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

IN THE APPEAL OF [redacted]
JAMES GOLDEN, JR.

DOCKET NO. 13-12 525) DATE *December 30, 2015*
) *TDV*
)

On appeal from the
Department of Veterans Affairs Regional Office
in Columbia, South Carolina

THE ISSUES

1. Whether new and material evidence to reopen a claim for service connection for hearing loss of the right ear has been received.

2. Entitlement to service connection for bilateral hearing loss.

3. Entitlement to service connection for erectile dysfunction and leakage, to include as secondary to service-connected prostatitis and any medication taken for prostatitis.

4. Entitlement to service connection for coronary artery disease (characterized as ischemic heart disease) (heart disorder), to include as due to exposure to herbicides (consistent with *Nehmer v. United States Veterans Admin*., 32 F. Supp. 2d 1175 (N.D. Cal. 1999) (*Nehmer*)).

5. Entitlement to an initial rating in excess of 70 percent for posttraumatic stress disorder (PTSD) with depressive disorder.

6. Entitlement to a total rating disability based on individual unemployability (TDIU).

REPRESENTATION

Appellant represented by: Jeany Mark, Attorney

ATTORNEY FOR THE BOARD

L. Crohe, Counsel

INTRODUCTION

The Veteran served on active duty from July 1956 to March 1978.

This appeal to the Board of Veterans' Appeals (Board) arose from a December 2009 rating decision, which *inter alia*, denied service connection for bilateral hearing loss (previously hearing loss, right ear).

A June 2011 rating decision, *inter alia*, denied service connection for erectile dysfunction and continued a previous denial of service connection for a heart condition for the purposes of entitlement to retroactive benefits under the provisions of *Nehmer*. At the same time, the RO determined that material evidence had not been submitted to reopen his previously denied claim for bilateral hearing loss. In June 2012, the Veteran filed a NOD with these issues. In February 2013, the RO issued a statement of the case (SOC), and the Veteran filed a substantive appeal (via a VA Form 9, Appeal to the Board of Veteran's Appeals) in April 2013.

In another July 2011 rating decision, the RO granted service connection for PTSD with depressive disorder and assigned a 50 percent disability rating, effective April 12, 2010. In June 2012, the Veteran filed a NOD with the initial rating assigned. In

February 2013, the RO issued a SOC addressing the matter as "[e]valuation of post traumatic stress disorder with depressive disorder evaluated as 70 percent disabling." The Veteran filed a substantive appeal in April 2013.

A September 2012 rating decision denied entitlement to a TDIU. In September 2013, the Veteran filed a NOD. In November 2014, the RO issued a SOC, and the Veteran filed a substantive appeal in January 2015.

A November 2014 rating decision formally increased the initial rating for PTSD from 50 percent to 70 percent disabling, effective April 12, 2010.

The Veteran's claim for service connection for a heart disorder was previously denied in an unappealed June 1996 Board decision. New and material evidence would ordinarily be required to reopen this claim. *See* 38 U.S.C.A. § 5108 (West 2014); 38 C.F.R. § 3.156 (2015). However, since that time, VA has issued a liberalizing regulation that creates a presumptive basis for the award of service connection for ischemic heart disease as secondary to herbicide exposure. *See* 75 Fed. Reg. 53,202 (Aug. 31, 2010). The final rule noted that VA will apply this rule in readjudicating certain previously denied claims as required by court orders in *Nehmer*. Accordingly, the Board will adjudicate the claim on a *de novo* basis without requiring new and material evidence to reopen.

The Veteran's claim for service connection for right ear hearing loss was previously denied in an unappealed May 1978 rating decision. In a December 2009 rating decision, the RO essentially reopened the claim for right ear hearing loss by addressing the matter as entitlement to service connection for bilateral hearing loss on the merits. The Veteran did not initiate an appeal from that determination with respect to this issue. However, applicable regulations provide that if new and material evidence was received during an applicable appellate period following a RO decision (1 year for a rating decision and 60 days for a SOC) or prior to an appellate (Board) decision (if an appeal was timely filed), the new and material evidence will be considered as having been filed in connection with the claim that was pending at the beginning of the appeal period. 38 C.F.R. § 3.156(b); *Young v. Shinseki*, 22 Vet. App. 461, 466 (2009). Thus, under 38 C.F.R. § 3.156(b) "VA

must evaluate submissions received during the relevant [appeal] period and determine whether they contain new evidence relevant to a pending claim, whether or not the relevant submission might otherwise support a new claim." *Bond v. Shinseki*, 659 F.3e 1362, 1367 - 68 (Fed. Cir. 2011). "[N]ew and material evidence" under 38 C.F.R. § 3.156(b) has the same meaning as "new and material evidence" as defined in 38 C.F.R. § 3.156(a). *See Young v. Shinseki*, 22 Vet. App. 461, 468 (2011). In the present case, new and material evidence concerning the etiology of the Veteran's hearing loss was received in November 2010, or within one year of the December 2009 rating decision. As this evidence is considered as having been filed in connection with the claim that was pending at the beginning of the appeal period, the December 2009 rating decision did not become final with respect to this issue. *See* 38 C.F.R. § 3.156(b). Although the RO determined in a June 2011 rating decision that new and material evidence had not been submitted to reopen his previously denied claim for bilateral hearing loss, the December 2009 rating decision remained on appeal.

As noted, the RO addressed the Veteran's right ear hearing loss (characterized as bilateral hearing loss) on the merits in the December 2009 rating decision. Regardless, the Board has a legal duty under 38 U.S.C.A. §§ 5108 and 7104 to address the question of whether new and material evidence has been received to reopen a previously denied claim for service connection. That matter goes to the Board's jurisdiction to reach the underlying claim and adjudicate the claim on a *de novo* basis. *See Barnett v. Brown*, 83 F.3d 1380, 1383 (Fed. Cir. 1996). As the Board must first decide whether new and material evidence to reopen the claim for right ear hearing loss has been received—and, in view of the Board's favorable decision on the request to reopen—the Board has characterized the appeal as to hearing loss as encompassing the first and second matters set forth on the title page.

This appeal has been processed utilizing the Veterans Benefits Management System (VBMS), a paperless, electronic claims processing system. The Board notes that, in addition to the VBMS file, the Veteran has a separate, paperless, electronic Virtual VA file. A review of the documents in Virtual VA reveals treatment records from Dorn Veterans' Hospital and Charleston VA Medical Center (VAMC) dated from March 2013 to May 2014, which were considered in a November 2014 rating

decision, a November 2014 SOC, and a November 2014 SSOC—all of which, collectively, addressed all issues on appeal.

This appeal has been advanced on the Board's docket pursuant to38 U.S.C.A. § 7107(a)(2) (West 2014) and 38 C.F.R. § 20.900(c) (2015).

The Board's decisions regarding the request to reopen the claim for service connection for right ear hearing loss and the claim for a higher initial rating for PTSD is set forth below. The remaining claims on appeal are addressed in the remand following the order; these matters are being remanded to the agency of original jurisdiction (AOJ). VA will notify the Veteran when further action, on his part, is required.

FINDINGS OF FACT

1. All notification and development actions needed to fairly adjudicate the claim herein decided have been accomplished.

2. In a May 1978 decision, the RO denied the claim for service connection for hearing loss of the right ear. Although notified of the denial and of his appellate rights, the Veteran did not initiate an appeal, and no pertinent exception to finality applies.

