impairment-related symptom that determines whether the impact of the symptom is exertional, nonexertional, or both.

4. The application of the medical-vocational rules in appendix 2 of subpart P of Regulations No. 4 depends on the nature of the limitations and restrictions imposed by an individual's medically determinable physical or mental impairment(s), and any related symptoms.

Citations (Authority): Sections 216(i), 223(d) and 1614(a)(3) of the Social Security Act, as amended; Regulations No. 4, sections 404.1505, 404.1508, 404.1520, 404.1528(a), 404.1529, 404.1569a and subpart P, appendix 2; and Regulations No. 16, sections 416.905, 416.908, 416.920, 416.924, 416.928(a), 416.929 and 416.969a.

Policy Interpretation

Need To Establish the Existence of a Medically Determinable Physical or Mental Impairment

The Act defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment that 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.[1] An ''impairment'' must result from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques. Although the regulations provide that the existence of a medically determinable physical or mental impairment must be established by medical evidence consisting of signs, symptoms,[2] and laboratory findings, the regulations further provide that under no circumstances may the existence of an impairment be established on the basis of symptoms alone. Thus, regardless of how many symptoms an individual alleges, or how genuine the individual's complaints may appear to be, the existence of a medically determinable physical or mental impairment cannot be established in the absence of objective medical abnormalities; i.e., medical signs and laboratory findings.

No symptom or combination of symptoms by itself can constitute a medically determinable impairment. In claims in which there are no medical signs or laboratory findings to substantiate the existence of a medically determinable physical or mental impairment, the individual must be found not disabled at step 2 of the sequential evaluation process set out in 20 CFR 404.1520 and 416.920 (or, for an individual under age 18 claiming disability benefits under title XVI, 20 CFR 416.924).

In addition, 20 CFR 404.1529 and 416.929 provide that an individual's symptoms, such as pain, fatigue, shortness of breath, weakness, or nervousness, will not be found to affect the individual's ability to do basic work activities (or, for an individual under age 18 claiming disability benefits under title XVI, to function independently, appropriately, and effectively in an age-appropriate manner) unless medical signs and laboratory findings show that there is a medically determinable physical or mental impairment(s) that could reasonably be expected to produce the symptom(s) alleged.

Exertional and Nonexertional Limitations

Once the existence of a medically determinable physical or mental impairment(s) that could reasonably be expected to produce the pain or other symptoms alleged has been established on the basis of medical signs and laboratory findings, allegations about the intensity and persistence of the symptoms must be considered with the objective medical abnormalities, and all other evidence in the case record, in evaluating the functionally limiting effects of the impairment(s). In addition, for determinations or decisions at step 5 of the sequential evaluation process for individuals claiming disability benefits under title II and individuals age 18 or older claiming disability benefits under title XVI, 20 CFR 404.1569a and 416.969a explain that an individual's impairment(s) and related symptoms, such as pain, may cause limitations of function or restrictions that limit an individual's ability to meet certain demands of jobs. These sections divide limitations or restrictions into three classifications: Exertional, nonexertional, and combined exertional and nonexertional. Exertional limitations or restrictions affect an individual's ability to meet the seven strength demands of jobs (sitting, standing, walking, lifting, carrying, pushing, and pulling), while nonexertional limitations or restrictions affect an individual's ability to meet the nonstrength demands of jobs (all physical limitations and restrictions that are not reflected in the seven strength demands, and mental limitations and restrictions). The nature of the limitations or restrictions affects whether the rules in appendix 2 to subpart P of Regulations No. 4 may be used to direct a decision or must be used as a framework for decisionmaking.

Likewise, under the regulations, symptoms in themselves are neither exertional nor nonexertional. An individual's symptoms, however, can cause limitations or restrictions that are classified as exertional, nonexertional, or a combination of both. For example, pain can result in an exertional limitation if it limits the ability to perform one of the strength activities (e.g., lifting), or a nonexertional limitation if it limits the ability to perform a nonstrength activity (e.g., fingering or concentrating). It is the nature of the limitations or restrictions resulting from the symptom (i.e., exertional, nonexertional, or both) that will determine whether the medical-vocational rules in appendix 2 may be used to direct a decision or must be used as a framework for decisionmaking. For additional discussion of this longstanding policy, see SSR 96–8p, ''Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims.''

Effective Date: This Ruling is effective on July 2, 1996.

