

updating a rule cross reference for an existing rule that is eligible for MRVP.

The Exchange further believes that it would remove impediments to and perfect the mechanism of a free and open market and a national market system to specify which current rules would not be applicable to trading on the Pillar trading platform. The Exchange believes that the following legend, which would be added to existing rules, "This Rule is not applicable to trading on the Pillar trading platform," would promote transparency regarding which rules would govern trading on the Exchange on Pillar. The Exchange has proposed to add this legend to rules that would be superseded by proposed rules or rules that would not be applicable because they relate to functions that would not be available when the Exchange transitions to Pillar.

Section 11(a) of the Act

For reasons described above, the Exchange believes that the proposal for the Exchange to operate on a fully automated trading market without a Floor is consistent with Section 11(a) of the Act and Rule 11a2-2(T) thereunder.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act. The proposed rule change is designed to provide for trading rules to support the migration to the Pillar trading platform consistent with the Framework Filing. The Exchange operates in a highly competitive environment in which its unaffiliated exchanges competitors operate multiple affiliated exchanges that operate under common rules. By proposing rules based on the rules of its affiliated exchanges, the Exchange believes that it will be able to compete on a more level playing field with its exchange competitors that similarly trade NMS Stocks on fully automated trading models. In addition, by basing its rules on those of its affiliated exchanges, the Exchange will provide its Participants with consistency across affiliated exchanges, thereby enabling the Exchange to compete with unaffiliated exchange competitors that similarly operate multiple exchanges on the same trading platforms.

In addition, the Exchange does not believe that the proposed rule change will impose any burden on competition on its Participants that is not necessary or appropriate in furtherance of the purposes of the Act because the

Exchange proposes to retain rules governing Participant membership and conduct and therefore such Participants would not need to update internal procedures in connection with the migration of the Exchange to the Pillar trading platform. The Exchange further believes that the proposed rule change would promote consistency and transparency on both the Exchange and its affiliated exchanges, thus making the Exchange's rules easier to navigate.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were solicited or received with respect to the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 45 days of the date of publication of this notice in the **Federal Register** or up to 90 days (i) as the Commission may designate if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consents, the Commission will:

- (A) By order approve or disapprove the proposed rule change, or
- (B) institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's internet comment form (<http://www.sec.gov/rules/sro.shtml>); or
- Send an email to rule-comments@sec.gov. Please include File Number SR-NYSECHX-2019-08 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street NE, Washington, DC 20549-1090. All submissions should refer to File Number SR-NYSECHX-2019-08. This file number should be included on the subject line if email is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's

internet website (<http://www.sec.gov/rules/sro.shtml>). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for website viewing and printing in the Commission's Public Reference Room, 100 F Street NE, Washington, DC 20549 on official business days between the hours of 10:00 a.m. and 3:00 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change. Persons submitting comments are cautioned that we do not redact or edit personal identifying information from comment submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR-NYSECHX-2019-08 and should be submitted on or before September 16, 2019.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.⁴⁹

Jill M. Peterson,

Assistant Secretary.

[FR Doc. 2019-18269 Filed 8-23-19; 8:45 am]

BILLING CODE 8011-01-P

SOCIAL SECURITY ADMINISTRATION

[Docket No. SSA-2018-0023]

Social Security Ruling, SSR 19-4p; Titles II and XVI: Evaluating Cases Involving Primary Headache Disorders

AGENCY: Social Security Administration.
ACTION: Notice of Social Security Ruling (SSR).

SUMMARY: We are providing notice of SSR 19-4p. This SSR provides guidance on how we establish that a person has a medically determinable impairment of a primary headache disorder and how we evaluate primary headache disorders in disability claims under titles II and XVI of the Social Security Act.

DATES: We will apply this notice on August 26, 2019.

FOR FURTHER INFORMATION CONTACT: Cheryl A. Williams, Office of Medical Policy, Social Security Administration,

⁴⁹ 17 CFR 200.30-3(a)(12).

6401 Security Boulevard, Baltimore, Maryland 21235–6401, (410) 965–1020. 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 site, Social Security Online, at <http://www.socialsecurity.gov>.

SUPPLEMENTARY INFORMATION: Although 5 U.S.C. 552(a)(1) and (a)(2) do not require us to publish this SSR, we are doing so in accordance with 20 CFR 402.35(b)(1).