3. New evidence associated with the claims file since the May 1978 denial relates to an unestablished fact necessary to substantiate the claim for service connection for hearing loss of the right ear, and raises a reasonable possibility of substantiating the claim.

4. Since the April 12, 2010 effective date of the award of service connection, the Veteran's psychiatric symptoms have included irritability, concentration problems, intrusive thoughts nightmares, flashbacks, avoidance behavior, emotional detachment, diminished interest, low energy, disturbances in motivation and mood, depression, flattened affect, decreased appetite and feelings of hope, anxiety,

exaggerated startle response, chronic sleep impairment, suicidal ideations, hallucinations, racing and jumping thoughts, difficulty in establishing and maintaining effective work and social relationships, difficulty in adapting to stressful circumstances, including work or a work like setting, and mildly to moderately impaired immediate information and for names, directions, or recent events; collectively, these symptoms are of the type, extent, and frequency or severity (as appropriate) that are indicative of no more than occupational and social impairment, with deficiencies in most areas, such as work, school, family relations, judgment, thinking, or mood.

5. The schedular criteria are adequate to rate the Veteran's PTSD with depressive disorder at all pertinent points.

CONCLUSIONS OF LAW

1. The RO's May 1978 denial of the claim of service connection for right ear hearing loss is final. 38 U.S.C.A. § 7105 (West 2014); 38 C.F.R. §§ 3.104, 20.302, 20.1103 (2015).

2. As additional evidence received since the RO's May 1978 denial is new and material, the criteria for reopening the claim for service connection for a right ear hearing loss are met. 38 U.S.C.A. § 5108 (West 2014); 38 C.F.R. § 3.156 (2015).

3. The criteria for an initial rating in excess of 70 percent for PTSD are not met. 38 U.S.C.A. §§ 1155, 5103, 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.102, 3.159, 3.321, 4.1, 4.3, 4.7, 4.10, 4.126, 4.130, Diagnostic Code 9411 (2015).

REASONS AND BASES FOR FINDINGS AND CONCLUSION

I. Due Process Considerations

The Veterans Claims Assistance Act of 2000 (VCAA), Pub. L. No. 106-475, 114 Stat. 2096 (Nov. 9, 2000) (codified at 38 U.S.C.A. §§ 5100, 5102, 5103, 5103A, 5106, 5107, and 5126 (West 2014)) includes enhanced duties to notify and assist claimants for VA benefits. VA regulations implementing the VCAA were codified as amended at 38 C.F.R. §§ 3.102, 3.156(a), 3.159, and 3.326(a) (2015).

With respect to the request to reopen, as the Board is granting this claim, all notification and development actions needed to fairly adjudicate the claim have been accomplished.

As regards the claim for a higher rating for PTSD, notice requirements under the VCAA essentially require VA to notify a claimant of any evidence that is necessary to substantiate the claim(s), as well as the evidence that VA will attempt to obtain and which evidence he or she is responsible for providing. *See, e.g.*, *Quartuccio v. Principi*, 16 Vet. App. 183 (2002) (addressing the duties imposed by 38 U.S.C.A. § 5103(a) and 38 C.F.R. § 3.159(b)).

As delineated in *Pelegrini v. Principi*, 18 Vet. App. 112 (2004), after a substantially complete application for benefits is received, proper VCAA notice must inform the claimant of any information and evidence not of record (1) that is necessary to substantiate the claim(s); (2) that VA will seek to provide; (3) that the claimant is expected to provide; and (4) must ask the claimant to provide any evidence in her or his possession that pertains to the claim(s), in accordance with 38 C.F.R. § 3.159(b)(1).

The Board notes that, effective May 30, 2008, 38 C.F.R. § 3.159 has been revised, in part. *See* 73 Fed. Reg. 23,353 - 23,356 (April 30, 2008). Notably, the final rule removes the third sentence of 38 C.F.R. § 3.159(b)(1), which had stated that VA will request that a claimant provide any pertinent evidence in his or her possession.

In rating cases, a claimant must be provided with information pertaining to assignment of disability ratings (to include the rating criteria for all higher ratings for a disability), as well as information regarding the effective date that may be assigned. *Dingess/Hartman v. Nicholson*, 19 Vet. App. 473 (2006).

VCAA-compliant notice must be provided to a claimant before the initial unfavorable decision on a claim for VA benefits by the AOJ (here, the RO). *Id.*; *Pelegrini*, 18 Vet. App. at 112. *See also Disabled American Veterans v. Secretary of Veterans Affairs*, 327 F.3d 1339 (Fed. Cir. 2003). However, the VCAA notice requirements may, nonetheless, be satisfied if any errors in the timing or content of such notice are not prejudicial to the claimant. *Id.*

In this appeal, April and October 2010 pre-rating letters provided notice to the Veteran regarding what information and evidence was needed to substantiate what was then a claim for service connection, as well as what information and evidence must be submitted by the Veteran and what information and evidence would be obtained by VA. These letters also provided the Veteran with general information pertaining to VA's assignment of disability ratings and effective dates, as well as the type of evidence that impacts those determinations.

After the award of service connection and the Veteran's disagreement with the initial rating assigned, no additional VCAA notice for the downstream higher rating issue was required. *See Hartman v. Nicholson*, 483 F.3d 1311, 1314-15 (Fed. Cir. 2007); *Dunlap v. Nicholson*, 21 Vet. App. 112, 116-17 (2007); VAOPGCPREC 8-2003 (2003). However, February 2013 SOC set forth the criteria for a higher rating for PTSD (the timing and form of which suffices, in part, for *Dingess/Hartman*). The claim was subsequently adjudicated in a November 2014 rating decision and December 2014 SSOC.

The record also reflects that VA has made reasonable efforts to obtain or to assist in obtaining all relevant records pertinent to the matters herein decided. Pertinent medical evidence associated with the claims file consists of the reports of VA examinations, as well as the Veteran's VA and private treatment records. Also of

record and considered in connection with the claims are various written statements provided by the Veteran and by his attorney, on his behalf. The Board finds that no further AOJ action on either claim, prior to appellate consideration, is required.

In summary, the duties imposed by the VCAA have been considered and satisfied. The Veteran has been notified and made aware of the evidence needed to substantiate these claims, the avenues through which he might obtain such evidence, and the allocation of responsibilities between himself and VA in obtaining such evidence. There is no additional notice that should be provided, nor is there any indication that there is additional existing evidence to obtain or development required to create any additional evidence to be considered in connection with the claim. Consequently, any error in the sequence of events or content of the notice is not shown to prejudice the Veteran or to have any effect on the appeal. Any such error is deemed harmless and does not preclude appellate consideration of the matters herein decided, at this juncture. *See Mayfield v. Nicholson*, 20 Vet. App. 537, 543 (2006) rejecting the argument that the Board lacks authority to consider harmless error). *See also ATD Corp. v. Lydall, Inc*., 159 F.3d 534, 549 (Fed. Cir. 1998).

II. Petition to Reopen

At the time of the prior denial and currently, service connection may be established for disability resulting from personal injury suffered or disease contracted in the line of duty, or from aggravation of a preexisting injury suffered or disease contracted in line of duty. *See* 38 U.S.C.A. § 1110; 38 C.F.R. § 3.303. Service connection may be granted for a disability diagnosed after discharge, when all the evidence, including that pertinent to service, establishes that the disability is due to disease or injury that was incurred or aggravated in service. 38 C.F.R. § 3.303(d).

