [the NP] oversaw [claimant's] long-term treatment"); see also NLCHP, *Improving Access: Expanding Acceptable Medical Sources*, *supra* note 357, at 4, 6-7; Perret/NASI, *Improving Social Security Disability for Homeless Adults*, *supra* note 362, at 8-10.

³⁷⁰ 2011 U.S. Dist. LEXIS 63457 (D. Mass. June 15, 2011).

³⁷¹ *Id.* at *15.

³⁷² Medical and Other Evidence of Your Impairment(s) and Definition of Medical Consultant, 65 Fed. Reg. 34,950 (June 1, 2000) [hereinafter 2000 Final Rule].

*[such as NPs]. Therefore, we believe it would be inappropriate to add these additional specialties at this time.*³⁷³

SSA, at least insofar as Federal Register notices, has not publicly addressed this issue since 2000. We thus conducted research to provide some perspective on current state law-based standards for NPs, PAs, and LCSWs relating to education, license/credentials, and scope of practice. We found their respective educational and professional requirements to be fairly uniform and on par with other nonphysician medical professionals currently deemed “acceptable medical sources.” As shown in Table 15, the education and licensing requirements for NPs, PAs, and LCSWs are rigorous and comprehensive. For licensure, each of these medical professions require: graduation from a specialized, nationally-accredited program (which, except for PAs, must be a post-graduate program at the masters or doctoral level); hundreds to thousands of hours of pre-licensure clinical practice; and, successful completion of a licensing examination which, with one exception, is administered nationally.³⁷⁴ Maintaining licensure also requires profession-specific continuing education and renewal every one to six years, depending on applicable national (certification) or state (license) requirements.³⁷⁵ Taken together, these education and licensing requirements compare favorably with other nonphysician medical professionals whom SSA currently considers “accepted” medical sources.³⁷⁶

State scope of practice standards show greater variance. However, while these rules vary markedly from state to state in some respects—most notably for NPs, they exhibit fundamental commonalities as well. For PAs and LCSWs, the state-by-state variance is less pronounced. For LCSWs, scope of practice standards are essentially uniform across the country (and several U.S. territories), with the only differences arising in the terminology used in state laws or rules to refer to LCSWs.³⁷⁷ In all states, LCSWs may practice independently to assess, diagnose, and treat mental, behavioral, and psychiatric disorders; no states afford social workers prescriptive authority.³⁷⁸ PAs, as well, show consistency in scope of practice standards. All states (and some U.S. territories) give PAs prescriptive authority and permit these clinicians to provide a comprehensive range of medical services, including diagnosing and treating illnesses, ordering and interpreting tests, assisting in surgery, and making rounds at hospitals and nursing homes.³⁷⁹ With respect to PAs, the scope of practice variations arise relative to oversight requirements. While all states require some type of oversight or supervision of PAs by physicians or other specified medical professional (such as osteopaths), the manner and extent of such oversight varies from state to state.³⁸⁰ Typically, such oversight need not be on-site and may consist of telecommunication availability (*e.g.*, telephone or email) or chart reviews.³⁸¹ Most states

³⁷³ 2000 Final Rule, *supra* note 105, at 34,955 (emphasis added).

³⁷⁴ See App. I at A-36 tbl. 15 (Licensing Standards for NPs, PAs, and LCSWs). The single exception is licensure in California for LCSWs. California administers its own state-level examination for LCSW candidates. *Id.*

³⁷⁵ *Id.*

³⁷⁶ See NLCHP, *Improving Access: Expanding Acceptable Medical Sources*, *supra* note 245, at 12-14 (comparing licensing standards for NPs, PAs, and LCSWs with standards for optometrists and speech therapists).

³⁷⁷ See App. I at A-38 tbl. 17.

³⁷⁸ *Id.*

³⁷⁹ *Id.*

³⁸⁰ *Id.*

³⁸¹ *Id.*

require written documentation delineating the role of the PA in any particular public or private medical practice.³⁸²

NPs exhibited the widest variance in state-by-state scope of practice standards. In 17 states and the District of Columbia, scope of practice rules permit NPs “full practice”—namely, providing them with the authority to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatment, and prescribe medication independently without physician oversight.³⁸³ Nine other states afford NPs similar practice autonomy except that oversight by physicians or other specified medical professionals is required for prescribing certain classes of medication.³⁸⁴ Lastly, in the other 24 states, PAs’ practice authority is circumscribed by requiring some form of oversight by a physician or other specified medical professional.³⁸⁵ However, as with PAs, the oversight requirements for NPs in the vast majority of these states do not require the on-site presence of a physician, relying instead on measures such as phone and email contact, or review of a certain percentage of charts.³⁸⁶ In the near future, NPs may be governed by more uniform standards in each state. In 2008, professional nursing bodies developed a consensus model for regulation of Advanced Practical Nurses, including NPs.³⁸⁷ This model rule both provides states with standardized language addressing licensure, accreditation, certification, and calls for NP licensure state boards of nursing as independent practitioners with no requirements for physician supervision, collaboration, or supervision.³⁸⁸ To date, states are in various stages of implementation. For example, five states and one U.S. territory have fully implemented the model rule, and twelve other states are nearing complete implementation.³⁸⁹

On balance, we think that NOSSCR and NADR’s views on the evaluation of medical opinions from NPs, PAs, and LCSWs bear some force. Individuals now increasingly visit NPs, PAs, and LCSWs for their direct primary care needs, whether such care relates to physical or mental health, or to ambulatory or chronic conditions. Any of these nonphysician clinicians now serve as treating sources (whether or not formally recognized as such in SSA’s current regulations) in any particular case depending, for example, on the nature of a claimant’s medical issue(s), insurance status, or geographical location. This blurring of once-distinct professional roles, moreover, adds another wrinkle to the conundrum of the treating physician rule: If NPs, PAs, and LCSWs can rightly be characterized as “accepted”/“treating” sources (and research suggests that, at least with respect to quality of care, education and

³⁸² *Id.*

³⁸³ *See* App. I at A-37 tbl. 17(Scope of Practice Standards for NPs).

³⁸⁴ *Id.*

³⁸⁵ *Id.*

³⁸⁶ *Id.* These 24 states variously describe physician oversight in terms of “delegation,” “collaboration,” or “supervision,” but, as a general matter, such variations in phraseology have little practical impact on the actual scope or nature of the requisite oversight. *See* Ritter, *supra* note 245, at 24-25. Only 7 of these states require the on-site presence of a physician and, even then, the requirements are minimal (*e.g.*, once per month, 10% – 20% of NP’s practice time). *Id.* Some states also relax oversight requirements for NPs in medically underserved areas. *Id.*

³⁸⁷ *See* National Council of State Boards of Nursing, Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education (2008), *available at* https://www.ncsbn.org/Consensus_Model_for_APRN_Regulation_July_2008.pdf.

³⁸⁸ *Id.*

³⁸⁹ *See* National Council of State Boards of Nursing, Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education, NCSBN’s APRN Campaign for Consensus: State Progress toward Uniformity, <https://www.ncsbn.org/2567.htm> (last visited Feb. 1, 2013) (maps of state-by-state implementation status).

licensing, and scope of practice, they can be in most circumstances), then the rule is drained of its force. A rule predicated on affording controlling weight to a single, “treating” source cannot coexist with multiple treating sources. But, on the other hand, blanket exclusion of NPs, PAs, and LCSWs from “accepted”/“treating” source status is to ignore the evolving nature of their role in our current health care system. It is likely that the tension created by this conundrum will continue—if not increase, given the ever-increasing role of these nonphysician clinicians in the provision of frontline treatment for physical and mental health—until addressed by SSA through regulatory changes or other program-wide directives.

2. SSR 06-03p: Review of Federal Caselaw Suggests This Ruling Is Not Providing Intended Clarity

Aside from raising the issue of expansion of the definition of “acceptable medical sources,” the comments from NOSSCR and NADR also state that agency guidance to adjudicators (SSR 06-03p) that was intended to “clarify” evaluation of opinions from “other sources,” has been roundly ignored (or downplayed) in practice.³⁹⁰ We examined federal district court cases issued from 2009 to 2012 to gauge the merit of their contention. This review showed that, despite the issuance of SSR 06-03p, proper consideration of opinions from “other sources” remains a significant issue.

In August 2006, SSA issued SSR 06-03p which, among other reasons, was issued “to clarif[y] how [the agency] consider[s] opinions and other evidence from medical sources who are not ‘acceptable medical sources.’”³⁹¹ The preamble posits two reasons for this clarification—that the current regulations provided no specific criteria to evaluate evidence from “other sources” and the growth of managed care meant that medical professionals other than “treating sources” (such as NPs, PAs, and LCSWs) “were increasingly assuming a greater percentage of the treatment and evaluation functions formerly handled by physicians and psychologists.”³⁹² The ruling thus purports to offer aid to adjudicators when evaluating evidence from these nonphysician practitioners who may be “valuable sources” of evidence on impairment severity and functioning.³⁹³

The “Policy Interpretation” section of the ruling sets forth several evidentiary guideposts for adjudicators. *First*, the ruling notes that, while the five factors enumerated in §§ 404.1527(d) and 416.927(d) expressly apply only to opinions from “acceptable medical sources,” they “can be applied” in the context of evaluating opinions from “other sources” because they represent “basic principles” for the assessment of evidence.³⁹⁴ *Second*, the ruling underscores the evidentiary hierarchy in the current regulations which affords greater weight to medical opinions from “acceptable medical sources” because these sources “are

³⁹⁰ *E.g.*, NADR 2012 Letter, *supra* note 344, at A-27, (“While SSR 06-03p gives guidance on accepting medical opinions from sources other than those who are deemed ‘acceptable’ by SSA, it is often the case in current adjudication . . . that medical evidence from years of treatment with a PA, NP, or LCSW is swept aside.”); *see also* Soc. Sec. Admin, Considering Opinions and Other Evidence from Sources Who Are Not “Acceptable Medical Sources” in Disability Claims (2006), *reprinted in* 71 Fed. Reg. 45,593 (Aug. 9, 2006).

³⁹¹ SSR 06-03p, *supra* note 389, at 45,594-95.

³⁹² *Id.* at 45,595.

³⁹³ *Id.*

³⁹⁴ *Id.*; *see also id.* at 45,596 (“Opinions from non-medical sources . . . should be evaluated by using the applicable [five] factors.”).

the most qualified health care professionals.”³⁹⁵ Nonetheless, opinions from a medical practitioner who is not an “acceptable medical source” may “under certain circumstances” outweigh opinions from medical sources (including treating sources) if, for example, that practitioner has a better longitudinal perspective of the claimant’s functioning and has superior supporting evidence.³⁹⁶ *Third*, while drawing a distinction between what adjudicators “must consider” versus “must explain” in their decisions, the ruling suggests that they “generally should explain the weight given to opinions from “other sources.”³⁹⁷

While SSR 06-03p was issued with the laudatory goal of clarifying the evaluation (and potential importance) of opinions from “other” medical sources—including PAs, NPs, and LCSWs—who are not deemed “acceptable medical sources,” our review of federal case law shows that the ruling has not had the intended effect. Even years after the issuance of SSR 06-3p, some ALJs still ignore the opinions of NPs, PAs, and LCSWs,³⁹⁸ while others reject such evidence out of hand because they are not “accepted” medical sources—even when these nonphysician clinicians are opining on severity or functionality which are matters plainly within their evidentiary province.³⁹⁹ Still others fail to explain the weight given to, or their bases for discounting, such evidence.⁴⁰⁰ As well, several district courts have expressed frustration with ambiguity in SSR 06-03p regarding whether the ruling provides binding guidelines for agency adjudicators. For example, among the district courts in the Sixth Circuit, there is an interpretive schism.⁴⁰¹ One view holds that, based on permissive language used in the ruling—such as distinguishing between what ALJs “must consider” and “should explain” and noting that ALJs “generally should” explain weight given to opinions—ALJs are not required either to explain weight given opinions from “other sources” or to provide rationale for discounting them.⁴⁰² Another view holds that SSR 06-03p requires an ALJ to explain the consideration (and weight) given opinions from medical providers who are not “acceptable medical sources,” and, if they fail to do so, it constitutes reversible error.⁴⁰³

Indeed, to get an empirical understanding of the impact of SSR 06-03p on SSA disability adjudications, we undertook a comprehensive review of all federal district court cases published in the LEXIS database from 2009 to 2012 that applied this ruling in the context of medical opinions offered by NPs, PAs, and LCSWs.⁴⁰⁴ From this review, we created a database that cataloged each decision by outcome (affirmance, remand, or reversal).⁴⁰⁵ In all, the database included the outcomes of just over 600 district court cases from every federal circuit, except the District of Columbia (which had no relevant published

³⁹⁵ *Id.* at 45,596 (quoting 65 Fed. Reg. 34,955 (June 1, 2000)).

³⁹⁶ *Id.* at 45,596.

³⁹⁷ *Id.*

³⁹⁸ *E.g.*, *Zambrano v. Astrue*, 2012 U.S. Dist. LEXIS 41997 (E.D. Okla. Mar. 27, 2012); *Maynor v. Astrue*, 2011 U.S. Dist. LEXIS 83105 (D. Tenn. July 8, 2011); *Phillips v. Astrue*, 2010 U.S. Dist. LEXIS 19830 (W.D. Wash. Jan. 6, 2010); *Watson v. Astrue*, 2008 U.S. Dist. LEXIS 113304 (D. Or. Dec. 4, 2009).

³⁹⁹ *See supra* note 367 (collecting cases).

⁴⁰⁰ *E.g.*, *Frantz*, 509 F.3d at 1302-03; *Shadwick*, 2011 U.S. Dist. LEXIS at *24-27; *Hoy*, 2011 U.S. Dist. LEXIS at *11-12; *Selinsky v. Astrue*, 2010 U.S. Dist. LEXIS 65494 (N.D.N.Y. June 30, 2010); *Neal v. Astrue*, 2009 U.S. Dist. LEXIS 86470 (S. D. Ohio Sept. 2, 2009); *Youngblood v. Astrue*, 2009 U.S. Dist. LEXIS 113980 (D. Kan. Nov. 2, 2009).

⁴⁰¹ *See Southward v. Astrue*, 2012 U.S. Dist. LEXIS 127501 (D. Mich. Sept. 7, 2012) (collecting cases).

⁴⁰² *Id.*

⁴⁰³ *Id.*

⁴⁰⁴ For a detailed description of how this database of federal cases was constructed and analyzed, see App. H.

⁴⁰⁵ *Id.*

decisions during these three years).⁴⁰⁶ Analysis of the results from these cases demonstrated that, from an empirical perspective, SSR 06-03p has not clarified for adjudicators the issue of proper consideration of opinions from NPs, PAs, and LCSWs. As shown in Table 13, the average remand rate for federal cases applying SSR 06-03p to opinions of these nonphysician clinicians was slightly *higher* (46.5%) than the average remand rate for all federal cases during the same time period that involved denial of disability benefits (45%).⁴⁰⁷ Moreover, the data also show that federal cases applying SSR 06-03p to medical opinions from NPs, PAs, and LCSWs have increased significantly over the last several years. Table 14 illustrates the high growth rate in these cases since 2010,⁴⁰⁸ which is consistent with SSA data evidencing a similar trend.⁴⁰⁹

Taken together, the number of cases still being remanded by federal courts for erroneous treatment of opinion evidence from “other sources” after the issuance of SSR 06-03p, along with the intra-circuit interpretive schism among district courts in the Sixth Circuit (and, perhaps, other federal courts), suggest that there are ambiguities in this ruling that warrant revision or clarification for the ruling to have its intended effect of ensuring that potentially valuable evidence from NPs, PAs, and LCSWs is properly considered in the adjudication process.