Cross-References: SSR 96–3p, ''Titles II and XVI: Considering Allegations of Pain and Other Symptoms in Determining Whether a Medically Determinable Impairment is Severe,'' SSR 96–7p, ''Titles II and XVI: Evaluation of Symptoms in Disability Claims: Assessing the Credibility of an Individual's Statements,'' and SSR 96–8p, ''Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims;'' and Program Operations Manual System, sections DI 24501.020, DI 24515.061, and DI 24515.063.

[FR Doc. 96–16687 Filed 7–1–96; 8:45 am]
BILLING CODE 4190–29–P

[1] This definition of disability applies to individuals claiming disability benefits under title II and individuals age 18 or older claiming disability benefits under title XVI. For title XVI, an individual under age 18 will be considered disabled if he or she is suffering from a medically determinable physical or mental impairment of comparable severity to an impairment that would disable an adult.

[2] 20 CFR 404.1528, 404.1529, 416.928, and 416.929 provide that symptoms, such as pain, fatigue, shortness of breath, weakness or nervousness, are an individual's own perception or description of the impact of his or her physical or mental impairment(s). (20 CFR 416.928 further provides that, for an individual under age 18 who is unable to adequately describe his or her symptom(s), the adjudicator will accept as a statement of this symptom(s) the description given by the person most familiar with the individual, such as a parent, other relative, or guardian.) However, when any of these manifestations is an anatomical, physiological, or psychological abnormality that can be shown by medically acceptable clinical diagnostic techniques, it represents a medical ''sign'' rather than a ''symptom.''

[Social Security Ruling (SSR) 96–2p.]

Titles II and XVI: Giving Controlling Weight To Treating Source Medical Opinions

AGENCY: Social Security Administration.

ACTION: Notice of Social Security Ruling.

SUMMARY: In accordance with 20 CFR 422.406(b)(1), the Commissioner of Social Security gives notice of Social Security Ruling 96–2p. This Ruling explains terms used in the Social Security Administration regulations on evaluating medical opinions concerning when treating source medical opinions are entitled to controlling weight, and clarifies how the policy is applied.

EFFECTIVE DATE: July 2, 1996.

FOR FURTHER INFORMATION CONTACT: Joanne K. Castello, Division of Regulations and Rulings, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235, (410) 965–1711.

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 422.406(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 the General Counsel, and other policy interpretations of the law and regulations.

Although Social Security Rulings do not have the force and effect of the law or regulations, they are binding on all components of the Social Security Administration, in accordance with 20 CFR 422.406(b)(1), and are to be 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; 96.002 Social Security—Retirement Insurance; 96.004 Social Security—Survivors Insurance; 96.005 Special Benefits for Disabled Coal Miners; 96.006 Supplemental Security Income)

Dated: June 7, 1995.

Shirley S. Chater,

Commissioner of Social Security.

Policy Interpretation Ruling

Titles II and XVI: Giving Controlling Weight To Treating Source Medical Opinions

Purpose: To explain terms used in our regulations on evaluating medical opinions concerning when treating source medical opinions are entitled to controlling weight, and to clarify how the policy is applied. In particular, to emphasize that:

1. A case cannot be decided in reliance on a medical opinion without some reasonable support for the opinion.

2. Controlling weight may be given only in appropriate circumstances to medical opinions, i.e., opinions on the issue(s) of the nature and severity of an individual's impairment(s), from treating sources.

3. Controlling weight may not be given to a treating source's medical opinion unless the opinion is well-supported by medically acceptable clinical and laboratory diagnostic techniques.

4. Even if a treating source's medical opinion is well-supported, controlling weight may not be given to the opinion unless it also is ''not inconsistent'' with the other substantial evidence in the case record.

5. The judgment whether a treating source's medical opinion is well-supported and not inconsistent with the other substantial evidence in the case record requires an understanding of the clinical signs and laboratory findings and what they signify.

6. If a treating source's medical opinion is well-supported and not inconsistent with the other substantial evidence in the case record, it *must* be given controlling weight; i.e., it must be adopted.

7. A finding that a treating source's medical opinion is not entitled to controlling weight does not mean that the opinion is rejected. It may still be entitled to deference and be adopted by the adjudicator.

Citations (Authority): Sections 205(a), 216(i), 223(d), 1614(a)(3), and 1631(d) of the Social Security Act, as amended; Regulations No. 4, sections 404.1502 and 404.1527, and Regulations No. 16, sections 416.902 and 416.927.

