BOARD OF VETERANS' APPEALS
Department of Veterans Affairs
Washington, DC 20420

IN THE APPEAL OF
KERRY E. SHEA

DOCKET NO. 09-31 300) DATE *July 27, 2016*
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On appeal from the
Department of Veterans Affairs Regional Office in St. Petersburg, Florida

THE ISSUES

1. Entitlement to an initial rating in excess of 40 percent for a lumbar spine disability.

2. Entitlement to an initial rating in excess of 10 percent for a right hip disability, as a residual of pelvic fractures.

3. Entitlement to a separate compensable rating for a left hip disability, as a residual of pelvic fractures.

4. Entitlement to a separate compensable rating for a muscle group injury, as a residual of pelvic fractures.

5. Entitlement to an initial compensable rating for fracture of the seventh and eighth ribs.

6. Entitlement to an effective date earlier than September 9, 2008 for service connection for a psychiatric disability.

REPRESENTATION

Appellant represented by: The American Legion

ATTORNEY FOR THE BOARD

M. Thomas, Associate Counsel

INTRODUCTION

The Veteran, who is the appellant in this case, served on active duty from October 2006 to July 2007.

This matter comes before the Board of Veterans' Appeals (Board) on appeal from February 2008 and February 2009 rating decisions of the Department of Veterans Affairs (VA) Regional Office (RO) in St. Petersburg, Florida.

The issues of increased initial ratings for service-connected low back, pelvic, and rib disabilities have been previously remanded by the Board in March 2014. There has been substantial compliance with the Board's remand directives. *Stegall v. West*, 11 Vet. App. 268 (1998) (remand by the Board confers on the Veteran the right to compliance with its remand orders). As requested by the Board, the RO obtained the outstanding VA treatment records and those private treatment records identified by the Veteran. The RO also scheduled the Veteran for VA examinations to determine the current severity of the low back disability, pelvic fracture, and rib fractures. The RO then readjudicated the claims. Only substantial compliance with the terms of the Board's engagement letter is required, not strict compliance. *D'Aries v. Peake*, 22 Vet. App. 97 (2008); *Dyment v. West*, 13 Vet. App. 141 (1999).

In March 2014, the Board denied the claim for an effective date prior to September 9, 2008 for service connection for PTSD. The Veteran appealed the March 2014

Board decision to the United States Court of Appeals for Veterans Claims (Court). In December 2015, the parties filed a Joint Motion for Partial Remand asking the Court to vacate the Board's March 2014 decision and remand the claim to the Board for further development and readjudication in compliance with the directives specified. The Court granted the December 2015 Joint Motion in a December 2015 order, finding that the Board erred insofar as the Board did not support the decision with an adequate statement of reasons and bases. Specifically, the Joint Motion found that the Board should discuss a July 2008 statement from appellant that referenced the Veteran's memory problems. The Joint Motion stated that the July 2008 statement was relevant to the Veteran's claim of entitlement to an effective date earlier than September 9, 2008 for the grant of service connection for PTSD, especially in light of the subsequent medical evidence of record highlighting the symptom of memory loss before diagnosing PTSD. The parties agreed that remand was necessary, and the Board should assess that statement in the statement of reasons or bases and address whether, liberally construed, it constituted an informal claim for service connection for a psychiatric disorder. Therefore, the Court vacated the portion of the Board's March 2014 decision denying entitlement to an effective date prior to September 9, 2008, for the grant of service connection for PTSD, and remanded the matter to the Board.

The issue of entitlement to service connection for a pulmonary disability, to include restrictive lung disease, has been raised by the record in a July 2007 private treatment record from Kent Pulmonary Associates, but has not been adjudicated by the Agency of Original Jurisdiction (AOJ). Therefore, the Board does not have jurisdiction over that issue, and it is referred to the AOJ for appropriate action. 38 C.F.R. § 19.9(b) (2015).

The issue of entitlement to a separate compensable rating for a muscle group injury, as a residual of pelvic fractures, is REMANDED to the AOJ.

FINDINGS OF FACT

1. For the entire rating period on appeal, the Veteran's low back disability has been manifested by flexion of the thoracolumbar spine of 30 degrees or less, and did not manifest in unfavorable ankylosis of the thoracolumbar spine or entire spine.

