coordinating the United States (U.S.) and Australian social security programs entered into force on October 1, 2002. The agreement with Australia, which was signed on September 27, 2001, is similar to U.S. social security agreements already in force with 19 other countries—Austria, Belgium, Canada, Chile, Finland, France, Germany, Greece, Ireland, Italy, Korea (South), Luxembourg, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, and the United Kingdom. Agreements of this type are authorized by section 233 of the Social Security Act.

The U.S.-Australian agreement eliminates dual coverage and contributions under the U.S. Social Security program and the Australian program of mandatory employer retirement contributions known as ''Superannuation Guarantee.'' U.S. companies that employ U.S. citizens or residents in Australia have frequently been required to pay contributions with respect to the employees' wages under both the U.S. Social Security program and Australia's Superannuation Guarantee program. Australian companies with Australian employees working in the United States have frequently faced the same dual contribution obligation. Under the U.S.-Australian agreement, workers are covered under one program or the other, but not both, and contributions are only due under that one program. A worker who is sent by an employer in one country to work in the other country for 5 years or less remains covered only by the program of the sending country. The agreement includes additional rules that eliminate dual U.S. and Australian coverage in other work situations.

The agreement also helps eliminate situations where workers suffer a loss of benefit rights under the social security system of one or both countries because they have divided their careers between the two countries. Under the agreement, workers may qualify for partial social security benefits from each country based on combined credits from both countries.

Individuals who wish to obtain copies of the agreement or want more information about its provisions may write to the Social Security Administration, Office of International Programs, Post Office Box 17741, Baltimore, MD 21235–7741 or visit the Social Security Web site at *www.ssa.gov/international*.

Dated: October 28, 2002.

Jo Anne B. Barnhart,

Commissioner of Social Security.

[FR Doc. 02–28027 Filed 11–4–02; 8:45 am]

BILLING CODE 4191–02–P

SOCIAL SECURITY ADMINISTRATION

Social Security Ruling, SSR 02–2p; Titles II and XVI: Evaluation of Interstitial Cystitis

AGENCY: Social Security Administration.

ACTION: Notice of Social Security Ruling.

SUMMARY: In accordance with 20 CFR 402.35(b)(1), the Commissioner of Social Security gives notice of Social Security Ruling, SSR 02–2p. This Ruling clarifies the policies of the Social Security Administration for developing and evaluating title II and title XVI claims for disability on the basis of Interstitial Cystitis (IC). IC is a complex, chronic bladder disorder characterized by urinary frequency, urinary urgency, and pelvic pain.

EFFECTIVE DATE: November 5, 2002.

FOR FURTHER INFORMATION CONTACT: Carolyn Kiefer, Office of Disability, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235–6401, (410) 965–9104. For information on eligibility or filing for benefits, call our national toll-free number 1–800–772–1213 or TTY 1–800–325–0778, or visit our Internet web site, Social Security Online, at *http://www.ssa.gov.*

SUPPLEMENTARY INFORMATION: Although we are not required to do so pursuant to 5 U.S.C. 552(a)(1) and (a)(2), we are publishing this Social Security Ruling in accordance with 20 CFR 402.35(b)(1).

Social Security Rulings make available to the public precedential decisions relating to the Federal old-age, survivors, disability, supplemental security income, and black lung benefits programs. Social Security Rulings may be based on case decisions made at all administrative levels of adjudication, Federal court decisions, Commissioner's decisions, opinions of the Office of General Counsel, and policy interpretations of the law and regulations.

Although Social Security Rulings do not have the same force and effect as the statute or regulations, they are binding on all components of the Social Security Administration, in accordance with 20 CFR 402.35(b)(1), and are relied upon as precedents in adjudicating cases.

If this Social Security Ruling is later superseded, modified, or rescinded, we will publish a notice in the **Federal Register** to that effect.

(Catalog of Federal Domestic Assistance, Programs 96.001 Social Security—Disability Insurance; 96.006 Supplemental Security Income.)

