

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas
The Honorable Dale Van Slambrook, Circuit Court Judge

Appellate Case No. 2024-001734

Olga Teslenko, Appellant,
v.
Joe Kocsis and Carpet King & Flooring, Respondents.

APPELLANT'S MOTION FOR REASONABLE DISABILITY ACCOMMODATION

Appellant, Olga Teslenko, appearing pro se, respectfully requests a reasonable disability accommodation under the Americans with Disabilities Act of 1990 (Title II), 42 U.S.C. § 12132, and the South Carolina Judicial Branch ADA Policy.

This motion is submitted in light of the October 12, 2026 final briefing deadline, set by the Court's September 21 letter. This deadline expires at 11:59 PM on October 12, 2026. Appellant respectfully requests prompt consideration of this motion before that deadline.

In support of this motion, Appellant submits the following:

I. DISABILITY DECLARATION AND NATURE OF DISABILITY

Appellant has a documented neurological disability described in the Disability Declaration attached hereto as Exhibit 1.

Appellant's disability yields progressively disabling results and causes persistent intermittent symptoms that impair her vision and overall functioning, substantially limiting her ability to sustain reading, typing, maintaining an upright posture and focused gaze for extended periods (See Exhibits 2, 3, 4, 5, 7). As a result, Appellant is markedly limited in her ability to read, type, remain upright and focused, or otherwise effectively participate in any activity for extended periods. While Appellant is not totally precluded from performing a function or activity, she is unable to effectively type, edit, or draft for more than approximately one hour a day (See Exhibit 1).

Pursuant to 42 U.S.C. § 12132, public entities—including state courts—shall not discriminate against qualified individuals with disabilities on the basis of disability. As recognized in *Tennessee v. Lane*, 541 U.S. 509 (2004), Title II's protections extend to court access and judicial proceedings. Appellant is a qualified individual with a disability seeking meaningful access to the appellate process.

II. PROCEDURAL HISTORY

On September 4, 2025, February 3, 2026, August 10, 2026, July 28, 2025, August 13, 2025, and April 6, 2026, Appellant filed evidentiary motions and motions for leave to exceed the standard page limit. The unopposed evidentiary motions were denied or remain pending. The unopposed page-limit motions were denied.

On April 8, 2026, Appellant filed a motion for reasonable disability accommodation under the Americans with Disabilities Act. The motion requested an extension of the final briefing schedule commencing after the Court permitted the completion of the Record and an 85-page limit. This request was necessary to allow disabled pro se Appellant to manage the workload necessary to prepare a compliant, fully-supported final brief.

In its April 21 Order, the Court stated that the April 8 motion was "granted," but instead (i) denied the completion of the Record and the 85-page limit, (ii) rejected timely filed Record on Appeal and Protective Final Brief, and (iii) permitted an extension of time to defaulted Respondents to attempt initial briefing again. The Order did not provide the requested disability accommodation.

On May 21, 2026, Appellant filed a Petition for Rehearing, which was denied in the June 24 No Action letter. On September 21, 2026, the Court directed Appellant to serve and file the Final Brief within twenty (20) days, expiring October 12, 2026.

Appellant notes that strict adherence to the twenty-day briefing schedule would necessarily prevent disabled Appellant from preparing a fully supported, compliant final brief and effectively deny access to the appellate process in violation of 42 U.S.C. § 12132.

III. REQUESTED ACCOMMODATION

The preparation of legal filings requires sustained visual focus, detailed review of large documents, and precise cross-referencing. Appellant's disability substantially impairs every function required for preparing and filing of pleadings, including her ability to prepare a compliant, properly supported final brief within standard time constraints. In order to access

judicial services and pursuant to the Americans with Disabilities Act and 42 U.S.C. § 12132, Appellant respectfully requests a sixty (60) day extension of time to serve and file Appellant's Final Brief. Specifically, Appellant requests the deadline be extended from October 12, 2026, to December 11, 2026.

IV. NO PREJUDICE IF ACCOMMODATION IS GRANTED

Granting a sixty-day extension will not prejudice Respondents or delay the ultimate resolution of this appeal. Respondents have already failed to file their Response Brief for the second time, and this extension affects only the date of Appellant's Final Brief; it does not alter any obligation of Respondents, interfere with the Court's other business, or extend the appeal indefinitely.

V. IRREPARABLE HARM IF ACCOMMODATION DENIED

Appellant's functional capacity for reading, typing, editing, and drafting is approximately one hour per day (Exhibit 1). If the extension is denied, Appellant must attempt to complete the Final Brief on a schedule that exceeds this capacity. The predictable and unavoidable result is a brief that is incomplete or noncompliant—an injury that cannot be remedied after the deadline passes, since denial of the requested extension followed by dismissal, rejection, or incomplete review would deprive Appellant of appellate review altogether.

VI. PRAYER FOR RELIEF

WHEREFORE, Appellant respectfully requests that this Court enter an Order granting a sixty (60) day extension of time, until December 11, 2026, to serve and file Appellant's Final Brief, and for such other relief as the Court deems just and proper.

Enclosed:

- Exhibit 1: Olga Teslenko's Declaration of Disability;
- Exhibit 2: Kaiser Permanente 2010 Brain MRI Report;
- Exhibit 3: Kaiser Permanente 2010 Diagnosis Note;
- Exhibit 4: Kaiser Permanente 2010 Neurology Letter;
- Exhibit 5: Dignity Health 2017 Brain MRI Report;
- Exhibit 6: Cerebellar Degeneration in the ICD-10;
- Exhibit 7: Medical Graphic: Cerebellar Degeneration Symptoms;
- Exhibit 8: Disability Evaluation Under Social Security: Cerebellar Degeneration;
- Exhibit 9: SSDI Medicare Card.
- Certificate of Service on Respondent

Respectfully submitted,

s/ Olga Teslenko

Olga Teslenko, Appellant, Pro Se
100 Fountain Pointe Ln, Unit 103
Myrtle Beach, South Carolina 29579
Email: osenochen@gmail.com
Tel: (510) 388-2780

Dated: September 28, 2026.

Exhibit 1
Olga Teslenko's
Declaration of Disability

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas

The Honorable Dale Van Slambrook, Circuit Court Judge

Appellate Case No. 2024-001734

Olga Teslenko, Appellant,

v.

Joe Kocsis and Carpet King & Flooring, Respondents.

OLGA TESLENKO'S DECLARATION OF DISABILITY

I, Olga Teslenko, appearing pro se, declare the following under penalty of perjury:

1. I have a documented medical disability, Cerebellar Degeneration – Inherited type, also known as ataxia or spinocerebellar degeneration, a progressive neurological disorder (See Exhibits 2, 3, 4, 5, 6, 7). Cerebellar Degeneration is recognized as a disability by the Social Security Administration (See Exhibits 8, 9).
2. Cerebellar Degeneration yields progressively disabling results and causes persistent intermittent symptoms that impair my vision and overall functioning, substantially limiting my ability to sustain reading, typing, maintaining an upright posture and focused gaze for extended periods (See Exhibits 2, 3, 4, 5, 7).
3. My ability to read, type, remain upright and focused, or otherwise effectively participate in any activity for extended periods is markedly limited. While I am not totally precluded from performing a function or activity, I am unable to effectively type, edit, or draft for more than approximately one hour a day. After about a half hour of focused reading and drafting, my vision blurs and I can't see the text. My ability to type deteriorates to where I have to re-type each sentence multiple times. My cognition begins to diminish and I can't remember the substance of large documents or think clearly. After about an hour of such functioning, all my faculties diminish completely. I am forced to take a break lying down. I need three hours to regain my faculties. Any subsequent performance is less effective and not guaranteed. My abilities are severely impaired when I am ill.
4. These functional limitations prevent me from completing substantial legal filings within standard court-imposed deadlines without reasonable accommodation.

I declare under penalty of perjury that the foregoing is true and correct.

Respectfully submitted,

s/ *Olga Teslenko*

Olga Teslenko, Appellant, Pro Se
100 Fountain Pointe Ln, Unit 103
Myrtle Beach, South Carolina 29579
Email: osenochen@gmail.com
Tel: (510) 388-2780

Dated: September 28, 2026

Exhibit 2
Kaiser Permanente 2010
Brain MRI Report.

Patient

**Kaiser Permanente Disclosure of Patient Medical Information**

Kaiser Permanente documents patient medical record information in a Federally certified electronic medical record.

The output contained in this file is one or more of the following:

- A true and accurate copy of the requested patient medical record information for the timeframe requested as authorized by the patient or allowed by law or regulation
- If a medical certification form was requested, we may have substituted relevant medical records in lieu of form completion
- We may have also substituted a standardized electronic form, generated from our certified electronic medical record in lieu of form completion

State and federal law permit the use of electronic signatures (e-signatures) and electronic records in connection with transactions between parties.

- Medical certification forms and electronic records that are signed using electronic signatures can be audited and validated to prevent fraud
- The relevant laws provide that electronic signatures are as legally valid and as legally acceptable as wet signatures

This record output was generated on 5/22/24 and certified by Kaiser Permanente Release of Medical Information

04/22/2010 - Appointment in MRI TRAILER**Imaging****Imaging****MRI BRAIN [231620715] (Final result)**Status: **Completed**

Order placed as a reflex to MRI (also refer in eConsult) ordered on 04/06/10 at 1348

Ordering user: Radstatus, Inbound 04/22/10 1211

Authorized by: Dustin, Frank Arthur (M.D.)

Ordering mode: Standard

Frequency: Routine -

Class: Normal

Quantity: 1

Lab status: Final result

Diagnoses

ATAXIA [781.3 (ICD-9-CM)]

Provider Details

Provider	NPI
Dustin, Frank Arthur (M.D.)	1578641353

MRI BRAIN [231620715]

Resulted: 04/22/10 1521, Result status: Final result

Order status: Completed

Filed on: 04/22/10 1521

Accession number: 41643031

Transcription

Type	ID	Date and Time	Dictating Provider
Procedures	1178633204/22/201012:11:2 0OAKX0101	4/22/2010 12:00 AM	Jumper, Jacque Renae (M.D.)