2. The Veteran's right hip disability was manifest by limitation of flexion to 40 degrees, with painful motion. It did not manifest in ankylosis of the hip, limitation of extension, abduction, adduction, or rotation of the thigh, flail hip joint, flexion limited to 30 degrees or less, or impairment of the femur.

3. The Veteran's left hip disability was manifest by limitation of flexion to 40 degrees, with painful motion. It did not manifest in ankylosis of the hip, limitation of extension, abduction, adduction, or rotation of the thigh, flail hip joint, flexion limited to 30 degrees or less, or impairment of the femur.

4. For the entire rating period on appeal, the Veteran's fracture of the seventh and eighth ribs has been manifested by symptoms of abdominal pain and bilateral anterior abdomen tenderness that approximate the criteria corresponding to the removal of one rib. The residual symptoms of the Veteran's rib fracture did not approximate the criteria responding to the removal of more than one rib.

5. The Veteran's July 7, 2008 statement describing her memory impairment constituted an informal claim for service connection for PTSD.

CONCLUSIONS OF LAW

1. The criteria for an initial rating in excess of 40 percent for a low back disability have not been met. 38 U.S.C.A. §§ 1155, 5103, 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.159, 3.321, 4.1, 4.3, 4.7, 4.10, 4.71a, Diagnostic Code 5237 (2015).

2. Resolving reasonable doubt in favor of the Veteran, an initial rating of 10 percent, but not higher, is warranted for a right hip disability, as a residual of pelvic fractures, for the entire period on appeal, in place of the current 10 percent rating assigned for bilateral pelvic disability. 38 U.S.C.A. §§ 1155, 5103, 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.159, 3.321, 4.1, 4.3, 4.7, 4.10, 4.71a, Diagnostic Code 5312 (2015).

3. Resolving reasonable doubt in favor of the Veteran, a rating of 10 percent, but no higher, is warranted for a left hip disability, as a residual of pelvic fractures for the entire period on appeal, in place of the current 10 percent rating assigned for bilateral pelvic disability. 38 U.S.C.A. §§ 1155, 5103, 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.159, 3.321, 4.1, 4.3, 4.7, 4.10, 4.67, 4.71a, Diagnostic Code 5312 (2015).

4. Resolving reasonable doubt in favor of the Veteran, an initial rating of 10 percent, but not higher, is warranted for fracture of the seventh and eighth ribs, for the entire period on appeal. 38 U.S.C.A. §§ 1155, 5103, 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.159, 3.321, 4.1, 4.3, 4.7, 4.10, 4.67, 4.71a, Diagnostic Code 5299-5297 (2015).

5. Resolving reasonable doubt in favor of the Veteran, the criteria for an effective date of July 7, 2008, but not earlier, for service connection for PTSD are met. 38 U.S.C.A. §§ 5103, 5103A, 5107, 5110 (West 2002); 38 C.F.R. §§ 3.102, 3.155, 3.159, 3.400 (2013).

REASONS AND BASES FOR FINDINGS AND CONCLUSION

Duties to Notify and Assist

VA has duties to provide claimants with notice and assistance. 38 U.S.C.A. §§ 5103, 5103A (West 2014); 38 C.F.R. § 3.159 (2015). The claims for increased ratings for a low back disability, pelvic fracture, and fracture of the seventh and eighth ribs arise from the Veteran's disagreement with the ratings assigned in connection with the grants of service connection for these disabilities. As to the

claim for an earlier effective date for service connection for PTSD, it also arises from the Veteran's disagreement with the effective date assigned in connection with the grant of service connection. Where an underlying claim for service connection has been granted and there is disagreement as to downstream issues such as the propriety of the assigned rating or effective date, the claim has been substantiated and there is no need to provide additional notice or prejudice from absent notice. *Hartman v. Nicholson*, 483 F.3d 1311 (Fed. Cir. 2007). Consequently, further discussion of the notification requirements with regard to those claims is unnecessary.

VA must make reasonable efforts to help a claimant obtain evidence necessary to substantiate a claim. 38 U.S.C.A. § 5103A (West 2014); 38 C.F.R. § 3.159(c)-(d) (2015). This duty to assist contemplates that VA will help a claimant obtain records relevant to the claim, whether or not the records are in Federal custody, and that VA will provide a medical examination or obtain an opinion when necessary to make a decision on the claim. 38 C.F.R. § 3.159(c)(4) (2015).