Service connection may also be presumed for certain chronic diseases, to include organic diseases of the nervous system (interpreted to include sensorineural hearing loss, which are manifested to a compensable degree within a prescribed period after

service (one year for other organic diseases of the nervous system). 38 U.S.C.A. §§ 1101, 1112, 1113, 1137 (West 2014); 38 C.F.R. §§ 3.307, 3.309 (2015).

Impaired hearing is considered a disability for VA purposes when: the auditory threshold in any of the frequencies 500, 1000, 2000, 3000, 4000 Hertz is 40 decibels or greater; or when the auditory thresholds for at least three of the frequencies 500, 1000, 2000, 3000, or 4000 Hertz are 26 decibels or greater; or when speech recognition scores using the Maryland CNC Test are less than 94 percent. 38 C.F.R. § 3.385.

The Veteran's original claim for service connection for hearing loss of the right ear was denied in a May 1978 RO decision, largely based on the reports of 1975 and 1977 examinations, which were negative for any hearing loss. Additional evidence of record at the time of the May 1978 denial included a VA Form 21-526e, Veteran's Application for Compensation or Pension at Separation from Service, received in April 1978, some service personnel records, as well as the Veteran's service treatment records.

Service personnel records, including a DD214 showed that the Veteran had active service in the regular Army for 21 years, eight months, and 8 days. He had three months of oversea service. He was awarded, *inter alia*, the Vietnamese Cross of Gallantry with Palm Device, the National Defense Service Medal, Vietnam Service with Four Bronze Service Stars, and the Republic of Vietnam Campaign Medal. Service treatment records included an August 1968 periodic examination specifically noting that the Veteran had hearing loss when compared to his induction examination. An August 1968 ENT consult noted that the Veteran demonstrated some decreased in hearing possibly secondary to noise. The record reported that the Veteran was in "artillery" for the past 12 years. An April 1969 treatment record noted that there was some question regarding hearing loss and that the Veteran had complaints of tinnitus near loud noises. On a June 1970 re-enlistment report of medical history, the Veteran checked "YES" when asked if he ever had or currently has ear, nose or throat trouble and hearing loss. In July 1969, the Veteran was diagnosed with otitis externa in both ears. In January 1973, he was seen for complaints of a right earache. The Veteran underwent audiometric testing

on October 1975 and 1977 annual reports of medical examination, which did not show that the Veteran had a hearing loss disability per 38 C.F.R. § 3.385. On June 1979 report of medical history, the Veteran indicated that he had hearing loss.

Although the Veteran was notified of the May 1978 denial and his appellate rights, he did not initiate an appeal. Moreover, no additional evidence was received within one-year following notification of the denial. See 38 C.F.R. § 3.156(b).

Notably, in May 2010, additional personnel records were received. Thus, it appears that these personnel records were not associated with the record at the time of the October 2009 rating decision. In this regard, 38 C.F.R. § 3.156(c) provides that, at any time after VA issues a decision on a claim, if VA receives or associates with the claims file relevant official service department records that existed and had not been associated with the claims file when VA first decided the claim, VA will reconsider the claim, notwithstanding paragraph (a) of the same section (which defines new and material evidence). The regulation further identifies service records related to a claimed in-service event, injury, or disease as relevant service department records. 38 C.F.R. § 3.156(c)(1)(i). However, the newly-associated service personnel records are not relevant to the claim for service connection for right ear hearing loss, as they do not address whether there were any in-service hearing complaints, findings, or diagnosis, a current hearing loss disability, or a relationship between right ear hearing loss and service. Accordingly, reconsideration of the Veteran's claim under 38 C.F.R. § 3.156(c) is not warranted based upon receipt of the service personnel records.

As such, the RO's May 1978 denial is final as to the evidence then of record, and is not subject to revision on the same factual basis. *See* 38 U.S.C.A. § 7105(b); 38 C.F.R. §§ 3.104, 20.302, 20.1103.

However, under pertinent legal authority, VA may reopen and review a claim that has been previously denied if new and material evidence is submitted by or on behalf of the Veteran. 38 U.S.C.A. § 5108; 38 C.F.R. § 3.156(a); *see also Hodge v. West,* 155 F.3d 1356 (Fed. Cir. 1998).

Here, the Veteran requested that VA reopen the previously-denied claim for service connection in September 2009. Regarding petitions to reopen filed on and after August 29, 2001, 38 C.F.R. § 3.156(a) defines "new" evidence as evidence not previously submitted to agency decision makers and "material" evidence as evidence that, by itself or when considered with previous evidence of record, relates to an unestablished fact necessary to substantiate the claim. New and material evidence can be neither cumulative nor redundant of the evidence of record at the time of the last final denial of the claim sought to be reopened, and must raise a reasonable possibility of substantiating the claim. 38 C.F.R. § 3.156(a).

In determining whether new and material evidence has been received, VA must initially decide whether evidence received since the prior final denial is, in fact, new. As indicated by the regulation cited above, and by judicial case law , "new" evidence is that which was not of record at the time of the last final disallowance (on any basis) of the claim, and is not duplicative or "merely cumulative" of other evidence then of record. This analysis is undertaken by comparing the newly received evidence with the evidence previously of record. After evidence is determined to be new, the next question is whether it is material.

The provisions of 38 U.S.C.A. § 5108 require a review of all evidence submitted by or on behalf of a claimant since the last final denial on any basis to determine whether a claim must be reopened. *See Evans v. Brown*, 9 Vet. App. 273, 282-83 (1996). Here, the last final denial of the claim is the RO's May 1978 decision. Furthermore, for purposes of the "new and material" analysis, the credibility of the evidence is presumed. *Justus v. Principi*, 3 Vet. App. 510, 512-13 (1992).

Pertinent evidence added to the claims file since the May 1978 RO's decision includes the report of a VA audiology examination, VA medical records, and various written statements provided by the Veteran and his attorney. Considering this additionally-received evidence in light of evidence already of record, the Board finds that the evidence provides a basis for reopening the claim for service connection for hearing loss of the right ear.

At the time of the May 1978 decision, there was no evidence hearing loss disability.y The additionally received evidence includes the report of a December 2009 audiological evaluation which documents testing results establishing that the Veteran has current hearing loss of the right ear to an extent recognized as a disability for VA compensation purposes. *See* 38 C.F.R. § 3.385 (2015). That examination report also documents the Veteran's reported history of experiencing exposure to artillery noise in service and no post service civilian noise exposure. Such is consistent with, the examiner's conclusion that the Veteran's tinnitus was related to noise exposure in service. Tinnitus was subsequently service-connected in the December 2009 rating decision. In a November 2010 statement, the Veteran reported that he lost his hearing while he was on active duty and exposed to noise while being assigned to artillery units in Korea, Germany, and Vietnam. In June 2012 correspondence, the representative stated that the Veteran contends that he suffered acoustic trauma in service. The attorney also suggested a relationship between tinnitus and hearing loss stating that both are caused by repeated exposure to loud noise and that the Veteran was currently service-connected for tinnitus. In his s April 2013 substantive appeal, the Veteran stated that the only history the Veteran had of noise exposure was in service. For purposes of the "new and material" analysis, the credibility of the evidence is presumed. *See Justus*, 3 Vet. App. at 513.

