BOARD OF VETERANS' APPEALS

DEPARTMENT OF VETERANS AFFAIRS

WASHINGTON, DC 20420

IN THE APPEAL OF [redacted]
GEORGE KEMP, JR.

DOCKET NO. 05-17 741) DATE *June 30, 2016*
) *TDV*
)

On appeal from the
Department of Veterans Affairs Regional Office in Montgomery, Alabama

THE ISSUE

Entitlement to special monthly compensation (SMC) due to loss of use of both feet.

REPRESENTATION

Appellant represented by: Robert V. Chisholm, Attorney at Law

WITNESS AT HEARING ON APPEAL

The Veteran

ATTORNEY FOR THE BOARD

C. J. Houbeck, Counsel

INTRODUCTION

The Veteran served on active duty in the United States Army from September 1973 to September 1976.

This matter comes before the Board of Veterans' Appeals (Board) on appeal from a December 2004 rating decision of the Department of Veterans Affairs (VA) Regional Office (RO) in Montgomery, Alabama, stemming from a claim for increased rating for bilateral pes planus.

In February 2010, the Veteran testified before the undersigned in a Travel Board hearing held at the RO, in relevant part, as to the underlying issue of entitlement to increased rating for the Veteran's foot disabilities. A copy of the hearing transcript has been associated with the claims file.

The issue of SMC due to loss of use of both feet was found to be before the Board as part of the Veteran's increased rating claims and remanded by the Board in its September 2013 determination. The matter again is before the Board.

The Board denied the Veteran's claim in a March 2015 decision. The Veteran appealed the Board's decision to the United States Court of Appeals for Veterans Claims (Court). Pursuant to a December 2015 Joint Motion for Remand (JMR), in a December 2015 Order the Court vacated the Board's decision with respect to the denial of SMC for loss of use of both feet and remanded the matter to the Board.

The record reflects that after the final SSOC, that additional relevant evidence was associated with the Veteran's electronic claims file. No subsequent SSOC was issued, but this is not necessary because in a May 2016 statement the Veteran's attorney representative specifically requested that the Board issue a decision based on the evidence of record. In context, the Board finds the foregoing a clear waiver of initial review by the agency of original jurisdiction in accordance with 38 C.F.R. § 20.1304 (2015).

The Board has not only reviewed the Veteran's physical claims file, but also the Virtual VA and Veteran's Benefits Management System (VBMS) paperless claims processing systems to ensure a total review of the evidence.

FINDING OF FACT

The Veteran has decreased function in his lower extremities below the knee, but the weight of the evidence does not support the conclusion that it is as likely as not that no effective function remains other than that which would be equally well served by an amputation stump at the site of election below the knee with use of a suitable prosthetic appliance.

CONCLUSION OF LAW

The criteria for SMC under 38 U.S.C.A. § 1114(k) and (l) due to the loss of use of one or both feet have not been met. 38 U.S.C.A. §§ 1114, 5107 (West 2014); 38 C.F.R. §§ 3.50(a)(2), 4.63 (2015).

REASONS AND BASES FOR FINDING AND CONCLUSION

Veterans Claims Assistance Act of 2000 (VCAA)

VA has met all statutory and regulatory notice and duty to assist provisions. 38 U.S.C.A. §§ 5100, 5102, 5103, 5103A, 5107, 5126 (West 2014); 38 C.F.R. §§ 3.102, 3.156(a), 3.159, 3.326(a) (2014). In that regard and as noted above, this matter was appealed to the Court at which time the Veteran's attorney representative advanced no argument with respect to a failure on VA's part to comply with the duties outlined in the VCAA, including the duties to notify and assist. Moreover, in a May 2016 statement the Veteran's attorney representative specifically waived the Veteran's right to any further development under the VCAA

and requested that the Board issue a decision based on the evidence of record. As such, no further consideration of the VCAA is necessary.

Factual Background

Private treatment records dated in 2003 and 2004 show that the Veteran sought treatment for bilateral pes planus and bilateral plantar fasciitis. He complained of pain in both of his heels, as well as in the arches of his feet. He received cortisone injections for heel spurs and prescription medication to treat inflammation in his feet. He was also fitted for orthotics to treat his symptomatology. On multiple examinations, to include in October 2003 and July 2004, there was no clubbing, cyanosis, or edema in the extremities. Moreover, muscle strength was 5 out of 5 in all muscle groups. Findings from a May 2004 MRI of the feet and ankles were considered normal other than a decreased signal on the left ankle consistent with a small osteochondral defect.