In this case, VA obtained the Veteran's service medical records, lay statements, and all of the identified post-service private and VA treatment records. The Veteran was given VA examinations in November 2007 and May 2014. The Board finds that the examinations were adequate.

The Board finds that VA has complied with the notification and assistance requirements. The claims for entitlement to increased initial ratings for a low back disability, pelvic fracture, and fracture of the seventh and eighth ribs are thus ready for consideration on the merits.

Increased Rating

Disability ratings are determined by evaluating the extent to which a service-connected disability adversely affects the Veteran's ability to function under the ordinary conditions of daily life, including employment, by comparing the symptomatology with the criteria set forth in the Schedule for Rating Disabilities. 38 U.S.C.A. § 1155 (West 2014); 38 C.F.R. §§ 4.1, 4.2, 4.10 (2015).

The Veteran's entire history is to be considered when assigning disability ratings. 38 C.F.R. § 4.1 (2015); *Schafrath v. Derwinski*, 1 Vet. App. 589 (1995). The Board will consider entitlement to staged ratings to compensate for times since filing the claim when the disability may have been more severe than at other times during the course of the claim on appeal. *Fenderson v. West*, 12 Vet. App. 119 (1999); *Hart v. Mansfield*, 21 Vet. App. 505 (2007). The relevant temporal focus for adjudicating an increased rating claim is on the evidence concerning the state of the disability from the time period one year before the claim was filed until VA makes a final decision on the claim. *Francisco v. Brown*, 7 Vet. App. 55 (1994); *Hart v. Mansfield*, 21 Vet. App. 505 (2007).

Where there is a question as to which of two ratings shall be applied, the higher rating will be assigned if the disability picture more nearly approximates the criteria for that rating. Otherwise, the lower rating will be assigned. 38 C.F.R. § 4.7 (2015). Any reasonable doubt regarding a degree of disability will be resolved in favor of the Veteran. 38 C.F.R. § 4.3 (2015).

In making a decision on appeal, the Board must analyze the credibility and probative value of the evidence, account for the evidence which it finds to be persuasive or unpersuasive, and provide the reasons for its rejection of any material favorable to the claimant. *Gabrielson v. Brown*, 7 Vet. App. 360 (1994); *Gilbert v. Derwinski*, 1 Vet. App. 49 (1990). Competency of evidence differs from weight and credibility. Competency is a legal concept determining whether testimony may be heard and considered by the trier of fact, while credibility is a factual determination going to the probative value of the evidence to be made after the evidence has been admitted. *Rucker v. Brown*, 10 Vet. App. 67 (1997); *Layno v. Brown*, 6 Vet. App. 465 (1994).

When considering whether lay evidence is competent, the Board must determine, on a case-by-case basis, whether a Veteran's particular disability is the type of disability for which lay evidence may be competent. *Kahana v. Shinseki*, 24 Vet. App. 428 (2011); *Jandreau v. Nicholson*, 492 F.3d 1372 (Fed. Cir. 2007). A Veteran is competent to report symptoms because that requires only personal

knowledge, not medical expertise, as it comes to a person through her senses. *Layno v. Brown*, 6 Vet. App. 465 (1994). Lay testimony is competent to establish the presence of observable symptomatology, where the determination is not medical in nature and is capable of lay observation. *Barr v. Nicholson*, 21 Vet. App. 303 (2007).

When all the evidence is assembled, VA is responsible for determining whether the evidence supports the claim or is in relative equipoise, with a Veteran prevailing in either event, or whether a preponderance of the evidence is against a claim, in which case, the claim is denied. 38 U.S.C.A. § 5107(b) (West 2014); 38 C.F.R. § 3.102 (2015).

Low Back Disability

The Veteran has been assigned a 40 percent initial disability rating for her low back disability. She asserts that a higher rating is warranted. The low back disability is currently rated under Diagnostic Code 5237 for lumbosacral or cervical strain.

Ratings under Diagnostic Code 5237 are evaluated based on the General Rating Formula for Diseases and Injuries of the Spine. A 40 percent disability rating is provided for forward flexion of the thoracolumbar spine to 30 degrees or less, or favorable ankylosis of the entire thoracolumbar spine. A 50 percent disability rating is assigned for unfavorable ankylosis of the entire thoracolumbar spine. A 100 percent disability rating is assigned for unfavorable ankylosis of entire spine. 38 C.F.R. § 4.71a, General Rating Formula for Diseases and Injuries of the Spine (2015).