VI. SSA REGULATORY OPTIONS TO IMPROVE EVALUATION OF MEDICAL OPINION EVIDENCE RELATING TO DISABILITY CLAIMS

This part first identifies the fundamental principles that should guide any effort to alter, by regulation, the treating physician rule. It then lays out in general terms the principal options that SSA may wish to consider in drafting any such regulation. The particular content of such regulation is beyond the scope of this report.

A. Guiding Principles

First, any changes to the treating physician rule should be based on the fact that the current regulations have not provided the clarity SSA sought to achieve when it enacted these regulations in 1991.⁴¹⁰ The treating source is cited with a ten percent frequency as the basis for remand from the Appeals Council to ALJs.⁴¹¹ While disability cases are complex, both

⁴⁰⁶ *Id.*

⁴⁰⁷ Compare App. H at A-33 tbl. 13 (Outcome of District Court Cases Applying SSR 06-03p) with App. at A-2 tbl. 1 (Frequency of Court Filings and Remand). Table 9 also underscores the fact that outcomes in disability benefits cases are not uniform across federal circuits. See App. B at A-11 tbl. 9. For cases applying SSR 06-03p, nearly one-half of the circuits fell outside the normal decisional distribution (as measured by one standard deviation). District courts in the First, Fourth, and Eighth Circuits affirmed the studied cases at a proportionally higher rate, while courts in the Seventh, Tenth, and Eleventh Circuits did so with respect to reversals or remands. *Id.*

⁴⁰⁸ See App. H at A-34 tbl. 14 (Total Number of District Court Cases Applying SSR 06-03p, By Circuit (2009 – 2012)).

⁴⁰⁹ See Cited Remandable Reasons on Court Remands, FY 2011, Prepared by ODAR/OESSI/DNIA (Oct. 19, 2011) (“heat map” showing that, from FY2010 to FY2011, federal cases remanded for reasons related to “non-medical sources” had some of the highest year-over-year percentage increases of all cited OEE & RFC-based remands) (data on file with ACUS).

⁴¹⁰ For a description of the hierarchy of physician’s opinions and how to weigh a non-treating source’s opinion, see *supra* Part I.B.3.

⁴¹¹ See App. B at A-7 - A-8 tbls. 8 & 9.

ALJs and the Appeals Council are experts on SSA regulations; the frequency with which the treating source is cited as remand reason belies the rule’s underlying purpose—to clarify, not confuse. It can thus be assumed that the regulations did not achieve the hoped-for clarity for adjudicators or the public.

Second, any revisions made to the regulations should note the varying standards among the various federal circuit courts, both before, and in the over twenty years since, the 1991 regulations.⁴¹² SSA attempted to promote a uniform standard to administer its national disability benefits programs. This commendable goal has been less than successful as the circuits have largely continued to apply their own common law to the treating physician context. Indeed, at the district court level, the rate for remands involving the treating physician rule is quite high—the treating source is cited 5138 times as a remand reason, which is about a thirty-five percent frequency rate.⁴¹³ Indeed, of the bases for remand by federal courts tracked by SSA in recent years, treating physician rule-based remands represent the most frequently cited category of remands.⁴¹⁴ It may be that the time is right in light of *Black & Decker* and related cases, for the Supreme Court to issue a decision on this rule.

Third, any proposed regulation should acknowledge the fact that the nature of the United States’ health care delivery system has changed significantly over the course of the last twenty years.⁴¹⁵ The Marcus Welby model no longer exists.⁴¹⁶ Moreover, the distinction between treating physicians and other medical practitioners (or practice groups) has become blurred as claimants seek medical treatment or consultations from primary care physicians, specialists, NPs, PAs, LCSWs, etc. With numerous types of managed care models—and the rise of specialists—one can no longer safely assume a patient-claimant will have a long-term relationship with a single medical professional. Even if a patient-claimant has a long-term relationship with a medical professional, one can no longer assume that the relationship will be with an “acceptable medical source,” as the term is currently defined. In the situation where a claimant does have a traditional relationship with a treating source, that source’s opinion should be accorded substantial weight. However, given the way the delivery of health care has evolved over the last two decades, not only should such weight be ascribed to that source’s opinion only after careful assessment of the relationship between the claimant and his or her source, but also the type of source that is included in the “acceptable medical source” category should be reconsidered.

Fourth, any alterations to the treating physician rule should take into account the efficacy (or lack thereof) of the treating physician rule in other state and federal administrative contexts.⁴¹⁷ Only one agency—DOL—has affirmatively adopted its own rule, and even then, only in one context. All other administrative bodies trust the fact-finder to effectively and fairly weigh the medical opinions before him or her. Moreover, when a court sought to introduce the treating physician rule in a new context—ERISA—the Supreme

⁴¹² For an analysis of the various standards applied by the federal courts, see *supra* Parts I.B.2 and II.

⁴¹³ See App. B at A-4 tbl. 3.

⁴¹⁴ See *id.* at A-3 - A-4 tbls. 2 & 3.

⁴¹⁵ For a description of changing structure of health care delivery, see *supra* Part III.A.

⁴¹⁶ See Astrue June 2012 Testimony, *supra* note 13 (“I think the treating physician rule historically, you know, relied on the different paradigm. You know there was a time when all we had [was] a Marcus Welby as a personal physician and that’s not true anymore.”).

⁴¹⁷ For a survey of the treating physician rule in other contexts, see *supra* Part V.A.

Court itself not only unanimously blocked that effort, but called into question the very efficacy of the rule in increasing the accuracy of disability determinations.

Fifth, any regulatory changes should assert a reviewing court’s obligation, under established principles of administrative law, to give effect to a validly promulgated SSA regulation.⁴¹⁸ An agency’s regulations are validly promulgated when they are issued according to the agency’s statutory authority and are not arbitrary or capricious. Courts have long-recognized SSA’s “exceptionally broad” authority to issue regulations governing the kinds of evidence, and the weight assigned to that evidence in adjudications.⁴¹⁹ Therefore, where the Social Security Act vests authority in SSA to issue regulations and the agency has not exceeded that authority, a court’s “review is limited to determining whether the regulations promulgated . . . are arbitrary and capricious.”⁴²⁰ A regulation is considered arbitrary and capricious if it has no supporting reasonable basis. “In order to avoid judicial reversal of its action as arbitrary and capricious, an agency must engage in ‘reasoned decisionmaking,’ defined to include an explanation of how the agency proceeded from its findings to the action it has taken.”⁴²¹ When substantively reviewing an agency’s interpretation of its own regulation, courts must “give the agency the benefit of the doubt as to the meaning of its regulation.”⁴²² Furthermore, when an agency engages in on-the-record fact-finding, a court may only set aside an agency’s action “if it is ‘unsupported by substantial evidence.’”⁴²³ The Supreme Court has noted that “[t]he ‘substantial evidence’ test *itself* already gives the agency the benefit of the doubt, since it requires not the degree of evidence which satisfies the court that the requisite fact exists, but merely the degree that *could* satisfy a reasonable factfinder.”⁴²⁴

Sixth, should SSA decide to undertake regulatory revisions, the agency should strive to make the regulations as clear as possible. Using a term or phrase that has meaning in another, related context ought to be avoided.⁴²⁵ As well, phraseology in headings (and in the

⁴¹⁸ A definitive prediction of courts’ adoption of new regulations may be hazardous since—given the history of creating their own treating physician rules—some courts may not accord the regulations appropriate deference. See *supra* Part II.D.

⁴¹⁹ See *infra* Part VI.B.; see also *Schisler III*, 3 F.3d at 567 (noting that the treating physician rule specifically falls within the scope of SSA’s authority to “guide adjudicators in their evaluation . . . of the opinions of treating physicians and the weight they should receive”); *Heckler*, 461 U.S. at 466 (noting that “Congress has ‘conferred on the Secretary exceptionally broad authority to prescribe standards for applying certain sections of the [Social Security] Act’”) (quoting *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981)).

⁴²⁰ *Heckler*, 461 U.S. at 466; see also *Schweiker*, 453 U.S. at 44 (describing a court’s review as limited to “ensuring the [Commissioner] did not ‘[exceed] his statutory authority’ and that the regulation is not arbitrary or capricious”) (quoting *Batterton v. Francis*, 432 U.S. 416, 426 (1977)); see also 5 U.S.C. § 706(2)(A) (2012) (“The reviewing court shall . . . hold unlawful and set aside agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.”).

⁴²¹ *PIERCE*, *supra* note 190, at 1022.

⁴²² *Allentown Mack v. NLRB*, 522 U.S. 359, 377 (1998) (describing the standard by which a court will review agency action).

⁴²³ *Id.* (quoting 5 U.S.C. § 706(2)(E)). For a definition of the substantial evidence standard, see Part I.A, *infra*.

⁴²⁴ *Allentown Mack*, 522 U.S. at 377 (emphasis in original).

⁴²⁵ For example, 20 C.F.R. §§ 404.1527(b)(2), 416.927(b)(2) use the term “substantial evidence” to label certain evidence an adjudicator should take into account when deciding whether to assign controlling weight to a treating physician’s opinion. When courts review SSA’s decisions, they do so according to the “substantial evidence standard.” Using the same term invites conflation and confusion.

text of rules rule) should be as consistent as possible across all parts of the regulations, so that terms do not have different meanings in different places.⁴²⁶

B. Regulatory Options

At least one court has explicitly invited SSA to revisit the treating physician rule:

This [treating physician] rule, now codified in social security regulations,[] has been around a long time and is cited and discussed in innumerable cases.[] Its meaning and utility, however, are uncertain. It seems to take back with one hand what it gives with the other, and as a result to provide little in the way of guidance to either administrative law judges or counsel. It is time that the Social Security Administration reexamined the rule.⁴²⁷

If SSA were to take the court up on its invitation, there are a number of options (and of course several variants on each) for addressing the treating physician rule. As the Second Circuit has noted:

[t]he Secretary’s authority to promulgate regulations concerning ‘proofs and evidence’ in disability cases under Section 405(a) is “exceptionally broad” . . . The regulations [regarding the treating physician rule] fall within the scope of Section 405(a)’s grant of authority because they guide disability adjudicators in their evaluation of the “nature and extent of . . . proofs and evidence.” Specifically, they instruct [disability adjudicators] on the evaluation of the opinions of treating physicians and the weight they should receive.⁴²⁸

One approach would be to consider adopting DOL’s version of the treating physician rule: guide the adjudicator by providing the various factors he or she must take into account (much like SSA does today when the ALJ does not give the treating physician’s opinion controlling weight), but do not provide a definition of either “treating physician” or “controlling weight.” While the regulations would give the ALJ greater flexibility, the trajectory of circuit courts’ precedent would likely undermine this flexibility by continuing to impose the courts’ own varied interpretations of the treating physician rule.⁴²⁹

Another approach would be to consider eliminating the special evidentiary preference (“controlling weight”) generally afforded treating physician opinions. Many of the problems

⁴²⁶ For example, the current regulations use the term “medical” in ways that may be construed as inconsistent. That is, sometimes “medical” appears to connote a term or art (*e.g.*, “We need evidence from acceptable medical sources to establish whether you have a medically determinable impairment.” (20 C.F.R. §§ 404.1513(a), 416.913(a) (2012)); “Medical opinions are statements from physicians and psychologists and other acceptable medical sources . . . about the nature and severity of your impairment.” (*id.* at §§ 404.1527(a)(2), 416.927(a)(2) (2012)); and “[O]nly ‘acceptable medical sources’ can give us medical opinions.” (SSR 06-03p)). On other occasions, however, it appears to have a broader meaning (*e.g.*, “Medical sources refers to acceptable medical sources, or other health care providers who are not acceptable medical sources.” *id.* at §§ 404.1502), 416.902 (2012)) Such usage makes the rules more difficult to understand and potentially invites confusion.

⁴²⁷ *Hofslien v. Barnhart*, 439 F.3d 375, 376-77 (7th Cir. 2006).

⁴²⁸ *Schisler III*, 3 F.3d at 567 (citing *Heckler*, 461 U.S. at 466).

⁴²⁹ This tendency of the circuit courts may be further exacerbated by the fact that the DOL regulations were inspired by SSA’s rule. As previously noted, another court has also called on SSA to revise its regulation defining “acceptable medical source.” *See Richard v. Astrue*, 2011 U.S. Dist. LEXIS 63,457 (D. Mass. June 15, 2011).

with the treating physician rule stem from its rigidity. ALJs instead should have the freedom to decide whether to follow a treating source's opinion based on the five factors listed in 20 C.F.R. §§ 404.1527 and 416.927.⁴³⁰ ALJs' decisions then could be reviewed based upon the reasonableness of their application of factors such as length and frequency of visits to physicians (or other "accepted" medical sources) rather than any errors in articulating the correct "weight" to afford particular medical opinions.⁴³¹

To be sure, testimony from treating sources could still be afforded more weight than other medical sources because of the frequency and nature of the claimants' visits to those treating sources. But other evidence in the record may be more probative. *Duren v. Astrue*⁴³² provides a helpful example. There, in affording the treating source's opinion little weight, the ALJ pointed to the inconsistencies within a treating source's opinion and the fact that the physician only treated the claimant twice.⁴³³ The reviewing court did not consider whether the ALJ's reasons for rejecting the treating source's opinion were specifically articulated and persuasive enough under judicial precedent. Instead, it persuasively concluded that it was "entirely reasonable for the administrative law judge to question the reliability of the opinion in light of the treatment notes, . . . with [the physician] having seen plaintiff only twice before deeming her disabled."⁴³⁴ *Duren* suggests an appropriate common sense approach to evaluation of physician testimony. The length-of-treatment factor served as a proxy for determining that the physician did not have a sufficiently nuanced picture of the claimant's condition to merit substantial deference.⁴³⁵ The focus was on the probity of all evidence in the record.

Eliminating the "controlling weight" aspect of the treating physician rule, therefore, would enable ALJs to assess claimant credibility or inconsistencies in the medical evidence without surmounting a "clear and convincing" or "substantial evidence" hurdle. And, if the "controlling weight" default was excised, SSA might become less susceptible to the credit-as-true rule. Thus, the ALJ—who is in a better position to evaluate evidence—would have more flexibility in weighing *all* medical evidence, including physician testimony, medical charts, and the testimony of claimants.

ALJ decisions would stand based on the thoroughness of their reasoning, inviting the reviewing courts to focus on whether the ALJ's decision is supported by substantial evidence in the entire record, including treating source opinion, other medical testimony, and credibility findings. The role for reviewing courts may become more consistent with that in other administrative law contexts—determining whether substantial evidence exists in the record as a whole to support the agency's determination.⁴³⁶ The reviewing court's focus would be trained on the disability determination, not the precise categorization of medical professionals and the formal weight to be afforded their opinions.

