To whom it may concern:

Using Chapter 38, Code of Federal Regulations, the following sections apply to Mr. Kevin [redacted]

SMC (l)

3.350(b)(1),(3), (4) Entitlement to SMC (l) - to wit:

1) Mr [redacted] effectively has total loss of use of his legs due to neurological damage from the hips down. Attributing "body balance" as a definition of the usefulness of his extremities, it can just as easily be said that having lower extremity prostheses will help redistribute body weight to achieve body balance during transfers between bed and wheelchair. Having lost the use of his legs/feet for ambulation, locomotion or excursion, he qualifies for SMC L on this alone. No amount of amputation will decrease his loss of use or improve his chances of locomotion.

In addition, due to diagnosed extreme upper body weakness in the right extremity, it can be said that he has also lost use of that extremity. This would satisfy the need for one foot and one arm to reach SMC (l).

The argument against R1 or R2 doesn't take into account that Mr. [redacted] is bedridden as evidenced by his numerous bedsores. 3.352(a) lists the criteria for (SMC L) regular aid and attendance **and being bedridden** (emphasis added) thusly:

(a) ***Basic criteria for regular aid and attendance and permanently bedridden.*** The following will be accorded consideration in determining the need for regular aid and attendance (§ 3.351(c)(3): inability of claimant to dress or undress himself (herself), or to keep himself (herself) ordinarily clean and presentable; frequent need of adjustment of any special prosthetic or orthopedic appliances which by reason of the particular disability cannot be done without aid (this will not include the adjustment of appliances which normal persons would be unable to adjust without aid, such as supports, belts, lacing at the back, etc.); inability of claimant to feed himself (herself) through loss of coordination of upper extremities or through extreme weakness; inability to attend to the wants of nature; or incapacity, physical or mental, which requires care or assistance on a regular basis to protect the claimant from hazards or dangers incident to his or her daily environment. "Bedridden" will be a proper basis for the determination. For the purpose of this paragraph "bedridden" will be that condition which, through its essential character, actually requires that the claimant remain in bed. The fact that claimant has voluntarily taken to bed or that a

physician has prescribed rest in bed for the greater or lesser part of the day to promote convalescence or cure will not suffice. It is not required that all of the disabling conditions enumerated in this paragraph be found to exist before a favorable rating may be made. The particular personal functions which the veteran is unable to perform should be considered in connection with his or her condition as a whole. It is only necessary that the evidence establish that the veteran is so helpless as to need regular aid and attendance, not that there be a constant need. Determinations that the veteran is so helpless, as to be in need of regular aid and attendance will not be based solely upon an opinion that the claimant's condition is such as would require him or her to be in bed. They must be based on the actual requirement of personal assistance from others.

Thus, Mr. [redacted] is *additionally* eligible for SMC L due to being bedridden (see 3.350(b)(4).

Mr. [redacted] suffers from Grand Mal seizures such that he requires constant aid and attendance which he is currently *not* receiving but paying for out of pocket currently. Seizures and the attendant risks of being helpless are also a consideration to qualify for 3.350(b)(3). See also 3.352(a). Mr. [redacted] cannot feed himself, prepare meals nor attend to the wants of nature. Additionally he cannot keep himself normally clean and presentable. Mr. [redacted] cannot clean, sterilize or bandage his bedsores without help.

Thus Mr. [redacted] s entitled to SMC L via three different paths- any one of which entitles him to SMC L. With his two 100% ratings, he also qualifies for a full step increase to SMC M via 3.350(f)(4). The argument for remuneration does not end there.

§3.350(b) states:

(b) ***Ratings under 38 U.S.C. 1114(l).*** The special monthly compensation provided by 38 U.S.C. 1114(l) is payable for anatomical loss **or loss of use of both feet**, **one hand and one foot**, blindness in both eyes with visual acuity of 5/200 or less **or being permanently bedridden** or **so helpless as to be in need of regular aid and attendance**. (emphasis added)

Please notice the conjunctive use of "or" in §3.350(b). Any one of the four above disabilities is sufficient to permit an award of SMC (l).