Any associated objective neurologic abnormalities, including, but not limited to, bowel or bladder impairment, should be separately evaluated under an appropriate diagnostic code. 38 C.F.R. § 4.71a, General Rating Formula for Diseases and Injuries of the Spine, Note (1) (2015).

For VA compensation purposes, normal forward flexion of the thoracolumbar spine is 0 to 90 degrees, extension is 0 to 30 degrees, left and right lateral flexion are 0 to

30 degrees, and left and right lateral rotation are 0 to 30 degrees. The combined range of motion refers to the sum of the range of forward flexion, extension, left and right lateral flexion, and left and right rotation. The normal combined range of motion of the thoracolumbar spine is 240 degrees. The normal ranges of motion for each component of spinal motion provided in this note are the maximum that can be used for calculation of the combined range of motion. 38 C.F.R. § 4.71a, General Rating Formula for Diseases and Injuries of the Spine, Note (2), Plate V (2015). Each range of motion measurement to the nearest five degrees. 38 C.F.R. § 4.71a, General Rating Formula for Diseases and Injuries of the Spine, Note (4) (2015).

In exceptional cases, an examiner may state that because of age, body habitus, neurologic disease, or other factors not the result of disease or injury of the spine, the range of motion of the spine in a particular individual should be considered normal for that individual, even though it does not conform to the normal range of motion. Provided that the examiner supplies an explanation, the examiner's assessment that the range of motion is normal for that individual will be accepted. 38 C.F.R. § 4.71a, General Rating Formula for Diseases and Injuries of the Spine, Note (3) (2015).

For VA compensation purposes, unfavorable ankylosis is a condition in which the entire thoracolumbar spine, or the entire spine is fixed in flexion or extension, and the ankylosis results in one or more of the following: difficulty walking because of a limited line of vision; restricted opening of the mouth and chewing; breathing limited to diaphragmatic respiration; gastrointestinal symptoms due to pressure of the costal margin on the abdomen; dyspnea or dysphagia; atlantoaxial or cervical subluxation or dislocation; or neurologic symptoms due to nerve root stretching. Fixation of a spinal segment in neutral position (zero degrees) always represents favorable ankylosis. 38 C.F.R. § 4.71a, General Rating Formula for Diseases and Injuries of the Spine, Note (5) (2015).

At a November 2007 VA examination, the Veteran reported pain on the low back on range of motion, when she carried something heavy, and on prolonged standing, sitting, and walking. The VA examiner noted that the Veteran’s lumbar and coccygeal area was painful and tender, and range of motion brought on the low

back pain. The Veteran reported experiencing weekly flare-ups of moderate severity, usually lasting for hours. She reported no additional limitation of motion during flare-ups. The Veteran reported experiencing numbness of the upper inner thighs, but the VA examiner noted that she showed intact sensation upon examination. No bladder or bowel impairment was indicated. The VA examiner indicated that there was no radiation of pain. The Veteran was able to walk a quarter of a mile. Scoliosis and lumbar flattening were noted. There was no spasm, atrophy, guarding, tenderness, and weakness. Pain with motion was noted. Flexion was 30 degrees. While there was objective evidence of pain on active range of motion, the VA examiner did not indicate the point at which pain began. There was no additional limitation after three repetitions of range of motion, though there was objective evidence of pain. Levoscoliosis was noted. The VA examiner opined that the low back disability would have significant effects on the Veteran's usual occupation as a locker room attendant, specifically noting problems with lifting and carrying, and pain and problems bending over. The low back disability would prevent the Veteran from participating in sports, and have a mild impact on chores, shopping, exercise, and traveling.

At a May 2014 VA examination, the VA examiner diagnosed lumbar scoliosis, mild degenerative joint disease of the lumbar spine, and low back pain. The Veteran reported that when she crossed the right thigh over the left thigh, pain was 8/10 at the low back area, not in the thigh. She stated that she had to be lying down on the bed while putting on socks and shoes due to back pain, as lumbar flexion was very painful and limited. She stated that there was no impairment of bladder or bowel function. The Veteran's forward flexion ended at 20 degrees. Extension was to 5 degrees. Lateral flexion was to 15 degrees, bilaterally. Lateral rotation was 15 degrees, bilaterally. For all range of motion measurements, painful motion was noted at the end of the motion. There was no additional loss of range of motion after repetitive use. The VA examiner stated that the Veteran had local tenderness on the lower lumbar spine and in the sacrocoggygeal area, more so on the right side than on the left side. The Veteran did not have muscle spasms or guarding. The VA examiner indicated that the Veteran did not have radicular pain or any other signs or symptoms due to radiculopathy. There was no ankylosis of the spine. No arthritis was documented by imaging. The Veteran had lumbar spine scoliosis. The