MRI OF THE BRAIN**** HISTORY **:**

Lifelong progressive ataxia with positive family history.
Evaluate for cerebellar degeneration.

**** FINDINGS **:**

MRI of the brain was performed. Sequences include axial diffusion, T1 sagittal, sagittal, axial and coronal flair and T2 axial weighted images.

There are no areas of reduced diffusion within the brain to suggest acute ischemia. There is no mass-effect or midline shift. There is no hydrocephalus or abnormal extra axial fluid collection.

There is no signal abnormality within the brain. There is diffuse cerebellar atrophy with a superior vermian predominance. The visualized spinal cord and brainstem are of normal size. There is no cerebral atrophy.

Flow voids are identified within the major vessels of the circle of Willis. The dural venous sinuses are also patent. The craniocervical junction, pineal region and sella are normal. Orbits and extracranial soft tissues are unremarkable. The paranasal sinuses and mastoid air cells are clear.

**** IMPRESSION **:**

Generalized cerebellar atrophy with a superior vermian predominance. The spinal cord and brainstem are of normal size. There is no cerebral atrophy and there is no T2 signal abnormality.

JUMPER J. M.D.

04/22/2010 - Appointment in MRI TRAILER (continued)**Imaging (continued)**

DD: 04/22/2010 DT: 04/22/2010 JJ

Reviewed by

Dustin, Frank Arthur (M.D.) on 04/22/10 1528

MRI BRAIN [231620715]

Resulted: 04/22/10 1329, Result status: In process

Order status: Completed
Accession number: 41643031Filed on: 04/22/10 1329
Resulting lab: TPMG OAKLAND RADIOLOGY - MRI TRAILER**Transcription**

Type	ID	Date and Time	Dictating Provider
Procedures	1178633204/22/201012:11:2 00AKX0101	4/22/2010 12:00 AM	Jumper, Jacque Renae (M.D.)

MRI OF THE BRAIN**** HISTORY **:**Lifelong progressive ataxia with positive family history.
Evaluate for cerebellar degeneration.**** FINDINGS **:**

MRI of the brain was performed. Sequences include axial diffusion, T1 sagittal, sagittal, axial and coronal flair and T2 axial weighted images.

There are no areas of reduced diffusion within the brain to suggest acute ischemia. There is no mass-effect or midline shift.
There is no hydrocephalus or abnormal extra axial fluid collection.

There is no signal abnormality within the brain. There is diffuse cerebellar atrophy with a superior vermian predominance. The visualized spinal cord and brainstem are of normal size. There is no cerebral atrophy.

Flow voids are identified within the major vessels of the circle of Willis. The dural venous sinuses are also patent. The craniocervical junction, pineal region and sella are normal. Orbits and extracranial soft tissues are unremarkable. The paranasal sinuses and mastoid air cells are clear.

**** IMPRESSION **:**

Generalized cerebellar atrophy with a superior vermian predominance. The spinal cord and brainstem are of normal size. There is no cerebral atrophy and there is no T2 signal abnormality.

JUMPER J. M.D.

DD: 04/22/2010 DT: 04/22/2010 JJ

04/22/2010 - Appointment in MRI TRAILER (continued)**Imaging (continued)****Reviewed by**

Dustin, Frank Arthur (M.D.) on 04/22/10 1528

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
822 - OAKMRI1	TPMG OAKLAND RADIOLOGY - MRI TRAILER	Unknown	3784 BROADWAY Oakland CA 94611	04/28/08 1707 - Present

Indications

ATAXIA [781.3 (ICD-9-CM)]

All Reviewers List

Dustin, Frank Arthur (M.D.) on 4/22/2010 3:28 PM

MRI [231620714] (Discontinued)

Electronically signed by: Dustin, Frank Arthur (M.D.) on 04/06/10 1348	Status: Discontinued
Ordering user: Dustin, Frank Arthur (M.D.) 04/06/10 1348	Authorized by: Dustin, Frank Arthur (M.D.)
Ordering mode: Standard	
Frequency: Routine 04/06/10 -	Class: Normal
Quantity: 1	Instance released by: Ontiveros, Octavio 4/22/2010 12:11 PM
Discontinued by: Radstatus, Inbound 04/22/10 1329	

Provider Details

Provider	NPI
Dustin, Frank Arthur (M.D.)	1578641353

MRI (also refer in eConsult) [231620714]

Result status: In process

Order status: Canceled
Filed on: 04/22/10 1211

Discontinued by: Radstatus, Inbound 04/22/10 1329

Exhibit 3
Kaiser Permanente 2010
Diagnosis Neurology Note.

05/11/2010 - Office Visit in NEUROLOGY DEPARTMENT**Visit Information****Provider Information**

Encounter Provider	Authorizing Provider
Dustin, Frank Arthur (M.D.)	Dustin, Frank Arthur (M.D.)

Department

Name	Address	Phone
NEUROLOGY DEPARTMENT	3701 BROADWAY Oakland CA 94611-5613	510-752-6509

Level of Service

Level of Service
OUTPT EST LEVEL 4

Reason for Visit**Chief Complaint**

- FOLLOW UP ROUTINE

Visit Diagnoses

Name	Code	Chronic?
PRIMARY CEREBELLAR DEGENERATION (primary)	334.2	Yes
GENETIC DISORDER.	758.9	No

All Charges for This Encounter

Code	Description	Service Date	Service Provider	Modifiers	Qty
99214	OFC/OUTPT VISIT E&M EST MOD-HI SEVERITY 25 MIN	5/11/2010	Dustin, Frank Arthur (M.D.)		1
4007	CO-PAYMENT CHARGE	5/11/2010	Dustin, Frank Arthur (M.D.)		1

Clinical Notes**Unknown****Progress Notes by Dustin, Frank Arthur (M.D.) at 5/11/2010 0749****Version 2 of 2**

Author: Dustin, Frank Arthur (M.D.)	Service: —	Author Type: Physician
Filed: 5/11/2010 3:45 PM	Encounter Date: 5/11/2010	Creation Time: 5/11/2010 7:49 AM
Status: Addendum	Editor: Dustin, Frank Arthur (M.D.) (Physician)	

Neurology F/U

Slowly progressive ataxia and dysarthria since childhood.

Father was ataxic. No other known family members with similat sx's.

Last visit 4/6/10

EXAM: + dysarthria, + ataxia

- cognitive problems, optic atrophy, nystagmus, tone changes, weakness,
- atrophy, reflex changes, peripheral neuropathy, myoclonus, tremor, or UE

dysmetria

4/22/10 MRI Brain: Generalized cerebellar atrophy with a superior vermian predominance. The spinal cord and brainstem are of normal size. There is no cerebral atrophy and there is no T2 signal abnormality.

6/6/10 Neurogenetics panel: SAC1,2,3,6,7 and DRPLA are negative.

05/11/2010 - Office Visit in NEUROLOGY DEPARTMENT (continued)**Clinical Notes (continued)**

IMP: Inherited ataxia - relatively isolated cerebellar syndrome, which is the case with SCA type 5,6,11,14,15,16,26. Disc'd ddx, workup. Will try to narrow down further clinically in an attempt to give more prognostic info. There is no cure or specific tx for the underlying d-o. Avoid etoh. Declines PT eval for now.

The total visit time face to face with the patient was 30 min. Time spent in counseling and discussion with the patient was 16 min, and we discussed the above.

Electronically signed by Dustin, Frank Arthur (M.D.) at 5/11/2010 3:45 PM

Version 1 of 2

Author: Dustin, Frank Arthur (M.D.)
Filed: 5/11/2010 8:29 AM
Status: Signed

Service: —
Encounter Date: 5/11/2010
Editor: Dustin, Frank Arthur (M.D.) (Physician)
Author Type: Physician
Creation Time: 5/11/2010 7:49 AM

Neurology F/U

Slowly progressive ataxia and dysarthria since childhood.

Father was ataxic. No other known family members with similar sx's.

Last visit 4/6/10

EXAM: + dysarthria, + ataxia

- cognitive problems, optic atrophy, nystagmus, tone changes, weakness,
- atrophy, reflex changes, peripheral neuropathy, myoclonus, tremor, or UE

dysmetria

4/22/10 MRI Brain: Generalized cerebellar atrophy with a superior vermal predominance. The spinal cord and brainstem are of normal size.

There is no cerebral atrophy and there is no T2 signal

Abnormality.

6/6/10 Neurogenetics panel: SAC1,2,3,6,7 and DRPLA are negative.

IMP:

05/11/2010 - Office Visit in NEUROLOGY DEPARTMENT (continued)

Clinical Notes (continued)

Electronically signed by Dustin, Frank Arthur (M.D.) at 5/11/2010 8:29 AM

Exhibit 4
Kaiser Permanente 2010
Neurology Letter.

The Permanente Medical Group, Inc.

NEUROLOGY
3701 Broadway
Oakland, CA 94611-5613
Dept: 510-752-6509

July 14, 2010

Ola Teslenko
4057 Birchgrove Way
Sacramento, CA 95826

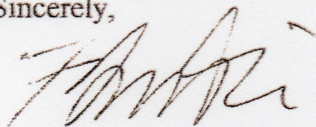
Ms. Teslenko,

I first saw you in April 2010 for lifelong progressively worsening symptoms of poor coordination and slurred speech. There is also a history of this in your father. Your MRI shows cerebellar degeneration. Laboratory testing was negative.

You are diagnosed with cerebellar degeneration - inherited type. The exact genotype is unknown. Many of the genetic forms of cerebellar degeneration do not yet have genetic tests available for them yet.

Unfortunately, your condition results in slurred speech, unsteady gait, poor arm and hand coordination, and visual difficulties, which as you have discovered, are often misinterpreted by laypeople and law enforcement officers as signs of intoxication. You should carry this letter of explanation with you in order to try to minimize any misunderstanding in those situations.