Dated: October 25, 2002.

Jo Anne B. Barnhart,

Commissioner of Social Security.

Policy Interpretation Ruling

Titles II and XVI: Evaluation of Interstitial Cystitis

Purpose: To provide guidance on SSA policy concerning the development and evaluation of interstitial cystitis (IC) in disability claims filed under titles II and XVI of the Social Security Act (the Act).

Citations: Sections 216(i), 223(d), 223(f), 1614(a), and 1614(c) of the Act, as amended; Regulations No. 4, subpart P, sections 404.1502, 404.1505, 404.1508, 404.1509, 404.1511, 404.1512, 404.1513, 404.1520, 404.1520a, 404.1521, 404.1523, 404.1525, 404.1526, 404.1528, 404.1529, 404.1530, 404.1545, 404.1546, 404.1561, 404.1594, and appendix 1; and Regulations No. 16, subpart I, sections 416.902, 416.905, 416.906, 416.908, 416.909, 416.911, 416.912, 416.913, 416.920, 416.920a, 416.921, 416.923, 416.924, 416.925, 416.926, 416.926a, 416.928, 416.929, 416.930, 416.945, 416.946, 416.961, 416.994, and 416.994a.

Introduction: The Act and our implementing regulations require that an individual establish disability based on the existence of a medically determinable impairment; that is, one that can be shown by medical evidence, consisting of symptoms, signs, and laboratory findings. Disability may not be established on the basis of an individual's statement of symptoms alone.

This Ruling explains that IC (a complex, chronic bladder disorder), when accompanied by appropriate symptoms, signs, and laboratory findings, is a medically determinable impairment that can be the basis for a finding of ''disability.'' It also provides guidance for the evaluation of claims involving IC.

Policy Interpretation

General

1. What Is IC?

IC is a complex, chronic bladder disorder characterized by urinary frequency, urinary urgency, and pelvic pain. IC occurs most frequently in women (about 10 times more often than in men), and sometimes prior to age 18. IC may be associated with other disorders, such as fibromyalgia, chronic fatigue syndrome, allergies, irritable bowel syndrome, inflammatory bowel

disease, endometriosis, and vulvodynia (vulvar/vaginal pain). IC also may be associated with systemic lupus erythematosus.

The symptoms of IC may vary in incidence, duration, and severity. The causes of IC are currently unknown, and treatments are directed towards relief of symptoms. While no treatment is uniformly effective for everyone, there are many treatments available, and individuals may obtain some measure of relief. However, response to treatment is variable, and some individuals may have symptoms that are intractable to the current treatments available. Treatment may include bladder distention; bladder instillation; oral drugs, such as the prescription drug Elmiron, antidepressants, antihistamines, and narcotic analgesics; and the use of transcutaneous electrical nerve stimulation.

2. How Is IC Diagnosed?

The diagnosis is one of exclusion. A physician must rule out other conditions before making a diagnosis of IC because there is currently no definitive test to identify IC. The symptoms of IC are similar to those of other disorders, such as acute urinary tract or vaginal infections, post-radiation bladder inflammation or infection, bladder cancer, kidney stones, endometriosis, neurological disorders, sexually transmitted diseases, and, in men, chronic bacterial and nonbacterial prostatitis.

Symptoms of IC vary both in kind and in intensity from individual to individual, and even in the same individual. The three most common symptoms are an urgent need to urinate (urgency), a frequent need to urinate (frequency), and pain in the bladder and surrounding pelvic region. These symptoms may occur either singly or in combination. The pain may range from mild discomfort to extreme distress. The intensity of the pain may increase as the bladder fills, and decrease as it empties. In addition, many patients experience vaginal, testicular or penile pain, or low back and thigh pain. A woman's symptoms may worsen around the time of menstruation.