Through SSRs, we make available to the public precedential decisions relating to the Federal old-age, survivors, disability, supplemental security income, and special veterans' benefits programs. We may base SSRs on determinations or decisions made at all levels of administrative adjudication, Federal court decisions, Commissioner's decisions, opinions of the Office of the General Counsel, or other interpretations of the law and regulations.

Although SSRs do not have the same force and effect as statutes or regulations, they are binding on all of our components in accordance with 20 CFR 402.35(b)(1) and are binding as precedents in adjudicating cases.

This SSR will remain in effect until we publish a notice in the **Federal Register** that rescinds it, or we publish a new SSR that replaces or modifies it. (Catalog of Federal Domestic Assistance, Programs Nos. 96.001, Social Security—Disability Insurance; 96.002, Social Security—Retirement Insurance; 96.004, Social Security—Survivors Insurance; 96.006, Supplemental Security Income.)

Andrew Saul,

Commissioner of Social Security.

Policy Interpretation Ruling

Titles II and XVI: Evaluating Cases Involving Primary Headache Disorders

Purpose: This SSR provides guidance on how we establish that a person has a medically determinable impairment (MDI) of a primary headache disorder and how we evaluate primary headache disorders in disability claims under titles II and XVI of the Social Security Act (Act).¹

Citations: Sections 216(i), 223(d), 223(f), 1614(a)(3) and 1614(a)(4) of the Social Security Act, as amended; Regulations No. 4, subpart P, sections 404.1502, 404.1505, 404.1509, 404.1512, 404.1513, 404.1520, 404.1520a, 404.1520b, 404.1521–404.1523, 404.1525, 404.1526, 404.1529, 404.1545, 404.1560, 404.1562–404.1569a, 404.1593, 404.1594, appendices 1 and 2; and Regulations No. 16, subpart I, sections 416.902, 416.905, 416.906, 416.909, 416.912, 416.913, 416.920, 416.920a, 416.920b, 416.921–416.924, 416.924a, 416.925, 416.926, 416.926a, 416.929, 416.945, 416.960, 416.962–416.969a, 416.987, 416.993, 416.994, and 416.994a.

Introduction

Primary headache disorders are among the most common disorders of the nervous system.² Examples of these disorders include migraine headaches, tension-type headaches, and cluster headaches. We are issuing this SSR to explain our policy on how we establish that a person has an MDI of a primary headache disorder and how we evaluate primary headache disorders in disability claims. In 2018, the Headache Classification Committee of the International Headache Society published the third edition of the International Classification of Headache Disorders (ICHD–3).³ The ICHD–3 provides classification of headache disorders and diagnostic criteria for scientific, educational, and clinical use. We referred to the ICHD–3 criteria in developing this SSR.

We consider a person age 18 or older disabled if he or she is unable to engage in any substantial gainful activity due to any medically determinable physical or mental impairment(s) that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months.⁴ In our sequential evaluation process, we determine whether a medically determinable physical or mental impairment is severe at step 2.⁵ A severe MDI or combination of MDIs significantly limits a person's physical or mental ability to do basic work

activities. We require that the MDI(s) result from anatomical, physiological, or psychological abnormalities that can be shown by medically acceptable clinical and laboratory diagnostic techniques.⁶ Our regulations further require that the MDI(s) be established by objective medical evidence⁷ from an acceptable medical source (AMS).⁸ We will not use a person's statement of symptoms, a diagnosis, or a medical opinion to establish the existence of an MDI(s).⁹ We also will not make a finding of disability based on a person's statement of symptoms alone.¹⁰

Policy Interpretation

In this SSR, we explain how we establish a primary headache disorder as an MDI and how we evaluate claims involving primary headache disorders. The following information is in a question and answer format. Question 1 explains what primary headache disorders are. Question 2 explains how the medical community diagnoses primary headache disorders. Questions 3, 4, 5, and 6 provide the ICHD–3 diagnostic criteria for four common types of primary headache disorders.¹¹ Question 7 explains how we establish a primary headache disorder as an MDI. Questions 8 and 9 address how we evaluate primary headache disorders in the sequential evaluation process.

