BOARD OF VETERANS' APPEAL
DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON, DC 20420

IN THE APPEAL OF [redacted]
LARRY E. GLENN

DOCKET NO. 11-32 260) DATE *September 1, 2015*
) *SDM*
)

On appeal from the
Department of Veterans Affairs Regional Office in Oakland, California

THE ISSUE

1. Entitlement to a disability rating in excess of 20 percent for intravertebral disc syndrome (IVDS), characterized as degenerative disc disease L3-L4.

2. Entitlement to an initial disability rating in excess of 20 percent for radiculopathy of the right leg.

3. Entitlement to an initial disability rating in excess of 20 percent for radiculopathy of the left leg.

REPRESENTATION

Appellant represented by: California Department of Veterans Affairs

ATTORNEY FOR THE BOARD

Aaron Moshiashwili, Associate Counsel

INTRODUCTION

The Veteran had active service from May 1973 to May 1977.

This matter comes before the Board of Veterans' Appeals (Board) on appeal from an April 2010 rating decision of the Department of Veterans Affairs (VA) Regional Office (RO) in Oakland, California, which increased the Veteran's disability rating for IVDS from 10 percent to 20 percent, effective January 19, 2010, the date of the Veteran's claim for increased rating. Later, the Veteran was separately awarded service connection for radiculopathy for each lower extremity and ultimately assigned a 20 percent rating for each leg, effective from January 2010. As radiculopathy is a manifestation of his low back disability, the rating assigned for radiculopathy will be considered in this decision.

FINDINGS OF FACT

1. The Veteran's intervertebral disc syndrome is characterized by forward flexion of the thoracolumbar spine greater than 30 degrees, no ankylosis, and no episodes of acute signs and symptoms due to IVDS that required bed rest prescribed by a physician and treatment by a physician in the past 12 months.

2. The Veteran's right leg radiculopathy is characterized by moderate incomplete paralysis.

3. The Veteran's left leg radiculopathy is characterized by moderate incomplete paralysis.

CONCLUSIONS OF LAW

1. The criteria for a disability rating in excess of 20 percent for intravertebral disc syndrome are not met. 38 U.S.C.A. §§ 1155, 5103, 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.105, 3.159, 3.344, 4.1, 4.2, 4.13, 4.71a; Diagnostic Code 5243 (2015).

2. The criteria for an initial disability rating in excess of 20 percent for right leg radiculopathy are not met. 38 U.S.C.A. §§ 1154(a), 1155, 5107(b) (West 2014); 38 C.F.R. §§ 3.102, 3.321, 4.1, 4.2, 4.123, 4.124, 4.124a, DC 8520 (2015).

3. The criteria for an initial disability rating in excess of 20 percent for left leg radiculopathy are not met. 38 U.S.C.A. §§ 1154(a), 1155, 5107(b) (West 2014); 38 C.F.R. §§ 3.102, 3.321, 4.1, 4.2, 4.123, 4.124, 4.124a, DC 8520 (2015).

REASONS AND BASES FOR FINDINGS AND CONCLUSION

Duties to Notify and Assist

As provided by the Veterans Claims Assistance Act of 2000 (VCAA), VA has a duty to notify and assist claimants in substantiating a claim for VA benefits. 38 U.S.C.A. §§ 5100, 5102, 5103, 5103A, 5107, 5126 (West 2014); 38 C.F.R. §§ 3.102, 3.156(a), 3.159 and 3.326(a) (2015).

Upon receipt of a complete or substantially complete application for benefits, VA is required to notify the claimant and his or her representative of any information, and any medical or lay evidence, that is necessary to substantiate the claim. 38 U.S.C.A. § 5103(a); 38 C.F.R. § 3.159(b). Proper notice must inform the claimant of any information and evidence not of record (1) that is necessary to substantiate the claim; (2) that VA will seek to provide; and (3) that the claimant is expected to provide in accordance with 38 C.F.R. § 3.159(b)(1). *Pelegrini v. Principi*, 18 Vet. App. 112, 120-121 (2004). This notice should be provided prior to an initial unfavorable decision on a claim by the AOJ. *Mayfield v. Nicholson*, 444 F.3d 1328 (Fed. Cir. 2006); *Pelegrini v. Principi*, 18 Vet. App. 112 (2004).