Sincerely,



FRANK ARTHUR DUSTIN MD
Department of Neurology

07/14/2010 - Office Visit in NEUROLOGY DEPARTMENT (continued)**Clinical Notes (continued)**

going on now. She would like a genetics eval - will arrange. Wonders about her pupils - likely autonomic related to migraines - discussed "migraine hygiene" for prevention.

The total visit time face to face with the patient was 30min. Time spent in counseling and discussion with the patient was 16min, and we discussed the above.

Electronically signed by Dustin, Frank Arthur (M.D.) at 7/14/2010 3:27 PM

Letters**Letter by Dustin, Frank Arthur (M.D.) on 7/14/2010**

Status: Sent

Letter body:

July 14, 2010

Ola Teslenko
4057 Birchgrove Way
Sacramento, CA 95826

Ms. Teslenko,

I first saw you in April 2010 for lifelong progressively worsening symptoms of poor coordination and slurred speech. There is also a history of this in your father. Your MRI shows cerebellar degeneration. Laboratory testing was negative.

You are diagnosed with cerebellar degeneration - inherited type. The exact genotype is unknown. Many of the genetic forms of cerebellar degeneration do not yet have genetic tests available for them yet.

Unfortunately, your condition results in slurred speech, unsteady gait, poor arm and hand coordination, and visual difficulties, which as you have discovered, are often misinterpreted by laypeople and law enforcement officers as

07/14/2010 - Office Visit in NEUROLOGY DEPARTMENT (continued)**Letters (continued)**

signs of intoxication. You should carry this letter of explanation with you in order to try to minimize any misunderstanding in those situations.

Sincerely,

FRANK ARTHUR DUSTIN MD
Department of Neurology

Vitals**Vital Signs - Last Recorded**

Most recent update: 7/14/2010 1:29 PM

BP
105/68

Pulse
68

The Permanente Medical Group, Inc.

NEUROLOGY
3701 Broadway
Oakland, CA 94611-5613
Dept: 510-752-6509

July 14, 2010

Ola Teslenko
4057 Birchgrove Way
Sacramento, CA 95826

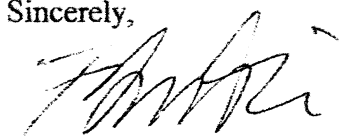
Ms. Teslenko,

I first saw you in April 2010 for lifelong progressively worsening symptoms of poor coordination and slurred speech. There is also a history of this in your father. Your MRI shows cerebellar degeneration. Laboratory testing was negative.

You are diagnosed with cerebellar degeneration - inherited type. The exact genotype is unknown. Many of the genetic forms of cerebellar degeneration do not yet have genetic tests available for them yet.

Unfortunately, your condition results in slurred speech, unsteady gait, poor arm and hand coordination, and visual difficulties, which as you have discovered, are often misinterpreted by laypeople and law enforcement officers as signs of intoxication. You should carry this letter of explanation with you in order to try to minimize any misunderstanding in those situations.

Sincerely,



FRANK ARTHUR DUSTIN MD
Department of Neurology

Exhibit 5
Dignity Health 2017
Brain MRI Report.



Dignity Health
3400 Data Drive
Rancho Cordova, CA 95670
Tel: (916) 851-2000

Patient Name: **Teslenko, Olga N**
Patient ID: **11784135A (MIC)**

Date of Birth: **12-Jan-1973**
Age: **44 years**
Gender: **female**
Accession Number: **8000001757060**
Location: **MIC Carmichael**
Referring Physician: **Peter Skaff**

Study Date: **28-Sep-2017 14:45**
Procedure Types: **MR BRAIN WO CONTRAST**

Verified

MR MR BRAIN WO CONTRAST

MRN: 11784135A
OLA N TESLENKO
DOB: 01/12/1973

Referred By:
PETER SKAFF, MD
6555 COYLE AVE STE 280

CARMICHAEL CA 95608

MR BRAIN WO CONTRAST
Exam Date: 09/28/2017
ACC: 8000001757060

EXAM: MR BRAIN WO CONTRAST

EXAM DATE: 9/28/2017 3:00 PM PDT

INDICATION: ATAXIA

TECHNIQUE: Multiplanar, multisequential MRI of the brain was performed without contrast.

IV CONTRAST: None

COMPARISON: No priors are available at the time of dictation

FINDINGS:

Extra axial spaces: No extraaxial fluid collection.
Hemorrhage: No acute intracranial hemorrhage.
Ventricular system: Normal for age. No hydrocephalus.
Basal cisterns: Normal

Cerebral parenchyma: Nonspecific few scattered periventricular white matter
Flair signal hyperintensities, most likely chronic microvascular ischemic
change in a patient this age. No evidence for acute infarct. No
microhemorrhage. Supratentorial brain demonstrates no significant atrophy.
Midline shift: No midline shift.
Posterior fossa: Moderate to severe atrophy of the superior cerebellum, more
advanced for patient's stated age.

Calvarium: Normal

Visualized Paranasal sinuses: Ethmoid sinus mucosal thickening, the remainder
of the paranasal sinuses and mastoid air cells are clear
Sella and skull base: Pituitary gland appears unremarkable. Normal intracranial
flow voids at the skull base and circle of willis. There is degenerative
change of the right temporomandibular joint.

Other findings: None.

IMPRESSION:

Moderate to severe superior cerebellar atrophy, more than expected for
patient's age. No acute intracranial findings. No acute infarct.

Electronically Signed By: CAM CHAU MD
CC/aa
CC:
Tech:ACM

MERCY IMAGING CENTER CARMICHAEL mercyimaging.org
A service of Dignity Health Medical Foundation
6305 Coyle Avenue, Carmichael, CA 95608
Phone: 916-535-2000 Fax: 916-966-5063

Exhibit 6

Cerebellar Degeneration in the

ICD-10.

ICD-10

International statistical classification of diseases and related health problems

10th revision

**Volume 1
Tabular list**

**Fifth edition
2016**



**World Health
Organization**

WHO Library Cataloguing-in-Publication Data

International statistical classification of diseases and related health problems. – 10th revision, Fifth edition, 2016.

3 v.

Contents: v. 1. Tabular list -- v. 2. Instruction manual -- v. 3. Alphabetical index.

1.Diseases – classification. 2.Classification. 3.Manuals. I.World Health Organization. II.ICD-10.

ISBN 978 92 4 154916 5

(NLM classification: WB 15)

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Printed in France



Contents

Introduction	1
Acknowledgements	5
Updates	7
Training	7
WHO Collaborating Centres for the Family of International Classifications	9
Report of the International Conference for the Tenth Revision of the International Classification of Diseases	12
List of three-character categories	31
Tabular list of inclusions and four-character subcategories	97
I Certain infectious and parasitic diseases	99
II Neoplasms	165
III Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	227
IV Endocrine, nutritional and metabolic diseases	247
V Mental and behavioural disorders	281
VI Diseases of the nervous system	347
VII Diseases of the eye and adnexa	379
VIII Diseases of the ear and mastoid process	407
IX Diseases of the circulatory system	417
X Diseases of the respiratory system	457
XI Diseases of the digestive system	487
XII Diseases of the skin and subcutaneous tissue	533
XIII Diseases of the musculoskeletal system and connective tissue	561
XIV Diseases of the genitourinary system	607
XV Pregnancy, childbirth and the puerperium	643
XVI Certain conditions originating in the perinatal period	681
XVII Congenital malformations, deformations and chromosomal abnormalities	707
XVIII Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified	757

XIX	Injury, poisoning and certain other consequences of external causes	791
XX	External causes of morbidity and mortality	893
XXI	Factors influencing health status and contact with health services	989
XXII	Codes for special purposes	1033
	Morphology of neoplasms	1037
	Special tabulation lists for mortality and morbidity	1043
	Definitions	1067
	Regulations regarding nomenclature	1073

Systemic atrophies primarily affecting the central nervous system (G10–G14)

G10 **Huntington disease**

Incl.: Huntington chorea

G11 **Hereditary ataxia**

Excl.: cerebral palsy (G80.-)
hereditary and idiopathic neuropathy (G60.-)
metabolic disorders (E70–E90)

G11.0 **Congenital nonprogressive ataxia**

G11.1 **Early-onset cerebellar ataxia**

Note: Onset usually before the age of 20 years

Early-onset cerebellar ataxia with:

- essential tremor
- myoclonus [Hunt ataxia]
- retained tendon reflexes

Friedreich ataxia (autosomal recessive)

X-linked recessive spinocerebellar ataxia

G11.2 **Late-onset cerebellar ataxia**

Note: Onset usually after the age of 20 years.