The Board finds that the above-described evidence is "new" in that it was not before agency decision makers at the time of the May 1978 final denial of the claims for service connection, and is not duplicative or cumulative of evidence previously of record. Moreover, this evidence is "material" in that it reflects the Veteran was exposed to acoustic trauma and began to experience hearing loss in service. In the alternative, the December 2009 VA examiner indicated that tinnitus was a symptom of hearing loss and the Veteran's representative suggested a relationship between the Veteran's hearing loss and tinnitus. Hence, this evidence, while certainly not conclusive, relates to an unestablished fact necessary to substantiate the claim for service connection for right ear hearing loss and, when presumed credible, also raises a reasonable possibility of substantiating the claim. *See, e.g., Shade v. Shinseki*, 24 Vet. App. 110 (2010).

Under these circumstances, the Board concludes that the criteria for reopening the claim for service connection for hearing loss of the right ear are met. *See* 38 U.S.C.A. § 5108; 38 C.F.R. § 3.156.

III. Higher Rating

Disability evaluations are determined by the application of VA's Schedule for Rating Disabilities, which is based on average impairment of earning capacity. 38 U.S.C.A. § 1155; 38 C.F.R. Part 4. Where there is a question as to which of two evaluations shall be applied, the higher rating will be assigned if the disability picture more nearly approximates the criteria required for that rating. Otherwise, the lower rating will be assigned. 38 C.F.R. § 4.7. After careful consideration of the evidence, any reasonable doubt remaining is resolved in favor of the veteran. 38 C.F.R. § 4.3.

A veteran's entire history is to be considered when making disability evaluations. *See generally* 38 C.F.R. 4.1; *Schafrath v. Derwinski*, 1 Vet. App. 589 (1995). Where entitlement to compensation already has been established and an increase in the disability rating is at issue, it is the present level of disability that is of primary concern. *See Francisco v. Brown*, 7 Vet. App. 55, 58 (1994). However, where, as here, the question for consideration is entitlement to a higher initial rating, evaluation of the medical evidence since the award of service connection to consider the appropriateness of "staged rating" (assignment of different ratings for distinct periods of time, based on the facts found) is required. *See Fenderson v. West,* 12 Vet. App. 119, 126 (1999).

The Veteran has been assigned a 70 percent rating for PTSD with depressive disorder under Diagnostic Code 9411. However, the actual criteria for evaluating psychiatric disorders other than eating disorders are set forth in a General Rating Formula. *See* 38 C.F.R. § 4.130.

Pursuant to the General Rating Formula, a 70 percent disability rating is warranted for PTSD if it is productive of occupational and social impairment with deficiencies in most areas, such as work, school, family relations, judgment, thinking, or mood,

due to such symptoms as: suicidal ideation; obsessional rituals which interfere with routine activities; speech intermittently illogical, obscure, or irrelevant; near-continuous panic or depression affecting the ability to function independently, appropriately and effectively; impaired impulse control (such as unprovoked irritability with periods of violence); spatial disorientation; neglect of personal appearance and hygiene; difficulty in adapting to stressful circumstances (including work or a work like setting); inability to establish and maintain effective relationships.

A 100 percent disability rating is warranted if there is total occupational and social impairment, due to such symptoms as: gross impairment in thought processes or communication; persistent delusions or hallucinations; gross inappropriate behavior; persistent danger of hurting self or others; intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene); disorientation to time or place; memory loss for names of close relatives, own occupation or own name.

As the United States Court of Appeals for the Federal Circuit has explained, evaluation under 38 C.F.R. § 4.130 is "symptom-driven," meaning that "symptomatology should be the fact-finder's primary focus when deciding entitlement to a given disability rating" under that regulation. *Vazquez-Claudio v. Shinseki*, 713 F.3d 112, 116-17 (Fed. Cir. 2013). The symptoms listed are not exhaustive, but rather "serve as examples of the type and degree of symptoms, or their effects, that would justify a particular rating." *Mauerhan v. Principi*, 16 Vet. App. 436, 442 (2002). In the context of determining whether a higher disability evaluation is warranted, the analysis requires considering "not only the presence of certain symptoms[,] but also that those symptoms have caused occupational and social impairment in most of the referenced areas"-i.e., "the regulation . . . requires an ultimate factual conclusion as to the Veteran's level of impairment in 'most areas.'" *Vazquez-Claudio*, 713 F.3d at 117-18; 38 C.F.R. § 4.130, Diagnostic Code 9411.

When evaluating a mental disorder, the Board must consider the "frequency, severity, and duration of psychiatric symptoms, the length of remissions, and the

Veteran's capacity for adjustment during periods of remission," and must also "assign an evaluation based on all the evidence of record that bears on occupational and social impairment rather than solely on the examiner's assessment of the level of disability at the moment of the examination." 38 C.F.R. § 4.126(a).

Psychiatric examinations frequently include assignment of a GAF score. According to the Fourth Edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), GAF is a scale reflecting the "psychological, social, and occupational functioning on a hypothetical continuum of mental health illness." There is no question that the GAF score and interpretations of the score are important considerations in rating a psychiatric disability. *See e.g., Richard v. Brown*, 9 Vet. App. 266, 267 (1996); *Carpenter v. Brown*, 8 Vet. App. 240 (1995). [However, the GAF score assigned in a case, like an examiner's assessment of the severity of a condition, is not dispositive of the evaluation issue; rather, the GAF score must be considered in light of the actual symptoms of the Veteran's disorder, which provide the primary basis for the rating assigned. *See* 38 C.F.R. § 4.126(a). [Parenthetically, the Board notes that the, revised DSM-5, which among other things, eliminates GAF scores, applies to claims certified to the Board after August 4, 2014. *See* 79 Fed. Reg. 45, 093 (Aug, 4, 2014))].

Considering the pertinent evidence of record in light of the above-cited provisions, the Board finds that a rating in excess of 70 percent is not warranted for the Veteran's PTSD with depressive disorder at any point since the effective date f the award for service connection.

Medical records from the Goldsboro Psychiatric Clinic document diagnoses of, and treatment for, post traumatic stress disorder and major depression with continued treatment. In May 2010 correspondence associated with the treatment records, Dr. E.W. Hoeper summarized the Veteran's treatment in May 2010 and reported a GAF of 40. At the time of treatment, the Veteran reported that he had been married for 32 years in his third marriage. The Veteran exhibited nightmares, waking in panic and sweat, flashbacks, and limited sleep. He had intrusive thoughts, startled easily, was hyper vigilant and could not tolerate anyone behind him. He rarely socialized outside of family. His recent memory was severely impaired, in that he could not

remember what he read and would get lost while traveling. His working memory was 90% impaired. He exhibited anger, sadness, fear, depression, low energy, little interest in things, agitation, and crying spells. Dr. E. W. Hoeper opined that the Veteran was unable to sustain social relationships and was moderately compromised in his ability to sustain work relationships due to his PTSD. He was prescribed trazadone, klonopin, and wellbutrin to treat his symptoms along with cognitive behavioral therapy and medication monitoring. A review of May and July 2010 treatment records also shows reported symptoms of hallucinations on a weekly basis, mood swings, worry, racing and jumping thoughts, and suicidal feelings.