List of Questions

1. *What are primary headache disorders?*
2. *How does the medical community diagnose a primary headache disorder?*
3. *What are the ICHD–3 diagnostic criteria for migraine with aura?*
4. *What are the ICHD–3 diagnostic criteria for migraine without aura?*
5. *What are the ICHD–3 diagnostic criteria for chronic tension-type headache?*
6. *What are the ICHD–3 diagnostic criteria for cluster headache (a type of trigeminal autonomic cephalalgias)?*
7. *How do we establish a primary headache disorder as an MDI?*
8. *How do we evaluate an MDI of a primary headache disorder under the Listing of Impairments?*

² See World Health Organization. (2016). *Headache disorders*. Retrieved from <http://www.who.int/news-room/fact-sheets/detail/headache-disorders>.

³ See International Headache Society (IHS). (2018). *The international classification of headache disorders (3rd ed.)*. Retrieved from <https://www.ichd-3.org/wp-content/uploads/2018/01/The-International-Classification-of-Headache-Disorders-3rd-Edition-2018.pdf>.

⁴ See sections 223(d)(1)(A) and 1614(a)(3)(A) of the Act.

⁵ See 20 CFR 404.1520(a)(4)(ii) and (c) and 416.920(a)(4)(ii) and (c).

⁶ See sections 223(d)(3) and 1614(a)(3)(D) of the Act, and 20 CFR 404.1521 and 416.921.

⁷ Objective medical evidence is defined as signs, laboratory findings, or both. See 20 CFR 404.1502(f).

⁸ See 20 CFR 404.1502, 404.1513, 404.1521, 416.902, 416.913, and 416.921.

⁹ See 20 CFR 404.1521 and 416.921.

¹⁰ See 20 CFR 404.1529(a) and 416.929(a).

¹¹ Although this SSR only provides information about four common types of primary headache disorders, diagnostic criteria for other types of primary headache disorders can be found in the ICHD–3.

¹ For simplicity, we refer in this SSR only to initial adult claims for disability benefits under titles II and XVI of the Act. The policy interpretations in this SSR, however, also apply to claims of children (that is, people who have not attained age 18) who apply for benefits based on disability under title XVI of the Act, continuing disability reviews of adults and children under sections 223(f) and 1614(a)(4) of the Act, and redeterminations of eligibility for benefits we make in accordance with section 1614(a)(3)(H) of the Act when a child who is receiving title XVI payments based on disability attains age 18.

9. *How do we consider an MDI of a primary headache disorder in assessing a person's residual functional capacity?*

1. *What are primary headache disorders?*

Headaches are complex neurological disorders involving recurring pain in the head, scalp, or neck. Headaches can occur in adults and children. The National Institute of Neurological Disorders and Stroke (NINDS), the American Academy of Neurology, and other professional organizations classify headaches as either *primary* or *secondary* headaches. Primary headaches occur independently and are not caused by another medical condition. Secondary headaches are symptoms of another medical condition such as fever, infection, high blood pressure, stroke, or tumors.

Primary headache disorders are a collection of chronic headache illnesses characterized by repeated exacerbations of overactivity or dysfunction of pain-sensitive structures in the head. Examples of common primary headaches include *migraines*, *tension-type headaches*, and *trigeminal autonomic cephalalgias*. They are typically severe enough to require prescribed medication and sometimes warrant emergency department visits.¹² The purpose of the emergency department care is to determine the correct headache diagnosis, exclude secondary causes of the headache (such as infection, mass-lesion, or hemorrhage), initiate acute therapy in appropriate cases, and provide referral to an appropriate healthcare provider for further care and management of the headaches.¹³

Migraines are vascular headaches involving throbbing and pulsating pain caused by the activation of nerve fibers that reside within the wall of brain blood vessels traveling within the meninges (the three membranes covering the brain and spinal cord). There are two major types of migraine: *Migraine with aura* and *migraine without aura*. Migraine with aura is accompanied by visual, sensory, or other central nervous system symptoms. Migraine without aura is accompanied by nausea, vomiting, or photophobia (light sensitivity) and phonophobia (sound sensitivity). Migraine without

aura is the most common form of migraine.