G11.3 **Cerebellar ataxia with defective DNA repair**

Ataxia telangiectasia [Louis–Bar]

Excl.: Cockayne syndrome (Q87.1)
xeroderma pigmentosum (Q82.1)

G11.4 **Hereditary spastic paraplegia**

G11.8 **Other hereditary ataxias**

G11.9 **Hereditary ataxia, unspecified**

Hereditary cerebellar:

- ataxia NOS
- degeneration
- disease
- syndrome

G12 **Spinal muscular atrophy and related syndromes**

G12.0 **Infantile spinal muscular atrophy, type I [Werdnig–Hoffman]**

- G12.1 Other inherited spinal muscular atrophy**
 Progressive bulbar palsy of childhood [Fazio–Londe]
 Spinal muscular atrophy:
 • adult form
 • childhood form, type II
 • distal
 • juvenile form, type III [Kugelberg-Welander]
 • scapuloperoneal form
- G12.2 Motor neuron disease**
 Familial motor neuron disease
 Lateral sclerosis:
 • amyotrophic
 • primary
 Progressive:
 • bulbar palsy
 • spinal muscular atrophy
- G12.8 Other spinal muscular atrophies and related syndromes**
- G12.9 Spinal muscular atrophy, unspecified**
- G13* Systemic atrophies primarily affecting central nervous system in diseases classified elsewhere**
- G13.0* Paraneoplastic neuromyopathy and neuropathy**
 Carcinomatous neuromyopathy (C00–C97†)
 Sensorial paraneoplastic neuropathy [Denny Brown] (C00–D48†)
- G13.1* Other systemic atrophy primarily affecting central nervous system in neoplastic disease**
 Paraneoplastic limbic encephalopathy (C00–D48†)
- G13.2* Systemic atrophy primarily affecting central nervous system in myxoedema (E00.1†, E03.-†)**
- G13.8* Systemic atrophy primarily affecting central nervous system in other diseases classified elsewhere**
- G14 Postpolio syndrome**
Incl.: postpolio myelitic syndrome
Excl.: sequelae of poliomyelitis (B91)

Exhibit 7

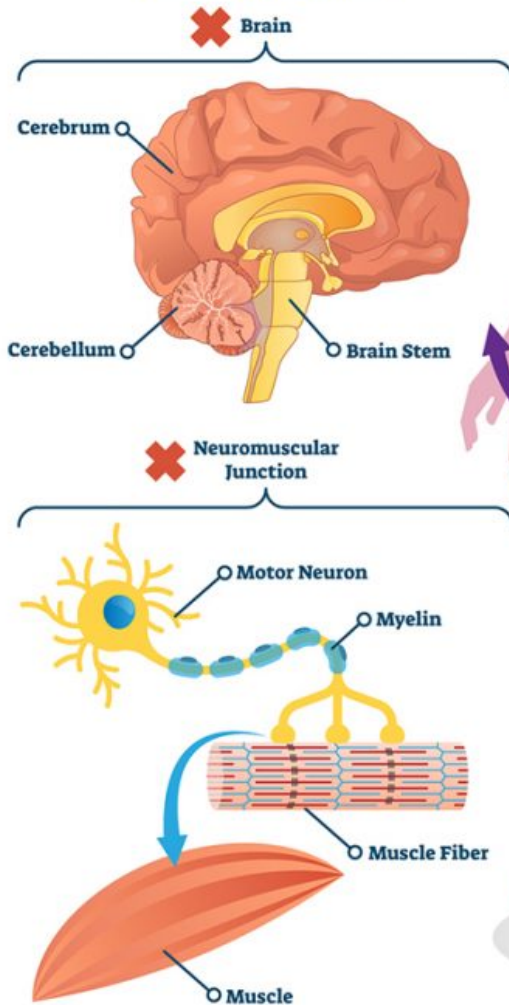
Medical Graphic:

Cerebellar Degeneration symptoms.

ATAXIA

Ataxia is a Degenerative Disease of the Nervous System Consisting of Lack of Voluntary Coordination of Muscle Movements

ATAXIA is a Clinical Manifestation Indicating **DYSFUNCTION** of the Parts of The **NERVOUS SYSTEM** that COORDINATE MOVEMENT



ATAXIA SYMPTOMS



Lack of Coordination



Eye Movement Abnormalities



Slurred Speech



Trouble Eating and Swallowing



Heart Problems



Tremors and Deterioration of Fine Motor Skills



Gait Abnormalities



Difficulty Walking and Poor Balance

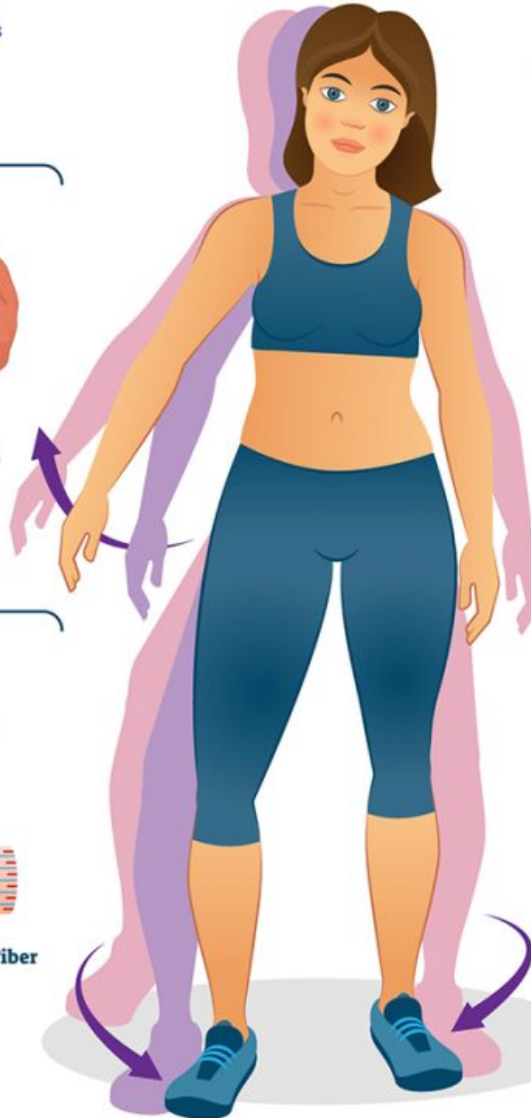


Exhibit 8

Disability Evaluation Under Social Security: Cerebellar Degeneration.

Medical/Professional Relations

[SSA Home](#) > [Disability](#) > [Medical/Professional Relations](#) > [Disability Evaluation Under Social Security](#) > [Listing of Impairments - Adult Listings \(Part A\)](#)

[Adult Listings \(Part A\)](#)

Disability Evaluation Under Social Security

[Childhood Listings \(Part B\)](#)

Listing of Impairments - Adult Listings (Part A)

[General Information](#)

The following sections contain medical criteria that apply to the evaluation of impairments in adults age 18 and over and that may apply to the evaluation of impairments in children under age 18 if the disease processes have a similar effect on adults and younger children.

[Evidentiary Requirements](#)

[Listing of Impairments \(overview\)](#)

[Revisions to Rules Regarding the Evaluation of Medical Evidence](#)

<u>1.00</u> <u>Musculoskeletal Disorders</u>	<u>2.00</u> <u>Special Senses and Speech</u>	<u>3.00</u> <u>Respiratory Disorders</u>
<u>4.00</u> <u>Cardiovascular System</u>	<u>5.00</u> <u>Digestive Disorders</u>	<u>6.00</u> <u>Genitourinary Disorders</u>
<u>7.00</u> <u>Hematological Disorders</u>	<u>8.00</u> <u>Skin Disorders</u>	<u>9.00</u> <u>Endocrine Disorders</u>
<u>10.00</u> <u>Congenital Disorders that Affect Multiple Body Systems</u>	<u>11.00</u> <u>Neurological Disorders</u>	<u>12.00</u> <u>Mental Disorders</u>
<u>13.00</u> <u>Cancer (Malignant Neoplastic Diseases)</u>	<u>14.00</u> <u>Immune System Disorders</u>	

Medical/Professional Relations

SSA > Disability > Medical/Professional Relations

> Disability Evaluation Under Social Security

> Listing of Impairments - Adult Listings (Part A)

> 11.00 Neurological - Adult

[Adult Listings \(Part A\)](#)

Disability Evaluation Under Social Security

[Childhood Listings \(Part B\)](#)

11.00 Neurological - Adult

[General Information](#)

Section

11.00 Neurological

[Evidentiary Requirements](#)

11.01
Category of Impairments, Neurological Disorders

A. [Which neurological disorders do we evaluate under these listings?](#)

[Listing of Impairments \(overview\)](#)

We evaluate epilepsy, amyotrophic lateral sclerosis, coma or persistent vegetative state (PVS), and neurological disorders that cause disorganization of motor function, bulbar and neuromuscular dysfunction, communication impairment, or a combination of limitations in physical and mental functioning such as early-onset Alzheimer’s disease. We evaluate neurological disorders that may manifest in a combination of limitations in physical and mental functioning. For example, if you have a neurological disorder that causes mental limitations, such as Huntington’s disease, which may limit executive functioning (e.g., regulating attention, planning, inhibiting responses, decision-making), we evaluate your limitations using the functional criteria under these listings (see [11.00G](#)). Under this body system, we evaluate the limitations resulting from the impact of the neurological disease process itself. If your neurological disorder results in only mental impairment or if you have a co-occurring mental condition that is not caused by your neurological disorder (for example, dementia), we will evaluate your mental impairment under the mental disorders body system, [12.00](#).

[Revisions to Rules Regarding the Evaluation of Medical Evidence](#)

11.02
Epilepsy

11.03
[\[Reserved\]](#)

11.04
[Vascular insult to the brain](#)

11.05
[Benign brain tumors](#)

11.06
[Parkinsonian syndrome](#)

B. [What evidence do we need to document your neurological disorder?](#)

11.07
[Cerebral palsy](#)

11.08

Spinal cord disorders

11.09

Multiple sclerosis

11.10

Amyotrophic lateral sclerosis (ALS)

11.11

Post-polio syndrome

11.12

Myasthenia gravis

11.13

Muscular dystrophy

11.14

Peripheral neuropathy

11.15

[Reserved]

11.16

[Reserved]

11.17

Neurodegenerative disorders of the central nervous

1. We need both medical and non-medical evidence (signs, symptoms, and laboratory findings) to assess the effects of your neurological disorder. Medical evidence should include your medical history, examination findings, relevant laboratory tests, and the results of imaging. Imaging refers to medical imaging techniques, such as x-ray, computerized tomography (CT), magnetic resonance imaging (MRI), and electroencephalography (EEG). The imaging must be consistent with the prevailing state of medical knowledge and clinical practice as the proper technique to support the evaluation of the disorder. In addition, the medical evidence may include descriptions of any prescribed treatment and your response to it. We consider non-medical evidence such as statements you or others make about your impairments, your restrictions, your daily activities, or your efforts to work.
2. We will make every reasonable effort to obtain the results of your laboratory and imaging evidence. When the results of any of these tests are part of the existing evidence in your case record, we will evaluate the test results and all other relevant evidence. We will not purchase imaging, or other diagnostic tests, or laboratory tests that are complex, may involve significant risk, or that are invasive. We will not routinely purchase tests that are expensive or not readily available.