On VA PTSD examination in September 2010, the Veteran reported that he last worked in July 2010 for the Department of Corrections and took an early retirement because he could no longer handle the job due to psychological and physical problems. He stated that he was irritable with co-workers in which he was able to walk away, but he also had concentration problems that slowed him down and caused him to make mistakes. In regards to his relationships with others, he had been married for the third time in 18 years. He claimed that he had a fairly good relationship with his wife, although he was sometimes irritable and withdrawn from her. He reported that he had a fairly good relationship with his five adult children and grandchildren, but only saw them approximately once a year because they lived far away. He had a close friend whom he saw once every couple of months. He denied having any casual friends. He stated that he was close to his sister and saw her about once or twice a week and talked to her on a daily basis. For activities, he watched TV, did occasional yardwork, cooked, and cleaned.

On mental status examination, the Veteran was alert, oriented, and attentive. He appeared his stated age. His mood appeared dysphoric and his affect was constricted. His speech was of a regular rate and rhythm. There was no evidence of psychomotor agitation or retardation. His contact was good and he was cooperative and pleasant. His thought process was logical and coherent. He did not exhibit any auditory or visual hallucinations or delusions. He denied current thoughts of hurting himself or hurting others. He denied a history of suicide attempts and said the last time he was physically aggressive with somebody was 10 to13 years ago.

His memory was mildly to moderately impaired for immediate information. It was fairly intact for recent and remote events. The examiner assigned a GAF score of 54, noting that that the Veteran described moderate to considerable symptoms associated with PTSD and also appeared to have related depression. He reported intrusive thoughts of his trauma, nightmares, and psychological and physiological reactivity to loud noises. He reported having flashbacks, did not like to talk about or think about his trauma, and avoided crowds and movies about the war. His affect was constricted. He described emotional detachment and reported less interest in activities at times. He slept 4-5 hours a night. He could be irritable and had problems with concentrations at times. He descried an exaggerated startle response to loud noises or unexpected approaches. He was hypervigilant and felt on guard. He reported periods of depression with low energy, low motivation, and fatigue. He had decreased feelings of hope and worth and a decreased appetite. He denied having problems with activities of daily living such as feeding, bathing, or toileting himself.

The examiner stated that in terms of the Veteran's social adaptability and interactions with others, he appeared to be moderately to considerably impaired. In terms of his ability to maintain employment perform job duties in a reliable, flexible, and efficient manner, he appeared to be moderately to considerably impaired. The examiner estimated the Veteran's overall level of disability to be in the moderate-to-considerable range.

In April 2012, the Veteran was afforded a VA PTSD examination. He then reported a history of living with his third wife of 20 years. He reported that their relationship has deteriorated although he remained married. He reported that he last worked at the Department of Corrections as a food service manager, took early retirement because of continuing physical and emotional difficulties, especially after injuring his shoulder in a car accident and being unable to defend himself in the event of a riot. The Veteran's PTSD symptoms caused clinically significant distress or impairment in social, occupational, or other important areas of functioning. The Veteran experienced depressed mood; anxiety; chronic sleep impairment; mild memory loss, such as forgetting names, directions, or recent events,; flattened affect; disturbances of motivation and mood; difficulty in

establishing and maintaining effective work and social relationships; difficulty in adapting to stressful circumstances, including work or a work like setting; and suicidal ideations. The examiner described the Veteran's mental disorder as causing occupational and social impairment with deficiencies in most areas, such as work, school, family relations, judgment, thinking and/or mood. He was assigned a GAF score of 50.

Treatment records from Columbia VAMC show that the Veteran was seen in January 2014 regarding his PTSD/anxiety/depression. On examination, the Veteran was neat, clean, and dressed appropriately. There was no cognitive impairment noted; he was oriented times three. There was no noticeable concentration, language, or communication difficulty. His short and long term memory was intact. His social behavior was within society norms.

The Board finds that, collectively, the above-described evidence reflects that throughout the period under consideration, the Veteran's psychiatric symptoms have been shown to be of the type, extent, and frequency or severity that approximate occupational and social impairment with deficiencies in most areas such as work, family relations, judgment, and mood due to symptoms such as irritability, concentration problems, intrusive thoughts nightmares, flashbacks, avoidance behavior, emotional detachment, diminished interest, low energy, disturbances in motivation and mood, depression, flattened affect, decreased appetite and feelings of hope, anxiety, exaggerated startle response, chronic sleep impairment, suicidal ideations, hallucinations, racing and jumping thoughts, and mildly to moderately impaired immediate information and for names, directions, or recent events. Furthermore, he has difficulty in establishing and maintaining effective work and social relationships and difficulty in adapting to stressful circumstances, including work or a work like setting. Thus, collectively, the evidence indicates that the Veteran's PTSD has resulted in a level of occupational and social impairment which more closely approximates a 70 percent disability rating

The Board finds that at no point pertinent to the current claim has the Veteran's PTSD with depressive disorder symptoms and resulting impairment met, or more

nearly approximated, the level of impairment contemplated in the maximum, 100 percent rating. As indicated, under the rating formula, such a rating is assigned for total occupational and social impairment. However, the evidence has shown no gross impairment in thought processes or communication, persistent delusions or hallucinations, gross inappropriate behavior, persistent danger of hurting self or others, intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene), disorientation to time or place, memory loss for names of close relatives, own occupation or own name-symptoms listed in the rating criteria as indicative of the level of impairment for which a 100 percent rating is assignable.

Considering the effect of the Veteran's symptoms on occupational and social functioning, as indicated above, although in May 2010 correspondence, Dr. E. W. Hoeper opined that the Veteran was unable to sustain social relationships, on September 2010 VA examination, the Veteran reported that he had a fairly good relationship with his children and grandchildren. The Board acknowledges that the Veteran reported at the time of his April 2012 VA examination that his relationship with his wife was deteriorating; however, he still remained married for more than 20 years. The record reflects that he last worked in July 2010; however, the VA examination reports as well as May 2010 correspondence from Dr. E.W. Hoeper demonstrated that the Veteran's psychiatric symptoms moderately to considerably impaired his ability to perform job duties and adapt to stressful circumstances including work or a work like setting. Under these circumstances, the Board finds that the Veteran is not shown to have experienced symptoms of the type, extent, and frequency or severity, as appropriate, to result in total occupational and social impairment as contemplated by the rating criteria for a 100 percent rating.

The Board further finds that GAF scores assigned during the relevant period do not provide a basis for assigning a higher rating. The Veteran's GAF scores have ranged from 40 to 54. Pursuant to the DSM-IV, a GAF score from 31 to 40 is indicative of some impairment in reality testing or communication (e.g., speech at times illogical, obscure, or irrelevant) or major impairment in several areas, such as work, school, family relations, judgment, thinking or mood (e.g., suicidal ideation, neglects family, and is unable to work). A GAF score from 41 to 50 is indicative of

serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job). Scores from 51 to 60 reflect moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) or moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).

While the Veteran's GAF scores have fluctuated over time, his lowest score assigned—40 in May 2010—is consistent with no greater impairment than that contemplated by the assigned 70 percent rating. In fact, the Veteran has also received GAF scores that would indicate only serious or moderate symptomatology. Again, there is no evidence of record that would indicate that the Veteran's disability has more nearly approximated the level of impairment contemplated in the maximum, 100 percent rating.