VA examiner opined that the Veteran's low back disability did not impact her ability to work. The VA examiner stated that there has not been an incapacitating episode of the Veteran's lumbar spine disability that required bed rest ordered by a physician. Flare-ups increase the Veteran's low back pain. Finally, the VA examiner stated that the Veteran had no neurological abnormalities associated with the low back disability.

Based on the above evidence, the Board finds that the criteria for an initial rating in excess of 40 percent are not met for the entire initial rating period on appeal. The Veteran's forward flexion was 20 degrees at the May 2014 VA examination report, and 30 degrees at the November 2007 VA examination report. That meets the criteria for a 40 percent rating. There is no evidence of unfavorable ankylosis of either the entire thoracolumbar spine or the entire spine, which is needed for a higher rating. Therefore, the evidence does not more nearly approximate the criteria for an initial rating in excess of 40 percent.

The Board has considered whether a higher rating may be assigned on the basis of functional loss due to pain under 38 C.F.R. § 4.40 and functional loss due to weakness, fatigability, incoordination, lack of endurance or pain on movement of a joint under 38 C.F.R. § 4.45. *DeLuca v. Brown*, 8 Vet. App. 202 (1995). In this case, there is no evidence of additional limitation of motion of the thoracolumbar spine due to pain or repetitive motion. While the November 2007 VA examination report indicated that there was objective evidence of pain when range of motion testing was conducted, there was no indication of the point at which pain began. Passive range of motion was unchanged from active range of motion on repetitive testing. Painful motion was documented at the end of the range of motion during the May 2014 VA examination. There was no additional loss of range of motion after repetitive use. Therefore, the Board finds that the service-connected low back disability is not shown to produce any additional impairment or limitation of motion due to pain, lack of endurance, weakness, fatigability, incoordination, or lack of endurance that would warrant an initial rating in excess of 40 percent. *DeLuca v. Brown*, 8 Vet. App. 202 (1995).

The Board has considered the Veteran's statements that her low back disability should be rated higher than the currently assigned 40 percent rating. In this case, the Veteran is competent to report symptoms because this requires only personal knowledge as it comes to her through her senses. *Layno v. Brown*, 6 Vet. App. 465 (1994). However, she is not competent to identify a specific level of disability of the low back disability according to the appropriate diagnostic codes. Competent evidence concerning the nature and extent of the low back disability has been provided by the medical examiner who examined her during the current appeal and who provided a pertinent opinion in conjunction with the examination. The medical findings as provided in the November 2007 and May 2014 VA examination reports directly address the criteria under which this disability is rated. The Board finds that those medical findings are the most persuasive evidence because of the training and expertise of the examiner.

Accordingly, the Board finds that the preponderance of the evidence is against the assignment of an initial rating in excess of 40 percent for a lumbar spine disability. Therefore, the claim must be denied. *Gilbert v. Derwinski*, 1 Vet. App. 49 (1990); 38 U.S.C.A. § 5107 (West 2014); 38 C.F.R. § 3.102 (2015).

Right Hip Disability

The Veteran has been assigned a 10 percent initial rating for pelvic fractures. She asserts that a higher rating is warranted. The variability of residuals following pelvic fractures necessitates rating on specific residuals, faulty posture, limitation of motion, muscle injury, painful motion of the lumbar spine, manifest by muscle spasm, mild to moderate sciatic neuritis, peripheral nerve injury, or limitation of hip motion. 38 C.F.R. § 4.67 (2015).

The pelvis fracture is currently rated under Diagnostic Code 5010 for arthritis due to trauma, which provides that arthritis should be rated as degenerative arthritis, under Diagnostic Code 5003. Under Diagnostic Code 5003, degenerative arthritis established by X-ray findings is rated on the basis of limitation of motion under the appropriate diagnostic codes for the specific joint involved. Diagnostic Code 5003 allows for a maximum 20 percent rating for arthritis with x-ray evidence of

involvement of two or more major joints or two or more minor joint groups, with occasional incapacitating exacerbations. Ratings under Diagnostic Code 5003 will not be combined with ratings based on limitation of motion of the same joint. Entitlement to a rating in excess of 20 percent may only be demonstrated based on limitation of motion or other specific clinical findings. 38 C.F.R. § 4.71a, Diagnostic Code 5003 (2015).