In addition, the notice requirements of the VCAA apply to all five elements of a claim, including: (1) Veteran status; (2) existence of a disability; (3) a connection between the Veteran's service and the disability; (4) degree of disability; and (5) effective date of the disability. *See Dingess v. Nicholson*, 19 Vet. App. 473 (2006). Further, this notice must include notice that a disability rating and an effective date

for the award of benefits will be assigned if service connection is awarded. *Id*. at 486.

For an increased-compensation claim, section § 5103(a) requires, at a minimum, that the Secretary notify the claimant that, to substantiate a claim, the claimant must provide, or ask the Secretary to obtain, medical or lay evidence demonstrating a worsening or increase in severity of the disability and the effect that worsening has on the claimant's employment and daily life. *Vazquez-Flores v. Peake*, 22 Vet. App. 37 (2008), vacated on other grounds sub nom., *Vazquez-Flores v. Shinseki*, 580 F.3d 1270 (Fed. Cir. 2009). Further, if the diagnostic code under which the claimant is rated contains criteria necessary for entitlement to a higher disability rating that would not be satisfied by the claimant demonstrating a noticeable worsening or increase in severity of the disability and the effect that worsening has on the claimant's employment and daily life (such as a specific measurement or test result), the Secretary must provide at least general notice of that requirement to the claimant. Additionally, the claimant must be notified that, should an increase in disability be found, a disability rating will be determined by applying relevant diagnostic codes, which typically provide for a range in severity of a particular disability from noncompensable to as much as 100 percent (depending on the disability involved), based on the nature of the symptoms of the condition for which disability compensation is being sought, their severity and duration, and their impact upon employment and daily life. As with proper notice for an initial disability rating and consistent with the statutory and regulatory history, the notice must also provide examples of the types of medical and lay evidence that the claimant may submit (or ask the Secretary to obtain) that are relevant to establishing entitlement to increased compensation-e.g., competent lay statements describing symptoms, medical and hospitalization records, medical statements, employer statements, job application rejections, and any other evidence showing an increase in the disability or exceptional circumstances relating to the disability.

Here, the duty to notify was satisfied by a letter dated March 2010, which was sent prior to the April 2010 decision by the RO.

Next, VA has a duty to assist the Veteran in the development of the claim. This duty includes assisting the Veteran in the procurement of service medical records and pertinent treatment records and providing an examination when necessary. 38 U.S.C.A. § 5103A; 38 C.F.R. § 3.159. In this case, the RO has obtained service treatment records, private and VA treatment records, and lay statements.

The Veteran was afforded VA compensation and pension examinations germane to his claims on appeal in April 2010 and February 2015; these examinations were adequate because the examiners based their opinions upon consideration of the Veteran's prior medical history, described the disabilities in sufficient detail so that the Board's evaluations of the disabilities will be fully informed, and supported all conclusions with analyses that the Board could consider and weigh against contrary opinions. Additionally, the VA examinations of record fully describe the functional effects caused by the Veteran's disabilities. *Martinak v. Nicholson*, 21 Vet. App. 447, 455 (2007).

For the foregoing reasons, the Board concludes that VA made all reasonable efforts to obtain evidence necessary to substantiate the Veteran's claims. Therefore, no further assistance to the Veteran with the development of evidence is required.