⁴³⁰ As has been noted before, the five factors include: (1) length of the treatment relationship and the frequency of examination; (2) nature and extent of the treatment relationship; (3) supportability; (4) consistency; and (5) specialization. There is also a catch-all factor which allows claimants to bring to SSA's attention anything else that may either support or contradict an opinion.

⁴³¹ As discussed previously, the efficacy of the current definition of "acceptable medical source" may also be questionable. See Parts III.A and V.B.

⁴³² 622 F. Supp. 2d 723 (W.D. Wis. 2009).

⁴³³ *Id.* at 733.

⁴³⁴ *Id.*

⁴³⁵ 20 C.F.R. §§ 404.1527(c)(2)(i), 416.927(c)(2)(i) (2012).

⁴³⁶ See *supra* Part V.A.2.

It must be acknowledged, however, that desirable elimination of the “controlling weight” formula is unlikely to produce a sea change in federal court remand rates. Some circuits would likely accept such a change and apply substantial evidence review accordingly.⁴³⁷ Yet, the last two decades have demonstrated that a number of circuits may continue to apply their own precedent, just as they did after the promulgation of the 1991 regulations.⁴³⁸ It would take a few years to determine whether the circuits accepted the new rule. If the circuits continued to apply their own standards, SSA could seek a uniform rule by seeking Supreme Court review should a split in circuit courts arise.⁴³⁹

As this report shows, a strong, routine presumption for the treating physician opinion is no longer viable. The structure of physician practices has changed sufficiently to undermine the “controlling weight” formulation used for the past two decades. And, the unanticipated difficulties in applying the treating physician rule may have resulted in awards to claimants who are not disabled. Accordingly, eliminating the weight automatically ascribed to the treating physician and focusing instead on the length and depth of the relationship between physician and patient as just two critical factors to consider in weighing the totality of the circumstances may be the better course to follow. This is especially true given both the pace at which health care has changed in the last twenty-five years and the unanticipated ways it may change in the future under the recent passage of the Affordable Care Act. Although this change may not result in a substantial alteration of the remand rate from federal court, the change would encourage reviewing courts to shift their focus to determine whether there is substantial evidence in the record to support the agency’s determination that a claimant is not disabled. Such a change may also assist the Appeals Council, either with respect to its appellate or post-effectuation review of ALJ decisions.

It is, of course, SSA’s decision on how best to proceed with the question of whether to revise the treating physician rule. The last twenty years have given SSA ample experience by which to judge the efficacy of the rule, as it has been applied both in its own adjudications and in district and circuit courts proceedings. The Office of the Chairman of the Administrative Conference of the United States believes that the Social Security Administration has the experience and knowledge it needs to decide how best to proceed on the question of the treating physician rule.

⁴³⁷ See App. D: Circuit Court Standards Relating to the Treating Physician Rule.

⁴³⁸ *Id.*

⁴³⁹ One cannot be sure that the Supreme Court would grant a petition for certiorari or, what the outcome would be if the Court did take the case, notwithstanding the result in *Black & Decker*, 538 I/S/ 822 (2003). However, in attempting to achieve a national standard, this may be the most viable option.

APPENDICES

APPENDIX A: METHODOLOGY

During the course of this study, we (1) reviewed statutes, regulations, and other publicly available information relating to SSA's disability benefits programs that relate to the treating physician rule; (2) analyzed SSA-provided data in order to identify the impact of this rule at both the administrative level and in the federal courts; (3) reviewed federal case law, law review articles, and treatises addressing SSA's treating physician rule; (4) documented the changing nature of the U.S. health care system through review of medical journals, federal and non-profit statistical resources, and other publicly available sources; and (5) conducted legal research on the evidentiary weight afforded the opinions of treating sources in other federal and state statutory disability benefits programs. Our review and research were supplemented by a questionnaire that was sent to both NOSSCR and NADR, as well as by interviews of SSA officials, ALJs, decision writers, and attorneys.

APPENDIX B: ANALYSIS OF SSA DATA ON REMAND RATES BY FEDERAL COURTS AND THE APPEALS COUNCIL

1. Frequency of Court Remands

SSA provided two datasets with information about court remands. The first provided summary information on the number of court filings and remands, while the second provided information on reasons for remand of individual remanded cases.

It should be noted that the summary frequencies reflect the number of cases filed and court remands issued during a fiscal year, and thus do not necessarily reflect the same cases. Cases filed in a particular year are often decided in subsequent years, and therefore the number of remands is not based only on the cases filed in that year. Assuming that the rate of court filings and court decisions is stable over time, the ratio of remands to cases filed should approximate the percentage of cases filed that are remanded.

Table 1: Federal Court Filings and Remands, By Year (FY2009 – 11)

Fiscal Year	Court Filings During Fiscal Year	Remands Issued During Fiscal Year	Percent Remanded
2009*	6441	3085	48%
2010	13106	6182	47%
2011	14648	6171	42%
Total	34195	15438	45%

(Note: Percentages are only approximate, because remand decisions may be issued in a different year than court filing. *Only 6 months of data were available for 2009.)

2. Reason for Court Remand

Detailed reasons for remand were available for 14,571 cases remanded by the courts between 2009 and 2011. Some remands were excluded from this data by SSA due to inability to match the remands to other system data. Thus, the number of remands included in this analysis is less than total reported above.

Remand reasons were classified by a specific code, which fell into one of 10 categories: Substantial Gainful Activity (“SGA”), Severe/Non-severe, Adult listings, Child listings, Credibility Evaluation, Opinion Evidence Evaluation & Residual Functional Capacity (“OEE & RFC”), Past Relevant Work, Grid/Vocational Expert, Dismissal/Procedural, and Miscellaneous.

Each case listed up to three remand reasons, and a particular case was included in the frequency counts for each category listed. As such, each case could be included in multiple categories, and the listed frequencies are not mutually exclusive.

The frequency of remand reason categories are summarized in Table 2. The most common reason was OEE & RFC, which comprised 54% of the remands. This category involves remands related to application of the treating physician rule, as well as other medical evidence and issues related to RFC.

APPENDIX B: ANALYSIS OF SSA DATA (CON'T)

Table 2: Federal Courts-Relative Frequency of Remand Reasons, By Category (FY2009-11)

Category Number	Category Label	Frequency	Frequency Percent of Remands
1	SGA	161	1%
2	Severe/Non-Severe	2160	15%
3	Adult Listings	665	5%
4	Child Listings	158	1%
5	Credibility Evaluation	2727	19%
6	OEE & RFC	7864	54%
7	Past Relevant Work	639	4%
8	Grid/Vocational Expert	2306	16%
9	Dismissal/Procedural	124	1%
0	Miscellaneous	3086	21%
	Total Remands	14571	

(Note: Remand categories are not mutually exclusive.)

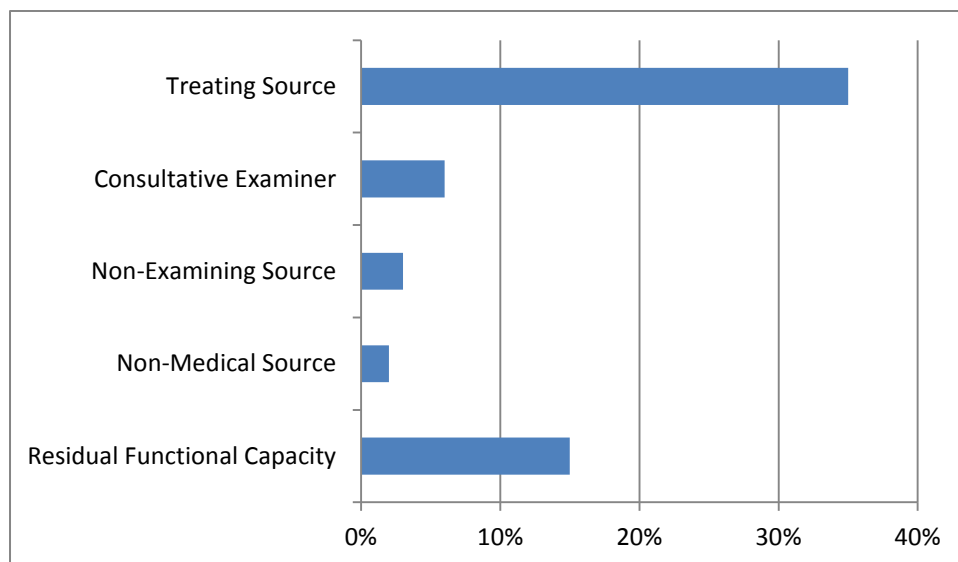
APPENDIX B: ANALYSIS OF SSA DATA (CON'T)

Of the OEE & RFC remands, a substantial number were due to issues involving the treating source (remand codes 611, 612, 613, 614, 615). These reasons were indicated on 5138 remands, 35% of the total. The most common issue involving the treating source was “Opinion rejected without adequate articulation.”

Table 3: Federal Courts-Relative Frequency of OEE & RFC Remands, By Subcategory (FY2009-11)

Remand Reason	Codes	Frequency	Frequency Percent of Remands
Treating Source	611-615	5138	35%
Consultative Examiner	621-624	803	6%
Non-Examining Source	631-634	471	3%
Non-Medical Source	641-644	278	2%
Residual Functional Capacity	651-661	2226	15%
Total OEE & RFC		7864	54%
Total remands		14571	

(Note: Remand categories are not mutually exclusive.)

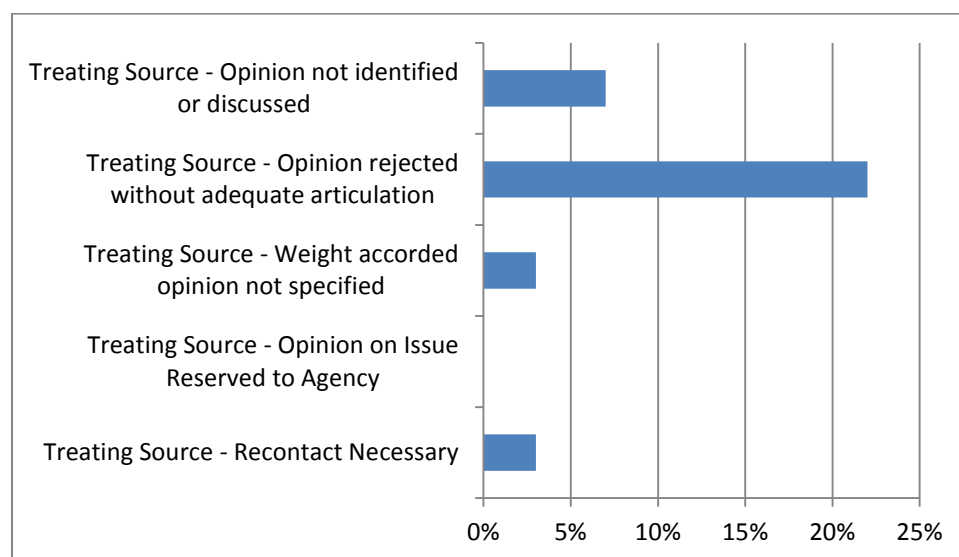


APPENDIX B: ANALYSIS OF SSA DATA (CON'T)

Table 4: Federal Courts-Relative Frequency of Treating Source Remands, By Subcategory (FY2009-11)

Remand Code	Remand Reason	Frequency	Frequency Percent of Remands
611	Treating Source - Opinion not identified or discussed	1069	7%
612	Treating Source - Opinion rejected without adequate articulation	3266	22%
613	Treating Source - Weight accorded opinion not specified	476	3%
614	Treating Source - Opinion on issue reserved to agency	9	<1%
615	Treating Source - Recontact necessary	442	3%
	Total Remands Related to Treating Source	5138	35%
	Total Remands	14571	

(Note: Remand categories are not mutually exclusive.)



3. Changes Over Time in Remands Related to the Treating Source

The proportion of remands related to OEE and RFC did not change significantly over the three year period 2009 - 2011, nor did the proportion related to the treating source. Analysis of yearly trends in specific remand reasons did not yield any substantial changes. A small change was observed in the use of reason 611 (Treating Source – Opinion not Identified or Discussed), and this change was statistically significant, $\chi^2 (2) = 25.3, p < .001$. However, the magnitude of the change was quite small: 9% in 2009, 7% in 2010 and 2011.

APPENDIX B: ANALYSIS OF SSA DATA (CON'T)

Table 5: Federal Courts-Annual Trends in Frequency of OEE & RFC and Treating Source Remands (FY2009-11)

FY	Total Remands	OEE & RFC Remands	Frequency Percent	Treating Source Remands	Frequency Percent
2009	2937	1554	53%	1096	37%
2010	5813	3099	53%	2010	35%
2011	5821	3211	55%	2032	35%
Total	14571	7864	54%	5138	35%

Table 6: Federal Courts-Annual Trends in Frequency of Treating Source Remands, By Remand Code (FY2009-11)

Remand Reason	2009 Remands	Frequency Percent	2010 Remands	Frequency Percent	2011 Remands	Frequency Percent	Total Remands	Frequency Percent
611	279	9%	394	7%	396	7%	1069	7%
612	660	22%	1303	22%	1303	22%	3266	22%
613	93	3%	186	3%	197	3%	476	3%
614	2	<1%	3	<1%	4	<1%	9	<1%
615	83	3%	164	3%	195	3%	442	3%
Total Remands	2937		5813		5821		14571	

(Note: Percentages are computed within year.)

APPENDIX B: ANALYSIS OF SSA DATA (CON'T)

4. Appeals Council Remands

Data on requests for review by the Appeals Council for 2009 – 2011 were obtained from the Appeals Council case processing database. The data indicate that 24% of reviewed cases are remanded each year.

Table 7: Appeals Council-Annual Remand Rates (FY2009-11)

Fiscal Year	Dispositions Reviewed	Remands	Percent Remand
2009	89074	21797	24%
2010	102076	24810	24%
2011	127029	30044	24%

Data on reasons for Appeals Council remands were obtained from heat maps prepared by Ben Gurga, ODAS/OESS/DMIA, 10/19/2011. For these tables, percentages are defined in terms of the number of cited remand reasons. Because each remanded case may have multiple cited reasons, these percentages will not necessarily match the percentage of remanded cases where the reason was cited. Remands involving the treating source comprised 10% of the total remands. The specific remand reasons are detailed below.

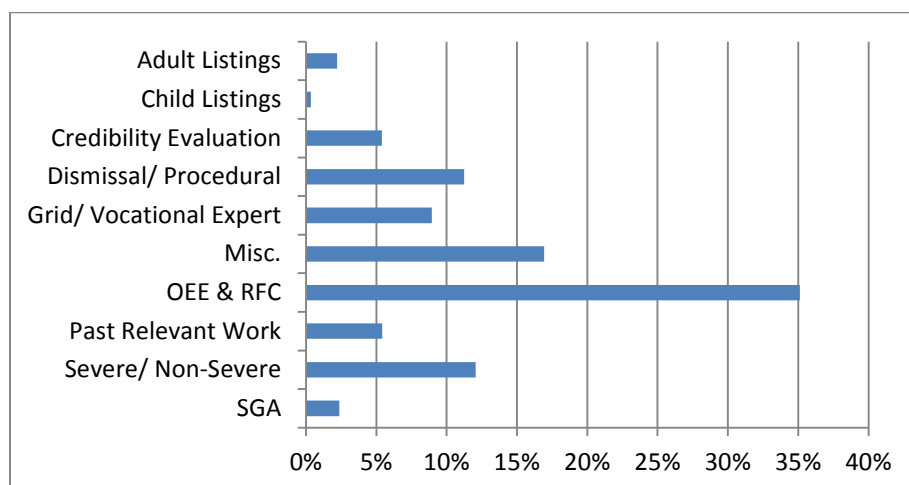
Table 8: Appeals Council-Reasons for Remand, By Category (FY2011)

Remand Reason	Percent of Cited Remand Reasons
Adult Listings	2%
Child Listings	0%
Credibility Evaluation	5%
Dismissal/ Procedural	11%
Grid/ Vocational Expert	9%
Misc.	17%
OEE & RFC	35%
Past Relevant Work	5%
Severe/ Non-Severe	12%
SGA	2%

(Note: Remand categories are not mutually exclusive.)