In reaching the above conclusions, the Board reiterates that the symptoms listed in the rating schedule under the criteria for the 100 percent rating are essentially examples of the type and degree of symptoms indicative of the level of impairment required for each such rating, and that the Veteran need not demonstrate those exact symptoms to warrant a higher rating. *See Vazquez-Claudio and Mauerhan, supra*. However, as discussed above, the Board finds that the evidence of record simply does not show that the Veteran has manifested sufficient symptoms of the type, extent and frequency or severity, as appropriate, to result in a level of impairment that meets, or more nearly approximates, the level of impairment contemplated by the 100 percent rating or any even higher rating under VA's rating schedule.

The above determinations are based upon application of pertinent provisions of VA's rating schedule. Additionally, the Board finds that, at no point since the effective date of the award of service connection has the Veteran's service-connected PTSD reflected so exceptional or so unusual a picture as to warrant the assignment of any higher rating on an extra-schedular basis. *See* 38 C.F.R. § 3.321(b).

There is a three-step analysis for determining whether an extra-schedular rating is appropriate. *Thun v. Peake*, 22 Vet. App. 111, 115 (2008). First, there must be a comparison between the level of severity and symptomatology of the claimant's service-connected disability and the established criteria found in the rating schedule to determine whether the Veteran's disability picture is adequately contemplated by the rating schedule. *Id*. If not, the second step is to determine whether the claimant's exceptional disability picture exhibits other related factors identified in the regulations as "governing norms." *Id.* at 115-16; *see also* 38 C.F.R. § 3.321(b)(1) (governing norms include marked interference with employment and frequent periods of hospitalizations). If the factors of step two are found to exist, the third step is to refer the case to the Under Secretary for Benefits or the Director of the Compensation and Pension Service for a determination whether, to accord justice, the claimant's disability picture requires the assignment of an extra-schedular rating. *Id*. at 116.

In this case, the Board finds that the schedular criteria are adequate to rate the Veteran's service-connected PTSD with depressive disorder at all pertinent points. The rating schedule fully contemplates the described symptomatology. Although, as noted, all psychiatric symptoms manifested are not listed among those identified as indicative of particular ratings, the Board has considered the full extent of his psychiatric impairment in evaluating the disability. The rating schedule provides for higher ratings based on more significant impairment which, as explained above, is not shown here. Notably, there is no indication or argument that the applicable criteria are otherwise inadequate to rate the disability.

The Board further notes that, pursuant to *Johnson v. McDonald*, 762 F.3d 1362 (Fed. Cir. 2014), a veteran may be awarded an extra-schedular rating based upon the combined effect of multiple conditions in an exceptional circumstance where evaluation of the individual conditions fails to capture all the symptoms associated with service-connected disabilities experienced. Here, however, the appeal only involves evaluation of PTSD with depressive disorder, a single disability. As the Board has fully considered all of the Veteran's psychiatric symptoms in evaluating the disability, and the evaluation of multiple service-connected disabilities is not presently at issue, the Board finds that the holding of *Johnson* is inapposite here.

As the threshold requirement for invoking the procedures set forth in 38 C.F.R. § 3.321(b)(1) is not met, referral of this claim for extra-schedular consideration is not warranted. *See Bagwell v. Brown*, 9 Vet. App. 337, 338-39 (1996); *Floyd v. Brown*, 9 Vet. App. 88, 96 (1996); *Shipwash v. Brown*, 8 Vet. App. 218, 227 (1995).

For all the foregoing reasons, the Board finds that there is no basis for staged rating of the Veteran's PTSD with depressive disorder, pursuant to *Fenderson,* and the claim for a rating in excess of of 70 percent for the disability must be denied. In reaching these conclusions, the Board has considered the applicability of the benefit-of-the-doubt doctrine. However, as the preponderance of the evidence is against assignment of a higher rating at any pertinent point, that doctrine is not applicable. *See* 38 U.S.C.A. § 5107(b); 38 C.F.R. § 3.102; *Gilbert v. Derwinski*, 1 Vet. App. 49, 53- 56 (1990).

ORDER

As new and material evidence to reopen the claim for service connection for hearing loss of the right ear has been received, to this limited extent, the appeal is granted.

An initial rating in excess of 70 percent for PTSD with depressive disorder is denied.

REMAND

The Board's review of the claims file reveals that further AOJ action on the claims remaining on appeal is warranted.

VA will provide a medical examination or obtain a medical opinion if the evidence indicates the existence of a disability or persistent or recurrent symptoms of a

disability that may be associated with an event, injury, or disease in service, but the record does not contain sufficient medical evidence to decide the claim. 38 U.S.C.A. § 5103A(d)(2) (West 2014); 38 C.F.R. § 3.159(c)(4)(i) (2015); *McLendon v. Nicholson*, 20 Vet. App. 79 (2006). The threshold for determining whether the evidence "indicates" that there "may" be a nexus between a current disability and an in-service event, injury, or disease is a low one. *McLendon*, 20 Vet. App. at 83.

Furthermore, once VA undertakes the effort to provide an examination when developing a service connection claim, even if not statutorily obligated to do so, it must provide one that is adequate for purposes of the determination being made. *Barr v. Nicholson*, 21 Vet. App. 303, 311 (2007).

In regard to the Veteran's claim for service connection for bilateral hearing loss, as noted above, the Veteran was afforded a VA audiology examination in December 2009. As reflected in the evaluation report, testing results reveal that the Veteran has current hearing loss of the right ear, which meets VA's definition of a hearing loss disability. *See* 38 C.F.R. § 3.385. The examiner noted the Veteran's assertion that he was exposed to noise from artillery fire. The December 2009 VA examiner opined that the Veteran's hearing loss was not related to noise exposure during service based on a normal audiogram at separation. However, the examiner's opinion does not reflect full consideration of the Veteran's report of experiencing hearing loss while on active duty. The Board finds that the Veteran's reported symptoms of an ear condition constitute competent of evidence of such. *See, e.g., Layno v. Brown*, 6 Vet. App. 465 (1994).

Although the Veteran was seen for complaints of decreased hearing in his right ear and diagnosed with otosclerosis in November 2009, for which he underwent surgery in February 2010, his service treatment records support his contentions that his decreased hearing began in service. As previously mentioned, an August 1968 periodic examiner specifically noted that the Veteran had hearing loss when compared to his induction examination. An August 1968 ENT consult notes that the Veteran demonstrated some decreased in hearing possibly secondary to noise. It was noted that the Veteran was in "artillery" for the past 12 years. An April 1969

treatment record notes that there was some question regarding hearing loss and that the Veteran had complaints of tinnitus near loud noises. In July 1969, the Veteran was diagnosed with otitis externa in both ears. On a June 1970 re-enlistment report of medical history, the Veteran checked "YES" when asked if he ever had or currently has ear, nose or throat trouble and hearing loss. In January 1973, he was seen for complaints of a right earache. On June 1979 report of medical history, the Veteran indicated that he had hearing loss.

Additionally, the examiner opined that the Veteran's tinnitus was likely related to noise exposure during service and indicated that the Veteran's tinnitus was a symptom of his hearing loss. The Veteran's attorney also suggested a relationship between the Veteran's hearing loss and his service-connected tinnitus. Therefore, in rendering a medical etiology opinion, the examiner should also address the Veteran's current assertions and service treatment records reflecting decreased hearing beginning in service along as well as any relationship between the Veteran's hearing loss and his service-connected tinnitus.