In October 2004, the Veteran underwent a VA examination to evaluate the severity of his bilateral pes planus with associated plantar fasciitis. The report shows that the Veteran complained of constant pain with stiffness, swelling, and fatigue in both of his feet. He described his bilateral foot pain between five and seven out of a scale up to ten. He experienced increased pain with standing and walking, and he had difficulty with prolonged standing and walking. His foot pain was better with rest. He reported that he had been treated with cortisone injections, orthotics, and pain medication that had provided some relief. The Veteran was currently employed as a correctional officer. Upon examination, the Veteran walked with a slightly antalgic gait without shoes and he walked with a slight limp with shoes on. He refused to walk on his heels or toes. There was no discernible swelling or redness in his feet. There was tenderness on palpation of the heels. The Veteran had minimal deviation in his Achilles tendons. There was objective evidence of pain on range of motion of his feet. X-ray film of the feet revealed bilateral pes planus and bilateral plantar spurring. The Veteran was assessed with bilateral pes planus with mild impairment and bilateral plantar fasciitis with plantar spurring.

In December 2004, the Veteran denied any decrease in his ability to perform activities of daily living.

The record also contains the report of a September 2005 general medical evaluation performed in conjunction with the Veteran's claim for SSA disability benefits. This SSA evaluation report shows that the Veteran complained of bilateral foot pain. He reported that he received treatment for heel spurs. He reported that he could walk about a quarter of a block before stopping due to pain in the back, hip, ankle, and foot. He did not drive, except less than a quarter of a mile to get the mail and did no yard work or housework. He complained of leg numbness and weakness. The Veteran was seen walking in the parking lot with a slight limp, but no foot drop. In the examination room, he demonstrated a severe right limp, although a subsequent notation indicated a slow right moderate limp. There was no foot drop, but the Veteran did slide his foot along the floor, picking the foot up only one half to one inch. He was unable to walk on his heels or toes or tandem walk. On physical examination, there was evidence of mild tenderness of his feet without deformity or swelling. The Veteran's arches were considered normal. He had mild pain on movement of his feet. Bilateral ankle range of motion was to 20 degrees of dorsiflexion and 40 degrees of plantar flexion. Muscle strength testing showed right great toe extension as 3+ out of 5, right leg strength of 4+ out of 5, and right ankle dorsiflexion of 4+ out of 5. Otherwise muscle strength was 5 out of 5. The Veteran had good muscle bulk and tone and there was no evidence of atrophy. There was decreased sensation in the L5-S1 dermatome in the right foot and right calf. Lower extremity reflexes were normal. It was opined that the Veteran could stand or walk for two to four hours out of an eight-hour work day and would require taking frequent breaks every 15 to 20 minutes. He was noted to hardly push off with his right great toe when walking.

An October 2005 private examination for SSA benefit eligibility purposes included the notation from the examiner that the Veteran's reports of arthritis, disc problems, and bone spurs in the feet that caused severe restrictions in standing, walking, and sitting were "only partially credible" as objective examination showed some limitations, but not to the level of severity asserted by the Veteran.

The Veteran was afforded a second VA examination in April 2007. In that examination report, the examiner noted that the Veteran complained of constant pain in his feet. He described the pain at a level of seven out of ten. He also complained of weakness, stiffness, and swelling in his feet. He experienced flare-ups of pain to a level ten approximately three times a month that would last for hours. Precipitating factors included prolonged standing and walking. He reported that he was only able to walk up to 200 yards and stand for a maximum of one to two hours on his feet. He stated that injections, orthotics, and pain medication did not resolve his symptomatology. He felt that he had additional limitation of motion and functional impairment of 10 to 25 percent because of the severity of his bilateral foot symptomatology. Physical examination revealed objective findings of moderate to marked tenderness on palpation of both heels. Tenderness along the plantar fascia was also noted. There was no evidence of obvious warmth, swelling or redness. The VA examiner noted that the Veteran had "obvious pes planus on examination." The Veteran walked with an antalgic gait and with the use of a cane. Diagnostic testing revealed bilateral pes planus and moderate sized plantar calcaneal tuberosities. An assessment of bilateral pes planus (with associated plantar fasciitis) was provided.