Due to Mr. [redacted] weakness in his upper right extremity, it might be alternately argued that he qualifies for SMC L on all four fronts. Again, the argument does not end here either.

SMC (o)

Regulations provide that where a Veteran shows entitlement to any two SMCs at levels (l), (m), or (n), entitlement to SMC (o) is established. 38 U.S.C.A. § 1114(o); 38 C.F.R. § 3.350(e)(1)(ii). To wit:

(e) ***Ratings under 38 U.S.C. 1114 (o).***
(1) The special monthly compensation provided by 38 U.S.C. 1114(o) is payable for any of the following conditions:
(ii) Conditions entitling to two or more of the rates (no condition being considered twice) provided in 38 U.S.C. 1114(l) through (n);

Thus, Mr. [redacted] has established his entitlement to SMC (o). In the alternative, Mr. [redacted] establishes entitlement to SMC (o) via SMC (l) and 3.350(e)(2) due to his loss of anal and bladder sphincter control.

SMC (o) can be arrived at a third way via 3.350(4). When a Veteran suffers the loss of use of extremities and is also helpless, they are entitled to SMC(o) as well. 3.350(4):

(4) ***Helplessness.*** The maximum rate, as a result of including helplessness as one of the entitling multiple disabilities, is intended to cover, in addition to obvious losses and blindness, conditions such as the **loss of use of two extremities** with absolute deafness and nearly total blindness **or with severe multiple injuries producing total disability outside the useless extremities, these conditions being construed as loss of use of two extremities and helplessness.** (emphasis added)

Please note the use of the phrase "useless extremities". This clearly encompasses the level of loss of use of Mr. [redacted] lower extremities.

SMC at (r-1) or (r-2)

Again, the argument does not end there. Entitlement to SMC (o) meets the threshold requirement for entitlement to SMC (r-1). The law states that when a Veteran is entitled to SMC (o) (or payment of an equal rate under SMC (p)), and establishes a factual need for A&A, entitlement to special A&A is demonstrated. 38 U.S.C.A. § 1114(r); 38 C.F.R. § 3.350(h). The need for A&A need not be independent of the underlying disabilities used to meet the threshold eligibility

requirement, as the regulation provides an exception to the pyramiding rule. 38 C.F.R. § 3.350(h)(1).

Maximum Compensation at (r-2) rate

(h) ***Special aid and attendance benefit; 38 U.S.C. 1114(r)*****—**
(1) Maximum compensation cases. A veteran receiving the maximum rate under 38 U.S.C. 1114 (o) or (p) who is in need of regular aid and attendance or a higher level of care is entitled to an additional allowance during periods he or she is not hospitalized at United States Government expense. (See § 3.552(b)(2) as to continuance following admission for hospitalization.) Determination of this need is subject to the criteria of § 3.352. The regular or higher level aid and attendance allowance is payable whether or not the need for regular aid and attendance or a higher level of care was a partial basis for entitlement to the maximum rate under 38 U.S.C. 1114 (o) or (p), or was based on an independent factual determination.

SMC (r) also contemplates A&A with a need for a "higher level of care (r-2)." This requires a showing that the Veteran requires daily personal health care services by a medical professional, or under the supervision of such, without which institutional care would be required. 38 C.F.R. § 3.350(h)(2). The Veteran has expressly raised the question of entitlement to this level of SMC, and has in fact argued for assignment of SMC at the (r-1) or (r-2) level. Further, the evidence of record indicates a need for such an intensive level of care. The Veteran requires assistance in life, but has also been able to maintain a quite high level of independent living. [See also AB v. Brown (1994) where the Veteran is seeking the highest level of compensation authorized by law.]

Mr. [redacted] set of deficits clearly demonstrate a complex interaction of diseases and helplessness. The licensed Registered Nurse caregiver's June 2015 statements, in conjunction with the incomplete day-to day-supervision and care afforded Mr. [redacted] by his part-time medically supervised caregiver reveal a dangerous gap in Aid and Attendance that he is entitled to and desperately needs.

38 CFR Part 4 -§ 4.2; § 4.7; § 4.10; § 4.40

In addition, 38 CFR §4.2 is for application:

§ 4.2 Interpretation of examination reports.