Tension-type headaches are characterized by pain or discomfort in the head, scalp, face, jaw, or neck, and are usually associated with muscle tightness in these areas. There are two types of tension-type headaches: Episodic and chronic. Episodic tension-type headaches are further divided into infrequent episodic tension-type headaches, which typically do not require medical management, and frequent episodic tension-type headaches, which may require medical management. Chronic tension-type headaches generally evolve from episodic tension-type headaches. Chronic tension-type headaches and frequent episodic tension-type headaches may be disabling depending on the frequency of the headache attacks, type of accompanying symptoms, response to treatment, and functional limitations.

Trigeminal autonomic cephalalgias are characterized by unilateral (one-sided) pain. There are three types: Cluster headache, paroxysmal hemicrania (rare), and short-lasting unilateral neuralgiform headache attacks with conjunctival injection and tearing (SUNCT; very rare). *Cluster headaches* are characterized by sudden headaches that occur in "clusters," are usually less frequent and shorter than migraine headaches, and may be mistaken for allergies because they often occur seasonally.

2. *How does the medical community diagnose a primary headache disorder?*

In accordance with the ICHD-3 guidelines, the World Health Organization (WHO) protocols, and the NINDS definition of headache disorders, physicians diagnose a primary headache disorder only after excluding alternative medical and psychiatric causes of a person's symptoms.¹⁴ Physicians diagnose a primary headache disorder after reviewing a person's full medical and headache history and conducting a physical and neurological examination.¹⁵ It is helpful to a physician when a person keeps a "headache journal" to document when the headaches occur, how long they last, what symptoms are associated with the headaches, and other co-occurring environmental factors.

To rule out other medical conditions that may result in the same or similar symptoms, a physician may also conduct laboratory tests or imaging

scans.¹⁶ For example, physicians may use magnetic resonance imaging (MRI) to rule out other possible causes of headaches—such as a tumor—meaning that an unremarkable MRI is consistent with a primary headache disorder diagnosis. Other tests used to exclude causes of headache symptoms include computed tomography (CT) scan of the head, CT angiography (CTA), blood chemistry and urinalysis, sinus x-ray, electroencephalogram (EEG), eye examination, and lumbar puncture. A scan may describe an incidental abnormal finding, which does not preclude the diagnosis of a primary headache disorder. While imaging may be useful in ruling out other possible causes of headache symptoms, it is not required for a primary headache disorder diagnosis.

3. *What are the ICHD-3 diagnostic criteria for migraine with aura?*

The ICHD-3 diagnostic criteria for migraine with aura are headaches not better accounted for by another ICHD-3 diagnosis *and* at least two headache attacks meeting the following criteria:

- One or more of the following fully reversible aura symptoms:

- Visual,
- Sensory,
- Speech or language,
- Motor,
- Brainstem, or
- Retinal; and

- At least three of the following six characteristics:

- At least one aura symptom spreads gradually over at least 5 minutes;
- Two or more aura symptoms occur in succession;
- Each individual aura symptom lasts 5 to 60 minutes;
- At least one aura symptom is unilateral (aphasia is always regarded as a unilateral symptom; dysarthria may or may not be);
- At least one aura symptom is positive (scintillations and pins and needles are positive symptoms of aura); or
- The aura is accompanied or followed within 60 minutes by headache.

4. *What are the ICHD-3 diagnostic criteria for migraine without aura?*

The ICHD-3 diagnostic criteria for migraine without aura are headaches not better accounted for by another ICHD-3 diagnosis *and* at least five headache attacks satisfying the following criteria:

¹⁶ Friedman, B.W. & Grosberg, B.M. (2009). Diagnosis and management of the primary headache disorders in the emergency department setting. *Emergency Medicine Clinics of North America*, 27(1). doi:10.1016/j.emc.2008.09.005.

¹² Clinicians may use terms such as "severe" or "moderate" to characterize a person's medical condition or symptoms and these terms may be seen in medical evidence. These terms will not always have the same meaning in the clinical setting as they do in our program.

¹³ Lange, S.E. (2011). Primary headache disorders in the emergency department. *Advanced Emergency Nursing Journal*, 33(3). doi:10.1097/TME.0b013e3182261105.

¹⁴ ICHD-3 provides classification of headache disorders and diagnostic criteria.

¹⁵ Ebell, M.H. (2006). Diagnosis of migraine headache. *American Family Physician*, 74(12).