A diagnosis of IC is based on the presence of some or all of the following:

- Presence of urinary urgency or frequency (day and/or night), either singly or in combination;
- Pain in the bladder and surrounding pelvic region;
- Suprapubic tenderness on physical examination;
- Glomerulations (pinpoint bleeding caused by recurrent irritation) on the bladder wall after hydrodistention on cystoscopy;
- Hunner's ulcers on the bladder wall after hydrodistention on cystoscopy; and,
- Absence of other disorders that could cause the symptoms.

Diagnostic tests used to identify or exclude other disorders include urinalysis, urine culture, urine cytology, cystoscopy, biopsy of the bladder wall, and, in men, culture of prostate secretions.

The standard test currently used to aid in the diagnosis of IC is a cystoscopy with hydrodistention of the bladder (performed under anesthesia). It can be used to reveal glomerulations or Hunner's ulcers. A biopsy of the bladder wall can be taken to rule out diseases such as bladder cancer. Cystoscopy with hydrodistention also makes it possible to estimate bladder capacity, which is an important guide to treatment. The hydrodistention of the bladder itself also sometimes provides a therapeutic benefit, with a reduction in pain and urinary frequency for a limited time period. A report on the results of a cystoscopy, if done, should be part of the medical record. An absence of glomerulations or Hunner's ulcers on cystoscopy does not exclude a diagnosis of IC; a minority of individuals with IC (10%) will not have either of these medical signs. Cystoscopy should not be purchased to establish a diagnosis of IC because it is an invasive procedure.

While the medical findings discussed above are the principal symptoms, signs, and laboratory findings currently used to establish a diagnosis of IC, and, consequently, the existence of a medically determinable impairment, they are not all-inclusive. As progress is made in medical research into IC, additional signs and laboratory findings may be identified and new diagnostic techniques may be developed that also would establish a diagnosis of IC. The existence of IC may be documented with medical signs or laboratory findings other than those listed above, provided that such documentation is consistent with medically accepted clinical practice and is consistent with the other evidence in the case record.

3. What Is a Medically Determinable Impairment?

Sections 216(i) and 1614(a)(3) of the Act define ''disability'' [1] as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment (or combination of impairments) 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.[2]

Sections 223(d)(3) and 1614(a)(3)(D) of the Act and 20 CFR 404.1508 and 416.908 require that an impairment result from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques. The Act and regulations further require that an impairment be established by medical evidence that consists of symptoms, signs, and laboratory findings, and not only by an individual's statement of symptoms.

4. How Is IC Identified as a Medically Determinable Impairment?

We [3] generally will rely on the judgment of a physician who has made the diagnosis after a review of the claimant's medical history, a physical examination of the claimant, and any pertinent testing to establish the existence of IC. In the absence of evidence to the contrary in the case record, we will find a medically determinable impairment is established if the evidence contains the appropriate symptoms, signs, and laboratory findings, as discussed under question 2 above. However, if there is evidence that indicates that the diagnosis is questionable, and the evidence is inadequate to determine whether or not the individual is disabled, we will contact the treating source for clarification, using the guidelines in 20 CFR 404.1512(e) and 416.912(e).

5. How Do We Consider IC in the Sequential Evaluation Process? [4]

Once we determine that the individual has the medically

[1] Except for statutory blindness.

[2] For a child under age 18 claiming benefits under title XVI, disability will be established if the child is suffering from a medically determinable physical or mental impairment (or combination of impairments) that results in ''marked and severe functional limitations.'' *See* section 1614(a)(3)(C) of the Act and 20 CFR 416.906. However, for clarity, the following discussions refer only to claims of individuals claiming disability benefits under title II and individuals age 18 or older claiming disability benefits under title XVI. The concepts in this ruling, however, are also intended to apply in determining disability based on IC for individuals under age 18 under title XVI.

[3] The terms *we* and *us* in this Social Security Ruling have the same meaning as in 20 CFR 404.1502 and 416.902. *We* or *us* refers to either the Social Security Administration or the State agency making the disability or blindness determination; *i.e.*, our adjudicators at all levels of the administrative review process and our quality reviewers.