In February 2009, the Veteran denied any recent injury to the feet and historically could recall only a left ankle twisting incident in 1974. The Veteran also indicated that past use of orthotics had been of no help. On examination, neither foot was tender overall, but there was some tenderness in the left ankle and both feet at the base of the calcaneus and along the metatarsal heads on the plantar side. The Veteran had bilateral low arches that were quite severe, but flexible. The Veteran could extend and flex his toes, retained sensation and pulses, and had no evidence of fracture or dislocation on x-ray. However, there was a possible small bone spur anteriorly at the left ankle joint. The impression was bilateral flat feet.

During his February 2010 Board hearing, the Veteran reported that he did not drive due to pain medication that caused blurry vision. He indicated that he used inserts in his shoes. He also noted constant swelling of the feet. He experienced "muscle spasms" in the toes that caused them to curl up.

Pursuant to the Board's March 2011 remand directives, the Veteran was afforded another VA examination in July 2011. The examiner noted review of the claims file. In addition, the examiner specifically stated that there was no history of trauma to the feet. The examination report included the Veteran's complaints of constant pain, swelling, and stiffness with activity and with rest. He also complained of fatigue, weakness, and lack of endurance with walking and standing. He experienced weekly flare-ups of pain that lasted one to two days. During a flare-up episode, he reported that he had additional functional impairment where he was unable to stand or walk for more than a few minutes. The Veteran used orthotic devices and a cane with good results. On physical examination, the VA examiner observed that the Veteran walked with an antalgic gait. There was evidence of painful motion, tenderness and weakness in both feet. The Veteran was unable to stand on his heels or toes. There was no evidence of swelling, instability, abnormal weight bearing, hammertoes, hallux valgus or rigidus, clawfoot, or malunion or nonunion of the tarsal or metatarsal bones. The Veteran had inward bowing with Achilles alignment and midfoot misalignment. There was evidence of pain on manipulation and the misalignment was not considered correctable. The Veteran had moderate pronation and a weight bearing line was over the great toe. No marked foot deformities were observed on physical examination and there was no atrophy of the foot muscles. X-ray film of the feet revealed the following findings: moderate pes planus, bilaterally; plantar calcaneal tuberosities; mild degenerative changes at the first metatarsal phalangeal joints; and minimal flexion deformities of the second through fourth toes on the left foot. The VA examiner assessed the Veteran with moderate pes planus, bilaterally.

In support of his claim, the Veteran also submitted a statement signed by multiple acquaintances who indicated that the Veteran had problems with everyday living, to include intermittent difficulty with activities such as walking and driving. On some days the Veteran needed help from these individuals, while on other days he did not.

In September 2011, the Veteran first sought treatment with VA for bilateral foot and ankle pain. Specifically, there was pain in both plantar feet and the midfoot. He also described cramping and aching in the feet, which was worsened with prolonged

standing. On examination, there was no edema or ataxia. A November 2011 VA treatment record noted intact sensation to light touch bilaterally, but a bilateral decreased medial arch. There was pain on palpation of the medial tuberosity of the calcaneous and along the arch bilaterally. There also was pain on palpation and pain with range of motion testing along the medial / anterior and lateral ankle bilaterally. The Veteran had orthotics that were too hard, but he continued to wear them. In March 2013, the Veteran had a steady gait. In April 2013, the Veteran denied falls and paresthesia. A November 2013 psychiatric treatment record noted that the Veteran had a steady gait and had no appearance of atrophy. In December 2013, the Veteran reported that his right lower extremity would give way at times, as well as both ankles. On examination, there was no extremity edema and no ataxia. The Veteran was referred for physical therapy for his orthopedic problems. In March 2014, the Veteran had no ataxia and no edema of the extremities on examination. An April 2014 VA treatment record showed bilateral lower extremity muscle strength to be 5- out of 5. There was decreased sensation in the right lower extremity in no specific dermatomal distribution. The Veteran had an antalgic gait with the use of a cane, but without ataxia. Reflexes were normal. Muscle tone was normal. There was no evidence of muscle atrophy or ankle clonus.