Analysis

Disability ratings are determined by applying a schedule of ratings that is based on average impairment of earning capacity. Separate diagnostic codes identify the various disabilities. 38 U.S.C.A. § 1155; 38 C.F.R., Part 4. Each disability must be viewed in relation to its history and the limitation of activity imposed by the disabling condition should be emphasized. 38 C.F.R. § 4.1. Examination reports are to be interpreted in light of the whole recorded history, and each disability must be considered from the point of view of the appellant working or seeking work. 38 C.F.R. § 4.2. Where there is a question as to which of two disability evaluations shall be applied, the higher evaluation is to be assigned if the disability picture more nearly approximates the criteria required for that rating. Otherwise, the lower rating is to be assigned. 38 C.F.R. § 4.7.

The Board notes that while the regulations require review of the recorded history of a disability by the adjudicator to ensure an accurate evaluation, the regulations do not give past medical reports precedence over the current medical findings. Where an increase in the disability rating is at issue, the present level of the Veteran's disability is the primary concern. *Francisco v. Brown*, 7 Vet. App. 55, 58 (1994). It is also noted that staged ratings are appropriate for an increased rating claim whenever the factual findings show distinct time periods where the service-connected disability exhibits symptoms that would warrant different ratings. *See Hart v. Mansfield*, 21 Vet. App. 505 (2007).

IVDS

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. Functional loss may be due to the absence or deformity of structures or other pathology, or it may be due to pain, supported by adequate pathology and evidenced by the visible behavior in undertaking the motion. Weakness is as important as limitation of motion, and a part that becomes painful on use must be regarded as seriously disabled. 38 C.F.R. § 4.40. In *Mitchell v. Shinseki*, 25 Vet. App. 32 (2011), the United States Court of Appeals for Veterans Claims (Court) held that, although pain may cause a functional loss, 'pain itself does not rise to the level of functional loss as contemplated by VA regulations applicable to the musculoskeletal system.' Rather, pain may result in functional loss, but only if it limits the ability 'to perform the normal working movements of the body with normal excursion, strength, speed, coordination, or endurance.' *Id*., quoting 38 C.F.R. § 4.40.

Evidence of pain, weakened movement, excess fatigability, or incoordination must be considered in determining the level of associated functional loss in light of 38 C.F.R. § 4.40, taking into account any part of the musculoskeletal system that becomes painful on use. *DeLuca v. Brown*, 8 Vet. App. 202 (1995). The provisions regarding the avoidance of pyramiding do not forbid consideration of a higher rating based on greater limitation of motion due to pain on use, including flare ups. 38 C.F.R. § 4.14 (2015).

Under Diagnostic Code (DC) 5243, Intervertebral Disc Syndrome is evaluated either under the General Rating Formula for Diseases and Injuries of the Spine, or on the total duration of incapacitating episodes over the past twelve months, whichever method results in the higher rating. *See* 38 C.F.R. § 4.71a, DC 5243. For VA compensation purposes, normal forward flexion of the thoracolumbar spine is 0 to 90 degrees, extension is 0 to 30 degrees, left and right lateral flexion are 0 to 30 degrees, and left and right lateral rotation are 0 to 30 degrees. *See* 38 C.F.R. § 4.71a, General Rating Formula for Diseases and Injuries of the Spine, Note 2.

Under the General Rating Formula for Diseases of the Spine, a 20 percent rating is warranted where there is "forward flexion of the thoracolumbar spine greater than 30 degrees but not greater than 60 degrees; or, the combined range of motion of the thoracolumbar spine not greater than 120 degrees; or, muscle spasm or guarding severe enough to result in an abnormal gait or abnormal spinal contour such as scoliosis, reversed lordosis, or abnormal kyphosis." DC 5243.