Pertinent History: Our regulations at 20 CFR 404.1502, 404.1527, 416.902, and 416.927 were revised on August 1, 1991, to define who we consider to be a ''treating source'' and to set out detailed rules for evaluating treating source medical opinions and other opinions. Among the provisions of these rules is a special provision in 20 CFR 404.1527(d)(2) and 416.927(d)(2) that requires adjudicators to adopt treating source medical opinions (i.e., opinions on the issue(s) of the nature and severity of an individual's impairment(s)) in one narrowly defined circumstance. As we stated in the preamble to the publication of the final rules:

> The provision recognizes the deference to which a treating source's medical opinion should be entitled. It does not permit us to substitute our own judgment for the opinion of a treating source on the issue(s) of the nature and severity of an impairment when the treating source has offered a medical opinion that is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with other substantial evidence.

56 FR 36932, 36936 (1991).

Policy Interpretation: Explanation of Terms

Controlling weight. This is the term used in 20 CFR 404.1527(d)(2) and 416.927(d)(2) to describe the weight we give to a medical opinion from a treating source that must be adopted. The rule on controlling weight applies when *all* of the following are present:

1. The opinion must come from a ''treating source,'' as defined in 20 CFR 404.1502 and 416.902. Although opinions from other acceptable medical sources may be entitled to great weight, and may even be entitled to more weight than a treating source's opinion in appropriate circumstances, opinions from sources other than treating sources can never be entitled to ''controlling weight.''

2. The opinion must be a ''medical opinion.'' Under 20 CFR 404.1527(a) and 416.927(a), ''medical opinions'' are opinions about the nature and severity of an individual's impairment(s) and are the only opinions that may be entitled to controlling weight. (See SSR 96–5p, ''Titles II and XVI: Medical Source Opinions on Issues Reserved to the Commissioner.'')

3. The adjudicator must find that the treating source's medical opinion is ''well-supported'' by ''medically acceptable'' clinical and laboratory diagnostic techniques. The adjudicator cannot decide a case in reliance on a medical opinion without some reasonable support for the opinion.

4. Even if well-supported by medically acceptable clinical and laboratory diagnostic techniques, the treating source's medical opinion also must be ''not inconsistent'' with the other ''substantial evidence'' in the individual's case record.

If any of the above factors is not satisfied, a treating source's opinion cannot be entitled to controlling weight. It is an error to give an opinion controlling weight simply because it is the opinion of a treating source if it is not well-supported by medically acceptable clinical and laboratory diagnostic techniques or if it is inconsistent with the other substantial evidence in the case record. However, when all of the factors are satisfied, the adjudicator *must* adopt a treating source's medical opinion irrespective of any finding he or she would have made in the absence of the medical opinion.

For a medical opinion to be *well-supported* by medically acceptable clinical and laboratory diagnostic techniques, it is not necessary that the opinion be *fully* supported by such evidence. Whether a medical opinion is well-supported will depend on the facts of each case. It is a judgment that adjudicators must make based on the extent to which the opinion is supported by medically acceptable clinical and laboratory diagnostic techniques and requires an understanding of the clinical signs and laboratory findings in the case record and what they signify.

It is not unusual for a single treating source to provide medical opinions about several issues; for example, at least one diagnosis, a prognosis, and an opinion about what the individual can still do. Although it is not necessary in every case to evaluate each treating source medical opinion separately, adjudicators must always be aware that one or more of the opinions may be controlling while others may not. Adjudicators must use judgment based on the facts of each case in determining whether, and the extent to which, it is necessary to address separately each medical opinion from a single source.

Medically acceptable. This term means that the clinical and laboratory diagnostic techniques that the medical source uses are in accordance with the medical standards that are generally accepted within the medical community as the appropriate techniques to establish the existence and severity of an impairment. The requirement that controlling weight can be given to a treating source medical opinion only if it is well-supported by medically acceptable clinical and laboratory diagnostic techniques helps to ensure that there is a sound medical basis for the opinion.

Not inconsistent. This is a term used to indicate that a well-supported treating source medical opinion need not be supported directly by all of the other evidence (i.e., it does not have to be *consistent* with all the other evidence) as long as there is no other substantial evidence in the case record that contradicts or conflicts with the opinion.