APPENDIX B: ANALYSIS OF SSA DATA (CON'T)

Table 8: Appeals Council-Reasons for Remand, By Category (FY2011) (Con't)

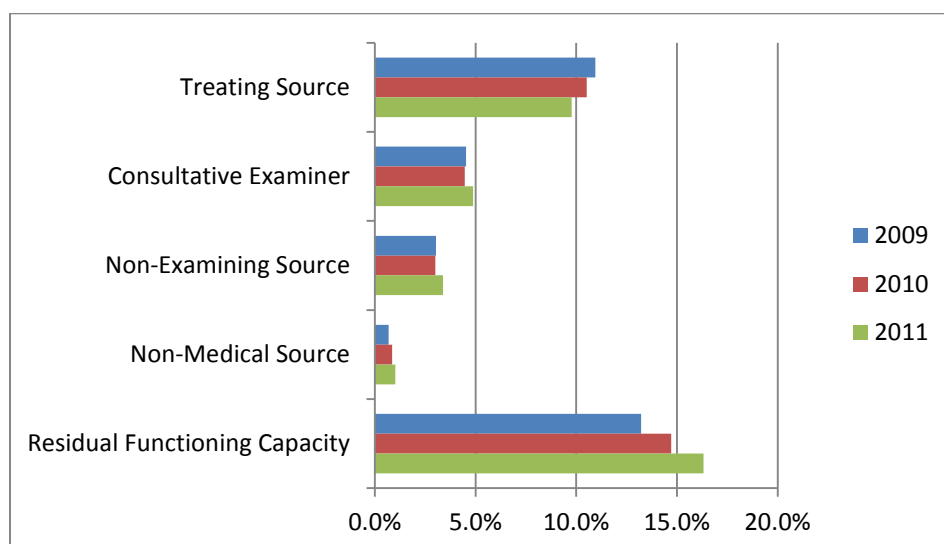


Remands involving the treating source comprised 10% of the total remand reasons.

Table 9: Appeals Council-Relative Frequency of OEE & RFC Remands, By Subcategory (FY2009-11)

Remand Reason	2009	2010	2011
Treating Source	10.9%	10.5%	9.8%
Consultative Examiner	4.5%	4.5%	4.9%
Non-Examining Source	3.0%	3.0%	3.4%
Non-Medical Source	0.7%	0.9%	1.0%
Residual Functioning Capacity	13.2%	14.7%	16.3%
Total OEE & RFC	32.4%	33.5%	35.4%

(Note: Remand categories are not mutually exclusive.)

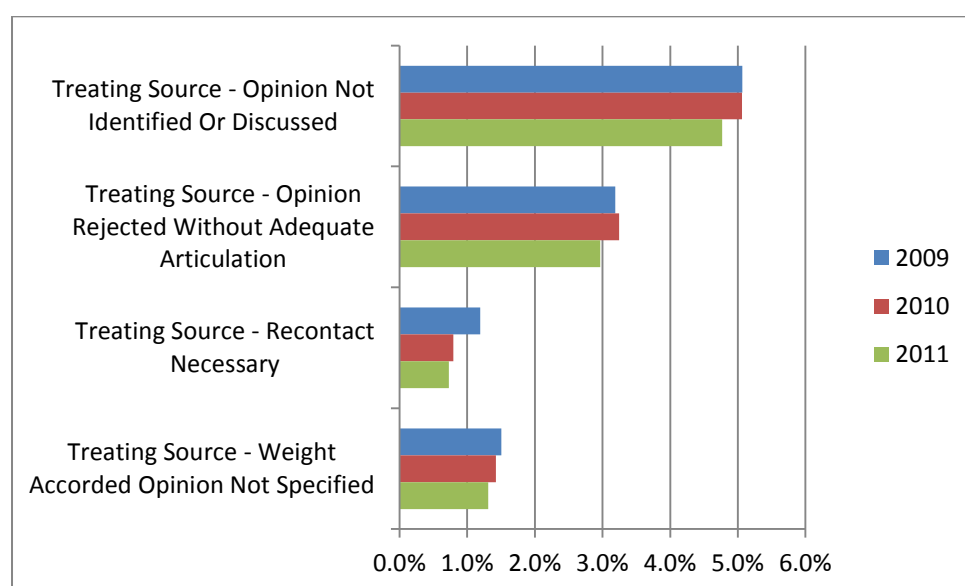


APPENDIX B: ANALYSIS OF SSA DATA (CON'T)

Table 10: Appeals Council-Relative Frequency of OEE & RFC Remands, By Subcategory (FY2009-11)

Reason for Remand	2009	2010	2011
Treating Source - Opinion not identified or discussed	5.1%	5.1%	4.8%
Treating Source - Opinion rejected without adequate articulation	3.2%	3.2%	3.0%
Treating Source - Recontact necessary	1.2%	0.8%	0.7%
Treating Source - Weight accorded opinion not specified	1.5%	1.4%	1.3%
Total Remands Related to Treating Source	11%	10.5%	9.8%

(Note: Remand categories are not mutually exclusive.)



5. Disposition Outcomes

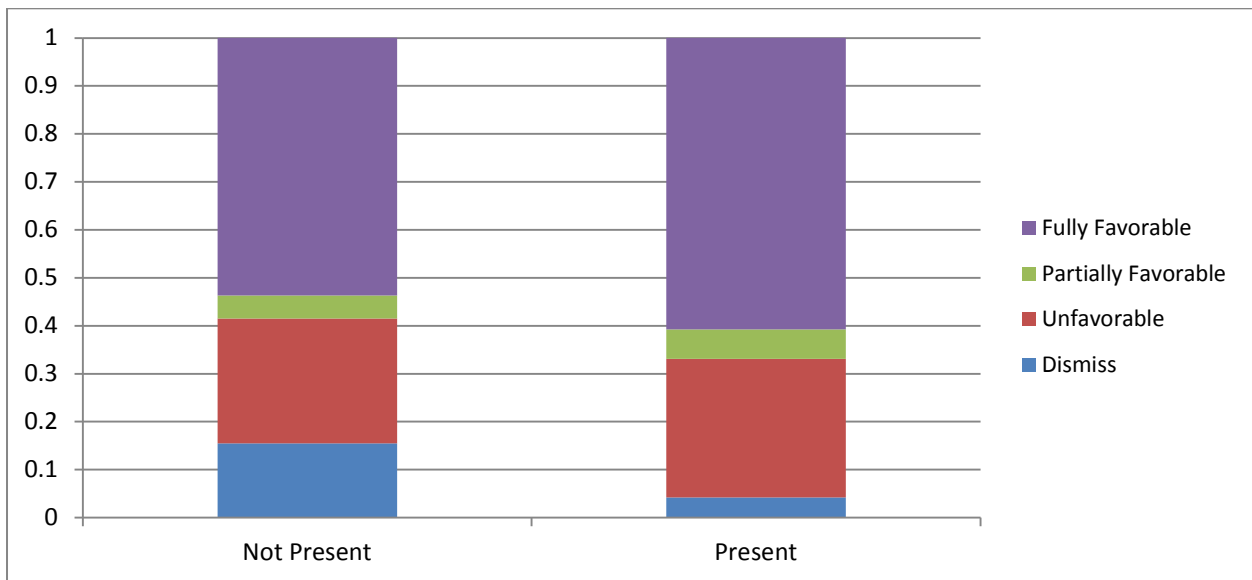
Data on ALJ dispositions involving medical expert testimony were obtained from the SSA case processing management system (“CPMS”) management information data tables. Monthly data on disposition frequency and favorable rates were available across three years (fiscal years 2009 - 2011). The data represented over two million dispositions issued by 1661 ALJs during that time period. We used this data to compare favorable rates for cases involving medical expert testimony to cases without such testimony. An important limitation of this analysis is that CPMS records information on the latest hearing held. If there were multiple hearings, the data only indicated whether a medical expert was present at the most recent hearing.

Dispositions were coded as fully favorable, partially favorable, unfavorable, or dismissed. A separate Analysis of Variance was conducted each type of disposition outcome (fully favorable, partially favorable, unfavorable, dismissal). This analysis compared systematic difference associated with presence of a medical expert to the variability that would be expected due to chance, where chance was operationalized as the variability across months within each group.

APPENDIX B: ANALYSIS OF SSA DATA (CON'T)

The presence of a medical expert (“ME”) was associated with a higher fully favorable rate (61% vs. 54%), $F(1, 70) = 124.14, p < .0001$, and a lower dismissal rate (4% vs. 16%), $F(1, 70) = 2245.35, p = < .0001$. The dismissal rate might reflect situations where a full hearing was not conducted, which would explain why a ME was less likely to be present at hearings that resulted in dismissal. To adjust for this possibility, the proportions were also using only non-dismissal cases. Excluding dismissals, no differences were found between hearings with and without a medical expert on fully favorable dispositions (63% with ME vs. 64% without ME).

Table 11: Comparison of Dispositions With and Without a Medical Expert Present at Hearing



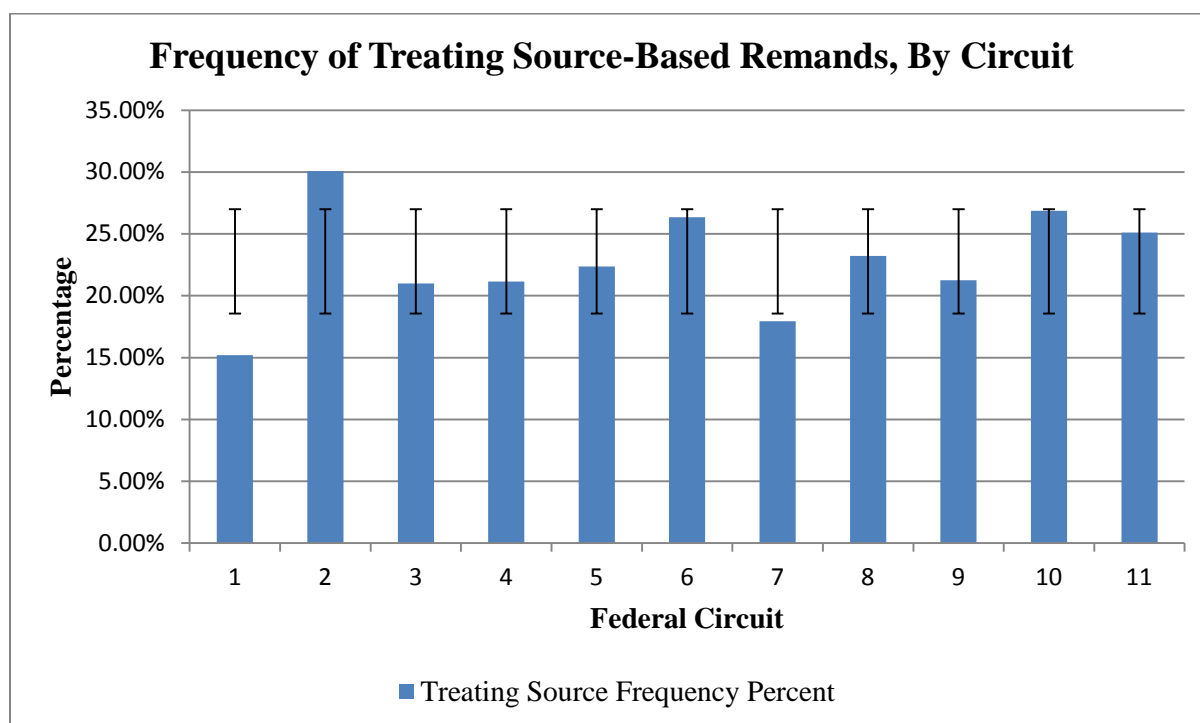
APPENDIX B: ANALYSIS OF SSA DATA (CON'T)

6. Federal Court Treating Source Remand Frequency by Circuit

SSA provided data noting the number of remands in FY 2011 that cited a remand reason. Up to 3 reasons may be cited per remand. In order to compare the frequency percentage with which treating source was cited as a remand reason among circuits, we compared the number of times treating source was cited as a remand reason with the number of times any remand reason was cited.

Table 12: Federal Courts-Frequency of Treating Source Remands, By Circuit (FY2011)

Circuit	Number of Times Treating Source Cited	Number of Times Any Reason was Cited	Treating Source Frequency Percent
1	65	428	15.19%
2	267	888	30.07%
3	119	567	20.99%
4	159	752	21.14%
5	70	313	22.36%
6	151	573	26.35%
7	75	418	17.94%
8	189	814	23.22%
9	437	2056	21.25%
10	192	715	26.85%
11	166	661	25.11%
TOTAL	1890	8185	23.09%



(Note: Vertical bars indicate one standard deviation.)

APPENDIX C: COMPARISON BETWEEN SELECTED PROVISIONS OF THE 1991 AND CURRENT REGULATIONS RELATING TO THE TREATING PHYSICIAN RULE

The text below shows how the 1991 regulations compare to the current regulations. Text that has been struck through was part of the 1991 iteration, but is not included today. Text in blue and underlined has been added and exists today.

Relevant section: Definition of treating source
(20 C.F.R. §§ 404.1502, 416.902)

Treating source means your own physician, ~~or~~ psychologist, or other acceptable medical source who provides you or ~~who~~ has provided you with medical treatment or evaluation and who has or has had an ongoing treatment relationship with you. Generally we will consider that you have an ongoing treatment relationship with a ~~physician or psychologist~~ an acceptable medical source when the medical evidence establishes that you see or have seen, ~~the physician or psychologist~~ the source with a frequency consistent with accepted medical practice for the type of treatment and/or evaluation required for your medical condition(s). We may consider a ~~physician or psychologist~~ an acceptable medical source who has treated or evaluated you only a few times or only after long intervals . . . to be your treating source if the nature and frequency of the treatment or evaluation is typical for your condition(s). We will not consider a ~~physician or psychologist~~ an acceptable medical source to be your treating ~~physician~~ source if your relationship with the ~~physician or psychologist~~ source is not based on your medical need for treatment or evaluation, but solely on your need to obtain a report in support of your claim for disability. In such a case, we will consider the ~~physician or psychologist to be a consulting physician or psychologist~~ acceptable medical source to be a nontreating source.