- Lasting 4 to 72 hours (untreated or unsuccessfully treated);^{17 18} and
 - At least two of the following four characteristics:
 - Unilateral location;
 - Pulsating quality;
 - Moderate or severe pain intensity;
- or
- Aggravation by or causing avoidance of routine physical activity (for example, walking or climbing stairs); and
 - During headache, at least one of the following:
 - Nausea or vomiting, or
 - Photophobia and phonophobia.

5. *What are the ICHD-3 diagnostic criteria for chronic tension-type headache?*

The ICHD-3 diagnostic criteria for chronic tension-type headache are headaches not better accounted for by another ICHD-3 diagnosis, occurring on at least 15 days per month on average for more than 3 months, and satisfying the following criteria:

- Lasting hours to days, or unremitting; and
- At least two of the following four characteristics:
 - Bilateral location;
 - Pressing or tightening (non-pulsating) quality;
 - Mild or moderate intensity; or
 - Not aggravated by routine physical activity (such as walking or climbing stairs); and
- No more than one of photophobia, phonophobia, or mild nausea; and
- Neither moderate nor severe¹⁹ nausea nor vomiting.

6. *What are the ICHD-3 diagnostic criteria for cluster headache (a type of trigeminal autonomic cephalalgias)?*

The ICHD-3 diagnostic criteria for cluster headache are headaches not better accounted for by another ICHD-3 diagnosis and at least five headache attacks satisfying the following criteria:

- Severe or very severe²⁰ unilateral orbital, supraorbital, or temporal pain lasting 15 to 180 minutes (when untreated);
- One or both of the following:
 - A sense of restlessness or agitation

- or
- At least one of the following symptoms or signs occurring on the same side of the body as the headache:
 - Conjunctival injection (red eye);
 - Lacrimation (secretion of tears);
 - Nasal congestion or rhinorrhea (runny nose);

- Eyelid edema (puffy eyelid);
- Forehead and facial sweating;
- Miosis (excessive constriction of the pupil); or
- Ptosis (drooping of the upper eyelid); and
- Occurring with a frequency between one every other day and eight per day.

7. *How do we establish a primary headache disorder as an MDI?*

We establish a primary headache disorder as an MDI by considering *objective medical evidence* (signs, laboratory findings, or both) from an AMS.²¹ We may establish only a primary headache disorder as an MDI. We will not establish secondary headaches (for example, headache attributed to trauma or injury to the head or neck or to infection) as MDIs because secondary headaches are symptoms of another underlying medical condition. We evaluate the underlying medical condition as the MDI. Generally, successful treatment of the underlying condition will alleviate the secondary headaches.

We will not establish the existence of an MDI based only on a diagnosis or a statement of symptoms; however, we will consider the following combination of findings reported by an AMS when we establish a primary headache disorder as an MDI:

- A primary headache disorder *diagnosis* from an AMS. Other disorders have similar symptoms, signs, and laboratory findings. A diagnosis of one of the primary headache disorders by an AMS identifies the specific condition that is causing the person's symptoms. The evidence must document that the AMS who made the diagnosis reviewed the person's medical history, conducted a physical examination, and made the diagnosis of primary headache disorder only after excluding alternative medical and psychiatric causes of the person's symptoms. In addition, the treatment notes must be consistent with the diagnosis of a primary headache disorder.²²
- An *observation of a typical headache event*, and a detailed

description of the event including all associated phenomena, by an AMS. During a physical examination, an AMS is often able to observe and document signs that co-occur prior to, during, and following the headache event. Examples of co-occurring observable signs include occasional tremors, problems concentrating or remembering, neck stiffness, dizziness, gait instability, skin flushing, nasal congestion or rhinorrhea (runny nose), puffy eyelid, forehead or facial sweating, pallor, constriction of the pupil, drooping of the upper eyelid, red eye, secretion of tears, and the need to be in a quiet or dark room during the examination. In the absence of direct observation of a typical headache event by an AMS, we may consider a third party observation of a typical headache event, and any co-occurring observable signs, when the third party's description of the event is documented by an AMS and consistent with the evidence in the case file.

