Ellis Clinic PC
Fair & Compassionate Occupational & Legal Medicine™
5100 N. Brookline Ave, #465 • Oklahoma City, OK 73112
(405) 917-5336 • Fax (405) 917-2250 • www.EllisClinic.com

John W. Ellis, M.D.
Fellowships:
American Academy Family Physicians
American Board of Disability Analysts
American Board of Forensic Examiners
American College of Forensic Examiners Institute
Board Certifications:
American Board Environmental Medicine
American Board Family Medicine
Professional Certifications:
American Board Disability Analysts
American Board Forensic Examiners
American Board Forensic Medicine
American Board Independent Medical Examiners
American College of Legal Medicine
Certified Forensic Consultant, ACFEI

INDEPENDENT MEDICAL EXAMINATION

September 3, 2019

Re:
VA File:
Expert Medical Opinion Concerning Service Connected Disability

Department of Veterans Affairs:

I have examined this 51 year old veteran in my office today. He served honorably in the US Air Force from 09/05/86-09/05/96.

SERVICE CONNECTED INJURIES, DISEASES and CONDITIONS:

Obstructive sleep apnea:
The patient was snoring a lot when he was serving in the US Air Force. His bunkmates complained about his loud snoring. The patient woke up tired with the headache, irritability and decreased focus. He had to drink excessive caffeine to keep himself awake during the daytime due to hypersomnolence. The patient's ex-wife witnessed apneic episodes where he stopped breathing for brief periods of time. The patient's symptoms got worse after discharge. The patient had a sleep study done in 2006 and he was diagnosed to have obstructive sleep apnea. The patient was prescribed a CPAP machine to help with his symptoms.

Service Connected Diagnoses:
6847 Obstructive Sleep Apnea

Service Connected Disability:
50% 6848 Obstructive Sleep Apnea

Causal Relationship and Connectedness to Military Service:
It is my medical opinion, it is more likely than not, that the patient's obstructive sleep apnea is service connected because of the occurrence of symptoms when he was serving in the US Air Force. The patient was snoring because of tissue laxity and the redundant

muscosa. The decreased muscle tone with REM sleep and airway collapse led to desaturation. No arousal with restoration of airway resulted in sleep fragmentation leading to hypersomnolence. The long-term complications of obstructive sleep apnea are weight gain, headache, sexual dysfunction and hypertension.

LUNGS:
The patient was exposed to jet fuel fumes when he was serving in the US Air Force. The patient had frequent bouts of bronchitis and was treated with antibiotics. He also had shortness of breath with exertion and physical training. Also, associated with wheezing and chest tightness. The patient was treated with an albuterol inhaler for his symptoms. His symptoms got worse after discharge and he had an chest x-ray and pulmonary function test done which came back normal. He went to the pulmonologist due to worsening of symptoms and he was diagnosed with moderate persistent asthma and was prescribed an Advair Diskus, singular and albuterol inhaler to help with symptoms. He gets at least 3 asthma attacks every year. He also is treated with systemic steroids during the exacerbations. His symptoms are worse in the winter time. His symptoms are under good control with inhalers but he has trouble with long distance walking, hiking and any other activities including backyard barbequing on the grill.

Service Connected Diagnoses:
6602 Bronchial Asthma

Service Connected Disability:
60% 6602 Bronchial Asthma

Causal Relationship and Connectedness to Military Service:
It is my medical opinion, it is more likely than not, that the patient's bronchial asthma is service connected because of the occurrence of symptoms when he was serving in the US Air Force. Due to the exposure to jet fuel fumes, the patient had hyperactivity of the bronchi with paroxysms of wheezing and bronchospasms. There is contraction of the bronchial smooth muscle with hypertrophy and increase of secretion of mucous associated with edema of the respiratory muscosa.