APPENDIX C: COMPARISON BETWEEN 1991 AND CURRENT REGULATIONS (CON'T)

Relevant section: Evaluating medical opinions about impairment(s) or disability
(20 C.F.R. §§ 404.1527(d), 416.927(d))

~~(d)~~ (c) *How we weigh medical opinions.* . . . Unless we give a treating source's opinion controlling weight under paragraph ~~(d)(2)~~ (c)(2) of this section, we consider all of the following factors in deciding the weight we give to any medical opinion. . . .

(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 below, ~~as well as the factors in paragraphs (d)(3) through (5) of this section~~ in paragraphs (c)(2)(i) and (c)(2)(ii) of this section, as well as the factors in paragraphs (c)(3) through (c)(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. . . . 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.

APPENDIX D: CIRCUIT COURT STANDARDS RELATING TO THE TREATING PHYSICIAN RULE

Standards for each circuit court are summarized based on an analysis of the caselaw. Particularly useful cases are cited in parenthesis.

Circuit	Standard
<i>First</i>	<p>Conflict in evidence among treating, examining, and non-examining physicians is for SSA, not the courts, to weigh. SSA bears the responsibility and has the freedom to assign appropriate weight to both treating and non-treating sources. If SSA’s determination is reasonable and supported by substantial evidence, according to 42 U.S.C. § 405(g), that determination will not be upset by the courts.</p> <p>(Sources: Rodriguez v. Sec’y of Health & Human Svcs., 647 F.2d 218 (1st Cir. 1981); Rodrigues Pagan v. Sec’y of Health & Human Svcs., 819 F.2d 1 (1st Cir. 1987); Rivera v. Sec’y of Health & Human Svcs., 1996 U.S. App. LEXIS 16047 (1st Cir. 1996); Silva-Valentin v. Comm’r of Soc. Sec. 74 Fed. Appx. 73 (1st Cir. 2003); Delucia v. Barnhart, 173 Fed. Appx. 5 (1st Cir. 2006); Libby v. Astrue, 473 Fed. Appx. 8 (1st Cir 2012)).</p>
<i>Second</i>	<p>The court conducts a “plenary review of the administrative record to determine if there is substantial evidence” to support SSA’s decision. SSA has “an affirmative obligation to develop the administrative record,” and while the treating physician rule usually requires SSA to give deference to a treating physician’s opinion, a treating physician’s opinion is only accorded controlling weight when it is well-supported and not inconsistent with substantial evidence in the record. SSA is required to give “good reasons” for the weight it assigns the treating physician’s opinion. The court will unhesitatingly remand a case when SSA fails to “comprehensively set forth reasons for the weight assigned to a treating physician’s opinion.” Substantial evidence for the weight ascribed treating physician opinions consists of a comprehensive explanation for that weight.</p> <p>(Sources: Schaal v. Apfel, 134 F.3d 496 (2d Cir. 1998); Snell v. Apfel, 177 F.3d 128 (2d Cir. 1999); Shaw v. Chater, 221 F.3d 126 (2d Cir. 2000); Halloran v. Barnhart, 362 F.3d 28 (2d Cir. 2004); Micheli v. Astrue, 2012 U.S. App. LEXIS 222172 (2d Cir. 2012)).</p>
<i>Third</i>	<p>The court’s review of SSA’s decision is more deferential than a plenary review—the court determines whether substantial evidence exists to support SSA’s decision, regardless of whether the court would have made the same decision itself. When the treating physician’s opinion is well-supported and not inconsistent, it will be given controlling weight. But when medical evidence exists that contradicts the treating physician’s opinion, that opinion may still be afforded substantial weight. When SSA properly considers a treating physician’s evidence and explains its reasons for the weight it assigns, the court will conclude that the agency’s decision</p>

Circuit	Standard
	<p>is supported by substantial evidence, but when the agency fails to provide adequate explanation, the court will remand the case.</p> <p><i>(Sources: Fagnoli v. Halter, 247 F.3d 34 (3d Cir. 2001); Brownawell v. Comm’r of Soc. Sec., 554 F.3d 352 (3d Cir. 2008); Johnson v. Comm’r of Soc. Sec., 529 F.3d 198 (3d Cir. 2008); Chandler v. Comm’r of Soc. Sec., 667 F.3d 356 (3d Cir. 2011)).</i></p>

APPENDIX D: CIRCUIT COURT STANDARDS (CON'T)

Circuit	Standard
<i>Fourth</i>	<p>The court is vested with responsibility to determine whether the agency’s finding is supported by substantial evidence. Substantial evidence means that there must be adequate evidence to support a reasonable conclusion. The court neither re-weighs conflicting evidence nor substitutes its judgment for that of the agency. In the treating source rule context, SSA evaluates every medical opinion, but decides the weight to assign a particular opinion according to the relationship between the physician and his or her patient. The treating source’s opinion is given controlling weight when it is well-supported and not contradicted by other substantial evidence in the record. However, when it is not well-supported or is contradicted, the opinion is given significantly less weight. In such instances, SSA has discretion “to give less weight to the testimony of a treating physician in the face of persuasive contrary evidence.”</p> <p><i>(Sources: Craig v. Chater, 76 F.3d 585 (4th Cir. 1996); Mastro v. Apfel, 270 F.3d 171 (4th Cir. 2001); Johnson v. Barnhart, 434 F.3d 650 (4th Cir. 2005); Thompson v. Astrue, 442 Fed. Appx. 804 (4th Cir. 2011)).</i></p>
<i>Fifth</i>	<p>The Social Security Act empowers SSA both with determining whether disability exists and how to analyze a treating physician’s opinions. Courts lack the power to re-weigh the evidence or substitute their own judgment for that of SSA. Rather, the courts review SSA’s determinations according to the substantial evidence standard, which is “more than a mere scintilla, but less than a preponderance.” While treating source opinions are usually afforded great weight, they are not conclusive. SSA may assign less, little, or no weight to those opinions, if it shows good cause—as recognized by case law—to do so.</p> <p><i>(Sources: Greenspan v. Shalala, 38 F.3d 232 (5th Cir. 1994); Paul v. Shalala, 29 F.3d 208 (5th Cir. 1994); Leggett v. Chater, 67 F.3d 558 (5th Cir. 1995); Perez v. Barnhart, 415 F.3d 457 (5th Cir. 2005); Foster v. Astrue, 410 Fed. Appx. 831 (5th Cir. 2011)).</i></p>

APPENDIX D: CIRCUIT COURT STANDARDS (CON'T)

Circuit	Standard
<i>Sixth</i>	<p>The court is limited in its review of SSA decisions. It reviews only whether SSA “applied the correct legal standard and made findings supported by substantial evidence in the record.” Substantial evidence is such evidence that “a reasonable mind might accept as adequate to support a conclusion.” In the treating source rule context, SSA must give a treating source’s opinion controlling weight if it is well-supported and not inconsistent with other substantial evidence in the record. If SSA does not give it controlling weight, the agency must give “good reasons” according to several regulatory factors and supported by evidence in the record. Providing anything less than good reasons—such as a mere summary dismissal of the treating source’s opinion, even if SSA’s decision is ultimately justified based on the record—in a sufficiently clear way “denotes a lack of substantial evidence” and will almost always result in remand to the agency. The only way remand will not result is if the court determines the agency made a harmless error, as determined and developed by case law.</p> <p><i>(Sources: Wilson v. Comm’r of Soc. Sec., 378 F.3d 541 (6th Cir. 2004); Allen v. Comm’r of Soc. Sec., 541 F.3d 646 (6th Cir. 2008); White v. Comm’r of Soc. Sec., 572 F.3d 272 (6th Cir. 2009); Cole v. Astrue, 661 F.3d 931, 937-40 (6th Cir. 2011); Helm v. Comm’r of SSA, 405 Fed. Appx. 997 (6th Cir. 2011); Stroud v. Comm’r of Soc. Sec., 2012 FED App. 1156N (6th Cir. 2012); Johnson-Hunt v. Comm’r of Soc. Sec., 2012 FED App. 01010N (6th Cir. 2012)).</i></p>
<i>Seventh</i>	<p>The court reviews SSA decisions deferentially, upholding them as long as they apply the correct legal standard and are supported by substantial evidence, which is “such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.” SSA must give a treating source’s opinion controlling weight if it is supported by “medically acceptable clinical and laboratory diagnostic techniques” and is “not inconsistent with substantial evidence in the record.” If the opinion fails to meet these two criteria, SSA may still accept it, but if the agency declines to give such opinion controlling weight, it “must provide a sound explanation for the rejection;” SSA “must provide an account of what value the treating physician’s opinion merits.” The court will remand the case if the agency’s decision lacks adequate explanation.</p> <p><i>(Sources: Hofslie v. Barnhart, 439 F.3d 375 (7th Cir. 2006); Schmidt v. Astrue, 496 F.3d 833 (7th Cir. 2007); Ketelboeter v. Astrue, 550 F.3d 620 (7th Cir. 2008); Schaaf v. Astrue, 602 F.3d 869 (7th Cir. 2010); Campbell v. Astrue, 627 F.3d 299 (7th Cir. 2010); Jelinek v. Astrue, 662 F.3d 805 (7th Cir. 2011)).</i></p>

APPENDIX D: CIRCUIT COURT STANDARDS (CON'T)

Circuit	Standard
<i>Eighth</i>	<p>When the court reviews SSA decisions, it decides whether the decisions are supported by substantial evidence, and considers evidence that both supports and detracts from SSA’s findings. Substantial evidence is less than a preponderance, but enough that a reasonable mind would accept the conclusion. The court might not agree with the outcome, but may only reverse SSA’s decision if the record lacks substantial evidence to support it. The treating source’s opinion is given special deference and is usually entitled to “great weight” if it is well-supported and not inconsistent with the record’s other substantial evidence. The opinion, however, does not automatically control, “since the record must be evaluated as a whole.” SSA may discount or disregard the opinion “where other medical assessments” are better supported or where the opinion itself is inconsistent, and therefore undermines its own credibility. In any event, SSA must consider a treating source’s opinion and give good reasons for the weight it accords such opinion—whether that weight is substantial or minimal.</p> <p><i>(Sources: Bentley v. Shalala, 52 F.3d 784 (8th Cir. 1995); Cruze v. Chater, 85 F.3d 1320 (8th Cir. 1996); Rogers v. Chater, 118 F.3d 600 (8th Cir. 1997); Rankin v. Apfel, 195 F.3d 427 (8th Cir. 1999); Prosch v. Apfel, 201 F.3d 110 (8th Cir. 2000); Hogan v. Apfel, 239 F.3d 958 (8th Cir. 2001); Vossen v. Astrue, 612 F.3d 1011 (8th Cir. 2010); Wildman v. Astrue, 596 F.3d 959 (8th Cir. 2010); Anderson v. Astrue, 2012 U.S. App. LEXIS 22025 (8th Cir. 2012)).</i></p>
<i>Ninth</i>	<p>SSA’s decision may only be reversed if it is based on legal error or is not supported by substantial evidence in the record. Substantial evidence is more than a mere scintilla, but less than a preponderance and the court may not substitute its judgment for that of SSA. The court recognizes a hierarchy of opinions: treating physician, examining physician, and non-examining physician. Generally, more weight is given to the opinion of a treating physician than that of a non-treating physician. Indeed, if the treating physician’s opinion is well-supported and not inconsistent, it is accorded controlling weight. When a treating physician’s opinion is not contradicted, it may only be rejected for “clear and convincing” reasons. Clear and convincing reasons are also required to reject a treating physician’s conclusions. Even if a treating physician’s opinion is contradicted, SSA may only reject that opinion if it provides “specific and legitimate reasons supported by substantial evidence in the record for so doing.” Not only does the contradictory opinion of a non-examining physician by itself not constitute such substantial evidence, but the reasons must be “sufficiently specific to make clear to any subsequent reviewers the weight the [agency] gave to the treating source’s opinion and the reasons for that weight.”</p> <p><i>(Sources: Magallanes v. Bowen, 881 F.2d 747 (9th Cir. 1989); Rodriguez v. Bowen, 876 F.2d 759 (9th Cir. 1989); Lester v. Chater, 81 F.3d 821 (9th Cir. 1995); Smolen v. Cater, 80 F.3d 1273 (9th Cir. 1996); Edlund v. Massanari, 2001 U.S. App. LEXIS 17960 (9th Cir. 2001); Thomas v. Barnhart, 278 F.3d 947 (9th Cir. 2002); Connett v. Barnhart, 340 F.3d 871 (9th Cir. 2003); Flores v. Comm’r of Soc. Sec., 237 Fed. Appx. 251 (9th Cir. 2007)).</i></p>

APPENDIX D: CIRCUIT COURT STANDARDS (CON'T)

Circuit	Standard
<i>Tenth</i>	<p>The court deferentially reviews SSA’s decision to determine whether it is supported by substantial evidence and is free from legal error. While the court neither re-weighs nor substitutes its judgment for that of the agency, it “meticulously examine[s] the record” to ensure that SSA has sufficient basis for deciding the way it did. In the treating physician rule context, SSA will usually give more weight to treating sources than non-treating sources. The agency must first determine whether the treating physician’s opinion qualifies for controlling weight. It qualifies for controlling weight only when it is well-supported and not inconsistent with other substantial evidence in the record. When SSA does not give a treating physician’s opinion controlling weight, it must show good cause for its decision and specifically and legitimately articulate the weight given to the opinion according to all appropriate regulatory factors. Failure to provide good reasons will inhibit a court’s ability to review the agency’s decision and will result in remand.</p> <p><i>(Sources: Frey v. Bowen, 816 F.2d 508 (10th Cir. 1987); Goatcher v. U.S. Dep’t of Health & Human Svcs., 52 F.3d 288 (10th Cir. 1995); Miller v. Chater, 99 F.3d 972 (10th Cir. 1996); Drapeau v. Massanari, 10 Fed. Appx. 657 (10th Cir. 2001); Doyal v. Barnhart, 331 F.3d 758 (10th Cir. 2003); Watkins v. Barnhart, 350 F.3d 1297 (10th Cir. 2003); Langley v. Barnhart, 373 F.3d 1116 (10th Cir. 2004); Kilpatrick v. Astrue, 2012 U.S. App. LEXIS 24049 (10th Cir. 2012)).</i></p>
<i>Eleventh</i>	<p>The court reviews SSA’s evidentiary findings according to the substantial evidence standard and its legal findings de novo. The substantial evidence standard requires that the agency’s “decision be based on evidence that a reasonable mind might accept as adequate to support a conclusion.” The court will not re-weigh evidence or make credibility determinations. In the treating physician context, according both to case law and agency regulations, SSA must give the treating physician’s opinion “substantial or considerable weight unless good cause is shown to the contrary.” On issues reserved to the agency, however, SSA does not have to give the opinion controlling weight. Good causes for giving the treating physician’s opinion less weight include when it is not supported by evidence, the evidence supported a contrary finding, or the opinion is itself conclusory or inconsistent. If SSA declines to give the treating physician opinion controlling weight, it must clearly articulate its reasons for doing so. If the agency articulates specific and particular reasons, failure to give the treating physician’s opinion controlling weight will not result in a reversible error, so long as its reasons are supported by substantial evidence.</p> <p><i>(Sources: MacGregor v. Bowen, 786 F.2d 1050 (11th Cir. 1986); Lewis v. Callahan, 125 F.3d 1436, 1440 (11th Cir. 1997); Phillips v. Barnhart, 357 F.3d 1232 (11th Cir. 2003); Moore v. Barnhart, 405 F.3d 1208 (11th Cir. 2005); Gainous v. Astrue, 402 Fed. Appx. 472 (11th Cir. 2010); Winschel v. Comm’r of Soc. Sec., 631 F.3d 1176 (11th Cir. 2011)).</i></p>

**APPENDIX E: LETTER FROM NATIONAL ORGANIZATION OF SOCIAL SECURITY CLAIMANTS'
REPRESENTATIVES**

**NATIONAL ORGANIZATION OF
SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES
(NOSSCR)**

560 Sylvan Avenue • Englewood Cliffs, NJ 07632
Telephone: (201) 567- 4228 • Fax: (201) 567-1542 • email: nosscr@att.net

Executive Director
Nancy G. Shor

December 19, 2012

Amber Williams
ACUS Attorney Advisor
Administrative Conference of the United States
1120 20th St., NW Suite 706 South
Washington, DC 20036

Re: Comments on the ACUS study of the role of courts in reviewing SSA disability decisions

Dear Ms. Williams:

Thank you for the opportunity to submit comments on the ACUS study of the role of courts in reviewing SSA disability decisions, specifically, as it relates to the “treating physician rule.”