C. How do we consider adherence to prescribed treatment in neurological disorders?

In 11.02 (Epilepsy), 11.06 (Parkinsonian syndrome), and 11.12 (Myasthenia gravis), we require that limitations from these neurological disorders exist despite adherence to prescribed treatment. "Despite adherence to prescribed treatment" means that you have taken medication(s) or followed other treatment procedures for your neurological disorder(s) as prescribed by a physician for three consecutive months but your impairment continues to meet the other listing requirements despite this treatment. You may receive your treatment at a health care facility that you visit regularly, even if you do not see the same physician on each visit.

D. What do we mean by disorganization of motor function?

system, such as Huntington's disease, Friedreich's ataxia, and spinocerebellar degeneration

11.18

Traumatic brain injury

11.19

[Reserved]

11.20

Coma or persistent vegetative state

11.21

[Reserved]

11.22

Motor neuron disorders other than ALS

1. Disorganization of motor function means interference, due to your neurological disorder, with movement of two extremities; i.e., the lower extremities, or upper extremities (including fingers, wrists, hands, arms, and shoulders). By two extremities we mean both lower extremities, or both upper extremities, or one upper extremity and one lower extremity. All listings in this body system, except for 11.02 (Epilepsy), 11.10 (Amyotrophic lateral sclerosis), and 11.20 (Coma and persistent vegetative state), include criteria for disorganization of motor function that results in an extreme limitation in your ability to:
 - Stand up from a seated position; or
 - Balance while standing or walking; or
 - Use the upper extremities (including fingers, wrists, hands, arms, and shoulders).
2. Extreme limitation means the inability to stand up from a seated position, maintain balance in a standing position and while walking, or use your upper extremities to independently initiate, sustain, and complete work-related activities. The assessment of motor function depends on the degree of interference with standing up; balancing while standing or walking; or using the upper extremities (including fingers, hands, arms, and shoulders).
 - a. Inability to stand up from a seated position means that once seated you are unable to stand and maintain an upright position without the assistance of another person or the use of an assistive device, such as a walker, two crutches, or two canes.
 - b. Inability to maintain balance in a standing position means that you are unable to maintain an upright position while standing or walking without the assistance of another person or an assistive device, such as a walker, two crutches, or two canes.
 - c. Inability to use your upper extremities means that you have a loss of function of both upper extremities (including fingers, wrists, hands, arms, and shoulders) that very seriously limits your ability to independently

initiate, sustain, and complete work-related activities involving fine and gross motor movements. Inability to perform fine and gross motor movements could include not being able to pinch, manipulate, and use your fingers; or not being able to use your hands, arms, and shoulders to perform gross motor movements, such as handling, gripping, grasping, holding, turning, and reaching; or not being able to engage in exertional movements such as lifting, carrying, pushing, and pulling.

E. How do we evaluate communication impairments under these listings? We must have a description of a recent comprehensive evaluation including all areas of communication, performed by an acceptable medical source, to document a communication impairment associated with a neurological disorder. A communication impairment may occur when a medically determinable neurological impairment results in dysfunction in the parts of the brain responsible for speech and language. We evaluate communication impairments associated with neurological disorders under 11.04A, 11.07C, or 11.11B. We evaluate communication impairments due to non-neurological disorders under 2.09.

1. Under 11.04A, we need evidence documenting that your central nervous system vascular accident or insult (CVA) and sensory or motor aphasia have resulted in ineffective speech or communication. Ineffective speech or communication means there is an extreme limitation in your ability to understand or convey your message in simple spoken language resulting in your inability to demonstrate basic communication skills, such as following one-step commands or telling someone about your basic personal needs without assistance.
2. Under 11.07C, we need evidence documenting that your cerebral palsy has resulted in significant interference in your ability to speak, hear, or see. We will find you have "significant interference" in your ability to speak, hear, or see if your signs, such as aphasia, strabismus, or sensorineural hearing loss, seriously limit your ability to communicate on a sustained basis.

3. Under 11.11B, we need evidence documenting that your post-polio syndrome has resulted in the inability to produce intelligible speech.

F. What do we mean by bulbar and neuromuscular dysfunction? The bulbar region of the brain is responsible for controlling the bulbar muscles in the throat, tongue, jaw, and face. Bulbar and neuromuscular dysfunction refers to weakness in these muscles, resulting in breathing, swallowing, and speaking impairments. Listings 11.11 (Post-polio syndrome), 11.12 (Myasthenia gravis), and 11.22 (Motor neuron disorders other than ALS) include criteria for evaluating bulbar and neuromuscular dysfunction. If your neurological disorder has resulted in a breathing disorder, we may evaluate that condition under the respiratory system, 3.00.

G. How do we evaluate limitations in physical and mental functioning under these listings?

1. Neurological disorders may manifest in a combination of limitations in physical and mental functioning. We consider all relevant information in your case record to determine the effects of your neurological disorder on your physical and mental functioning. To satisfy the requirement described under 11.00G, your neurological disorder must result in a marked limitation in physical functioning and a marked limitation in at least one of four areas of mental functioning: understanding, remembering, or applying information; interacting with others; concentrating, persisting, or maintaining pace; or adapting or managing oneself. If your neurological disorder results in an extreme limitation in at least one of the four areas of mental functioning, or results in marked limitation in at least two of the four areas of mental functioning, but you do not have at least a marked limitation in your physical functioning, we will consider whether your condition meets or medically equals one of the mental disorders body system listings, 12.00.
2. Marked Limitation. To satisfy the requirements of the functional criteria, your neurological disorder must result in a marked limitation in physical functioning and a

marked limitation in one of the four areas of mental functioning (see [11.00G3](#)). Although we do not require the use of such a scale, "marked" would be the fourth point on a five-point scale consisting of no limitation, mild limitation, moderate limitation, marked limitation, and extreme limitation. We consider the nature and overall degree of interference with your functioning. The term "marked" does not require that you must be confined to bed, hospitalized, or in a nursing home.

- a. Marked limitation and physical functioning. For this criterion, a marked limitation means that, due to the signs and symptoms of your neurological disorder, you are seriously limited in the ability to independently initiate, sustain, and complete work-related physical activities (see [11.00G3](#)). You may have a marked limitation in your physical functioning when your neurological disease process causes persistent or intermittent symptoms that affect your abilities to independently initiate, sustain, and complete work-related activities, such as standing, balancing, walking, using both upper extremities for fine and gross movements, or results in limitations in using one upper and one lower extremity. The persistent and intermittent symptoms must result in a serious limitation in your ability to do a task or activity on a sustained basis. We do not define "marked" by a specific number of different physical activities or tasks that demonstrate your ability, but by the overall effects of your neurological symptoms on your ability to perform such physical activities on a consistent and sustained basis. You need not be totally precluded from performing a function or activity to have a marked limitation, as long as the degree of limitation seriously limits your ability to independently initiate, sustain, and complete work-related physical activities.
- b. Marked limitation and mental functioning. For this criterion, a marked limitation means that, due to the signs and symptoms of your neurological disorder, you are seriously limited in the ability to function independently, appropriately, effectively, and on a sustained basis in work settings (see [11.03G3](#)). We do

not define “marked” by a specific number of mental activities, such as: the number of activities that demonstrate your ability to understand, remember, and apply information; the number of tasks that demonstrate your ability to interact with others; a specific number of tasks that demonstrate you are able to concentrate, persist or maintain pace; or a specific number of tasks that demonstrate you are able to manage yourself. You may have a marked limitation in your mental functioning when several activities or functions are impaired, or even when only one is impaired. You need not be totally precluded from performing an activity to have a marked limitation, as long as the degree of limitation seriously limits your ability to function independently, appropriately, and effectively on a sustained basis, and complete work-related mental activities.

3. Areas of physical and mental functioning.

- a. Physical functioning. Examples of this criterion include specific motor abilities, such as independently initiating, sustaining, and completing the following activities: standing up from a seated position, balancing while standing or walking, or using both your upper extremities for fine and gross movements (see 11.00D). Physical functioning may also include functions of the body that support motor abilities, such as the abilities to see, breathe, and swallow (see 11.00E and 11.00F). Examples of when your limitation in seeing, breathing, or swallowing may, on its own, rise to a “marked” limitation include: prolonged and uncorrectable double vision causing difficulty with balance; prolonged difficulty breathing requiring the use of a prescribed assistive breathing device, such as a portable continuous positive airway pressure machine; or repeated instances, occurring at least weekly, of aspiration without causing aspiration pneumonia. Alternatively, you may have a combination of limitations due to your neurological disorder that together rise to a “marked” limitation in physical functioning. We may also find that you have a “marked” limitation in this area if, for example, your

symptoms, such as pain or fatigue (see 11.00T), as documented in your medical record, and caused by your neurological disorder or its treatment, seriously limit your ability to independently initiate, sustain, and complete these work-related motor functions, or the other physical functions or physiological processes that support those motor functions. We may also find you seriously limited in an area if, while you retain some ability to perform the function, you are unable to do so consistently and on a sustained basis. The limitation in your physical functioning must last or be expected to last at least 12 months. These examples illustrate the nature of physical functioning. We do not require documentation of all of the examples.

b. Mental functioning.

- i. Understanding, remembering, or applying information. This area of mental functioning refers to the abilities to learn, recall, and use information to perform work activities. Examples include: understanding and learning terms, instructions, procedures; following one- or two-step oral instructions to carry out a task; describing work activity to someone else; asking and answering questions and providing explanations; recognizing a mistake and correcting it; identifying and solving problems; sequencing multi-step activities; and using reason and judgment to make work-related decisions. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples.
- ii. Interacting with others. This area of mental functioning refers to the abilities to relate to and work with supervisors, co-workers, and the public. Examples include: cooperating with others; asking for help when needed; handling conflicts with others; stating your own point of view; initiating or sustaining conversation; understanding and responding to social cues (physical, verbal, emotional); responding to requests, suggestions, criticism, correction, and challenges; and keeping

social interactions free of excessive irritability, sensitivity, argumentativeness, or suspiciousness. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples.

iii. Concentrating, persisting, or maintaining pace.