TYPE 2 DIABETES:
The patient started gaining a significant amount of weight approximately 130 pounds since he was discharged due to severe low back pain, hip pain, knee pain, ankle pain and bilateral foot pain. The patient has not been able to exercise due to the pain and he has tried a stationary bike, elliptical and also swimming in the pool. He could not tolerate the chlorine in the pool water. He slowly started having increased abdominal obesity with insulin resistence and his blood sugars started going in the past few years. He finally had abnormal labs and was diagnosed with type 2 diabetes in December of 2018. The patient was prescribed metformin and also recommended to be on restricted diet and exercise to help lowering the blood sugars.

Service Connected Diagnoses:
7913 Type 2 Diabetes

Service Connected Disability:
20% 7913 Type 2 Diabetes

Causal Relationship and Connectedness to Military Service:
It is my medical opinion, it is more likely than not, that the patient's type 2 diabetes is secondary to his significant weight gain from pain in multiple joints with interferes with his exercise regimen. Due to increase in the insulin resistence from abdominal obesity the patient started having high blood sugar readings and eventually was diagnosed with type 2 diabetes.

BACK:
The patient strained his lower back on multiple occasions while doing vigorous physical training going up and down the stairs and ladders, and also walking on uneven terrain while carrying heavy equipment to different floors and buildings. The patient was working as a security police officer and was carrying his riffle on his shoulder, ammo on his waist and radios on his waist. The patient was seen in the sick hall several times due to the low back pain, stiffness and spasms. He was treated with muscle relaxers and NSAIDs. His symptoms got worse after discharge and he went to see his PCP to be evaluated. X-rays were done which showed degenerative disc disease. He had some help from chiropractic sessions.

Pain is 7/10 in severity, dull ache and constant. It goes up to 10/10 in severity which is sharp and stabbing in nature with prolonged standing, walking, sitting, long distance driving, using stairs, bending over and carrying heavy things. Pain radiates into his bilateral lower extremities, right more than left, associated with tingling, numbness and burning pain. The patient has to lay down flat with pillows under his thighs to help with the pain. The pain is better with NSAIDs, heat, ice and TENS unit.

Service Connected Diagnoses:
5237 Lumbosacral Strain
5242 Degenerative Disc Arthritis of the Lumbar Spine
5243 Intravertebral Disc Syndrome of the Lumbar Spine
8520 Lumbar Radiculopathy with Right-Sided Sciatica
8520 Lumbar Radiculopathy with Left-Sided Sciatica

Service Connected Disability:
60% 5237 Lumbosacral Strain
60% 5242 Degenerative Disc Arthritis of the Lumbar Spine
60% 5243 Intravertebral Disc Syndrome of the Lumbar Spine
40% 8520 Lumbar Radiculopathy with Right-Sided Sciatica
20% 8520 Lumbar Radiculopathy with Left-Sided Sciatica

Causal Relationship and Connectedness to Military Service:
It is my medical opinion, it is more likely than not, that the patient's lumbar degenerative disc disease is service connected because of the occurrence of symptoms when he was serving in the US Air Force. The patient strained the muscles, ligaments and structures

of the lumbar vertebra when he was lifting heavy equipment and carrying the ammo around his waist. The antalgic gait from his bilateral ankle and foot pain also caused abdominal biomechanical stressors in the spine causing more stressors and abdominal strains on the vertebra and the disc structures in the lumbar spine contributing to lumbosacral strain, degenerative arthritis and subsequent deranged discs. This also caused an impingement of bilateral L5-S1 spinal nerves going down the legs.

RIGHT HIP:
The patient started having right hip pain 2 years ago due to limping and compensating for bilateral knees, ankles and feet. The patient's gait and posture changed due to chronic limping and his symptoms include pain, stiffness and decreased range of motion in the right hip. The patient had x-rays done which showed early degenerative joint disease. The pain is a dull ache, constant, 6/10 in severity and goes up to 9/10 with prolonged standing, sitting, walking, squatting and long distance driving. Pain is better with laying down flat, rest, heat, ice and NSAIDs. The patient is unable to cross his thighs due to pain.