[4] For ease of reading, we refer in this Ruling only to the steps of the sequential evaluation processes for initial adult claims, 20 CFR 404.1520 and 416.920. We use separate sequential evaluation processes when we do continuing disability

Continued

determinable impairment IC, we will consider it in determining whether:

- The individual's impairment(s) is severe.
- The individual's impairment(s) meets or equals the requirements of a listed impairment in the listings.
- The individual's impairment(s) prevents him or her from doing past relevant work and other work that exists in significant numbers in the national economy.

6. Can We Find an Individual Disabled Based on IC Alone?

If an individual has the medically determinable impairment IC that is ''severe'' as described in question 7 below, we may find that the IC medically equals a listing, if appropriate. (*See* 20 CFR 404.1525 and 416.925.) (In the case of a child seeking benefits under title XVI, we also may find that it functionally equals the listings (20 CFR 416.926a).) We also may find in a title II claim, or an adult claim under title XVI, that the IC results in a finding that the individual is disabled based on his or her residual functional capacity (RFC), age, education, and past work experience.

An individual with IC also may report symptoms suggestive of a mental impairment (for example, the individual may say that he or she is anxious or depressed, having difficulties with memory and concentration, *etc.*). If the evidence supports a possible discrete mental impairment or symptoms such as anxiety or depression resulting from the individual's IC or the side effects of medication, we will develop the possible mental impairment. If the evidence does not establish a medically determinable mental impairment, but does establish the presence of symptoms such as anxiety or depression resulting from the individual's IC or side effects of medication, we will determine whether there are any work-related functional limitations resulting from the symptoms. We will address any work-related functional limitations at steps 4 and 5 of the sequential evaluation process.

Sequential Evaluation: Step 2, Severe Impairment

7. When Is IC a ''Severe'' Impairment?

As with any other medical condition, we will find that IC is a ''severe'' impairment when, alone or in combination with another medically determinable physical or mental impairment(s), it significantly limits an individual's physical or mental ability to do basic work activities. (For children applying for disability under title XVI, we will find that IC is a ''severe'' impairment when it causes more than minimal functional limitations.) We also will consider the effects of any symptoms (such as pain or fatigue) that could limit functioning. (*See* SSR 85–28, ''Titles II and XVI: Medical Impairments That Are Not Severe'' and SSR 96–3p, ''Titles II and XVI: Considering Allegations of Pain and Other Symptoms In Determining Whether a Medically Determinable Impairment Is Severe.'') Therefore, we will find that an impairment(s) is ''not severe'' only if it is a slight abnormality (or a combination of slight abnormalities) that has no more than a minimal effect on the individual's ability to do basic work activities (or, for a child applying under title XVI, if it causes no more than minimal functional limitations).

Sequential Evaluation: Step 3, the Listings

8. How Do We Evaluate IC at Step 3 of Sequential Evaluation, the Listings?

IC may be a factor in both ''meets'' and ''equals'' determinations.

Because there is no listing for IC, we will find that an individual with IC ''meets'' the requirements of a listing if he or she has another impairment that, by itself, meets the requirements of a listing. We also will find that a listing is met if there is an impairment that, in combination with IC, meets the requirements of a listing. For example, IC may increase the severity of coexisting or related impairments, including mental disorders, to the extent that the combination of impairments meets the requirements of a listing. This also may be true in the reverse; coexisting or related impairments may increase the severity of IC.

We also may find that IC, by itself, is medically equivalent to a listed impairment (or, in the case of a child applying under title XVI, also functionally equivalent to the listings).

We also will find equivalence if an individual has multiple impairments, including IC, no one of which meets or equals the requirements of a listing, but the combination of impairments is equivalent in severity to a listed impairment.

However, we will not make assumptions about the severity or functional effects of IC combined with other impairments. IC in combination with another impairment may or may not increase the severity or functional limitations of the other impairment. We will evaluate each case based on the information in the case record.