This area of mental functioning refers to the abilities to focus attention on work activities and to stay on-task at a sustained rate. Examples include: initiating and performing a task that you understand and know how to do; working at an appropriate and consistent pace; completing tasks in a timely manner; ignoring or avoiding distractions while working; changing activities or work settings without being disruptive; working close to or with others without interrupting or distracting them; sustaining an ordinary routine and regular attendance at work; and working a full day without needing more than the allotted number or length of rest periods during the day. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples.

iv. Adapting or managing oneself. This area of mental functioning refers to the abilities to regulate emotions, control behavior, and maintain well-being in a work setting. Examples include: responding to demands; adapting to changes; managing your psychologically based symptoms; distinguishing between acceptable and unacceptable work performance; setting realistic goals; making plans for yourself independently of others; maintaining personal hygiene and attire appropriate to a work setting; and being aware of normal hazards and taking appropriate precautions. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples.

4. Signs and symptoms of your disorder and the effects of treatment.

- a. We will consider your signs and symptoms and how they affect your ability to function in the work place. When we evaluate your functioning, we will consider whether your signs and symptoms are persistent or intermittent, how frequently they occur and how long they last, their intensity, and whether you have periods of exacerbation and remission.
- b. We will consider the effectiveness of treatment in improving the signs, symptoms, and laboratory findings related to your neurological disorder, as well as any aspects of treatment that may interfere with your ability to function. We will consider, for example: the effects of medications you take (including side effects); the time-limited efficacy of some medications; the intrusiveness, complexity, and duration of your treatment (for example, the dosing schedule or need for injections); the effects of treatment, including medications, therapy, and surgery, on your functioning; the variability of your response to treatment; and any drug interactions.

H. What is epilepsy, and how do we evaluate it under 11.02?

1. Epilepsy is a pattern of recurrent and unprovoked seizures that are manifestations of abnormal electrical activity in the brain. There are various types of generalized and "focal" or partial seizures. However, psychogenic nonepileptic seizures and pseudoseizures are not epileptic seizures for the purpose of 11.02. We evaluate psychogenic seizures and pseudoseizures under the mental disorders body system, 12.00. In adults, the most common potentially disabling seizure types are generalized tonic-clonic seizures and dyscognitive seizures (formerly complex partial seizures).
 - a. Generalized tonic-clonic seizures are characterized by loss of consciousness accompanied by a tonic phase (sudden muscle tensing causing the person to lose postural control) followed by a clonic phase (rapid cycles of muscle contraction and relaxation, also called convulsions). Tongue biting and incontinence may occur during generalized tonic-clonic seizures, and injuries may result from falling.

- b. Dyscognitive seizures are characterized by alteration of consciousness without convulsions or loss of muscle control. During the seizure, blank staring, change of facial expression, and automatisms (such as lip smacking, chewing or swallowing, or repetitive simple actions, such as gestures or verbal utterances) may occur. During its course, a dyscognitive seizure may progress into a generalized tonic-clonic seizure (see 11.00H1a).
2. Description of seizure. We require at least one detailed description of your seizures from someone, preferably a medical professional, who has observed at least one of your typical seizures. If you experience more than one type of seizure, we require a description of each type.
3. Serum drug levels. We do not require serum drug levels; therefore, we will not purchase them. However, if serum drug levels are available in your medical records, we will evaluate them in the context of the other evidence in your case record.
4. Counting seizures. The period specified in 11.02A, B, or C cannot begin earlier than one month after you began prescribed treatment. The required number of seizures must occur within the period we are considering in connection with your application or continuing disability review. When we evaluate the frequency of your seizures, we also consider your adherence to prescribed treatment (see 11.00C). When we determine the number of seizures you have had in the specified period, we will:
 - a. Count multiple seizures occurring in a 24-hour period as one seizure.
 - b. Count status epilepticus (a continuous series of seizures without return to consciousness between seizures) as one seizure.
 - c. Count a dyscognitive seizure that progresses into a generalized tonic-clonic seizure as one generalized tonic-clonic seizure.
 - d. We do not count seizures that occur during a period when you are not adhering to prescribed treatment without good reason. When we determine that you

had good reason for not adhering to prescribed treatment, we will consider your physical, mental, educational, and communicative limitations (including any language barriers). We will consider you to have good reason for not following prescribed treatment if, for example, the treatment is very risky for you due to its consequences or unusual nature, or if you are unable to afford prescribed treatment that you are willing to accept, but for which no free community resources are available. We will follow guidelines found in our policy, such as §§ 404.1530(c) and 416.930(c) of this chapter, when we determine whether you have a good reason for not adhering to prescribed treatment.

- e. We do not count psychogenic nonepileptic seizures or pseudoseizures under 11.02. We evaluate these seizures under the mental disorders body system, 12.00.

5. Electroencephalography (EEG) testing. We do not require EEG test results; therefore, we will not purchase them. However, if EEG test results are available in your medical records, we will evaluate them in the context of the other evidence in your case record.

I. What is vascular insult to the brain, and how do we evaluate it under 11.04?

1. Vascular insult to the brain (cerebrum, cerebellum, or brainstem), commonly referred to as stroke or cerebrovascular accident (CVA), is brain cell death caused by an interruption of blood flow within or leading to the brain, or by a hemorrhage from a ruptured blood vessel or aneurysm in the brain. If you have a vision impairment resulting from your vascular insult, we may evaluate that impairment under the special senses body system, 2.00.
2. We need evidence of sensory or motor aphasia that results in ineffective speech or communication under 11.04A (see 11.00E). We may evaluate your communication impairment under listing 11.04C if you have marked limitation in physical functioning and marked limitation in one of the four areas of mental

functioning.

3. We generally need evidence from at least 3 months after the vascular insult to evaluate whether you have disorganization of motor functioning under 11.04B, or the impact that your disorder has on your physical and mental functioning under 11.04C. In some cases, evidence of your vascular insult is sufficient to allow your claim within 3 months post-vascular insult. If we are unable to allow your claim within 3 months after your vascular insult, we will defer adjudication of the claim until we obtain evidence of your neurological disorder at least 3 months post-vascular insult.

J. What are benign brain tumors, and how do we evaluate them under 11.05? Benign brain tumors are noncancerous (nonmalignant) abnormal growths of tissue in or on the brain that invade healthy brain tissue or apply pressure on the brain or cranial nerves. We evaluate their effects on your functioning as discussed in 11.00D and 11.00G. We evaluate malignant brain tumors under the cancer body system in 13.00. If you have a vision impairment resulting from your benign brain tumor, we may evaluate that impairment under the special senses body system, 2.00.

K. What is Parkinsonian syndrome, and how do we evaluate it under 11.06? Parkinsonian syndrome is a term that describes a group of chronic, progressive movement disorders resulting from loss or decline in the function of dopamine-producing brain cells. Dopamine is a neurotransmitter that regulates muscle movement throughout the body. When we evaluate your Parkinsonian syndrome, we will consider your adherence to prescribed treatment (see 11.00C).

L. What is cerebral palsy, and how do we evaluate it under 11.07?

1. Cerebral palsy (CP) is a term that describes a group of static, nonprogressive disorders caused by abnormalities within the brain that disrupt the brain's ability to control movement, muscle coordination, and posture. The resulting motor deficits manifest very early in a person's

development, with delayed or abnormal progress in attaining developmental milestones. Deficits may become more obvious as the person grows and matures over time.

2. We evaluate your signs and symptoms, such as ataxia, spasticity, flaccidity, athetosis, chorea, and difficulty with precise movements when we determine your ability to stand up, balance, walk, or perform fine and gross motor movements. We will also evaluate your signs, such as dysarthria and apraxia of speech, and receptive and expressive language problems when we determine your ability to communicate.
3. We will consider your other impairments or signs and symptoms that develop secondary to the disorder, such as post-impairment syndrome (a combination of pain, fatigue, and weakness due to muscle abnormalities); overuse syndromes (repetitive motion injuries); arthritis; abnormalities of proprioception (perception of the movements and position of the body); abnormalities of stereognosis (perception and identification of objects by touch); learning problems; anxiety; and depression.

M. What are spinal cord disorders, and how do we evaluate them under 11.08?

1. Spinal cord disorders may be congenital or caused by injury to the spinal cord. Motor signs and symptoms of spinal cord disorders include paralysis, flaccidity, spasticity, and weakness.
2. Spinal cord disorders with complete loss of function (11.08A) addresses spinal cord disorders that result in a complete lack of motor, sensory, and autonomic function of the affected part(s) of the body.
3. Spinal cord disorders with disorganization of motor function (11.08B) addresses spinal cord disorders that result in less than a complete loss of function of the affected part(s) of the body, reducing, but not eliminating, motor, sensory, and autonomic function.
4. When we evaluate your spinal cord disorder, we generally need evidence from at least 3 months after your symptoms began in order to evaluate your

disorganization of motor function. In some cases, evidence of your spinal cord disorder may be sufficient to allow your claim within 3 months after the spinal cord disorder. If the medical evidence demonstrates total cord transection causing a loss of motor and sensory functions below the level of injury, we will not wait 3 months but will make the allowance decision immediately.

N. What is multiple sclerosis, and how do we evaluate it under 11.09?

1. Multiple sclerosis (MS) is a chronic, inflammatory, degenerative disorder that damages the myelin sheath surrounding the nerve fibers in the brain and spinal cord. The damage disrupts the normal transmission of nerve impulses within the brain and between the brain and other parts of the body, causing impairment in muscle coordination, strength, balance, sensation, and vision. There are several forms of MS, ranging from mildly to highly aggressive. Milder forms generally involve acute attacks (exacerbations) with partial or complete recovery from signs and symptoms (remissions). Aggressive forms generally exhibit a steady progression of signs and symptoms with few or no remissions. The effects of all forms vary from person to person.
2. We evaluate your signs and symptoms, such as flaccidity, spasticity, spasms, incoordination, imbalance, tremor, physical fatigue, muscle weakness, dizziness, tingling, and numbness when we determine your ability to stand up, balance, walk, or perform fine and gross motor movements. When determining whether you have limitations of physical and mental functioning, we will consider your other impairments or signs and symptoms that develop secondary to the disorder, such as fatigue; visual loss; trouble sleeping; impaired attention, concentration, memory, or judgment; mood swings; and depression. If you have a vision impairment resulting from your MS, we may evaluate that impairment under the special senses body system, 2.00.