As regards the claim for service connection for erectile dysfunction, the Veteran was afforded a VA genitourinary examination in October 2010, in which the examiner opined that it was as less as likely as not that Veteran's current erectile dysfunction with leakage was attributed to his prostatitis, which he had in the 1960's. However, this opinion did not contain a rationale. *See Nieves-Rodriguez v. Peake*, 22 Vet. App. 295, 301 (2008) (stating that a medical examination report must contain not only clear conclusions with supporting data, but also a reasoned medical explanation connecting the two). Further, the physician did not address the Veteran's contentions that medication for his service-connected prostatitis caused or aggravated his erectile dysfunction.

Also, in support of his contentions, in April 2013, the Veteran submitted internet articles indicating that there is a relationship between erectile dysfunction and prostatitis. One article acknowledges that the available literature demonstrating the influence of prostatitis [chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS)] on the incidence of erectile dysfunction is scant. However, the article explained that from the literature, it is known that lower urinary tract symptoms and

benign prostate hyperplasia are definitely related to erectile dysfunction. Any kind of pain is likely to be the most significant symptom in men with CP/CPPS as it relates to sexual dysfunction. Sexual dysfunction like ejaculation discomfort is described as a symptom of CP/CPPS. The article states that most of the data linking the two suggest that CP/CPPS impairs the overall quality of life and it is this that contributes to or causes erectile dysfunction. Therefore, in rendering a medical etiology opinion, the examiner should also address the Veteran's current assertions as well as the submitted internet articles indicating a relationship between prostatitis and erectile dysfunction.

Regarding service connection for a heart disorder, the Veteran was afforded a VA ischemic heart disease examination in March 2011. The examiner reported that the Veteran had no known history of coronary artery disease; however, the examiner noted that the Veteran did have sinus bradycardia on March 2009 electrocardiogram (EKG) and a first-degree AV block on 2007 EKG. The examiner specifically stated that the Veteran never had a catheterization or any other study that would confirm a diagnosis of heart disease at this time. The examiner noted that there was no echocardiogram in the CPRS chart available for him to comment on and as of March 25, 2011, the Veteran’s prescribed echocardiogram that was ordered remained in pending status.

On review of the record, VA treatment records include an August 2011 cardiology echocardiogram report that noted mild concentric left ventricular hypertrophy (LVH) with normal systolic function. An August 2011 cardiology nuclear stress report revealed a fixed defect in the inferior wall consistent with diaphragmatic attenuation (artifact). However, the examiner did not have these reports to review when providing an opinion.

In April 2013, the Veteran submitted internet articles indicating that bradycardia could be a sign of a problem with the heart.

Thus, the Board finds that the Veteran should be afforded another VA examination to clarify whether he a has a current heart disability, and, if so, whether it is at least likely as not related to military service , to include Agent Orange exposure therein.

The Veteran is hereby advised that failure to report to any scheduled examination(s), without good cause, may well result in denial of the claim(s) for service connection—in particular, the reopened claim. *See* 38 C.F.R. § 3.655(a),(b) (2015). Examples of good cause include, but are not limited to, the illness or hospitalization of the claimant and death of an immediate family member. If the Veteran fails to report to the scheduled examination, obtain and associate with the claims file (a) copy(ies) of any correspondence referencing the date and time of the examination—preferably, the notice of examination—sent to him by the pertinent VA medical facility.

As for the matter of the Veteran's entitlement to a TDIU, the Board points out that that, as any decision with respect to the service connection claims may affect the Veteran's claim for a TDIU, this claim is inextricably intertwined with the remaining other claims on appeal. *See Parker v. Brown*, 7 Vet. App. 116 (1994); *Harris v. Derwinski*, 1 Vet. App. 180, 183 (1991) (two issues are "inextricably intertwined" when they are so closely tied together that a final Board decision cannot be rendered unless both are adjudicated). As the claims should be considered together, it follows that, any Board action on the TDIU claim, at this juncture, would be premature. Hence, a remand of this matter is warranted, as well.

Prior to arranging for the Veteran to undet further examinations in connection with the service connection claims, to ensure that all due process requirements are met, and the record is complete, the AOJ should undertake appropriate action to obtain and associate with the claims file all outstanding, pertinent records.

As for VA records, the claims file reflects that the Veteran has been receiving treatment from Dorn Veterans' Hospital as well as the Charleston and Columbia VA Medical Centers (VAMCs), and that records from these facilities dated through May 2014 are associated with the file; however, more recent records may exist. The Board emphasizes that records generated by VA facilities that may have an impact on the adjudication of a claim are considered constructively in the possession of VA adjudicators during the consideration of a claim, regardless of whether those records are physically on file. *See Dunn v. West*, 11 Vet. App. 462,

466-67 (1998); *Bell v. Derwinski*, 2 Vet. App. 611, 613 (1992). Hence, the AOJ should obtain from the above-noted facility all records of VA evaluation and/or treatment of the Veteran since November 2014, following the current procedures prescribed in 38 C.F.R. § 3.159(c) with regard to requests for records from Federal facilities.

The AOJ should also give the Veteran another opportunity to provide additional information and/or evidence pertinent to the claims remaining on appeal, explaining that he has a full one-year period for response. *See* 38 U.S.C.A § 5103(b)(1); but *see also* 38 U.S.C.A. § 5103(b)(3) (clarifying that VA may make a decision on a claim before the expiration of the one-year notice period). The AOJ should specifically request that the Veteran provide, or provide appropriate authorization to obtain, any outstanding, pertinent private (non-VA) medical records. In the letter, the AOJ should also explain what is needed to establish service connection on a secondary basis.

Thereafter, the AOJ should attempt to obtain any additional evidence for which the Veteran provides sufficient information, and, if needed, authorization, following the current procedures prescribed in 38 C.F.R. § 3.159.

The actions identified herein are consistent with the duties imposed by the VCAA. *See* 38 U.S.C.A. §§ 5103, 5103A; 38 C.F.R. § 3.159. However, identification of specific actions requested on remand does not relieve the AOJ of the responsibility to ensure full compliance with the VCAA and its implementing regulations. Hence, in addition to the actions requested above, the AOJ should also undertake any other development and/or notification action deemed warranted by the VCAA prior to adjudicating the claims remaining on appeal.

Accordingly, these matters are hereby REMANDED for the following action:

> 1. Obtain from Dorn Veterans' Hospital as well as the Charleston and Columbia VAMCs all outstanding, pertinent records of evaluation and/or treatment of the Veteran since May 2014. Follow the procedures set forth

in 38 C.F.R. § 3.159(c) with regards to requesting records from Federal facilities. All records and/or responses received should be associated with the claims file.

2. Send to the Veteran and his attorney a letter requesting that the Veteran provide information and, if necessary, authorization, to obtain any additional evidence pertinent to the claims on appeal that is not currently of record. ***Specifically request that the Veteran furnish, or furnish appropriate authorization to obtain, all outstanding, pertinent private (non-VA) records.***

In the letter, explain how to establish entitlement to service connection for bilateral knee and low back disorders as well as radiculopathy of the lower extremities on a secondary basis, pursuant to 38 C.F.R. § 3.310.

Also, clearly explain to the Veteran that he has a full one-year period to respond (although VA may decide the claim within the one-year period).