A 40 percent rating is warranted where there is forward flexion of the thoracolumbar spine 30 degrees or less; or, favorable ankylosis of the entire thoracolumbar spine. *Id.*

A 50 percent rating is warranted where there is "unfavorable ankylosis of the entire thoracolumbar spine." *Id.*

An 100 percent rating is warranted where there is "unfavorable ankylosis of the entire spine." *Id.*

Under the Formula for Rating Intervertebral Disc Syndrome Based on Incapacitating Episodes, rating is based on the total duration of incapacitating episodes over the course of a year. An incapacitating episode is a period of acute signs and symptoms due to intervertebral disc syndrome that requires bed rest prescribed by a physician and treatment by a physician. With incapacitating episodes having a duration of at least one but less than two weeks, a 10 percent rating is warranted. *Id.*

With a duration of at least two but less than four weeks, a 20 percent rating is warranted. *Id.*

With a duration of at least four but less than six weeks, a 40 percent rating is warranted. *Id.*

With a duration of at least six weeks, a 60 percent rating is warranted. *Id.*

The Board notes that the General Rating Formula for Diseases and Injuries of the Spine expressly contemplates pain as a symptom of spinal disease. *Id.* ("With or without symptoms such as pain (whether or not it radiates), stiffness, or aching in the area of the spine affected by residuals of injury or disease.")

In his May 2010 Notice of Disagreement to the April 2010 decision granting him an increase from 10 percent to 20 percent for his IVDS, the Veteran asserted that his increasing back pain, along with radiation of pain into his lower extremities, warranted a rating higher than the 20 percent he was currently receiving.

In an April 2010 C&P examination, the examiner noted that the Veteran's gait was antalgic, and listed the Veteran's range of motion as forward flexion limited to 65 degrees, right and left lateral flexion of 25 degrees, and right and left lateral rotation limited to 25 degrees. The examiner also reported the Veteran's statement that he could not stand for more than 10 minutes or sit for more than 20 minutes.
In a February 2015 C&P examination, the VA examiner found that the Veteran's IVDS limited his forward flexion to 80 degrees (90 being normal), and limited his right and left lateral rotation to 20 degrees (30 being normal). The examiner reported that there was no ankylosis of the spine, and that there were no episodes of "acute signs and symptoms due to IVDS" in the past 12 months which required bed rest prescribed by a physician and treatment by a physician.

The Veteran's private treatment records from 2005 to the present were reviewed, and show that the Veteran is under regular care from his private doctor. The Veteran's private treatment records do not show any compensable symptoms not already noted during the Veteran's VA examinations.

The Board finds that the Veteran's symptoms do not more nearly approximate a rating of 30 percent under the General Rating Formula for Diseases and Injuries of the Spine, which requires forward flexion of the thoracolumbar spine limited to 30 degrees or less, or ankylosis of the spine; or a rating of 50 or 100 percent, each of which require ankylosis of the spine. The Veteran's February 2015 VA examiner reported forward flexion limited to 80 degrees and that there was no ankylosis of the spine.

The Veteran's symptoms also do not more nearly approximate a rating of 40 or 60 percent on the Formula for Rating Intervertebral Disc Syndrome Based on Incapacitating Episodes, which requires incapacitating episodes requiring bedrest prescribed by and treatment by a physician with a duration of four to six or greater than six weeks total over the course of 12 months, respectively. In this case, as confirmed in the February 2015 VA examination, the Veteran has never had bedrest prescribed by a physician nor treatment by a physician for any incapacitating episodes he may have had.

Radiculopathy

The Veteran is also in receipt of disability ratings for radiculopathy of both lower extremities, rated at 20 percent each. Sciatic nerve disabilities are rated at 80 percent where there is complete paralysis; the foot dangles and drops, there is no active movement possible of muscles below the knee, and flexion of the knee is weakened or (very rarely) lost. A 60 percent rating applies where there is severe incomplete paralysis with marked muscular atrophy. A 40 percent rating applies where there is moderately severe incomplete paralysis. Moderate incomplete paralysis is rated at 20 percent. Mild incomplete paralysis is rated at 10 percent. 38 C.F.R. § 4.124a, DC 8520.

In the Veteran's November 2011 form VA-9, he stated "At the present time I experience recurrent pain in my lower extremities on a daily basis which I believe to a minimum of moderate degree of incomplete paralysis." In a February 2015 VA

examination, the examiner found that the Veteran experienced moderate radiculopathy, with sciatic nerve involvement, in both of his lower extremities.