To provide background about our organization, NOSSCR was founded in 1979 and is a professional association of attorneys and other advocates who represent individuals seeking Social Security disability and Supplemental Security Income (SSI) disability benefits. NOSSCR members represent these individuals at all Social Security Administration (SSA) administrative levels and in federal court. We are a national organization with a current membership of more than 4,000 members from the private and public sectors and are committed to the highest quality legal representation for claimants.

Our comments focus on the impact of the study on the millions of claimants and beneficiaries with severe disabilities for whom Title II and SSI cash benefits, along with the related Medicaid and Medicare benefits, are the means of survival.

1. What is NOSSCR’s position on SSA’s current regulations and/or policies regarding the treating physician rule?

APPENDIX E: LETTER FROM NOSSCR (CON'T)

We believe that the current regulations and policies provide detailed guidance for adjudicators and the public.

Prior to 1991, SSA had failed to promulgate comprehensive rules for weighing medical evidence in disability claims. As a result, the courts stepped in to fill the void. The circuit courts established an extensive collection of precedent in this area. The “treating physician rule” existed in every circuit and provided fairly similar guidance. Generally, the opinion of a treating physician was to be given more weight than that of a consulting or non-examining physician. While some variations existed from circuit to circuit, the biggest split at the time was between the circuits and SSA.

Finally, in 1991, SSA moved to address this problem when it published final rules describing the weight to be given all medical evidence, including reports from treating physicians and consultative examinations.¹ The extensive circuit case law played an important role in development of the regulations. Even SSA stated that it had “been guided” by basic principles upon which the majority of circuit courts generally agreed. These principles are:

1. “[T]reating source evidence tends to have a special intrinsic value by virtue of the treating source’s relationship with the claimant.”
2. “[I]f the Secretary [now Commissioner] decides to reject such an opinion, he should provide the claimant with good reasons for doing so.”²

Since 1991, the courts have applied and upheld the validity of the regulations, even when they differed from pre-1991 circuit precedent. In the Second Circuit, which arguably had one of the most liberal treating physician rules, the court upheld the validity of the 1991 medical evidence regulations.³

2. What suggestions does NOSSCR have, if any, for improving the current regulations and/or policies regarding the treating physician rule?

Under the SSA regulations, only an “acceptable medical source” can establish the existence of a “medically determinable impairment.”⁴ SSA considers evidence from “acceptable medical sources” to be “medical opinions” subject to the “treating source” rule.⁵

¹ 56 Fed. Reg. 36932 (Aug. 1, 1991).

² *Id.* at 36934.

³ *See Schisler v. Sullivan*, 3 F.3d 563 (2nd Cir. 1993).

⁴ 20 C.F.R. §§ 404.1513(a) and 416.913(a).

⁵ 20 C.F.R. §§ 404.1527(d) and 416.927(d); 20 C.F.R. §§ 404.1527(d)(2) and 416.927(d)(2).

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SSA should expand the list of “acceptable medical sources” to include nurse practitioners, physician assistants, and clinical social workers, who are all licensed and credentialed under state law. Delays in the disability claims process often arise when SSA requires a consultative examination to confirm the diagnosis made by a nurse practitioner, physician assistant, or licensed clinical social worker.

Millions of Americans now rely on these licensed practitioners as their primary providers of physical and mental health care. Based on current trends, these health professionals will become an increasing part of the nation’s healthcare workforce – a role that the federal government is committed to promoting. Because these professionals are licensed by states, expanding the list of acceptable medical sources to include them protects the integrity of the disability programs. Most importantly, it will streamline the process, ensuring that eligible individuals access benefits in a timely manner.

A recent report by the National Law Center on Homelessness & Poverty makes the argument for expanding the types of health care workers who can be acceptable medical sources, especially for claimants who are homeless. The report makes recommendations for how SSA can expand the categories of treating health care professionals who are considered acceptable medical sources.⁶

3. What legal or practical concerns does NOSSCR have, if any, regarding the treating physician rule as applied within the SSA adjudicatory process and as reviewed by the federal courts?

The current regulations require adjudicators to “evaluate every medical opinion we [i. e., SSA] receive” when determining the weight to give these opinions, including those from treating sources.⁷ The regulations also require adjudicators to “consider all of the ... factors [in the regulations] in deciding the weight we give to any medical opinion”⁸ and to “make findings about what the evidence shows.”⁹ Consistent with the second guiding principle for the regulations, the

⁶ *Improving Access: Expanding Acceptable Medical Sources for the Social Security Administration Disability Determination Process* (May 2012) (“NLCHP Report”). Available at <http://www.nlchp.org/content/pubs/5.14.12%20Improving%20Access,%20FINAL.pdf>.

⁷ 20 C.F.R. §§ 404.1527(d) and 416.927(d).

⁸ *Id.*

⁹ 20 C.F.R. §§ 404.1527(c) and 416.927(c).

APPENDIX E: LETTER FROM NOSSCR (CON'T)

courts have required adjudicators to provide a rationale, explaining how the factors were applied to determine the weight given to medical opinions and to provide valid reasons for discounting or rejecting the opinions of treating sources.

We review hundreds of district court and circuit court cases involving Social Security and SSI disability claims every year, with many decisions resulting in court-ordered remands. The most frequent reason for the remands is the ALJ's failure to articulate supported and valid reasons for rejecting or discounting medical evidence from treating sources.

SSA's regulations require that "[w]e will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion."¹⁰ The failure to provide a rationale leaves the court unable to adequately review the record since the court cannot determine how the ALJ weighed the evidence or why the ALJ may have rejected an opinion. As a result, the court has no choice but to remand the case for further development of the record.

4. What legal or practical concerns would NOSSCR have, if any, if SSA weighed all evidence under the same standards, regardless of the source of the evidence?

Unless a treating source opinion is entitled to controlling weight, SSA's regulations already provide that all medical opinions are evaluated under the same factors.¹¹ These factors are: (1) treatment relationship, including length of relationship, frequency of examination, and nature and extent of treatment relationship; (2) supportability; (3) consistency; and (4) specialization.¹²

It should be noted that evidence from a treating source is not automatically accorded "controlling weight." Under the regulations, a treating source's opinion is given controlling weight *only if*: (1) it is "well-supported by medically acceptable clinical and laboratory diagnostic techniques"; and (2) it is "not inconsistent with the other substantial evidence in your case record."¹³ If a treating source opinion is not given controlling weight, SSA will apply the other factors listed above.¹⁴

¹⁰ 20 C.F.R. §§ 404.1527(d)(2) and 416.927(d)(2).

¹¹ 20 C.F.R. §§ 404.1527(d) and 416.927(d).

¹² 20 C.F.R. §§ 404.1527(d)(2)–(d)(6) and 416.927(d)(2)–(d)(6).

¹³ 20 C.F.R. §§ 404.1527(d)(2) and 416.927(d)(2).

¹⁴ *Id.*

APPENDIX E: LETTER FROM NOSSCR (CON'T)

5. Does NOSSCR believe that the changes in the health care system over the past twenty years since the regulations were originally adopted affect the basis or efficacy of the treating physician rule today? If so, why? If not, why not?

As discussed above, we recommend that SSA expand the definition of “acceptable medical source” to include a broader range of primary treating sources, specifically nurse practitioners, physician assistants, and clinical social workers, who are all licensed and credentialed under state law.

Non-physician health care providers are increasingly the primary care providers for many individuals. As a result, these treating medical providers will become an important source of medical information about their patients. The federal government has recognized the importance of these medical providers as part of the network of health providers. As noted by the National Law Center on Homelessness & Poverty in its report:

Finally, expanding the list of acceptable medical sources to include these professionals protects the integrity of the SSDI and SSI programs. Nurse practitioners, physician assistants, and licensed clinical social workers are all highly trained professionals who provide excellent primary physical and mental health care. Practice and licensing standards are generally consistent across states, so SSA can be assured that all nurse practitioners, physician assistants, and licensed clinical social workers are held to appropriately high standards.¹⁵

* * *

Thank you for asking us to provide these comments.

Very truly yours,

Nancy G. Shor
Executive Director, NOSSCR

Ethel Zelenske
Director of Government Affairs, NOSSCR

¹⁵ NLCHP Report at 15.

APPENDIX F: LETTER FROM NATIONAL ASSOCIATION OF DISABILITY REPRESENTATIVES



December 28, 2012

Administrative Conference of the United States
Amber Williams,
Attorney Advisor
1120 20th Street NW, Suite 706 South
Washington, DC 20036

Dear Ms. Williams:

Thank you for the opportunity to share our suggestions and concerns with the ACUS. Our responses to your questions are below.

1. What is NADR's position on SSA's current regulations and/or policies regarding the treating physician rule?

SSA defines a "treating source" at 20 CFR 404.1502 (2012):

"Treating source means your own physician, psychologist, or other acceptable medical source who provides you, or has provided you, with medical treatment or evaluation and who has, or has had, an ongoing treatment relationship with you. Generally, we will consider that you have an ongoing treatment relationship with an acceptable medical source when the medical evidence establishes that you see, or have seen, the source with a frequency consistent with accepted medical practice for the type of treatment and/or evaluation required for your medical condition(s). We may consider an acceptable medical source who has treated or evaluated you only a few times or only after long intervals (e.g., twice a year) to be your treating source if the nature and frequency of the treatment or evaluation is typical for your condition(s). We will not consider an acceptable medical source to be your treating source if your relationship with the source is not based on your medical need for treatment or evaluation, but solely on your need to obtain a report in support of your claim for disability. In such a case, we will consider the acceptable medical source to be a nontreating source."

SSA explains how opinion evidence is evaluated at 20 CFR 404.1527 (2012):

http://ssa.gov/OP_Home/cfr20/404/404-1527.htm

APPENDIX F: LETTER FROM NADR (CON'T)

The length of the treating relationship, frequency of examination, nature and extent of the treatment relationship, supportability, consistency, specialization, and other factors are supposed to be considered, when SSA is deciding how much weight to give to opinion evidence. Generally, treating source's opinions are entitled to great, if not controlling weight, as long as they are not inconsistent with the record as a whole (see also Policy Interpretation Ruling SSR 96-2p, re: Giving Controlling Weight to Treating Source Medical Opinions: http://www.ssa.gov/OP_Home/rulings/di/01/SSR96-02-di-01.html and SSR 96-5p re: Medical Source Opinions on Issues Reserved to the Commissioner: http://www.ssa.gov/OP_Home/rulings/di/01/SSR96-05-di-01.html).

These Regulations are simple yet concise, and the Rulings give excellent guidance. NADR supports this approach, as representatives understand that no source is in a better position to know the nature and severity of a claimant's impairments and their functional restrictions than the treating physician. It is important that adjudicators at the state agencies receive better training and encouragement to apply these Regulations and Rulings. Treating physicians' opinions – especially regarding the claimants' functioning – should routinely be requested at the initial and reconsideration levels, and given the proper weighting per the Regulations. Better training of adjudicators and enforcement of the current Regulations and Rulings would ensure that accurate decisions are made as early in the process as possible, benefitting vulnerable claimants and saving SSA resources that are wasted by unnecessary appeals. Administrative Law Judges (ALJs) and staff attorneys, on the whole, seem to understand and apply the Regulations and Rulings more often than adjudicators – which is a principle reason why so many denials are reversed by ALJs. Another important factor is that the record is often incomplete at the initial and reconsideration levels, yet with representative involvement (particularly at the hearing level), better and more complete evidence (most often from the treating physicians) enables the ALJs to make more accurate decisions.

SSA issued a Notice of Proposed Rulemaking (NPRM) re: “How We Collect and Consider Evidence of Disability” (76 Fed. Reg. 20282, 4/12/11). Here is a link to the text: <http://www.gpo.gov/fdsys/pkg/FR-2011-04-12/html/2011-8388.htm>

NADR submitted comments to this NPRM on 6/10/11; a copy of our submitted comments is attached. SSA's Regulations and policies require adjudicators and ALJs to recontact the treating physician when additional information or clarification is needed, before ordering a consultative examination (see 20 CFR 404.1512(d) and (e)(2012) and HALLEX I-2-5-18 to 20 and II-4-1-2). This requirement should be reinforced during the training process.

APPENDIX F: LETTER FROM NADR (CON'T)

2. What suggestions does NADR have, if any, for improving the current regulations and/or policies regarding the treating physician rule?

NADR's position is that the majority of existing Regulations and Rulings are sufficient; there may be a need for better training to assure that adjudicators and ALJs are aware of the procedures in place, and follow them accordingly.

3. What legal or practical concerns does NADR have, if any, regarding the treating physician rule as applied within the SSA adjudicatory process and as reviewed by the federal courts?

We are concerned that despite the fact that SSRs 96-2p and 96-5p were issued more than 16 years ago, to date they are not applied consistently.

4. What legal or practical concerns would NADR have, if any, if SSA weighed all evidence under the same standards, regardless of the source of the evidence?

NADR would strongly oppose a change in existing policy to allow SSA to weigh all evidence under the same standards. SSA's Regulations and Rulings make it clear that there is a hierarchy of medical sources that should be followed, depending on numerous factors, including specialization, length of treating relationship, supportability and consistency with the evidence. NADR supports this approach as logical and pragmatic, but with the understanding that the world of medicine has changed over the last two decades (see our response to number 5). There is simply no way that a consultative examination – representing a single, often very brief “snapshot in time” - should have the same weight as medical records and opinions from a treating source that has known the claimant for years. There is even less support for the state agency reviewing physicians' opinions, given that they never examine the claimants, have incomplete records, and are under tremendous production pressures that lead to insufficient analysis.

5. Does NADR believe that the changes in the health care system over the past twenty years since the regulations were originally adopted affect the basis or efficacy of the treating physician rule today? If so, why? If not, why not?