- Remarkable or unremarkable findings on *laboratory tests*. We will make every reasonable effort to obtain the results of laboratory tests. We will not routinely purchase tests related to a person's headaches or allegations of headaches. We will not purchase imaging or other diagnostic or laboratory tests that are complex, may involve significant risk, or are invasive.

- *Response to treatment*. Medications and other medical interventions are generally tailored to a person's unique symptoms, predicted response, and risk of side effects. Examples of medications used to treat primary headache disorders include, but are not limited to, botulinum neurotoxin (Botox®), anticonvulsants, and antidepressants. We will consider whether the person's headache symptoms have improved, worsened, or remained stable despite treatment and consider medical opinions related to the person's physical strength and functional abilities. When evidence in the file from an AMS documents ongoing headaches that persist despite treatment, such findings may constitute medical signs that help to establish the presence of an MDI.²³

8. *How do we evaluate an MDI of a primary headache disorder under the Listing of Impairments?*

Primary headache disorder is not a listed impairment in the Listing of Impairments (listings);²⁴ however, we may find that a primary headache disorder, alone or in combination with

¹⁷ When the person falls asleep during a migraine attack and wakes up without it, duration of the attack is calculated until the time of awakening.

¹⁸ In children (persons under age 18), attacks may last 2–72 hours.

¹⁹ See note 12 above.

²⁰ Id.

²¹ See 20 CFR 404.1502(a) and 416.902(a).

²² As explained in question 2, a person's "headache journal" may aid a physician in diagnosing a headache disorder after reviewing a person's full medical and headache history. We do not require evidence from a person's "headache journal" in order to establish an MDI of a headache disorder. Our current rules require objective medical evidence, consisting of signs, laboratory finding, or both, from an AMS to establish an MDI. We will, however, consider evidence from a person's "headache journal" when it is part of the record, either as part of the treatment notes or as separate evidence, along with all evidence in the record.

²³ See 20 CFR 404.1502(g) and 416.902(l).

²⁴ See 20 CFR part 404, subpart P, Appendix 1, and 20 CFR 404.1525 and 416.925.

another impairment(s), medically equals a listing.²⁵

Epilepsy (listing 11.02) is the most closely analogous listed impairment for an MDI of a primary headache disorder. While uncommon, a person with a primary headache disorder may exhibit equivalent signs and limitations to those detailed in listing 11.02 (paragraph B or D for dyscognitive seizures), and we may find that his or her MDI(s) medically equals the listing.

Paragraph B of listing 11.02 requires dyscognitive seizures occurring at least once a week for at least 3 consecutive months despite adherence to prescribed treatment. To evaluate whether a primary headache disorder is equal in severity and duration to the criteria in 11.02B, we consider: A detailed description from an AMS of a typical headache event, including all associated phenomena (for example, premonitory symptoms, aura, duration, intensity, and accompanying symptoms); the frequency of headache events; adherence to prescribed treatment; side effects of treatment (for example, many medications used for treating a primary headache disorder can produce drowsiness, confusion, or inattention); and limitations in functioning that may be associated with the primary headache disorder or effects of its treatment, such as interference with activity during the day (for example, the need for a darkened and quiet room, having to lie down without moving, a sleep disturbance that affects daytime activities, or other related needs and limitations).

Paragraph D of listing 11.02 requires dyscognitive seizures occurring at least once every 2 weeks for at least 3 consecutive months despite adherence to prescribed treatment, and marked limitation in one area of functioning. To evaluate whether a primary headache disorder is equal in severity and duration to the criteria in 11.02D, we consider the same factors we consider for 11.02B and we also consider whether the overall effects of the primary headache disorder on functioning results in marked limitation in: Physical functioning; understanding, remembering, or applying information; interacting with others; concentrating, persisting, or maintaining pace; or adapting or managing oneself.

9. *How do we consider an MDI of a primary headache disorder in assessing a person's residual functional capacity?*

If a person's primary headache disorder, alone or in combination with another impairment(s), does not medically equal a listing at step three of the sequential evaluation process, we assess the person's residual functional capacity (RFC). We must consider and discuss the limiting effects of all impairments and any related symptoms when assessing a person's RFC.²⁶ The RFC is the most a person can do despite his or her limitation(s).