The Board finds, based on the report of the VA examiner and the Veteran's statement, that the Veteran's radiculopathy in each extremity is best described as moderate incomplete paralysis, which is rated at 20 percent under DC 8520. Neither the Veteran nor the examiner considered the Veteran's radiculopathy to be "moderately severe incomplete paralysis," warranting a 40 percent rating, "severe incomplete paralysis," warranting a 60 percent rating, or "complete paralysis," warranting an 80 percent rating.

Extraschedular rating and TDIU

In exceptional cases an extraschedular rating may be provided. 38 C.F.R. § 3.321. The Court has set out a three-part test, based on the language of 38 C.F.R. § 3.321(b)(1), for determining whether a Veteran is entitled to an extra-schedular rating: (1) the established schedular criteria must be inadequate to describe the severity and symptoms of the claimant's disability; (2) the case must present other indicia of an exceptional or unusual disability picture, such as marked interference with employment or frequent periods of hospitalization; and (3) the award of an extra-schedular disability rating must be in the interest of justice. *Thun v. Peake*, 22 Vet. App. 111 (2008), aff'd, *Thun v. Shinseki*, 572 F.3d 1366 (Fed. Cir. 2009).

Here, the rating criteria contemplate the Veteran's IVDS, lower back pain, limitation of motion and radiculopathy. Therefore, referral for consideration of an extraschedular rating is not warranted.

Finally, the Court has held that a total disability rating based on individual unemployability (TDIU) is a part of a claim for increased rating. *Rice v. Shinseki*, 22 Vet. App. 447 (2009). Where a Veteran: (1) submits evidence of a medical disability; (2) makes a claim for the highest rating possible; and (3) submits evidence of unemployability, the requirement in 38 C.F.R. § 3.155(a) (2001) that an informal claim 'identify the benefit sought' has been satisfied and VA must consider whether the Veteran is entitled to a total rating for compensation purposes

based on individual unemployability (TDIU). *Roberson v. Principi*, 251 F.3d 1378 (Fed. Cir. 2001). The Board finds that the most probative evidence shows that the Veteran is not unemployable due to his IVDS and radiculopathy, either on their own or in combination with the Veteran's other service-connected disabilities. The record shows that the Veteran was employed at least as recently as May 2014, at least four years after his disability manifested to its current level. (See, e.g., telephone note from the Veteran to his doctor on May 14, 2014, requesting a note for his employer.) Thus, a TDIU is not justified by the facts of this case.

After reviewing all of the clinical evidence and subjective complaints, the Board finds that the Veteran's IVDS symptoms do not result in ankylosis, a limitation of forward flexion 30 degrees or less, or any incapacitating episodes in the last 12 months requiring bed rest prescribed by and treatment by a physician. Therefore, a rating above 20 percent is not warranted. The Veteran's radiculopathy in each leg is best characterized as "moderate"; therefore, a rating above 20 percent is not warranted. Accordingly, the Board concludes that reasonable doubt does not apply, and the criteria for a rating above 20 percent for the Veteran's IVDS and radiculopathy in each lower extremity have not been met.

ORDER

An evaluation in excess of 20 percent for L3-L4 intervertebral disc syndrome is denied.

An initial disability rating in excess of 20 percent for radiculopathy of the right leg is denied.

An initial disability rating in excess of 20 percent for radiculopathy of the left leg is denied.