O. What is amyotrophic lateral sclerosis, and how do we

evaluate it under 11.10? Amyotrophic lateral sclerosis (ALS) is a type of motor neuron disorder that rapidly and progressively attacks the nerve cells responsible for controlling voluntary muscles. We establish ALS under 11.10 when you have a documented diagnosis of ALS. We require documentation based on generally accepted methods consistent with the prevailing state of medical knowledge and clinical practice. We require laboratory testing to establish the diagnosis when the clinical findings of upper and lower motor neuron disease are not present in three or more regions. Electrophysiological studies, such as nerve conduction velocity studies and electromyography (EMG), may support your diagnosis of ALS; however, we will not purchase these studies.

P. What are neurodegenerative disorders of the central nervous system, such as Huntington's disease, Friedreich's ataxia, and spinocerebellar degeneration, and how do we evaluate them under 11.17? Neurodegenerative disorders of the central nervous system are disorders characterized by progressive and irreversible degeneration of neurons or their supporting cells. Over time, these disorders impair many of the body's motor, cognitive, and other mental functions. We consider neurodegenerative disorders of the central nervous system under 11.17 that we do not evaluate elsewhere in section 11.00, such as Huntington's disease (HD), Friedreich's ataxia, spinocerebellar degeneration, Creutzfeldt-Jakob disease (CJD), progressive supranuclear palsy (PSP), early-onset Alzheimer's disease, and frontotemporal dementia (Pick's disease). When these disorders result in solely cognitive and other mental function effects, we will evaluate the disorder under the mental disorder listings.

Q. What is traumatic brain injury, and how do we evaluate it under 11.18?

1. Traumatic brain injury (TBI) is damage to the brain resulting from skull fracture, collision with an external force leading to a closed head injury, or penetration by an object that enters the skull and makes contact with brain tissue. We evaluate TBI that results in coma or

persistent vegetative state (PVS) under 11.20.

2. We generally need evidence from at least 3 months after the TBI to evaluate whether you have disorganization of motor function under 11.18A or the impact that your disorder has on your physical and mental functioning under 11.18B. In some cases, evidence of your TBI is sufficient to determine disability within 3 months post-TBI. If we are unable to allow your claim within 3 months post-TBI, we will defer adjudication of the claim until we obtain evidence of your neurological disorder at least 3 months post-TBI. If a finding of disability still is not possible at that time, we will again defer adjudication of the claim until we obtain evidence at least 6 months after your TBI.

R. What are coma and persistent vegetative state, and how do we evaluate them under 11.20? Coma is a state of unconsciousness in which a person does not exhibit a sleep/wake cycle, and is unable to perceive or respond to external stimuli. People who do not fully emerge from coma may progress into a persistent vegetative state (PVS). PVS is a condition of partial arousal in which a person may have a low level of consciousness but is still unable to react to external stimuli. In contrast to coma, a person in a PVS retains sleep/wake cycles and may exhibit some key lower brain functions, such as spontaneous movement, opening and moving eyes, and grimacing. Coma or PVS may result from TBI, a nontraumatic insult to the brain (such as a vascular insult, infection, or brain tumor), or a neurodegenerative or metabolic disorder. Medically induced comas are not considered under 11.20 and should be considered under the section pertaining to the underlying reason the coma was medically induced and not under this section.

S. What are motor neuron disorders, other than ALS, and how do we evaluate them under 11.22? Motor neuron disorders such as progressive bulbar palsy, primary lateral sclerosis (PLS), and spinal muscular atrophy (SMA) are progressive neurological disorders that destroy the cells that control voluntary muscle activity, such as walking, breathing, swallowing, and speaking. We evaluate the effects of these

disorders on motor functioning, bulbar and neuromuscular functioning, oral communication, or limitations in physical and mental functioning.

T. How do we consider symptoms of fatigue in these listings? Fatigue is one of the most common and limiting symptoms of some neurological disorders, such as multiple sclerosis, post-polio syndrome, and myasthenia gravis. These disorders may result in physical fatigue (lack of muscle strength) or mental fatigue (decreased awareness or attention). When we evaluate your fatigue, we will consider the intensity, persistence, and effects of fatigue on your functioning. This may include information such as the clinical and laboratory data and other objective evidence concerning your neurological deficit, a description of fatigue considered characteristic of your disorder, and information about your functioning. We consider the effects of physical fatigue on your ability to stand up, balance, walk, or perform fine and gross motor movements using the criteria described in 11.00D. We consider the effects of physical and mental fatigue when we evaluate your physical and mental functioning described in 11.00G.

U. How do we evaluate your neurological disorder when it does not meet one of these listings?

1. If your neurological disorder does not meet the criteria of any of these listings, we must also consider whether your impairment(s) meets the criteria of a listing in another body system. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing. See §§ 404.1526 and 416.926 of this chapter.
2. If your impairment(s) does not meet or medically equal the criteria of a listing, you may or may not have the residual functional capacity to perform your past relevant work or adjust to other work that exists in significant numbers in the national economy, which we determine at the fourth and, if necessary, the fifth steps of the sequential evaluation process in §§ 404.1520 and 416.920 of this chapter.

3. We use the rules in §§ [404.1594](#) and [416.994](#) of this chapter, as appropriate, when we decide whether you continue to be disabled.

11.01 Category of Impairments, Neurological Disorders

11.02 Epilepsy, documented by a detailed description of a typical seizure and characterized by A, B, C, or D:

A. Generalized tonic-clonic seizures (see [11.00H1a](#)), occurring at least once a month for at least 3 consecutive months (see [11.00H4](#)) despite adherence to prescribed treatment (see [11.00C](#)).

OR

B. Dyscognitive seizures (see [11.00H1b](#)), occurring at least once a week for at least 3 consecutive months (see [11.00H4](#)) despite adherence to prescribed treatment (see [11.00C](#)).

OR

C. Generalized tonic-clonic seizures (see [11.00H1a](#)), occurring at least once every 2 months for at least 4 consecutive months (see [11.00H4](#)) despite adherence to prescribed treatment (see [11.00C](#)); and a marked limitation in one of the following:

1. Physical functioning (see [11.00G3a](#)); or
2. Understanding, remembering, or applying information (see [11.00G3b\(i\)](#)); or
3. Interacting with others (see [11.00G3b\(ii\)](#)); or
4. Concentrating, persisting, or maintaining pace (see [11.00G3b\(iii\)](#)); or
5. Adapting or managing oneself (see [11.00G3b\(iv\)](#)).

OR

D. Dyscognitive seizures (see [11.00H1b](#)), occurring at least once every 2 weeks for at least 3 consecutive months (see [11.00H4](#)) despite adherence to prescribed treatment (see [11.00C](#)); and a marked limitation in one of the following:

1. Physical functioning (see [11.00G3a](#)); or

2. Understanding, remembering, or applying information (see [11.00G3b\(i\)](#)); or
3. Interacting with others (see [11.00G3b\(ii\)](#)); or
4. Concentrating, persisting, or maintaining pace (see [11.00G3b\(iii\)](#)); or
5. Adapting or managing oneself (see [11.00G3b\(iv\)](#)).

11.03 [Reserved]

11.04 Vascular insult to the brain, characterized by A, B, or C:

A. Sensory or motor aphasia resulting in ineffective speech or communication (see [11.00E1](#)) persisting for at least 3 consecutive months after the insult.

OR

B. Disorganization of motor function in two extremities (see [11.00D1](#)), resulting in an extreme limitation (see [11.00D2](#)) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities, persisting for at least 3 consecutive months after the insult.

OR

C. Marked limitation (see [11.00G2](#)) in physical functioning (see [11.00G3a](#)) and in one of the following areas of mental functioning, both persisting for at least 3 consecutive months after the insult:

1. Understanding, remembering, or applying information (see [11.00G3b\(i\)](#)); or
2. Interacting with others (see [11.00G3b\(ii\)](#)); or
3. Concentrating, persisting, or maintaining pace (see [11.00G3b\(iii\)](#)); or
4. Adapting or managing oneself (see [11.00G3b\(iv\)](#)).

11.05 Benign brain tumors, characterized by A or B:

A. Disorganization of motor function in two extremities (see [11.00D1](#)), resulting in an extreme limitation (see [11.00D2](#)) in

the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

OR

B. Marked limitation (see [11.00G2](#)) in physical functioning (see [11.00G3a](#)), and in one of the following:

1. Understanding, remembering, or applying information (see [11.00G3b\(i\)](#)); or
2. Interacting with others (see [11.00G3b\(ii\)](#)); or
3. Concentrating, persisting, or maintaining pace (see [11.00G3b\(iii\)](#)); or
4. Adapting or managing oneself (see [11.00G3b\(iv\)](#)).

11.06 Parkinsonian syndrome, characterized by A or B despite adherence to prescribed treatment for at least 3 consecutive months (see [11.00C](#)):

A. Disorganization of motor function in two extremities (see [11.00D1](#)), resulting in an extreme limitation (see [11.00D2](#)) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

OR

B. Marked limitation (see [11.00G2](#)) in physical functioning (see [11.00G3a](#)), and in one of the following:

1. Understanding, remembering, or applying information (see [11.00G3b\(i\)](#)); or
2. Interacting with others (see [11.00G3b\(ii\)](#)); or
3. Concentrating, persisting, or maintaining pace (see [11.00G3b\(iii\)](#)); or
4. Adapting or managing oneself (see [11.00G3b\(iv\)](#)).