Further, we will never deny an individual's claim because the individual's IC does not meet or medically equal a listing. If an individual with IC has a severe impairment that does not meet or medically equal a listing, we may still find the individual disabled based on other rules in the ''sequential evaluation process'' that we use to evaluate all disability claims.

Sequential Evaluation: Steps 4 and 5, Assessing Functioning in Adults; Step 3, Assessing Functional Equivalence in Children

9. How Do We Evaluate IC in Assessing Residual Functional Capacity (RFC) in Adults and Functional Equivalence in Children?

IC can cause limitation of function. The functions likely to be limited depend on many factors, including urinary frequency and pain. An individual may have limitations in any of the exertional functions such as sitting, standing, walking, lifting, carrying, pushing, and pulling. It also may affect ability to do postural functions, such as climbing, balancing, stooping, and crouching. The ability to tolerate extreme heat, humidity, or hazards also may be affected.

The effects of IC may not be obvious. For example, many people with IC have chronic pelvic pain, which can affect the ability to focus and sustain attention on the task at hand. Nocturia (nighttime urinary frequency) may disrupt sleeping patterns. This can lead to drowsiness and lack of mental clarity during the day. IC also may affect an individual's social functioning. The presence of urinary frequency alone can necessitate trips to the bathroom as often as every 10 to 15 minutes, day and night. Consequently, some individuals with IC essentially may confine themselves to their homes. In assessing RFC, we must consider all of the individual's symptoms in deciding how such symptoms may affect functional capacities.

An assessment also should be made of the effect IC has upon the individual's ability to perform routine movement and necessary physical activity within the work environment. Individuals with IC may have problems with the ability to sustain a function over time.

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reviews; *i.e.*, reviews to determine whether individuals who are receiving disability benefits are still disabled, or when we determine whether an individual has a ''closed period of disability.'' These rules are set out in 20 CFR 404.1594 and 416.994, and the guidance in this Ruling applies to all of the appropriate steps in those regulations as well.

As explained in SSR 96–8p (''Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims''), our RFC assessments must consider an individual's *maximum* remaining ability to do sustained work activities in an ordinary work setting on a regular and continuing basis. A ''regular and continuing basis'' means 8 hours a day, for 5 days a week, or an equivalent work schedule.[5] In cases involving IC, fatigue may affect the individual's physical and mental ability to sustain work activity. This may be particularly true in cases involving urinary frequency.

For a child applying for benefits under title XVI, we will evaluate the functional consequences of IC (either alone or in combination with other impairments) to decide if the child's impairment(s) functionally equals the listings. For example, the functional limitations imposed by IC, by itself or in combination with another impairment(s), may establish an extreme limitation in one broad area of functioning (*e.g.*, attending and completing tasks) or marked limitations in two broad areas of functioning (*e.g.*, attending and completing tasks, and interacting and relating with others).

As with any other impairment, we will explain how we reached our conclusions on whether IC caused any physical or mental limitations.

EFFECTIVE DATE: This Ruling is effective November 5, 2002.

Cross-References: SSR 85–28, ''Titles II and XVI: Medical Impairments That Are Not Severe''; SSR 96–2p, ''Titles II and XVI: Giving Controlling Weight to Treating Source Medical Opinions''; SSR 96–3p, ''Titles II and XVI: Considering Allegations of Pain and Other Symptoms in Determining Whether a Medically Determinable Impairment is Severe''; SSR 96–4p, ''Titles II and XVI: Symptoms, Medically Determinable Physical and Mental Impairments, and Exertional and Nonexertional Limitations''; SSR 96–5p, ''Titles II and XVI: Medical Source Opinions on Issues Reserved to the Commissioner''; SSR 96–6p, ''Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence''; SSR 96–7p, ''Titles II and XVI: Evaluation of Symptoms in Disability Claims: Assessing the Credibility of an Individual's Statements''; SSR 96–8p, ''Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims''; and SSR 96–9p, ''Titles II and XVI: Determining Capability to Do Other Work—Implications of a Residual Functional Capacity for Less Than a Full Range of Sedentary Work.''