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MICHAEL E. KILCOYNE
Veterans Law Judge, Board of Veterans' Appeals

YOUR RIGHTS TO APPEAL OUR DECISION

The attached decision by the Board of Veterans' Appeals (BVA or Board) is the final decision for all issues addressed in the "Order" section of the decision. The Board may also choose to remand an issue or issues to the local VA office for additional development. If the Board did this in your case, then a "Remand" section follows the "Order." However, you cannot appeal an issue remanded to the local VA office because a remand is not a final decision. *The advice below on how to appeal a claim applies only to issues that were allowed, denied, or dismissed in the "Order."*

If you are satisfied with the outcome of your appeal, you do not need to do anything. We will return your file to your local VA office to implement the BVA's decision. However, if you are not satisfied with the Board's decision on any or all of the issues allowed, denied, or dismissed, you have the following options, which are listed in no particular order of importance:

- Appeal to the United States Court of Appeals for Veterans Claims (Court)
- File with the Board a motion for reconsideration of this decision
- File with the Board a motion to vacate this decision
- File with the Board a motion for revision of this decision based on clear and unmistakable error.

Although it would not affect this BVA decision, you may choose to also:

- Reopen your claim at the local VA office by submitting new and material evidence.

There is *no* time limit for filing a motion for reconsideration, a motion to vacate, or a motion for revision based on clear and unmistakable error with the Board, or a claim to reopen at the local VA office. None of these things is mutually exclusive - you can do all five things at the same time if you wish. However, if you file a Notice of Appeal with the Court and a motion with the Board at the same time, this may delay your case because of jurisdictional conflicts. If you file a Notice of Appeal with the Court ***before*** you file a motion with the BVA, the BVA will not be able to consider your motion without the Court's permission.

How long do I have to start my appeal to the court? You have **120 days** from the date this decision was mailed to you (as shown on the first page of this decision) to file a Notice of Appeal with the Court. If you also want to file a motion for reconsideration or a motion to vacate, you will still have time to appeal to the court. *As long as you file your motion(s) with the Board within 120 days of the date this decision was mailed to you,* you will have another 120 days from the date the BVA decides the motion for reconsideration or the motion to vacate to appeal to the Court. You should know that even if you have a representative, as discussed below, *it is your responsibility to make sure that your appeal to the Court is filed on time*. Please note that the 120-day time limit to file a Notice of Appeal with the Court does not include a period of active duty. If your active military service materially affects your ability to file a Notice of Appeal (e.g., due to a combat deployment), you may also be entitled to an additional 90 days after active duty service terminates before the 120-day appeal period (or remainder of the appeal period) begins to run.

How do I appeal to the United States Court of Appeals for Veterans Claims? Send your Notice of Appeal to the Court at:

Clerk, U.S. Court of Appeals for Veterans Claims
625 Indiana Avenue, NW, Suite 900
Washington, DC 20004-2950

You can get information about the Notice of Appeal, the procedure for filing a Notice of Appeal, the filing fee (or a motion to waive the filing fee if payment would cause financial hardship), and other matters covered by the Court's rules directly from the Court. You can also get this information from the Court's website on the Internet at: http://www.uscourts.cavc.gov, and you can download forms directly from that website. The Court's facsimile number is (202) 501-5848.

To ensure full protection of your right of appeal to the Court, you must file your Notice of Appeal **with the Court**, not with the Board, or any other VA office.

How do I file a motion for reconsideration? You can file a motion asking the BVA to reconsider any part of this decision by writing a letter to the BVA clearly explaining why you believe that the BVA committed an obvious error of fact or law, or stating that new and material military service records have been discovered that apply to your appeal. It is important that such letter be as specific as possible. A general statement of dissatisfaction with the BVA decision or some other aspect of the VA claims adjudication process will not suffice. If the BVA has decided more than one issue, be sure to tell us which issue(s) you want reconsidered. Issues not clearly identified will not be considered. Send your letter to:

Director, Management, Planning and Analysis (014)
Board of Veterans' Appeals
810 Vermont Avenue, NW
Washington, DC 20420

Remember, the Board places no time limit on filing a motion for reconsideration, and you can do this at any time. However, if you also plan to appeal this decision to the Court, you must file your motion within 120 days from the date of this decision.