APPENDIX F: LETTER FROM NADR (CON'T)

The world of medicine has changed, and continues to change. Per 20 CFR 404.1513(a)(2012), SSA currently defines "Acceptable Medical Sources" as:

- "(1) Licensed physicians (medical or osteopathic doctors);
- (2) Licensed or certified psychologists. Included are school psychologists, or other licensed or certified individuals with other titles who perform the same function as a school psychologist in a school setting, for purposes of establishing mental retardation, learning disabilities, and borderline intellectual functioning only;
- (3) Licensed optometrists, for purposes of establishing visual disorders only (except, in the U.S. Virgin Islands, licensed optometrists, for the measurement of visual acuity and visual fields only);
- (4) Licensed podiatrists, for purposes of establishing impairments of the foot, or foot and ankle only, depending on whether the State in which the podiatrist practices permits the practice of podiatry on the foot only, or the foot and ankle; and
- (5) Qualified speech-language pathologists, for purposes of establishing speech or language impairments only. For this source, "qualified" means that the speech-language pathologist must be licensed by the State professional licensing agency, or be fully certified by the State education agency in the State in which he or she practices, or hold a Certificate of Clinical Competence from the American Speech-Language-Hearing Association."

Increased involvement of Physicians' Assistants, Nurse Practitioners, Physical Therapists, and social workers in patient care is a reality with which SSA has yet to contend. While SSR 06-3p gives guidance on accepting medical opinions from sources other than those that are deemed "acceptable" by SSA, it is often the case in current adjudication (especially at the initial and reconsideration levels) that medical evidence from years of treatment with a PA, NP or LCSW is swept aside, to be replaced by the opinion of a consulting MD who sees the patient for 30 minutes or less...solely because the primary treating source is not deemed "acceptable." SSA should consider revising the Regulations to better reflect today's treatment practices. Here is a link to SSR 06-3p:
http://www.ssa.gov/OP_Home/rulings/di/01/SSR2006-03-di-01.html

The move towards electronic medical records has already demonstrated the potential to dramatically reduce SSA's adjudicative processing times, while ensuring a more complete medical record is obtained. SSA should incorporate functional questionnaires ("medical source statements" and "interrogatories" commonly used by representatives) to better obtain the clinical information and restrictions from the treating physicians earlier in the process.

We appreciate the opportunity to share our members' concerns and suggestions with you.

Regards,



Trisha Cardillo, ADR

President of NADR

Attachment: NADR Comments re: Docket No. SSA-2010-0044 [76 FR 20282 (April 12, 2011)]

APPENDIX F: LETTER FROM NADR (CON'T)



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2010-2011

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June 10, 2011

Office of Regulations
Social Security Administration
137 Altmeyer Building
6401 Security Boulevard
Baltimore, MD 21235-6401

Submitted on www.regulations.gov

RE: Docket No. SSA-2010-0044

Dear Sir or Madam:

On behalf of the more than 600 members of the National Association of Disability Representatives (NADR), we write in reply to the Social Security Administration's (SSA) request for comments [76 Fed. Reg. 20282 (April 12, 2011)] on its notice of proposed rulemaking on "How We Collect and Consider Evidence of Disability." NADR is a professional organization comprised of non-attorneys and attorneys who assist people in applying for disability income assistance from the Social Security Administration. We appreciate this opportunity to comment on the proposed rule.

In general, we believe that the editorial corrections and non-substantive changes proposed in the rule will provide more clarity and consistency. We agree that SSA's efforts to dramatically improve the evidence-collection process through the increased use of Health Information Technology will speed the review of evidence, reduce the need to recontact treating sources, and reduce the number of Consultative Examinations (CE) needed. However, we strongly disagree with SSA's proposal to eliminate the requirement that it recontact a claimant's medical source(s) when it needs to resolve an inconsistency or insufficiency in the evidence provided. We believe -- and Social Security's own rulings and regulations recognize -- that the treating physician is the best-informed and most-likely source of information about a claimant's medical condition. Rather than abandoning the effort to obtain

APPENDIX F: LETTER FROM NADR (CON'T)

information from the treating source, SSA should explore ways to make the process by which it requests information from the treating physician more efficient and effective when it attempts to fill gaps in a claimant's medical record.

Following are our comments on specific sections of the proposed rule.

Sec. 404.1519a When we will purchase a consultative examination and how we will use it.

The proposed rule would eliminate the current requirement that SSA first recontact a claimant's treating physician or psychologist or other medical source when it determines that the evidence received from those sources is inadequate to determine whether the claimant is disabled. In the explanation of changes, SSA asserts that "[t]here are situations where we need the flexibility to determine how best to resolve inconsistencies and insufficiencies in the evidence," and that the proposed change would "shorten case processing time and conserve resources" in some situations.

SSA provides two examples to demonstrate the need for the change. The first is "when your medical source(s) does not specialize in the area of the impairment you have alleged;" the second is when "issues revealed in the medical evidence are better clarified by someone other than your medical source(s)."

Existing regulations give SSA the flexibility to determine how best to resolve inconsistencies and insufficiencies in the evidence. Section 404.1512(e)(2) states: "We may not seek additional evidence or clarification from a medical source when we know from past experience that the source either cannot or will not provide the necessary findings."

Further, Section 404.1512(f) states: "Generally, we will not request a consultative examination until we have made every reasonable effort to obtain evidence from your own medical sources. However, in some instances, such as when a source is known to be unable to provide certain tests or procedures or is known to be nonproductive or uncooperative, we may order a consultative examination while awaiting receipt of medical source evidence."

The flexibility to order a consultative examination without first recontacting medical sources is contained in the current regulations. Therefore, the proposed change is unnecessary.

Further, we are concerned that, while SSA indicates that it "expect[s] that our adjudicators would continue to recontact your medical source(s) first when we believe such recontact is the most effective and efficient way to resolve an inconsistency or insufficiency", the proposed change will instead result in significantly more CEs being ordered at the taxpayer's expense, when a clear, specific request to the treating source would result in more informed and accurate information being provided faster and without the added expense of ordering a CE. NADR believes that more diligent efforts to obtain specific

APPENDIX F: LETTER FROM NADR (CON'T)

information from treating sources will result in a clearer picture of a claimant's longitudinal treatment, as opposed to a one-time "snapshot" produced by a CE.

We are concerned that eliminating the requirement that SSA recontact a claimant's medical sources would not result in greater efficiency or effectiveness. Medical evidence from treating providers is key to ensuring that eligible claimants are awarded benefits at the initial level when the one-time evaluation made during a consultative examination would not provide the evidence necessary to make a favorable determination. If more cases are decided at the initial level without evidence from the treating providers, ALJs will bear a greater burden of completing the evidentiary record at the hearing level.

Rather than eliminating the requirement that SSA recontact the treating physician or other medical source -- the best-informed and most-likely source of information about a claimant's medical condition -- NADR proposes that SSA develop better processes for requesting medical records. Providing clear questions to the treating physician that are targeted to SSA's disability criteria will make it easier and less time-consuming for that medical source to provide specific answers that can fill in the blanks when the evidence is either inconclusive or insufficient to make a determination.

For example, SSA might develop templates of condition-specific questions to send to treating physicians in addition to blanket requests for medical records. This would help SSA obtain more accurate and better information from the treating physician more expeditiously. Also, taking steps to assure that the request actually reaches the treating physician rather than languishing in the medical-records office will greatly improve the process. A direct phone call to the treating physician is often the most expedient way to fill gaps in the medical record. Better training for DDS staff on these procedures also will help to assure that the DDS is building a record that is more in line with the process employed by ALJs, thus improving the prospects of getting the right decision sooner in the process and reducing the need to push such cases to the hearing level.

NADR recommends that SSA be required to document at least three attempts to contact the medical source before ordering a CE. For claimants who have representatives, SSA should make it standard operating procedure to send a copy of the requested additional information to the representative at the time it is requested of the treating physician. Representatives are willing and able to assist SSA in getting the information it needs. Such coordination will reduce the administrative burden on DDS offices as well.

Improving SSA's process for recontacting treating physicians will be much more effective and efficient- and less costly- than ordering CEs in providing SSA with the evidence it needs to make an informed decision.

APPENDIX F: LETTER FROM NADR (CON'T)

Sec. 404.1520b How we consider evidence

When SSA does order a CE, NADR recommends that the following steps be taken to assure that the examination produces information that is as accurate and informed as possible:

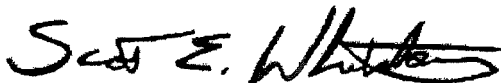
- Before the exam, SSA should provide the claimant and, if there is one, his/her representative a list of what medical information will be sent to the CE provider.
- The claimant and representative should be given the opportunity to submit interrogatories to the examiner before the exam.
- Unless a fully favorable decision can be made based on the CE, the results of the CE should be provided to the representative for comment before SSA makes a decision, and the treating physicians should have the right to raise objections or comment on the CE report.
- As happens at the hearing level, SSA should be required to proffer a CE report and provide the claimant and representative an opportunity to comment and/or object.
- The results of the CE should only be considered supportive and never considered more unless it is the only medical documentation.

Conclusion

We urge SSA to retain the current requirement that SSA recontact a claimant's treating physician, psychologist or other medical source when evidence is insufficient or inconclusive. Further, we believe that better training for DDS staff about process unification will result in better record building at the DDS level, and therefore fewer appeals. Finally, when CEs are requested, claimants, representatives and treating physicians should have the opportunity to both provide questions to the examiner and review and comment on the CE report.

NADR appreciates the opportunity to share the views of our members with SSA. Thank you for consideration of our comments.

Sincerely,



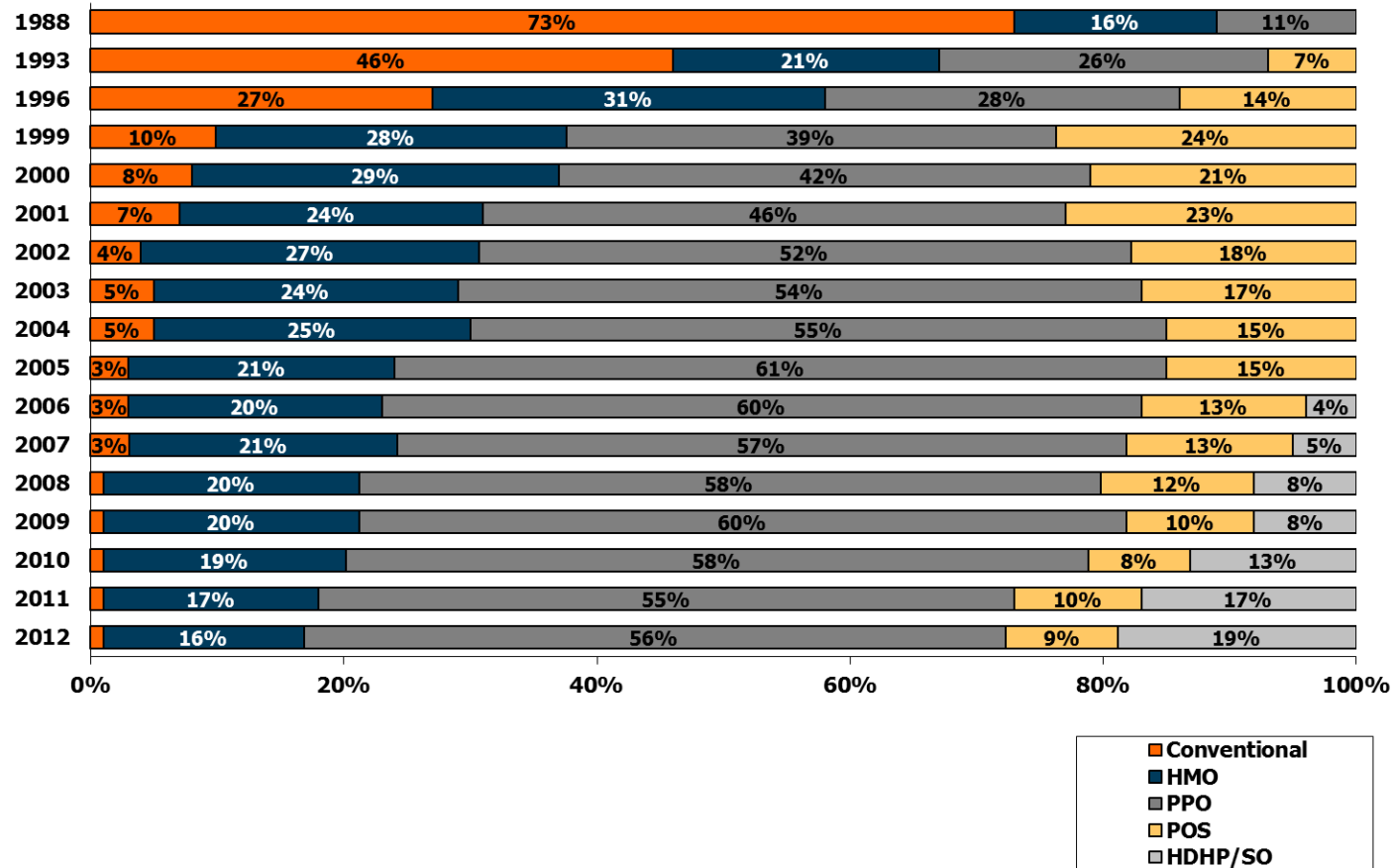
Scot E. Whitaker
President



Art Kaufman
Legislative Chair

APPENDIX G: PRIVATE HEALTH PLAN ENROLLMENT (1988 – 2012)

Distribution of Health Plan Enrollment for Covered Workers (by Plan Type), 1988 – 2012



(Source: Kaiser Family Foundation/Health Research & Educational Trust, 2012 Employer Benefits Health Survey, Exhibit 5.1 (2012), available at <http://ehbs.kff.org/pdf/2012/8345.pdf>)

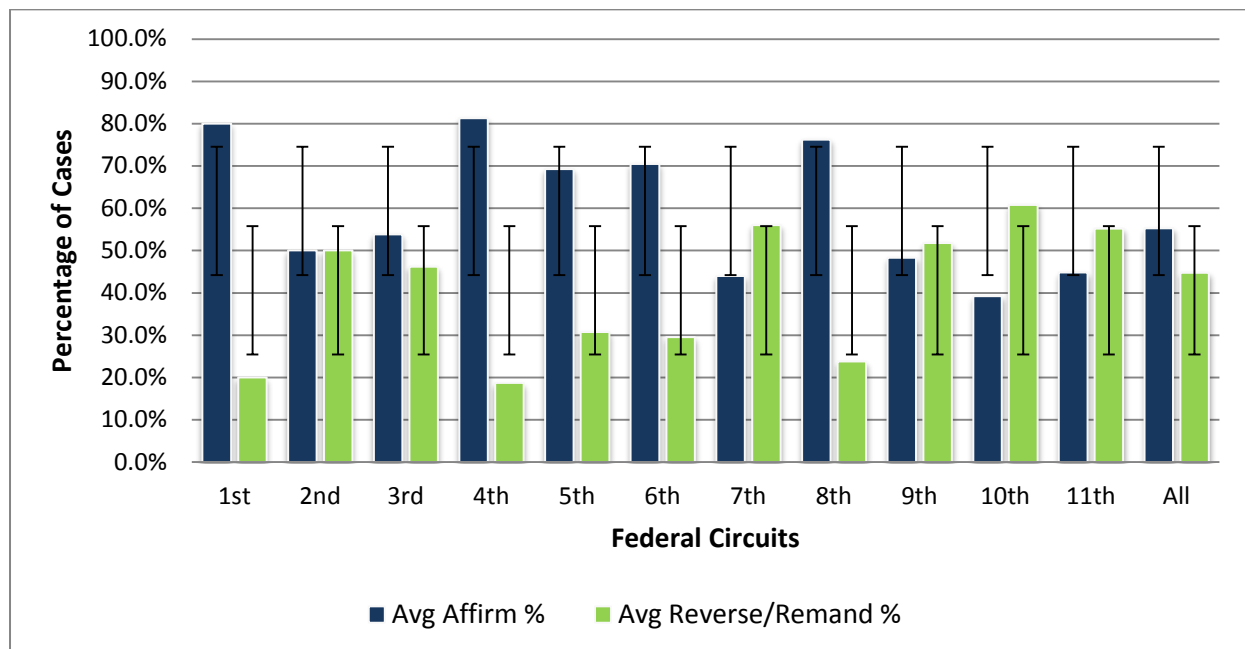
APPENDIX H: FEDERAL JUDICIAL APPLICATION OF SSR-06-03P (2009 – 12)

To empirically assess the impact of SSR 06-03p on SSA disability adjudications, staff from the Administrative Conference reviewed the outcomes of all federal district court cases published in the LEXIS database from 2009 to 2012 that involved (a) application of this (b) to opinions of other evidence offered by nurse practitioners, physician assistants, or licensed clinical social workers. The database of cases was compiled by using the following search string:

"SSR 06-03p" and "other source" and ("nurse practitioner" or nurse or "physician's assistant" or "physician assistant" or "social worker" or LCSW or MSW or NP) and (remand! or reverse! or affirm! or vacate! or deny or denied or grant! or award! or recommend!) and ("district judge" or "magistrate judge" or "chief judge" or "district court judge") and date(geq (01/01/2009) and leq (12/31/2012))

In all, the database included 606 district court cases from every federal circuit, except the District of Columbia (which had no relevant published decisions during these three years). Each case was reviewed to determine its outcome (*i.e.*, affirmance, remand, or reversal). The results of this analysis are presented in Tables 13 and 14 below.