The Veteran was afforded another VA examination in May 2014. The examiner noted diagnoses of bilateral pes planus and plantar fasciitis. The Veteran reported pain in his feet and muscle spasms since the 1970s, but worsening in 2004. He had pain with or without walking and was on pain medication. He described intermittent swelling below the ankles and in the big toes. He denied calluses and used orthotics. He had been using a cane for combined problems with his back, hips, knees, ankles, and feet. He reported pain in the feet and flare-ups that resulted in trouble walking. There was functional impairment in that he was unable to walk for very long. There was bilateral pain on the use of his feet that was accentuated by manipulation. There was bilateral swelling on use, but no calluses. There was extreme tenderness of the plantar surfaces on one or both feet. The tenderness was not improved with the use of orthopedic shoes or appliances. The Veteran had decreased longitudinal arch height on both feet. There was no noted deformity of the feet, such as pronation or abduction. The weight bearing line of the feet did not fall over or medial to the great toe. There was no inward bowing, inward

displacement, or severe spasm of the Achilles tendon. There was bilateral metatarsalgia. There were no other foot injuries. The examiner noted that there was functional loss due to pain without weight bearing and walking, which worsened with walking. The examiner could not differentiate the contribution of the various orthopedic disabilities to the Veteran's need to use a cane. The examiner found that there was no functional impairment of the feet such that no effective function remained other than that which would be equally well served by an amputation with prosthesis. X-rays showed mild arthritis of the left first metatarsophalangeal joint and bilateral flat feet, but no calcaneal spur or hallux valgus.

A June 2015 VA treatment record documented a normal gait and prior visits wherein the Veteran reported a pain level of 0 out of 10 in December 2013, January 2014, March 2014, July 2014, February 2015, and March 2015. In November 2014, the Veteran had described pain as a 7 out of 10 due to his back and feet.

A November 2015 VA treatment record noted that the Veteran had "NORMAL WALKING AT HOME." His exercise screen was mild. In a separate November 2015 VA treatment record, the Veteran reported feeling less stable since his last visit due to his feet hurting, but on examination there was no appearance of atrophy flaccidity, or spascity.

During a November 2015 VA examination of the back, muscle strength testing showed normal ankle plantar flexion and dorsiflexion strength bilaterally. Great toe extension was slightly decreased, at 4 out of 5, in the right great toe and normal in the left great toe. There was no evidence of muscle atrophy. Ankle reflexes were normal bilaterally and sensation in the lower leg / ankle was normal bilaterally. There was decreased sensation in the right foot / toes, but normal sensation in the left foot / toes.

A January 2016 VA treatment record included the Veteran's complaints of ankle and foot numbness. He also stated that he had orthotics many years previously, but they had broken. He also had used over-the-counter shoe inserts from the VA many years previously, but they had not worked. Other than the numbness, the Veteran

had no other pedal complaints at that time. On examination, the Veteran was ambulating with the assistance of a cane. On examination, there was decreased muscle strength in the dorsiflexors and plantar flexors bilaterally, but without indication as to the degree of decreased muscle strength. There was generalized foot pain and decreased light touch in the right and great fifth toe.

SMC

The Veteran asserts that special monthly compensation (SMC) based on loss of use of his feet due to his service-connected disabilities is warranted.

SMC is a special statutory award, in addition to awards based on the schedular evaluations provided by the diagnostic codes in the Rating Schedule. Claims for SMC, other than those pertaining to one-time awards and the annual clothing allowance, are governed by 38 U.S.C.A. § 1114 (k) through (s) and 38 C.F.R. §§ 3.350 and 3.352.

A veteran who, as the result of a service-connected disability, has suffered the anatomical loss or loss of use of both feet shall receive SMC under the provisions of 38 U.S.C.A. § 1114(l). *See* 38 C.F.R. § 3.350(b).

The term "loss of use" of a hand or foot is defined by 38 C.F.R. § 3.350(a)(2) and 4.63 as that condition where no effective function remains other than that which would be equally well served by an amputation stump at the site of election below elbow or knee with use of a suitable prosthetic appliance. The determination will be made on the basis of the actual remaining function, whether the acts of grasping, manipulation, etc., in the case of the hand, or balance, propulsion, etc., in the case of a foot, could be accomplished equally well by an amputation stump with prosthesis. Examples under 38 C.F.R. §§ 3.350(a)(2) and 4.63 which constitute loss of use of a foot or hand are extremely unfavorable ankylosis of the knee, or complete ankylosis of two major joints of an extremity, or shortening of the lower extremity of 3 1/2 inches or more.