How do I file a motion to vacate? You can file a motion asking the BVA to vacate any part of this decision by writing a letter to the BVA stating why you believe you were denied due process of law during your appeal. *See* 38 C.F.R. 20.904. For example, you were denied your right to representation through action or inaction by VA personnel, you were not provided a Statement of the Case or Supplemental Statement of the Case, or you did not get a personal hearing that you requested. You can also file a motion to vacate any part of this decision on the basis that the Board allowed benefits based on false or fraudulent evidence. Send this motion to the address above for the Director, Management, Planning and Analysis, at the Board. Remember, the Board places no time limit on filing a motion to vacate, and you can do this at any time. However, if you also plan to appeal this decision to the Court, you must file your motion within 120 days from the date of this decision.

How do I file a motion to revise the Board's decision on the basis of clear and unmistakable error? You can file a motion asking that the Board revise this decision if you believe that the decision is based on "clear and unmistakable error" (CUE). Send this motion to the address above for the Director, Management, Planning and Analysis, at the Board. You should be careful when preparing such a motion because it must meet specific requirements, and the Board will not review a final decision on this basis more than once. You should carefully review the Board's Rules of Practice on CUE, 38 C.F.R. 20.1400 -- 20.1411, and *seek help from a qualified representative before filing such a motion.* See discussion on representation below. Remember, the Board places no time limit on filing a CUE review motion, and you can do this at any time.

How do I reopen my claim? You can ask your local VA office to reopen your claim by simply sending them a statement indicating that you want to reopen your claim. However, to be successful in reopening your claim, you must submit new and material evidence to that office. *See* 38 C.F.R. 3.156(a).

Can someone represent me in my appeal? Yes. You can always represent yourself in any claim before VA, including the BVA, but you can also appoint someone to represent you. An accredited representative of a recognized service organization may represent you free of charge. VA approves these organizations to help veterans, service members, and dependents prepare their claims and present them to VA. An accredited representative works for the service organization and knows how to prepare and present claims. You can find a listing of these organizations on the Internet at: http://www.va.gov/vso/. You can also choose to be represented by a private attorney or by an "agent." (An agent is a person who is not a lawyer, but is specially accredited by VA.)

If you want someone to represent you before the Court, rather than before the VA, you can get information on how to do so at the Court's website at: http://www.uscourts.cavc.gov. The Court's website provides a state-by-state listing of persons admitted to practice before the Court who have indicated their availability to the represent appellants. You may also request this information by writing directly to the Court. Information about free representation through the Veterans Consortium Pro Bono Program is also available at the Court's website, or at: http://www.vetsprobono.org, mail@vetsprobono.org, or (855) 446-9678.

Do I have to pay an attorney or agent to represent me? An attorney or agent may charge a fee to represent you after a notice of disagreement has been filed with respect to your case, provided that the notice of disagreement was filed on or after June 20, 2007. *See* 38 U.S.C. 5904; 38 C.F.R. 14.636. If the notice of disagreement was filed before June 20, 2007, an attorney or accredited agent may charge fees for services, but only after the Board first issues a final decision in the case, and only if the agent or attorney is hired within one year of the Board's decision. *See* 38 C.F.R. 14.636(c)(2).

The notice of disagreement limitation does not apply to fees charged, allowed, or paid for services provided with respect to proceedings before a court. VA cannot pay the fees of your attorney or agent, with the exception of payment of fees out of past-due benefits awarded to you on the basis of your claim when provided for in a fee agreement.

Fee for VA home and small business loan cases: An attorney or agent may charge you a reasonable fee for services involving a VA home loan or small business loan. *See* 38 U.S.C. 5904; 38 C.F.R. 14.636(d).

Filing of Fee Agreements: In all cases, a copy of any fee agreement between you and an attorney or accredited agent must be sent to the Secretary at the following address:

Office of the General Counsel (022D)
810 Vermont Avenue, NW
Washington, DC 20420

The Office of General Counsel may decide, on its own, to review a fee agreement or expenses charged by your agent or attorney for reasonableness. You can also file a motion requesting such review to the address above for the Office of General Counsel. *See* 38 C.F.R. 14.636(i); 14.637(d).