Service Connected Diagnoses:
5010 Traumatic Arthritis of Right Hip Joint
5253 Impairment of Right Thigh in Adduction

Service Connected Disability:
10% 5010 Traumatic Arthritis of Right Hip Joint
10% 5253 Impairment of Right Thigh in Adduction

Causal Relationship and Connectedness to Military Service:
It is my medical opinion, it is more likely than not, that the patient's right hip pain is secondary to his bilateral knees and ankles, as well as low back pain which started when he was serving in the US Air Force. The patient injured the cartilage due to overcompensating for the knee and ankle pain. He had abnormal biomechanical stressors on the hip joint leading to osteophyte formation and degenerative arthritis.

LEFT HIP:
The patient started having left hip pain 2 years ago due to limping and compensating for bilateral knees, ankles and feet. The patient's gait and posture changed due to chronic limping and his symptoms include pain, stiffness and decreased range of motion in the left hip. The patient had x-rays done which showed early degenerative joint disease. The pain is a dull ache, constant, 6/10 in severity and goes up to 9/10 with prolonged standing, sitting, walking, squatting and long distance driving. Pain is better with laying down flat, rest, heat, ice and NSAIDs. The patient is unable to cross his thighs due to pain.

Service Connected Diagnoses:
5010 Traumatic Arthritis of Left Hip Joint
5253 Impairment of Left Thigh in Adduction

Service Connected Disability:
10% 5010 Traumatic Arthritis of Left Hip Joint
10% 5253 Impairment of Left Thigh in Adduction

Causal Relationship and Connectedness to Military Service:
It is my medical opinion, it is more likely than not, that the patient's left hip pain is secondary to his bilateral knees and ankles, as well as low back pain which started when he was serving in the US Air Force. The patient injured the cartilage due to overcompensating for the knee and ankle pain. He had abnormal biomechanical stressors on the hip joint leading to osteophyte formation and degenerative arthritis.

RIGHT KNEE:
The patient twisted his right knee on several occasions during physical training including running, jogging and while playing sports while serving in the US Air Force. The patient ignored it for the first time and went to the sick hall later on and was treated with Motrin. The patient had pain, stiffness and swelling at the end of the day. Symptoms got worse after discharge and he had x-rays done which shows degenerative joint disease. He describes the pain as a dull ache, 5/10 in severity, constant and goes up to 10/10 is sharp and stabbing in nature with prolonged walking, standing, sitting, using stairs, squatting and driving long distances. His right knee gives out daily. The patient has to catch himself from falling when it buckles. The pain is better with NSAIDs, brace, heat, ice and rest.

Service Connected Diagnoses:
5010 Traumatic Arthritis of Right Knee Joint
5257 Moderate Lateral Instability with Medial Collateral Ligament Laxity
5261 Limitation of Extension of the Right Leg

Service Connected Disability:
10% 5010 Traumatic Arthritis of Right Knee Joint
20% 5257 Moderate Lateral Instability with Medial Collateral Ligament Laxity
20% 5261 Limitation of Extension of the Right Leg

Causal Relationship and Connectedness to Military Service:
It is my medical opinion, it is more likely than not, that the patient's right knee pain and instability are service connected due to the occurrence of the twisting injuries while he was serving in the US Air Force. The twisting injuries to the knee put stress on the cartilage and meniscus leading to tears. Injuries of the muscles and tendons surrounding the right knee are caused by acute hyperflexion, hyperextension and also by overuse. These strains and injuries to the cartilage and menisci lead to instability in the ligaments resulting in arthritis and unstable knee.