Whether a medical opinion is ''not inconsistent'' with the other substantial evidence is a judgment that adjudicators must make in each case. Sometimes, there will be an obvious inconsistency between the opinion and the other substantial evidence; for example, when a treating source's report contains an opinion that the individual is significantly limited in the ability to do work-related activities, but the opinion is inconsistent with the statements of the individual's spouse about the individual's actual activities, or when two medical sources provide inconsistent medical opinions about the same issue. At other times, the inconsistency will be less obvious and require knowledge about, or insight into, what the evidence means. In this regard, it is especially important to have an understanding of the clinical signs and laboratory findings and any treatment provided to determine whether there is an inconsistency between this evidence and medical opinions about such issues as diagnosis, prognosis (for example, when deciding whether an impairment is expected to last for 12 months), or functional effects. Because the evidence is in medical, not lay, terms and information about these issues may be implied rather than stated, such an inconsistency may not be evident without an understanding of what the clinical signs and laboratory findings signify.

Substantial evidence. This term describes a quality of evidence. Substantial evidence is ''* * * 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. 389 (1971), SSR 71–53c, C.E. 1971–1975, p. 418.) The term is intended to have this same meaning in 20 CFR 404.1527(d)(2) and 416.927(d)(2). It is intended to indicate that the evidence that is inconsistent with the opinion need not prove by a preponderance that the opinion is wrong. It need only be such relevant evidence as a reasonable mind would accept as adequate to support a conclusion that is contrary to the conclusion expressed in the medical opinion.

Depending upon the facts of a given case, any kind of medical or nonmedical evidence can potentially satisfy the substantial evidence test. For example, a treating source's medical opinion on what an individual can still do despite his or her impairment(s) will not be entitled to controlling weight if substantial, nonmedical evidence shows that the individual's actual activities are greater than those provided in the treating source's opinion. The converse is also true: Substantial evidence may demonstrate that an individual's ability to function may be less than what is indicated in a treating source's opinion, in which case the opinion will also not be entitled to controlling weight.

When a Treating Source's Medical Opinion Is Not Entitled to Controlling Weight

Adjudicators must remember that a finding that a treating source medical opinion is not well-supported by medically acceptable clinical and laboratory diagnostic techniques or is inconsistent with the other substantial evidence in the case record means only that the opinion is not entitled to ''controlling weight,'' not that the opinion should be rejected. Treating source medical opinions are still entitled to deference and must be weighed using all of the factors provided in 20 CFR 404.1527 and 416.927. In many cases, a treating source's medical opinion will be entitled to the greatest weight and should be adopted, even if it does not meet the test for controlling weight.

Also, in some instances, additional development required by a case—for example, to obtain more evidence or to clarify reported clinical signs or laboratory findings—may provide the requisite support for a treating source's medical opinion that at first appeared to be lacking or may reconcile what at first appeared to be an inconsistency between a treating source's medical opinion and the other substantial evidence in the case record. In such instances, the treating source's medical opinion will become controlling if, after such development, the opinion meets the test for controlling weight. Conversely, the additional development may show that the treating source's medical opinion is not well-supported by medically acceptable clinical and laboratory diagnostic techniques or may create an inconsistency between the medical opinion and the other substantial evidence in the case record, even though the medical opinion at first appeared to meet the test for controlling weight. Ordinarily, development should not be undertaken for the purpose of determining whether a treating source's medical opinion should receive controlling weight if the case record is otherwise adequately developed. However, in cases at the administrative law judge (ALJ) or Appeals Council (AC) level, the ALJ or the AC may need to

consult a medical expert to gain more insight into what the clinical signs and laboratory findings signify in order to decide whether a medical opinion is well-supported or whether it is not inconsistent with other substantial evidence in the case record.

Explanation of the Weight Given to a Treating Source's Medical Opinion

Paragraph (d)(2) of 20 CFR 404.1527 and 416.927 requires that the adjudicator will always give good reasons in the notice of the determination or decision for the weight given to a treating source's medical opinion(s), i.e., an opinion(s) on the nature and severity of an individual's impairment(s). Therefore:

- When the determination or decision:

—Is not fully favorable, e.g., is a denial; or

—is fully favorable based in part on a treating source's medical opinion, e.g., when the adjudicator adopts a treating source's opinion about the individual's remaining ability to function;

the notice of the determination or decision must contain specific reasons for the weight given to the treating source's medical opinion, supported by the evidence in the case record, and must be sufficiently specific to make clear to any subsequent reviewers the weight the adjudicator gave to the treating source's medical opinion and the reasons for that weight.

- When the determination or decision is fully favorable and would be even without consideration of a treating source's medical opinion, the notice of the determination or decision must contain an explanation of the weight given to the treating source's medical opinion. This explanation may be brief.

Effective Date: This Ruling is effective on July 2, 1996.