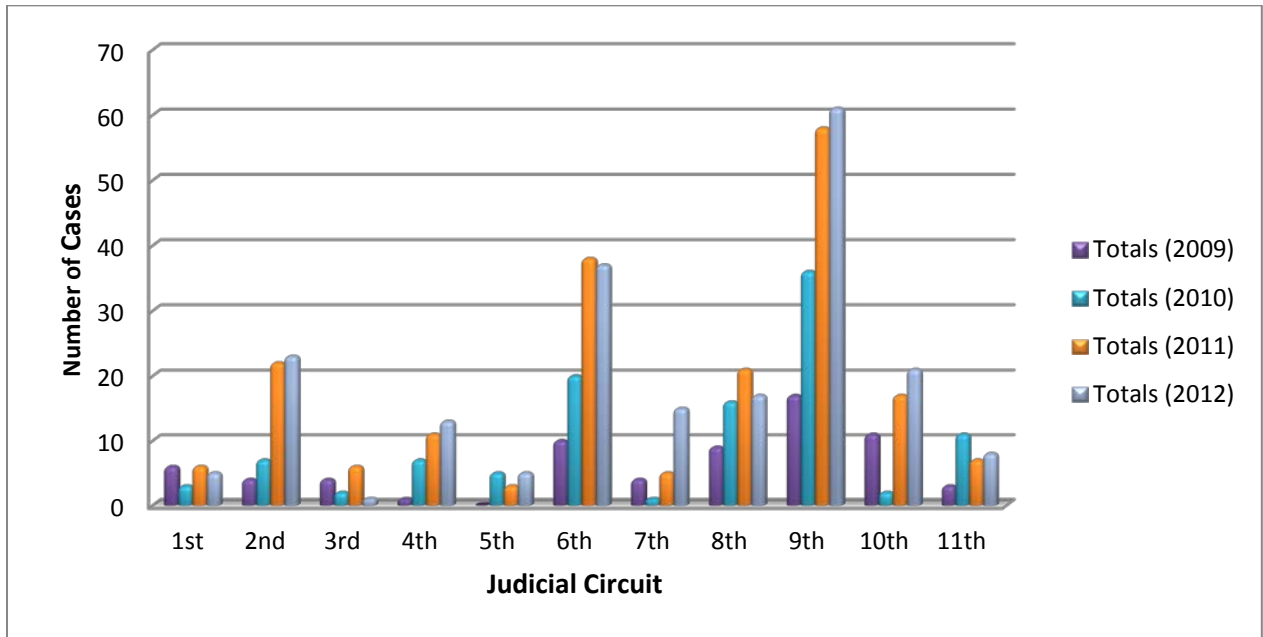
Table 13: Outcomes of District Court Cases Applying SSR 06-03p, By Circuit (2009-12)



(Note: Vertical bars indicate one standard deviation.)

APPENDIX H: FEDERAL JUDICIAL APPLICATION OF SSR-06-03P (CON'T)

Table 14: Annual Number of District Court Cases Applying SSR 06-03p, By Circuit (2009-12)



APPENDIX I: SUMMARY OF STATE STANDARDS FOR NPs, PAs, & LCSWs

The tables in this appendix were developed using publicly available information posted on the Internet by relevant professional organizations and secondary sources listed below:

RESOURCES

NURSE PRACTITIONERS

Professional/Educational Organizations

- American Association of Nurse Practitioners (www.aanp.org)
- National Nursing Centers Consortium (www.nncc.us)
- American Nurses Credentialing Center (www.nursecredentialing.org)
- National Council of State Boards of Nursing (www.ncsbn.org)
- American Association of Colleges of Nursing (www.aacn.edu)
- American Nurses Credentialing Center (www.nursecredentialing.org)

Secondary Sources (Reports/Articles/Studies)

- Institute of Medicine, National Academy of Science, *The Future of Nursing: Leading Change, Advancing Health* (2011)
- Kaiser Family Foundation, *Nurse Practitioner Prescribing Authority and Physician Supervision Requirements for Diagnosis and Treatment* (2011) (<http://www.statehealthfacts.org>)
- Kaiser Commission on Medicaid and the Uninsured, *Improving Access to Adult Primary Care in Medicaid: Exploring the Potential Role of Nurse Practitioners and Physicians Assistants* (2011)
- National Health Policy Forum, *Tapping the Potential of the Health Care Workforce: Scope-of-Practice and Payment Policies for Advanced Practice Nurses and Physicians Assistants* (Background Paper No. 76) (July 2010)
- Ann Ritter and Tine Hansen-Turton, *The Primary Care Paradigm Shift*, 20 *Health Lawyer* 21 (April 2008)
- Center for Health Professions, Univ. of Calif., San Francisco, *Overview of Nurse Practitioner Scopes of Practice in the United States* (2007)

PHYSICIAN ASSISTANTS

Professional Organizations

- American Academy of Physician Assistants (www.aapa.org)
- National Commission on Certification of Physician Assistants (www.nccpa.net)
- Association of Family Practice Physicians Assistants (www.afppa.org)
- Accreditation Review Commission on Education for the Physician Assistant (www.arc-pa.org)

Secondary Sources (Reports/Articles/Studies)

- National Health Policy Forum, *Tapping the Potential of the Health Care Workforce: Scope-of-Practice and Payment Policies for Advanced Practice Nurses and Physicians Assistants* (Background Paper No. 76) (July 2010)

LICENSED CLINICAL SOCIAL WORKERS

Professional Organizations

- Association of Social Work Boards (www.aswb.org)
- National Association of Social Workers (www.naswdc.org)

APPENDIX I: SUMMARY OF STATE STANDARDS FOR NPs, PAs, & LCSWs (CON'T)

Table 15: State Licensing Standards for NPs, PAs, and LCSWs

	Education	Clinical Requirements	Examination	Continuing Education & Renewal/Recertification
NP	Post-Graduate Nursing Degree from Accredited Program (Master's degree, Post-Master's certificate, or DNP) [50 states & DC]	500 hrs of clinical practice [50 states & DC]	National Exam [50 states & DC]	CE: Professional development requirements <u>and</u> 5,000 practice hrs <i>or</i> renewal exam Renewal: Every 5 yrs [50 states & DC]
PA	Graduation from Accredited PA Program ^a [50 states & DC]	2,000 hrs of clinical rotations [50 states & DC]	National Exam (PANCE) [50 states & DC]	CE: 100 hours every 2 yrs Renewal: Every 6 yrs [50 states & DC]
LCSW	Post-Graduate Social Work Degree (MSW or PhD) [50 states & DC, USVI, PR]	2 - 4 years of supervised post-graduate clinical practice [50 states & DC, USVI, PR] ^b	National Exam (Clinical or Advanced Generalist) [49 states & DC, USVI, PR] State Exam (CA) ^c	CE: 20 - 40 hours (avg.) [47 states & DC, USVI, PR] Renewal: Every 1-3 yrs [50 states & DC, USVI, PR]

^a There are currently 170 accredited PA programs nationally. Most PA programs award some form of master's degree (*e.g.*, Master of Science in Medicine ("MMSc"), Master of Physician Assistant Studies ("MPAS"), Master of Health Science ("MHS"), or Master of Clinical Medical Science). PA education is modeled on the medical school curriculum, with an average length of 27 months. *See* <http://www.aapa.org>; http://arc-pa.org/acc_programs/. Some states also impose additional educational requirements for licensure. *See* https://www.aapa.org/uploadedFiles/content/Your_PA_Career/Licensing_and_Certification/Resource_Items/Requirements%20for%20Licensure%20Summary%20Chart_%2011-22-11.pdf.

^b Colorado requires two years supervised post-graduate clinical experience for certification as an Advanced-Generalist LCSW, and one year of such clinical experience for Clinical certification.

^c Currently, in California, clinical social workers must pass written and clinical vignette examinations administered by the state Board of Behavioral Services for licensure. However, recent legislation modified the state-administered examinations. As of January 1, 2014, the state-administered examinations for LCSWs will consist of a separate law and ethics examination (to be taken while the LCSW candidate during his or her supervised clinical work experience) and a clinical examination (to be taken after completion of all supervised work experience). *See* http://www.bbs.ca.gov/bd_activity/legarchive_12.shtml (last visited Feb. 1, 2013).

APPENDIX I: SUMMARY OF STATE STANDARDS FOR NPs, PAs, & LCSWs (CON'T)

Table 16: State Scope of Practice Standards for NPs

	Independent Practice Permitted?	Oversight Requirements	Practice Authorities (Diagnosis & Treatment)	Prescriptive Authority
NP	Yes [18 states & DC] ^a	None	Take medical histories and conduct physical examinations; diagnose and treat illnesses; order and interpret tests; make referrals to other health care providers; counsel on preventive health care ^b	Yes
	No [8 states]	Prescription oversight only (9 states) ^c		Yes
	No [24 states]	Oversight by physician or other specified medical professional via collaboration, delegation, or supervision; typically need not be on-site (e.g., telephone or email availability, review of specified percentage of charts) (24 states) ^d		Yes

^a States that permit NPs to practice autonomously without protocols for supervision or collaboration with a physician or other medical professional are: AK, AZ, CO, HI, ID, IA, ME, MD, MT, ND, NH, NM, OR, RI, UT, VT, WA, WY, and the District of Columbia. See Kaiser Family Foundation, Nurse Practitioner Prescribing Authority and Physician Supervision Requirements for Diagnosis and Treatment (2011), available at <http://www.statehealthfacts.org/comparetable.jsp?ind=890&cat=8&sub=103&yr=200&typ=5&rgnhl=41#notes-1>; AANP, 2013 Nurse Practitioner State Practice Environment, <http://www.aanp.org/legislation-regulation/state-practice-environment> (last visited Feb. 1, 2013); NNCC, NNCC's State-by-State Guide to Regulations Regarding Nurse Practitioner and Physician Practice, <http://www.nncc.us/site/images/pdf/final%20-%20nncc%20guide%20to%20np%20practice%20regulations%2010-2011.pdf> (last visited Feb. 1, 2013); see also National Council of State Boards of Nursing, Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education, NCSBN's APRN Campaign for Consensus: State Progress toward Uniformity, <https://www.ncsbn.org/2567.htm> (last visited Feb. 1, 2013) (maps of implementation status of 2008 APRN model rules).

^b These are the NP practice authorities relating to diagnosis and treatment for the vast majority of states. For nuances in particular states, see, e.g., AANP & NNCC websites listed above. See *supra* note a.

^c NP prescription oversight required in AR, KY, MA, MI, NJ, OK, TN, and WV. See *id.*

^d These states are: AL, CA, CO, DE, FL, GA, IL, IN, KA, LA, MN, MS, MO, NE, NV, NY, NC, OH, PA, SC, SD, TX, and VA. With a few exceptions, (*i.e.*, CT, IN, MN, and PA), these states also require some form of written agreement. See *id.* Only 7 states require on-site physician oversight or supervision, and, even in these states, the on-site presence is minimal (*e.g.*, once per month, 10% of NP's practice time). See Ann Ritter and Tine Hansen-Turton, The Primary Care Paradigm Shift, 20 HEALTH LAWYER 21, 25 & Tbl.1 (April 2008).

APPENDIX I: SUMMARY OF STATE STANDARDS FOR NPs, PAs, & LCSWs (CON'T)

Table 17: State Scope of Practice Standards for PAs & LCSWs

	Independent Practice Permitted?	Oversight Requirements	Practice Authorities (Diagnosis & Treatment)	Prescriptive Authority
PA	No	Oversight required by physician or other specified medical professional (such as osteopath), but supervision/collaboration typically need not be on-site (<i>e.g.</i> , telephone or email availability, review of specified percentage of charts) ^a	Take medical histories and conduct physical examinations; diagnose and treat illnesses; order and interpret tests; assist in surgery and perform other procedures; counsel on preventive health care; make rounds in hospitals and nursing homes ^b	Yes [50 states & DC, Guam, NMI]
LCSW	Yes ^c	No	Assess, diagnose, and treat of mental, emotional, cognitive, behavioral, and psychiatric disorders; provision of psychotherapy or counseling services; crisis intervention; case management [50 states & DC, USVI, PR]	No

^a For a summary of the state laws and regulations governing physician assistants' scope of practice, see http://www.aapa.org/the_pa_profession/federal_and_state_affairs/resources/item.aspx?id=755. A typical scope of practice standard provides, for example: "Practice by PAs means performance, in collaboration with licensed physician or osteopath, of acts of medical diagnosis and treatment, prescription, preventive health care and other functions authorized by the Board of Medicine." D.C. CODE ANN. § 3-1201.02(13).

^b Some states also require written documentation of PA's scope of practice outlining his or her role within a particular medical practice. For example, under Vermont law "[t] is obligation of each PA/supervising physician team to insure that written scope of practice submitted to board for approval clearly delineates role of PA in medical practice." 13-141-001 VT. CODE R. §5.1.

^c While the vast majority of state regulations use the term "licensed clinical social workers," a handful of states use other references, such as "licensed certified social worker" or "licensed master clinical social worker-master." See <https://www.datapathdesign.com/ASWB/Laws/Prod/cgi-bin/LawWebRpts2DLL.dll/EXEC/1/0f7wpke0xq6rjw1agtd0r08knxtg>. Additionally, some states impose additional licensing, continuing education, or other requirements for independent clinical social work practice. *Id.*