Also considered as loss of use of a foot under 38 C.F.R. § 3.350(a)(2) is complete paralysis of the external popliteal (common peroneal) nerve and consequent foot drop, accompanied by characteristic organic changes, including trophic and circulatory disturbances and other concomitants confirmatory of complete paralysis of this nerve. Under 38 C.F.R. § 4.124a, DC 8521 (2015), complete paralysis of the external popliteal (common peroneal) nerve also encompasses foot drop and slight droop of the first phalanges of all toes, an inability to dorsiflex the foot, loss of extension (dorsal flexion) of the proximal phalanges of the toes, loss of abduction of the foot, weakened adduction of the foot, and anesthesia covering the entire dorsum of the foot and toes.

The Veteran is currently service-connected for a low back condition, degenerative disc disease, rated as 40 percent disabling from March 31, 2004; bilateral pes planus with associated plantar fasciitis, rated as 10 percent disabling until April 27, 2007, as 30 percent disabling from April 27, 2007; and radiculopathy, right lower extremity associated with low back condition, degenerative disc disease, rated as 20 percent disabling from March 31, 2004. The Veteran also is in receipt of a total disability rating based on individual unemployability (TDIU) from June 1, 2005.

In light of the evidence discussed above, the Board finds the preponderance of the evidence against the Veteran's claim. He does not meet the criteria for a finding of the loss of use of either foot due to his service-connected disabilities.

In reaching that conclusion, the Board has considered the arguments of the Veteran and his representative. In September 2013, an agent for the Veteran's representative argued that the Veteran was entitled to SMC benefits due to the loss of use of both feet. The agent pointed out that the Veteran required the use of bilateral orthotics and a cane to assist in ambulation and, even then, could walk or stand for only a few minutes, particularly during flare-ups. Moreover, such a level of functioning could be achieved only while on pain medication and/or steroid injections, which demonstrated significant functional loss. The agent contended that the issue properly should be analyzed under the following framework, "[W]ith amputations and suitable prostheses followed by the rehabilitative therapy on the use of such prostheses, could the Veteran then stand and ambulate with the same

level of function he currently experiences. In fact, could he stand and ambulate for longer periods of time than he can currently. If the answer is in the affirmative, then a finding of functional loss of use is in order."

In a July 2014 statement, the agent for the Veteran's representative argued that the Veteran had "no effective function of his feet – he requires [the] use of multiple appliances for balance and propulsion and therefore has lost the use of both feet." The agent indicated that the Veteran was unable to go to the grocery store unaided, walk into the store unaided, and gather the basics needed to maintain his daily life. As such, the agent concluded that the Veteran exceeded the standard required for the award of SMC based on the loss of use of both feet.

In a May 2016 statement, the agent for the Veteran's representative cited to 38 C.F.R. §§ 3.350(a)(2)(i) and 4.63 for the proposition that loss of use of a foot would be held to exist when there was "no *effective* remaining function other than that which would be equally well served by an amputation stump with the use of a suitable prosthetic appliance" and when the acts of "balance, propulsion, etc…. could be accomplished equally well by an amputation stump with prosthesis." The agent argued that "balance and propulsion problems are, in and of themselves, sufficient to qualify as loss of use of a foot." The agent went on to contend that the "record is replete with evidence unequivocally showing his lack of effective functioning with balance and propulsion without the use of a prosthetic appliance" and that this evidence established that the Veteran suffered loss of use of both feet due to his service-connected disabilities.