Different examiners, at different times, will not describe the same disability in the same language. Features of the disability which must have persisted unchanged may be overlooked or a change for the better or worse may not be accurately appreciated or described. **It is the responsibility of the rating specialist to interpret reports of examination in the light of the whole recorded history, reconciling the various reports into a consistent picture so that the current rating may accurately reflect the elements of disability present**. Each disability must be considered from the point of view of the veteran working or seeking work. If a diagnosis is not supported by the findings on the examination report or if the report does not contain sufficient detail, it is incumbent upon the rating board to return the report as inadequate for evaluation purposes.

§ 4.7 Higher of two evaluations.
Where there is a question as to which of two evaluations shall be applied, **the higher evaluation will be assigned if the disability picture more nearly approximates the criteria required for that rating.** Otherwise, the lower rating will be assigned.

§ 4.10 Functional impairment.
The basis of disability evaluations is the ability of the body as a whole, or of the psyche, or of a system or organ of the body to function under the ordinary conditions of daily life including employment. Whether the upper or lower extremities, the back or abdominal wall, the eyes or ears, or the cardiovascular, digestive, or other system, or psyche are affected, **evaluations are based upon lack of usefulness, of these parts or systems, especially in self-support**. This imposes upon the medical examiner the responsibility of furnishing, in addition to the etiological, anatomical, pathological, laboratory and prognostic data required for ordinary medical classification, full description of the effects of disability upon the person's ordinary activity. In this connection, it will be remembered that a person may be too disabled to engage in employment although he or she is up and about and fairly comfortable at home or upon limited activity.

§ 4.40 Functional loss.

Disability of the musculoskeletal system is primarily the inability, due to damage or infection in parts of the system, to perform the normal working movements of the body with normal excursion, strength, speed, coordination and endurance. It is essential that the examination on which ratings are based adequately portray the anatomical damage, and the functional loss, with respect to all these elements. The functional loss may be due to absence of part, or all, of the necessary bones, joints and muscles, or associated structures, or to deformity, adhesions, defective innervation, or other pathology, or it may be due to pain, supported by adequate pathology and evidenced by the visible behavior of the claimant undertaking the motion. Weakness is as important as

limitation of motion, and a part which becomes painful on use must be regarded as seriously disabled. A little used part of the musculoskeletal system may be expected to show evidence of disuse, either through atrophy, the condition of the skin, absence of normal callosity or the like.

Mr. [redacted] clearly doesn't have use of his lower extremities. In the clarification of the findings in the September 2015 VA Examination, the VA examiner unequivocally opined on further instructions to elucidate his rationale that:

bilateral lower extremity radiculopathy affecting the sciatic, femoral, and ilio-inguinal nerves **are less likely than not (less than 50 percent probability**) of such severity that the functional impairment remaining would be equally well served by an amputation with prosthesis. (emphasis added)

It would appear the VA examiner is suggesting that an amputation would not repair the sciatic, femoral, and ilio-inguinal nerve radiculopathy. Amputation is not for application here as there is no salvage operation via amputation that will restore full use of the lower extremities under any circumstances.

the veteran was assessed to have SEVERE IMPAIRMENTS to his both(sic) Lower extremities brought about by his Bilateral lower extremity radiculopathy affecting the sciatic, femoral, and ilioinguinal nerves, (emphasis in original)

Here, the examiner has identified the source of the loss of use. As it is not a physical defect brought about by deformity or injury to the muscle/bone tissue, the argument for amputation and or use of prosthesis is not for application.