LEFT KNEE:
The patient twisted his left knee on several occasions during physical training including running, jogging and while playing sports while serving in the US Air Force. The patient ignored it for the first time and went to the sick hall later on and was treated with Motrin. The patient had pain, stiffness and swelling at the end of the day. Symptoms got worse after discharge and he had x-rays done which shows degenerative joint disease. He describes the pain as a dull ache, 5/10 in severity, constant and goes up to 10/10 is sharp and stabbing in nature with prolonged walking, standing, sitting, using stairs, squatting and driving long distances. His left knee gives out less frequently. The patient has to catch himself from falling when it buckles. The pain is better with NSAIDs, brace, heat, ice and rest.

Service Connected Diagnoses:
5010 Traumatic Arthritis of Left Knee Joint
5257 Mild Lateral Instability with Medial Collateral Ligament Laxity Left Knee
5261 Limitation of Extension of the Left Leg

Service Connected Disability:
10% 5010 Traumatic Arthritis of Left Knee Joint
10% 5257 Mild Lateral Instability with Medial Collateral Ligament Laxity Left Knee
30% 5261 Limitation of Extension of the Left Leg

Causal Relationship and Connectedness to Military Service:
It is my medical opinion, it is more likely than not, that the patient's right knee pain and instability are service connected due to the occurrence of the twisting injuries while he was serving in the US Air Force. The twisting injuries to the knee put stress on the cartilage and meniscus leading to tears. Injuries of the muscles and tendons surrounding the right knee are caused by acute hyperflexion, hyperextension and also by overuse. These strains and injuries to the cartilage and menisci lead to instability in the ligaments resulting in arthritis and unstable knee.

RIGHT ANKLE:
The patient twisted and sprained his right ankle on multiple occasions while he was serving in the US Air Force. The patient noticed swelling and stiffness in the right ankle but did not go to the sick hall. His symptoms got worse from everyday activities including go up and down the ladders, prolonged walking, running and jogging. The patient's symptoms got worse after discharge due to his knee pain and low back pain. He describes the pain as a dull ache 5/10 in severity, constant and goes up to 10/10 with prolonged walking, standing and sitting. Walking on uneven and hard surfaces is the worse pain. Stepping up on the ladders and using stairs also causes severe stabbing pain. His right ankle pops a lot and buckles 1 to 2 times per month. The patient has the worst pain when he does that. Pain is better with the NSAIDs, rest, heat and ice.

SERVICE CONNECTED DIAGNOSES:
5010 Traumatic Arthritis of Right Ankle
5262 Moderate Right Ankle Instability
5271 Limitation of Motion of the Right Ankle

SERVICE CONNECTED DISABILITY:
10% 5010 Traumatic Arthritis of Right Ankle
20% 5262 Moderate Right Ankle Instability
10% 5271 Limitation of Motion of the Right Ankle

Causal Relationship and Connectedness to Military Service:
It is my medical opinion, it is more likely than not, that the patient's right ankle pain and instability are service connected because of the occurrence of injuries while he was serving in the US Air Force. Due to his ankle sprain, the patient strained some of the ligaments and also partial rupture of certain ligaments which lead to joint pain and weakness. The repeated sprains involving ankle rolling outwards and foot turning inward caused the

ligaments on the outside of the ankle to stretch and tear. This injury to the cartilage and ligaments lead to unstable and wobbly ankle, and also caused degenerative arthritis.

LEFT ANKLE:
The patient twisted and sprained his left ankle on multiple occasions while he was serving in the US Air Force. The patient noticed swelling and stiffness in the left ankle but did not go to the sick hall. His symptoms got worse from everyday activities including go up and down the ladders, prolonged walking, running and jogging. The patient's symptoms got worse after discharge due to his knee pain and low back pain. He describes the pain as a dull ache 5/10 in severity, constant and goes up to 10/10 with prolonged walking, standing and sitting. Walking on uneven and hard surfaces is the worse pain. Stepping up on the ladders and using stairs also causes severe stabbing pain. His left ankle pops a lot and buckles 1 to 2 times per month. The patient has the worst pain when he does that. Pain is better with the NSAIDs, rest, heat and ice.