We consider the extent to which the person's impairment-related symptoms are consistent with the evidence in the record. For example, symptoms of a primary headache disorder, such as photophobia, may cause a person to have difficulty sustaining attention and concentration. Consistency and supportability between reported symptoms and objective medical evidence is key in assessing the RFC.

This SSR is applicable on August 26, 2019.²⁷

Cross References: SSR 83–12: Title II and XVI: Capability To Do Other Work—The Medical-Vocational Rules as a Framework for Evaluating Exertional Limitations Within a Range of Work or Between Ranges of Work; SSR 83–14: Titles II and XVI: Capability To Do Other Work—The Medical-Vocational Rules as a Framework for Evaluating a Combination of Exertional and Nonexertional Impairments; SSR 85–15: Titles II and XVI: Capability To Do Other Work—The Medical-Vocational Rules as a Framework for Evaluating Solely Nonexertional Impairments; SSR 86–8: Titles II and XVI: The Sequential Evaluation Process; SSR 96–8p: Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims; 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; SSR 11–2p: Titles II and XVI: Documenting and Evaluating Disability in Young Adults; SSR 16–3p: Titles II and XVI: Evaluation of

Symptoms in Disability Claims; SSR 17–2p: Titles II and XVI: Evidence Needed by Adjudicators at the Hearings and Appeals Council Levels of the Administrative Review Process to Make Findings about Medical Equivalence; and Program Operations Manual System (POMS) DI 22001.001, DI 22505.001, DI 22505.003, DI 24501.020, DI 24501.021, DI 24503.005, DI 24503.025, DI 24503.030, DI 24503.035, DI 24505.001, DI 24510.005, DI 24510.057, DI 24515.012, DI 24515.062, DI 24515.063, DI 25025.001, DI 25505.025, and DI 25505.030.

[FR Doc. 2019–18310 Filed 8–23–19; 8:45 am]

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DEPARTMENT OF STATE

[Public Notice: 10855]

Bureau of International Security and Nonproliferation; Imposition of Additional Sanctions on Russia Under the Chemical and Biological Weapons Control and Warfare Elimination Act of 1991

SUMMARY: On August 6, 2018, a determination was made that the Russian government used chemical weapons in violation of international law or lethal chemical weapons against its own nationals. Notice of this determination was published on August 27, 2018 in the **Federal Register**, under Public Notice 10519, which resulted in sanctions against Russia. Section 307(B) of the Chemical and Biological Weapons Control and Warfare Elimination Act of 1991 (CBW Act), requires a decision within three months of August 6, 2018 regarding whether Russia has met certain conditions described in the law. Additional sanctions on Russia are required if these conditions are not met. The Secretary of State decided on November 2, 2018 that Russia had not met the CBW Act's conditions and decided to impose additional sanctions on Russia on March 29, 2019.

DATES: This determination is effective on August 26, 2019.

FOR FURTHER INFORMATION CONTACT: Pamela K. Durham, Office of Missile, Biological, and Chemical Nonproliferation, Bureau of International Security and Nonproliferation, Department of State, Telephone (202) 647–4930.

SUPPLEMENTARY INFORMATION: Pursuant to Section 307(b) of the Chemical and Biological Weapons Control and Warfare Elimination Act of 1991, as amended (22 U.S.C. Section 5604(a) and Section 5605(a)), on March 29, 2019 the Secretary of State decided to impose

²⁵ See 20 CFR 404.1526 and 416.926 and SSR 17–2p: Titles II and XVI: Evidence Needed by Adjudicators at the Hearings and Appeals Council Levels of the Administrative Review Process to Make Findings about Medical Equivalence, 82 FR 15263 (2017) (also available at: https://www.bssa.gov/OP_Home/rulings/di/01/SSR2017-02-di-01.html).

²⁶ See 20 CFR 404.1545 and 416.945.

²⁷ We will use this SSR beginning on its applicable date. We will apply this SSR to new applications filed on or after the applicable date of the SSR and to claims that are pending on and after the applicable date. This means that we will use this SSR on and after its applicable date in any case in which we make a determination or decision. We expect that Federal courts will review our final decisions using the rules that were in effect at the time we issued the decisions. If a court reverses our final decision and remands a case for further administrative proceedings after the applicable date of this SSR, we will apply this SSR to the entire period at issue in the decision we make after the court's remand.