11.07 Cerebral palsy, characterized by A, B, or C:

A. Disorganization of motor function in two extremities (see [11.00D1](#)), resulting in an extreme limitation (see [11.00D2](#)) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

OR

B. Marked limitation (see [11.00G2](#)) in physical functioning (see [11.00G3a](#)), and in one of the following:

1. Understanding, remembering, or applying information (see [11.00G3b\(i\)](#)); or
2. Interacting with others (see [11.00G3b\(ii\)](#)); or
3. Concentrating, persisting, or maintaining pace (see [11.00G3b\(iii\)](#)); or
4. Adapting or managing oneself (see [11.00G3b\(iv\)](#)).

OR

C. Significant interference in communication due to speech, hearing, or visual deficit (see [11.00E2](#)).

11.08 Spinal cord disorders, characterized by A, B, or C:

A. Complete loss of function, as described in [11.00M2](#), persisting for 3 consecutive months after the disorder (see [11.00M4](#)).

OR

B. Disorganization of motor function in two extremities (see [11.00D1](#)), resulting in an extreme limitation (see [11.00D2](#)) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities persisting for 3 consecutive months after the disorder (see [11.00M4](#)).

OR

C. Marked limitation (see [11.00G2](#)) in physical functioning (see [11.00G3a](#)) and in one of the following areas of mental functioning, both persisting for 3 consecutive months after the disorder (see [11.00M4](#)):

1. Understanding, remembering, or applying information (see [11.00G3b\(i\)](#)); or
2. Interacting with others (see [11.00G3b\(ii\)](#)); or
3. Concentrating, persisting, or maintaining pace (see

11.00G3b(iii)); or

4. Adapting or managing oneself (see 11.00G3b(iv)).

11.09 Multiple sclerosis, characterized by A or B:

A. Disorganization of motor function in two extremities (see 11.00D1), resulting in an extreme limitation (see 11.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

OR

B. Marked limitation (see 11.00G2) in physical functioning (see 11.00G3a), and in one of the following:

1. Understanding, remembering, or applying information (see 11.00G3b(i)); or
2. Interacting with others (see 11.00G3b(ii)); or
3. Concentrating, persisting, or maintaining pace (see 11.00G3b(iii)); or
4. Adapting or managing oneself (see 11.00G3b(iv)).

11.10 Amyotrophic lateral sclerosis (ALS) established by clinical and laboratory findings (see 11.00O).

11.11 Post-polio syndrome, characterized by A, B, C, or D:

A. Disorganization of motor function in two extremities (see 11.00D1), resulting in an extreme limitation (see 11.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

OR

B. Unintelligible speech (see 11.00E3).

OR

C. Bulbar and neuromuscular dysfunction (see 11.00F), resulting in:

1. Acute respiratory failure requiring mechanical ventilation;
or

2. Need for supplemental enteral nutrition via a gastrostomy or parenteral nutrition via a central venous catheter.

OR

D. Marked limitation (see 11.00G2) in physical functioning (see 11.00G3a), and in one of the following:

1. Understanding, remembering, or applying information (see 11.00G3b(i)); or
2. Interacting with others (see 11.00G3b(ii)); or
3. Concentrating, persisting, or maintaining pace (see 11.00G3b(iii)); or
4. Adapting or managing oneself (see 11.00G3b(iv)).

11.12 Myasthenia gravis, characterized by A, B, or C despite adherence to prescribed treatment for at least 3 months (see 11.00C):

A. Disorganization of motor function in two extremities (see 11.00D1), resulting in an extreme limitation (see 11.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

OR

B. Bulbar and neuromuscular dysfunction (see 11.00F), resulting in:

1. One myasthenic crisis requiring mechanical ventilation;
or
2. Need for supplemental enteral nutrition via a gastrostomy or parenteral nutrition via a central venous catheter.

OR

C. Marked limitation (see 11.00G2) in physical functioning (see 11.00G3a), and in one of the following:

1. Understanding, remembering, or applying information

(see [11.00G3b\(i\)](#)); or

2. Interacting with others (see [11.00G3b\(ii\)](#)); or
3. Concentrating, persisting, or maintaining pace (see [11.00G3b\(iii\)](#)); or
4. Adapting or managing oneself (see [11.00G3b\(iv\)](#)).

11.13 Muscular dystrophy, characterized by A or B:

A. Disorganization of motor function in two extremities (see [11.00D1](#)), resulting in an extreme limitation (see [11.00D2](#)) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

OR

B. Marked limitation (see [11.00G2](#)) in physical functioning (see [11.00G3a](#)), and in one of the following:

1. Understanding, remembering, or applying information (see [11.00G3b\(i\)](#)); or
2. Interacting with others (see [11.00G3b\(ii\)](#)); or
3. Concentrating, persisting, or maintaining pace (see [11.00G3b\(iii\)](#)); or
4. Adapting or managing oneself (see [11.00G3b\(iv\)](#)).

11.14 Peripheral neuropathy, characterized by A or B:

A. Disorganization of motor function in two extremities (see [11.00D1](#)), resulting in an extreme limitation (see [11.00D2](#)) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

OR

B. Marked limitation (see [11.00G2](#)) in physical functioning (see [11.00G3a](#)), and in one of the following:

1. Understanding, remembering, or applying information (see [11.00G3b\(i\)](#)); or
2. Interacting with others (see [11.00G3b\(ii\)](#)); or
3. Concentrating, persisting, or maintaining pace (see

11.00G3b(iii)); or

4. Adapting or managing oneself (see 11.00G3b(iv)).

11.15 [Reserved]

11.16 [Reserved]

11.17 Neurodegenerative disorders of the central nervous system, such as Huntington's disease, Friedreich's ataxia, and spinocerebellar degeneration, characterized by A or B:

A. Disorganization of motor function in two extremities (see 11.00D1), resulting in an extreme limitation (see 11.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

OR

B. Marked limitation (see 11.00G2) in physical functioning (see 11.00G3a), and in one of the following:

1. Understanding, remembering, or applying information (see 11.00G3b(i)); or
2. Interacting with others (see 11.00G3b(ii)); or
3. Concentrating, persisting, or maintaining pace (see 11.00G3b(iii)); or
4. Adapting or managing oneself (see 11.00G3b(iv)).

11.18 Traumatic brain injury, characterized by A or B:

A. Disorganization of motor function in two extremities (see 11.00D1), resulting in an extreme limitation (see 11.00D2) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities, persisting for at least 3 consecutive months after the injury.

OR

B. Marked limitation (see 11.00G2) in physical functioning (see 11.00G3a), and in one of the following areas of mental functioning, persisting for at least 3 consecutive months

after the injury:

1. Understanding, remembering, or applying information (see [11.00G3b\(i\)](#)); or
2. Interacting with others (see [11.00G3b\(ii\)](#)); or
3. Concentrating, persisting, or maintaining pace (see [11.00G3b\(iii\)](#)); or
4. Adapting or managing oneself (see [11.00G3b\(iv\)](#)).

11.19 [Reserved]

11.20 Coma or persistent vegetative state, persisting for at least 1 month.

11.21 [Reserved]

11.22 Motor neuron disorders other than ALS,

characterized by A, B, or C:

A. Disorganization of motor function in two extremities (see [11.00D1](#)), resulting in an extreme limitation (see [11.00D2](#)) in the ability to stand up from a seated position, balance while standing or walking, or use the upper extremities.

OR

B. Bulbar and neuromuscular dysfunction (see [11.00F](#)), resulting in:

1. Acute respiratory failure requiring invasive mechanical ventilation; or
2. Need for supplemental enteral nutrition via a gastrostomy or parenteral nutrition via a central venous catheter.

C. Marked limitation (see [11.00G2](#)) in physical functioning (see [11.00G3a](#)), and in one of the following:

1. Understanding, remembering, or applying information (see [11.00G3b\(i\)](#)); or
2. Interacting with others (see [11.00G3b\(ii\)](#)); or
3. Concentrating, persisting, or maintaining pace (see

11.00G3b(iii)); or

4. Adapting or managing oneself (see 11.00G3b(iv)).

Exhibit 9
SSDI Medicare Card.

This is your official Medicare card. It's for your use only. For your protection, Medicare cards have a unique number that's different from a Social Security number. Show your card when you get health services. Turn over to read more.

Esta es su tarjeta oficial de Medicare. Es para su uso solamente. Para su protección, las tarjetas de Medicare tienen un número único diferente a un número del Seguro Social. Muestre su tarjeta cuando reciba servicios médicos. Dé vuelta para leer más.

i4348-0073163 *****ALL FOR AADC 290 P006 T00229



OLGA TESLENKO
UNIT 103
100 FOUNTAIN POINTE LN
MYRTLE BEACH, SC 29579-7421



 **MEDICARE HEALTH INSURANCE**

OLGA TESLENKO

Medicare Number/Número de Medicare
3AN7-TJ1-UM68

Entitled to/Con derecho a
**HOSPITAL (PART A)
MEDICAL (PART B)**

Coverage starts/Cobertura empieza
**01-01-2013
01-01-2013**

0073163



Proof of Service

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM HORRY COUNTY

Court of Common Pleas

The Honorable Dale Van Slambrook, Circuit Court Judge

Appellate Case No. 2024-001734

Olga Teslenko, Appellant,

v.

Joe Kocsis and Carpet King & Flooring, Respondents.

PROOF OF SERVICE

Appellant hereby certifies that she has served her Motion for Reasonable Disability Accommodation upon Respondent, Mr. Joe Kocsis, who at all relevant times represented himself to be the owner of Carpet King & Flooring. Service was made by depositing a true copy thereof with United States Mail, postage prepaid, on September 28, 2026, addressed to: Joe Kocsis, Carpet King & Flooring, 532 Broadway Street, Myrtle Beach, SC 29577.

Respectfully submitted,

s/ Olga Teslenko

Olga Teslenko, Appellant, Pro Se
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Email: osenochen@gmail.com
Tel: (510) 388-2780

Dated: September 28, 2026.

RECEIVED

Sep 28 2026

SC Court of Appeals

THE STATE OF SOUTH CAROLINA
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s/ Olga Teslenko

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Dated: September 28, 2026.