Cross-References: SSR 96–5p, ''Titles II and XVI: Medical Source Opinions on Issues Reserved to the Commissioner;'' Program Operations Manual System, sections DI 22505.001, and DI 24515.001–24515.003; Hearings, Appeals, and Litigation Law manual, sections I–2–530, I–2–532, I–2–534, I–2–539, I–2–540, I–2–825, I–3–111, I–3–712, I–3–812, and Temporary Instruction 5–310.

[FR Doc. 96–16685 Filed 7–1–96; 8:45 am]

BILLING CODE 4190–29–P

COMMITTEE FOR THE IMPLEMENTATION OF TEXTILE AGREEMENTS

Adjustment of Import Limits for Certain Cotton, Wool and Man-Made Fiber Textile Products Produced or Manufactured in Costa Rica

June 26, 1996.

AGENCY: Committee for the Implementation of Textile Agreements (CITA).

ACTION: Issuing a directive to the Commissioner of Customs increasing limits.

EFFECTIVE DATE: June 27, 1996.

FOR FURTHER INFORMATION CONTACT: Jennifer Aldrich, International Trade Specialist, Office of Textiles and Apparel, U.S. Department of Commerce, (202) 482–4212. For information on the quota status of these limits, refer to the Quota Status Reports posted on the bulletin boards of each Customs port or call (202) 927–5850. For information on embargoes and quota re-openings, call (202) 482–3715.

SUPPLEMENTARY INFORMATION:

Authority: Executive Order 11651 of March 3, 1972, as amended; section 204 of the Agricultural Act of 1956, as amended (7 U.S.C. 1854); Uruguay Round Agreements Act.

The current limits for certain categories are being increased for carryover.

A description of the textile and apparel categories in terms of HTS numbers is available in the CORRELATION: Textile and Apparel Categories with the Harmonized Tariff Schedule of the United States (see Federal Register notice 60 FR 65299, published on December 19, 1995). Also see 61 FR 3002, published on January 30, 1996.

The letter to the Commissioner of Customs and the actions taken pursuant to it are not designed to implement all of the provisions of the Uruguay Round Agreements Act and the Uruguay Round Agreement on Textiles and Clothing, but are designed to assist only in the implementation of certain of their provisions.

D. Michael Hutchinson,

Acting Chairman, Committee for the Implementation of Textile Agreements.

Committee for the Implementation of Textile Agreements

June 26, 1996.

Commissioner of Customs,
Department of the Treasury, Washington, DC 20229.

Dear Commissioner: This directive amends, but does not cancel, the directive issued to you on January 24, 1996, by the Chairman, Committee for the Implementation of Textile Agreements. That directive concerns imports of certain cotton, wool and man-made fiber textile products, produced or manufactured in Costa Rica and exported during the twelve-month period which began on January 1, 1996 and extends through December 31, 1996.

Effective on June 27, 1996, you are directed to increase the limits for the following categories, as provided for under the Uruguay Round Agreements Act and the Uruguay Round Agreement on Textiles and Clothing:

Category	Adjusted twelve-month limit [1]
340/640	987,044 dozen.
342/642	364,373 dozen.
347/348	1,663,387 dozen.
443	216,806 numbers.
447	12,517 dozen.

[1] The limits have not been adjusted to account for any imports exported after December 31, 1995.

The guaranteed access levels for the foregoing categories remain unchanged.

The Committee for the Implementation of Textile Agreements has determined that these actions fall within the foreign affairs exception to the rulemaking provisions of 5 U.S.C. 553(a)(1).

Sincerely,

D. Michael Hutchinson,

Acting Chairman, Committee for the Implementation of Textile Agreements.

[FR Doc. 96–16820 Filed 7–1–96; 8:45 am]

BILLING CODE 3510–DR–F

Establishment of an Import Limit for Certain Cotton and Man-Made Fiber Textile Products Produced or Manufactured in El Salvador

June 26, 1996.

AGENCY: Committee for the Implementation of Textile Agreements (CITA).

ACTION: Issuing a directive to the Commissioner of Customs establishing a limit.

EFFECTIVE DATE: June 27, 1996.

FOR FURTHER INFORMATION CONTACT: Jennifer Aldrich, International Trade Specialist, Office of Textiles and Apparel, U.S. Department of Commerce, (202) 482–4212. For information on the quota status of this limit, refer to the Quota Status Reports posted on the bulletin boards of each Customs port or call (202) 927–5850. For information on embargoes and quota re-openings, call (202) 482–3715. For information on categories on which consultations have been requested, call (202) 482-3740.

SUPPLEMENTARY INFORMATION:

Authority: Executive Order 11651 of March 3, 1972, as amended; section 204 of the