SERVICE CONNECTED DIAGNOSES:
5010 Traumatic Arthritis of Left Ankle
5262 Moderate Left Ankle Instability
5271 Limitation of Motion of the Left Ankle

SERVICE CONNECTED DISABILITY:
10% 5010 Traumatic Arthritis of Left Ankle
20% 5262 Moderate Left Ankle Instability
10% 5271 Limitation of Motion of the Left Ankle

Causal Relationship and Connectedness to Military Service:
It is my medical opinion, it is more likely than not, that the patient's right ankle pain and instability are service connected because of the occurrence of injuries while he was serving in the US Air Force. Due to his ankle sprain, the patient strained some of the ligaments and also partial rupture of certain ligaments which lead to joint pain and weakness. The repeated sprains involving ankle rolling outwards and foot turning inward caused the ligaments on the outside of the ankle to stretch and tear. This injury to the cartilage and ligaments lead to unstable and wobbly ankle, and also caused degenerative arthritis.

BILATERAL FEET:
The patient started having pain in bilateral arches and heels while he was serving in the US Air Force. During his physical training which involved running, marching, jogging and going up and down ladders in ill-fitted combat boots with no arch supports, the patient started having inflammation in his arches and heels. He went to the medic and was diagnosed with plantar fasciitis and acquired flat feet. The patient symptoms got worse after a few years, especially at the end of the day and also early in the morning when he walks on bare feet. The patient was seen by the podiatrist after discharge and he was diagnosed with plantar fasciitis and acquired flat feet. The patient was prescribed arch supports, custom insoles and he was treated with steroid injection into the arches. None of the above helped his symptoms. He describes the pain as a dull ache, 7/10 in severity and constant. It goes up to 10/10 with walking in bare feet, standing too long on uneven and hard surfaces and doing housework chores as well as stepping up and going down ladders. Pain is better with Epsom salt soaks, NSAIDs and rest.

SERVICE CONNECTED DIAGNOSES:
5276 Bilateral Acquired Flat Feet
5278 Bilateral Plantar Fasciitis

SERVICE CONNECTED DISABILITY:
30% 5276 Bilateral Acquired Flat Feet
30% 5278 Bilateral Plantar Fasciitis

Causal Relationship and Connectedness to Military Service:
It is my medical opinion, it is more likely than not, that the patient's acquired flat feet deformity and also bilateral plantar fasciitis are service connected because of the occurrence of symptoms while he was serving in the US Air Force. The symptomatic progressive deformity of the feet caused by loss of dynamic and supportive structures of the medial and longitudinal arch leads to acquired flat feet deformity. The sequential ruptures of key ligaments in the ankle and hind foot lead to the collapse of the arch and progressive disability. The painful inflammation of the plantar fascia that runs along the bottom of the foot and connects the heel bone to the ball of the foot is called the plantar fasciitis. It is common in people who do a lot of running, jumping, jogging on hard surfaces in poorly ill-fitted shoes with no arch supports. Pain feels worse in the morning because plantar fascia suddenly elongates which stretches and pulls on the heel.

RECORDS REVIEWED:
Attached summary list of reviewed records.

EXAMINATION and DIAGNOSTIC TESTS:
Ht: 5' 10 ½" without shoes Wt: 284 BP: 120/81 P: 100 SaO2: 98% Temp: 98.2
GENERAL: Appears to be stated age. Looks anxious.
HEAD: Unremarkable.
EYES: Pupils are equal, round and reactive to light bilaterally.
ENT: The patient has mild edema of the nasal mucosa turbinates noted.
NECK: Is thick. No carotid bruits heard. No thyromegaly noted.
CHEST: Clear to auscultation bilaterally. No wheezing noted.
HEART: Regular rate and rhythm. No murmurs noted.
ORTHOPEDIC AND NEUROLOGICAL EXAM:
Lumbar spine has decreased range of motion, see attached range of motion worksheet. There is loss of the normal lordotic curved noted. There is mild discomfort in the paraspinal muscles and tenderness in the iliolumbar ligaments. Percussion on the buttocks reproduces sciatica pain, more on the right than the left. Bragard's sign and straight raise leg raising tests are positive bilaterally with decreased sensation to pin prick in the lateral aspect of the bilateral feet. Deep tendon reflexes are 1+ bilaterally. There is weakness in toe walking and heel walking.