[FR Doc. 02–28057 Filed 11–4–02; 8:45 am]

BILLING CODE 4191–02–P

[5] However, *see* footnote 2 of SSR 96–8p. That footnote explains that the ability to work 8 hours a day for 5 days a week is not always required for a finding at step 4 of the sequential evaluation process for adults when an individual can do past relevant work that was part-time work, if that work was substantial gainful activity, performed within the applicable period, and lasted long enough for the person to learn to do it.

DEPARTMENT OF STATE

[Public Notice 4159]

Renewal of the Overseas Schools Advisory Council

The Department of State is renewing the Overseas Schools Advisory Council to provide a formal channel for regular consultation and advice from U.S. corporations and foundations regarding American-sponsored overseas schools. The Under Secretary for Management has determined that the committee is necessary and in the public interest.

Members of the committee will be appointed by the Assistant Secretary for Administration. The committee will follow the procedures prescribed by the Federal Advisory Committee Act (FACA). Meetings will be open to the public unless a determination is made in accordance with the FACA section 10(d) and 5 U.S.C. 552b(c) (1) and (4) that a meeting or a portion of the meeting should be closed to the public. Notice of each meeting will be provided in the **Federal Register** at least 15 days prior to the meeting date.

For further information, contact Dr. Keith D. Miller, Executive Secretary of the committee at 202–261–8200.

Dated: October 30, 2002.

Keith D. Miller,

Executive Secretary, Overseas Schools Advisory Council, Department of State.

[FR Doc. 02–28088 Filed 11–4–02; 8:45 am]

BILLING CODE 4710–24–P

OFFICE OF THE UNITED STATES TRADE REPRESENTATIVE

Determinations Under the African Growth and Opportunity Act: Correction

AGENCY: Office of the United States Trade Representative.

ACTION: Correction.

Correction to Previous Notice

In the **Federal Register** of October 23, 2002, Volume 67, Page 65169, the Office of the United States Trade Representative published a notice entitled ''Determinations Under the African Growth and Opportunity Act.'' A correction is being made to the information that appeared under **SUPPLEMENTARY INFORMATION**. The reference to Presidential Proclamation 7360 of October 2, 2000 was incorrect. The correct citation is Presidential Proclamation 7350 of October 2, 2000.

Rosa M. Whitaker,

Assistant United States Trade Representative for Africa, Office of the United States Trade Representative.

[FR Doc. 02–28063 Filed 11–4–02; 8:45 am]

BILLING CODE 3190–01–M

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

Aviation Proceedings, Agreements Filed During the Week Ending October 25, 2002

The following Agreements were filed with the Department of Transportation under the provisions of 49 U.S.C. Sections 412 and 414. Answers may be filed within 21 days after the filing of the application.

Docket Number: OST–2002–13631.
Date Filed: October 22, 2002.
Parties: Members of the International Air Transport Association.
Subject:
PTC23 AFR–TC3 0184 dated 22 October 2002.
Mail Vote 247—TC23/TC123 Africa-South East Asia.
Special Passenger Amending Resolution 010e r1–r2.
PTC23 AFR–TC3 0185 dated 22 October 2002.
Mail Vote 248—TC23/TC123 Africa-Japan/Korea.
Special Passenger Amending Resolution 010f r3–r13.
Intended effective date: 15 November 2002.

Docket Number: OST–2002–13681.
Date Filed: October 23, 2002.
Parties: Members of the International Air Transport Association.
Subject:
Mail Vote 239.
PTC123 0201 dated 16 September 2002 r1–r18.
PTC123 0210 dated 11 October 2002 (Affirmative).
Minutes—PTC123 0217 dated 22 October 2002.
Tables—PTC123 Fares 0072 dated 11