The Board acknowledges that there is myriad evidence demonstrating decreased effective functioning of the feet due to his service-connected disabilities. The Board, however, does not find that the evidence shows ***no*** effective remaining function other than that which would be equally well served by an amputation stump with the use of a suitable prosthetic appliance. The Veteran's representative has cited to evidence showing that the Veteran uses a cane, has an antalgic gait, requires shoe inserts, is unable to stand for more than a few minutes or walk more than a few yards, and is unsteady even with the use of a cane. The foregoing evidence certainly shows decreased effective functioning, but does not represent ***no***

effective remaining function, as would be necessary to grant entitlement to SMC based on the loss of use of one or both feet. The lay and medical evidence clearly demonstrates that the Veteran is able to walk, stand, and balance for limited periods of time, but not for *no* effective periods of time. The phrase "no effective function remains other than that which would be equally well served by an amputation stump… with the use of a suitable prosthetic appliance" in 38 C.F.R. § 3.350(a)(2) clearly contemplates the absence of effective functioning in the acts of "balance, propulsion, etc." and not simply limitation (even severe limitation) of those actions. As evidence of this conclusion, the examples provided in 38 C.F.R. § 3.350(a)(2)(a) and (b) discuss "complete paralysis" and "complete ankylosis" entirely preventing use of the joint at issue. In this case, the Veteran retains the ability to walk, stand, and balance for limited periods of time, including with the use of a cane and sometimes for extremely limited periods of time. Moreover, the Board finds it extremely significant that multiple findings have noted normal or only slightly decreased muscle strength in the ankles and toes. These findings indicate that the Veteran is able to use the ankles, feet, and toes in close to a normal manner, to include duration of use, and, in fact, does so. *See* 38 C.F.R. § 4.40 (noting that, "A little used part of the musculoskeletal system may be expected to show evidence of disuse, either through atrophy, the condition of the skin, absence of normal callosity or the like."). In this case, there is no evidence of atrophy or callouses to support a finding of no effective functioning of the ankles, feet, and toes.

The Board also has considered the statement in the JMR that, "the inability to stand for more than a few minutes or walk more than a few yards is patently indicative of severe symptomatology, and the Board makes no attempt to compare this to amputation with prosthetics, which is particularly egregious in context of the advances that prosthetics for amputees have taken." Again, the Board recognizes that the Veteran has severe symptomatology due to his service-connected disabilities; however, the Veteran already receives compensation for these symptoms in his current individual disability ratings and overall TDIU award. The evidence, by contrast, does not show that *no* effective function remains in either foot other than that which would be equally well served by an amputation stump with the use of a suitable prosthetic appliance.

The Board has considered the arguments of the agent of the Veteran's representative that the May 2014 VA examination report was inadequate because it did "not address 'effective function' in any terms, much less in terms of explaining the legal meaning in a manner that an examiner can illustrate in medical terms." The examiner went on define "effective" as "[w]ithin the range of normal and expected standards" and argued that "[b]asic yes or no remarks are just not suitable or conclusive enough for such a complex issue." To the extent that the May 2014 VA examination report may not be sufficient alone to adjudicate the Veteran's claims, given the other lay and medical evidence of record, as documented above, the Board concludes that there is sufficient evidence of record to establish the Veteran's level of functioning such that his claim can be adjudicated. Even were such an error demonstrated, the Veteran's attorney representative has since explicitly waived any errors with respect to VA's duty to assist in obtaining an adequate examination and requested that a decision be reached based on the evidence of record.

Again, the Board acknowledges significant problems with balance and propulsion affecting the feet due to the Veteran's service connected disabilities. That said, the Veteran has no muscle atrophy in the feet, toes, or ankles or callosities indicative of decreased, abnormal, or loss of functioning of the feet. Moreover, as a prosthetic or amputated foot would not retain effective reflex, sensory, or circulatory functioning, as contemplated by the relevant laws and regulations, and the evidence demonstrates that the Veteran retains some or all of such functioning in the feet, ankles, and toes, the evidence of record shows that there is some measure of effective functioning of the bilateral feet and that he would not be equally well served by an amputation stump at the site of election below the knee with use of a suitable prosthetic appliance. Finally, as discussed above, the Veteran retains some effective functioning in his ankles, feet, and toes that permit him to walk, stand, and balance for limited periods of time / distances. As there is no evidence showing that no effective function remains in either foot other than that which would be equally well served by an amputation stump with the use of a suitable prosthetic appliance, the Board finds by a clear preponderance of the evidence that loss of use of the feet is not demonstrated. 38 C.F.R. §§ 3.350, 4.63. Therefore, the claim must be denied.

ORDER

Entitlement to SMC due to loss of use of both feet is denied.

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BETHANY L. BUCK
Veterans Law Judge, Board of Veterans' Appeals

Department of Veterans Affairs

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).