Bilateral hips reveals mild discomfort in the inguinal area. There is decreased range of motion of the bilateral hips, see attached range of motion worksheet. The patient is unable to cross his thighs.

Bilateral knees reveals moderate valgus deformity in the right knee and mild valgus deformity in the left knee. There is minimal discomfort in the infrapatellar areas. There is

decreased range of motion of the bilateral knees, see attached range of motion worksheet. Bilateral ankles reveals decreased range of motion of the bilateral ankles, see attached range of motion worksheet. There is mild tenderness on palpation just below the lateral malleoli.

Bilateral feet reveals severe bilateral flat foot deformity noted with abduction and pronation. There is tenderness on palpation of the bilateral calcaneal tuberosities and also in the metatarsal heads. There is tenderness along the plantar fascia bilaterally.

MEDICAL OPINION and CAUSE of INJURY:
My medical opinions are based upon my examination of the veteran, review of records, my education, training and experience and upon reasonable medical probability and reasonable medical certainty.

It is my medical opinion that the impairments and disabilities set forth in this report were, more likely than not, due to and a consequence of this veteran's military service.

Respectfully,

John W. Ellis, M.D.

JE/DrAB/pls File C:\WP\092019\wilj03 092019.wpd

Enclosures:
1. Attached summary list of reviewed records
2. VA Joint Range of Motion Worksheet

VA Disability Summary List

Records:

1. DD Form 214
2. VA Decisions: 10/28/1996, 2/11/2010, 4/23/2010, 8/19/2010
3. Entrance & Exit Physical
4. Pre-Service Back exam records
5. Knee Pain
   a. Active Duty Records: 12/1990
   b. Physician Records: 1/3/2019
6. Back and Hip Pain
   a. Active Duty Records: 3/5/1989, 8/29/1989, 2/7/1992, 7/5/1992, 10/26/1992, 10/27/1992, 11/10/1992, 7/4/1995, 7/3/1996
   b. Physician Records: 5/9/2019 Dr. Meiyu Lai
7. Flat Feet/Plantar Fasciitis
   a. Active Duty Records: 3/28/1995, 4/5/1995
   b. Physician Records: 3/26/2019 – Dr. Roxanne Toole
   c. Radiology Report: 1/9/2019
8. Asthma (Bronchitis)
   a. Active Duty Records: 5/23/1991, 5/23/1994
   b. Physician Records: 5/2/2017 – Dr Bashar Farjo
   c. Physician Records: 11/26/2008, 3/26/2009, 3/17/2009, 3/23/2012, 4/9/2012, 12/09/2013, 11/6/2014 – Dr. Henry Mata
9. Sleep Apnea
   a. Physician Records: 11/20/2008 – Dr Henry Mata, 5/2/2017 – Dr. Bashar Farjo
10. Diabetes
   a. Physician Records: 12/28/2018 – Dr Felicia Jordan

Ellis Clinic Fair & Compassionate Occupational & Legal Medicine™

5100 N. Brookline Ave., Oklahoma City, OK 73112

Veteran
VA#
Date 9/3/19

VA Joint Range of Motion Worksheet

Federal Regulations Title 38 - Pensions, Bonuses & Veterans Relief

General Rating Formula for Spine		Normal	Veteran	Rounded
Cervical Neck	Flexion	45		
	Extension	45		
	Right Lateral Flexion	45		
	Left Lateral Flexion	45		
	Right Rotation	80		
	Left Rotation	80		
		340	Total:	
Thoraco Lumbar Back	Flexion	90	19	20
	Extension	30	16	20
	Right Lateral Flexion	30	6	10
	Left Lateral Flexion	30	8	10
	Right Rotation	30	4	0
	Left Rotation	30	2	0
		240	Total:	60