3. If the Veteran responds, assist him in obtaining any additional evidence identified, following the current procedures set forth in 38 C.F.R. § 3.159. All records/responses received should be associated with the claims file. If any records sought are not obtained, notify the Veteran of the records that were not obtained, explain the efforts taken to obtain them, and describe further action to be taken.

4. After all records and/or responses received are associated with the claims file, arrange for the Veteran to undergo VA examination, by an audiologist or appropriate physician, for evaluation of his bilateral hearing loss.

The contents of the entire, electronic claims file, to include a complete copy of this REMAND, must be made available to the designated examiner, and the examination report should include discussion of the appellant's documented history and assertions. All appropriate tests and studies should be accomplished (with all results made available to the requesting examiner prior to the completion of his or her report), and all clinical findings should be reported in detail.

With respect to the Veteran's bilateral hearing loss, the examiner should provide an opinion, consistent with sound medical principles, as to:

(a) whether it is ***at least as likely as not*** (i.e., a 50 percent probability or greater probability) that the disability had its onset during service or is otherwise medically-related to service, including noise exposure and decreased hearing documented in-service; ***or, if not.***

(b) whether it is ***at least as likely as not*** (i.e., a 50 percent or greater probability) that the hearing loss (a) was ***caused or*** (b) is ***aggravated*** (worsened beyond the natural progression) by the Veteran's service-connected tinnitus. If aggravation is found, the examiner should attempt to quantify the degree of additional disability resulting from the aggravation.

In addressing the above, the examiner ***must*** consider and discuss all pertinent medical and lay evidence of record.

The examiner should specifically comment on the December 2009 VA examiner's findings that the

Veteran's tinnitus is a symptom of his hearing loss, but that the Veteran's hearing loss was not related to military noise exposure, whereas his tinnitus was related to military noise exposure.

The examiner should also address the the Veteran's competent assertions as to nature, onset and continuity of symptoms, to include his reports of decreased hearing prior to being diagnosed with otosclerosis of the right ear in November 2009. If the Veteran's assertions in any regard are discounted, the examiner should clearly so state, and explain why.

All examination findings/testing results, along with complete, clearly- rationale for the conclusions reached, must be provided.

5. After all records and/or responses received from each contacted entity have been associated with the claims file, arrange for the Veteran to undergo further VA examination, by an appropriate physician, for evaluation of his erectile dysfunction.

The contents of the entire, electronic claims file, to include a complete copy of this REMAND, must be made available to the designated physician, and the examination report should include discussion of the appellant's documented history and assertions. All appropriate tests and studies should be accomplished (with all results made available to the requesting examiner prior to the completion of his or her report), and all clinical findings should be reported in detail.

The examiner should offer an opinion, consistent with sound medical principles, as to whether it ***at least as likely as not*** (i.e., a 50 percent or greater probability) that the disability (a) was ***caused or*** (b) is ***aggravated*** (worsened beyond the natural progression) by the Veteran's service-prostatitis, including any medications taken for the same. If aggravation is found, the examiner should attempt to quantify the degree of additional disability resulting from the aggravation.

In rendering the requested opinions, the physician ***must*** consider and discuss all relevant medical and other objective evidence—to include the internet articles submitted by the Veteran in April 2013 indicating a relationship between erectile dysfunction and prostatitis, as well as lay assertions—to include the Veteran's competent assertions as to nature, onset and continuity of symptoms. If the Veteran's assertions in any regard are discounted, the examiner should clearly so state, and explain why.

All examination findings/testing results, along with complete, clearly–stated rationale for the conclusions reached, must be provided.

6. After all records and/or responses received from each contacted entity have been associated with the claims file, arrange for the he Veteran to undergo further VA cardiology examination, by an appropriate physician for evaluation of his heart disability.

The contents of the entire, electronic claims file, to include a complete copy of this REMAND, must be made available to the designated physician, and the

examination report should include discussion of the appellant's documented history and assertions. All appropriate tests and studies should be accomplished (with all results made available to the requesting examiner prior to the completion of his or her report), and all clinical findings should be reported in detail.

The examiner should identify all current cardiac disabilities, to include any valid diagnosis(es) of cardiac disability/disease at any time pertinent to the claim on appeal (December 2008), even if currently resolved. In so doing, the examiner should clarify whether sinus bradycardia, first-degree AV block, mild concentric LVF, and/or fixed defect in the inferior wall consistent with diaphragmatic attenuation (artifact) is/are indicative of a heart disease or disorder. The examiner should also clarify whether there is any evidence that the appellant currently has, or at any time pertinent to the current appeal has had any heart disease or disorder.

It the VA examiner decides not perform a cardiac catheterization, he or she ***must*** explain why such testing is not necessary to confirm whether or not the Veteran has a current heart disease/disorder. The examiner should consider the March 2011 VA examiner's statement that the Veteran never had a catheterization or any other study that would confirm a diagnosis of heart disease.

Then, with respect to ***each*** such diagnosed heart disease and/or disability, the examiner should provide an opinion, consistent with sound medical judgment, as to whether it is ***at least as likely as not*** (i.e., a 50 percent or greater probability) that the disability had its onset in, or is

otherwise medically related to, the Veteran's service , to include any Agent Orange exposure therein..

In providing the requested opinions, the examiner must consider and discuss all pertinent medical and lay evidence of record, to include the Veteran's competent assertions as to the nature, onset, and continuity of symptoms. If the examiner discounts the Veteran's assertions in any regard, he or she should clearly so state, and explain why.

All examination findings/testing results, along with complete, clearly-stated rationale for the conclusions reached, must be provided.

7. If the Veteran fails to report to any scheduled examination(s), obtain and associate with the claims file (a) copy(ies) of any correspondence referencing the date and time of the examination(s)—preferably, the notice(s) of examination—sent to him by the pertinent VA medical facility.

8. To help avoid future remand, ensure that all requested actions have been accomplished (to the extent possible) in compliance with this REMAND. If any action is not undertaken, or is taken in a deficient manner, appropriate corrective action should be undertaken. *Stegall v. West*, 11 Vet. App. 268 (1998).

9. After completing the requested actions, and any additional notification and/or development deemed warranted, readjudicate the claims remaining on appeal.

> If the Veteran fails, without good cause, to report to the examination scheduled in connection with the hearing loss claim, in adjudicating the reopened claim, apply the provisions of 38 C.F.R. § 3.655(b), as appropriate.
>
> Otherwise, adjudicate each claim in light of all pertinent evidence (to include all evidence added to the claims file since the last adjudication) and legal authority.
>
> 10. If any benefit sought on appeal remains denied, furnish to the Veteran and his attorney an appropriate supplemental statement of the case that includes clear reasons and bases for all determinations, and afford them the appropriate time period for response.

The purpose of this REMAND is to afford due process and to accomplish additional development and adjudication; it is not the Board's intent to imply whether the benefits requested should be granted or denied. The Veteran need take no action until otherwise notified, but he may furnish additional evidence and/or argument during the appropriate time frame. *See Kutscherousky v. West*, 12 Vet. App. 369 (1999).

This REMAND must be afforded expeditious treatment. The law requires that all claims remanded by the Board of Veterans' Appeals or by the United States Court of Appeals for Veterans Claims for additional development or other appropriate action must be handled in an expeditious manner. *See* 38 U.S.C.A. §§ 5109B, 7112 (West 2014). ***The AOJ is reminded that this appeal has been advanced on the Board's docke***t.

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JACQUELINE E. MONROE
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).