Even though he has manifestations of severe nerve deficits affecting both lower extremity (sic), such that he is **almost paralyzed and dependent on a wheelchair for transfers**, his bilateral lower extremity (sic) are still important in terms of "body balance" for transfers with the aid of an attendant.(emphasis added)

Here, the examiner clearly identifies the lower extremities as being "almost paralyzed and dependent upon a wheelchair for transfers. "Transfers" is assumed to describe the transition from the documented state of being bedridden to the wheelchair for washing up and attending to the wants of

nature or the changing of bedlinens. At no time does the VA examiner discuss or imply the actual ability to walk or stand unaided. As Mr. [redacted] is incapable of this without the aid of an attendant as stated by the examiner, any other perceived benefits of the extremities still do not negate a finding of loss of use. Merely having the legs attached without amputating them still does not aid in use of the legs to ambulate-even with the aid of an attendant. Here, a clear reading of §4.3 is in order:

§ 4.3 Resolution of reasonable doubt.
It is the defined and consistently applied policy of the Department of Veterans Affairs to administer the law under a broad interpretation, consistent, however, with the facts shown in every case. When after careful consideration of all procurable and assembled data, a reasonable doubt arises regarding the degree of disability such doubt will be resolved in favor of the claimant.

Mr. [redacted] condition clearly exhibits a the need for continuous, round –the-clock medical supervision at the (r-2) rate as his seizure disorder alone is a risk factor of immense proportions. Giving the benefit of the doubt in this instance is more than warranted because the evidence 'for' clearly is in equipoise with any evidence 'against'.

The Veterans Administration is a nonadversarial, Veteran-friendly agency that is required to grant any and all benefits where the need, requirement and mostly, the entitlement, is indisputable. Mr. [redacted] without incurring any pyramiding of benefits, has more than presented a cogent argument for SMC (o). In conjunction with his need for higher Aid and Attendance, he meets all the requirements of §3.350(h)(1) and §3.352(a)(b)(i),(ii),(iii),(2).

Accordingly, Mr. [redacted] should be awarded compensation at the (r-2) rate at the earliest date it can be ascertained that the compensation was due and payable for the present set of disabilities and a demonstrated need for Aid and Attendance at a higher rate.

The relevant law and precedence which control this Tucker v, West 11 Vet. App. 369; 1998 where the Court held:

The relevant inquiry concerning an SMC award is not whether amputation is warranted but whether the appellant has had effective function remaining other than that which would be equally well served by an amputation with use of a suitable prosthetic appliance. See 38 C.F.R. 3.350(a)(2)

The VA examiner, in Mr. [redacted] case, concluded that, because his situation was not of such severity that it would improve with amputation, the appellant was not eligible for SMC(l) based on solely on loss of use . This incorrect application of the standard was error.

Lower extremity amputations are reserved for extreme cases of recurrent lower extremity infection, traumatic amputations and lower extremity tumors (salvage procedures) which can compromise the patient's life if amputation is not to be done.
However, in the veteran's case, the root cause of his lower extremity condition are the nerves originating from the lumbar spine innervates the lower extremities. And strictly speaking, the major pathology/problem does not originate from any part of the lower extremity itself (from the hip down to the foot). But instead, the problem originates from the nerves that supply the muscles of the lower extrmity (sic) joints and surrounding stuctures (sic).

Therefore based on the above premise, the veterans service-connected bilateral lower extremity radiculopathy affecting the sciatic, femoral, and ilio-inguinal nerves are less likely than not (less than 50 percent probability) of such severity that the functional impairment remaining would be equally well served by an amputation with prosthesis.

Again, the wrong standard is being applied. Mr. [redacted] sincerely hopes the VA examiner is not suggesting that Mr. [redacted] need have any part of his lower extremities amputated in order to qualify for (r-1) or (r-2). His lower extremity disability is not of a salvage nature so any discussion of amputation is inapposite. Whether or not the injury/disease "originates" in the lower extremities is immaterial. It is only necessary for the resultant loss of use of his lower extremities to be attributable to a service connected injury. Here, it is unarguable that Mr. [redacted] service connected injury/disease renders his lower extremities inoperable from the hips down and hence he has loss of use as determined by SMC (l).

In conclusion, Mr. [redacted] has demonstrated entitlement to two (or more) of the requirements of SMCs (l), (m) or (n) that entitle him to SMC (o). In addition, with the clearly demonstrated finding of a need for aid and attendance recognized by the VA examiner, the only argument left is for a determination of the proper level of a higher need for aid and attendance at the (r-1) or (r-2) level. With the

evidence of record, and granting him the benefit of the doubt, Mr. [redacted] disability picture clearly shows entitlement to (r-2).