		Normal	Right	Left
Shoulders	Flexion	180		
	Extension	50		
	Abduction Pronation	180		
	Adduction	40		
	Internal Rotation	90		
	External Rotation	90		
Elbows	Flexion	145		
	Extension	0		
	Pronation	80		
	Supination	85		
Hands	Palmar Flexion	80		
	Dorsiflexion/Extension	70		
	Radial Deviation	20		
	Ulnar Deviation	45		
Hips	Flexion	125	121	111
	Extension	30	26	21
	Abduction	45	12	10
	Adduction	25	13	8
	Internal Rotation	40	19	10
	External Rotation	60	25	16
Knees	Flexion	140	109	101
	Extension	0	-15	-28
Ankles	Plantar Flexion	45	25	16
	Dorsiflexion/Extension	20	12	8
	Inversion	20	8	6
	Eversion	10	4	0

Rating%		General Rating Formula for the Spine
	40%	Unfavorable ankylosis entire cervical spine
	30%	Flexion 15 or less or favorable ankylosis entire cervical spine
	20%	Flexion 15 to 30 or combined ROM not greater than 170 degrees, or
	20%	Spasm> abnormal spinal contour: scoliosis, reversed lordosis, or kyphosis
	10%	Flexion 30 to 40 or combined ROM 170 to 335, or
	10%	Spasm> localized tenderness but not abnormal spinal contour
	10%	Vertebral body fracture with loss of 50% or more in height
	50%	Unfavorable ankylosis entire thoracolumbar spine
	40%	Flexion 30 or less or favorable ankylosis entire thoracolumbar spine
	20%	Flexion 30 to 60 or combined ROM not greater than 120, or
	20%	Spasm> abnormal gait or spinal contour: scoliosis, reversed lordosis, or kyphosis
	10%	Flexion 60 to 85 or combined ROM 120 to 235 or
	10%	Spasm> localized tenderness but not abnormal gait or spinal contour
	10%	Vertebral body fracture with loss of 50% or more in height
	5235	Vertebral fracture or dislocation
	5236	Sacroiliac injury and weakness
	5237	Cervical Strain
	5237	Lumbosacral Strain
	5238	Spinal stenosis
	5239	Spondylolisthesis
	5240	Ankylosing spondylitis
	5241	Spinal fusion
	5242	Degenerative arthritis of the spine
	5243	Intervertebral Disc Syndrome Cervical Spine
	5243	Intervertebral Disc Syndrome Thoracic Spine
	5243	Intervertebral Disc Syndrome Lumbar Spine

Percentage of Disability: Incapacitating episodes in the last 12 months

60%	6 weeks +
40%	4 to 6 weeks
20%	2 to 4 weeks
10%	1 to 2 weeks

Right	Left	Cervical Spinal Nerves (Complete Paralysis / Incomplete Severe / Moderate / Mild)	
		8510	Upper Radicular Group C5 & C6 (Major:70/50/40/20 Minor:60/40/30/20)
		8511	Middle Radicular Group C7 (Major:70/50/40/20 Minor:60/40/30/20)
		8512	Lower radicular group C8 & T1 (Major:70/50/40/20 Minor:60/40/30/20)
		8513	All radicular groups C5 thru T1 (Major: 90/70/40/20 Minor: 80/60/30/20)

Lumbar Spinal Nerves (Complete Paralysis/Incomplete Severe/Moderate Severe/Moderate/Mild)

40	20	8520	Sciatic Nerve - Spinal Nerves L2 thru S1 (80/60/40/20/10)