When the limitation of motion of the specific joint or joints involved is noncompensable under the appropriate diagnostic codes, a rating of 10 percent is for application for each major joint or group of minor joints affected by limitation of motion, to be combined, not added, under Diagnostic Code 5003. The limitation of motion must be objectively confirmed by findings such as swelling, muscle spasm, or satisfactory evidence of painful motion. 38 C.F.R. § 4.71a, Diagnostic Code 5003 (2015). For rating purposes, normal range of motion in a hip joint is from 0 to 125 degrees of flexion and 0 to 45 degrees of abduction. 38 C.F.R. § 4.71, Plate II (2015).

With any form of arthritis, painful motion is an important factor of disability, the facial expression, wincing, and such, on pressure or manipulation, should be carefully noted and definitely related to affected joints. Muscle spasm will greatly assist the identification. The intent of the rating schedule is to recognize painful motion with joint or periarticular pathology as productive of disability. It is the intention to recognize actually painful, unstable, or malaligned joints, due to healed injury, as entitled to at least the minimum compensable rating for the joint. Crepitation either in the soft tissues such as the tendons or ligaments, or crepitation within the joint structures should be noted carefully as points of contact which are diseased. Flexion elicits such manifestations. The joints involved should be tested for pain on both active and passive motion, in weight-bearing and nonweight-bearing and, if possible, with the range of the opposite undamaged joint. 38 C.F.R. § 4.59 (2015).

The Board notes that the Veteran was originally service connected for a pelvic fracture. The Board has considered the symptoms of the disability and has recharacterized the issue as a right hip disability and a left hip disability, as a

residual of pelvic fractures. The Board finds that the disability is more properly rated as separate disabilities of the right and left hip.

The Rating Schedule provides for ratings of 10, 20, 30, or 40 percent where there is limitation of flexion of the thigh to 45, 30, 20, or 10 degrees, respectively. 38 C.F.R. § 4.71a, Diagnostic Code 5262 (2015). The Rating Schedule also provides for ratings of 10 percent for limitation of rotation, cannot toe-out more than 15 degrees, affected leg; 10 percent for limitation of adduction of, cannot cross legs; and 20 percent for limitation of abduction of, motion lost beyond 10 degrees. 38 C.F.R. § 4.71a, Diagnostic Code 5263 (2015).

At a November 2007 VA examination, the Veteran indicated that she still had persistent pain and tenderness on the right side and anterior pelvis, as well as on the lateral part of the right hip. The VA examiner indicated that the Veteran had symptoms of pain, stiffness and limited motion of her right hip. The Veteran had flare ups of the right hip symptoms, with precipitating factors of walking or sitting for 20 minutes or standing for one hour. The Veteran reported no additional limitation of motion during flare ups. The VA examiner indicated that there was right hip tenderness at the lateral aspect. Flexion of the right hip was 90 degrees, with pain at 90 degrees. Extension was 30 degrees, adduction was 20 degrees, abduction was 30 degrees, external rotation was 60 degrees, and internal rotation was 40 degrees, all without pain. There was no additional limitation of motion with repetitive flexion.

At a May 2014 VA examination, the VA examiner noted that the Veteran's right pubic bone was abnormal, with tenderness over the right pubic bone and right groin area. The VA examiner further noted that the Veteran's right hip was affected, with abnormal motion, painful motion, and limitation of motion. The Veteran was diagnosed with right hip arthralgia, and the Veteran's in-service injuries were noted to include a left sacral iliac fracture, right acetabular fracture, and right inferior pubis ramus fracture. The Board notes that all of those fractures are located in the pelvic region, and involve or relate to the hips. There was no evidence of genu recurvatum. There was no malunion or nonunion of the femur, flail hip joint, or leg length discrepancy. The VA examiner noted tenderness in the right groin, and on

the left pubic bone, lower sacrocoggygeal area at the left side, and the bilateral upper anterior abdomen along the lower rib cage. Bilateral hip flexion ended at 40 degrees, which was the point where objective evidence of painful motion began. Bilateral hip extension was greater than 5 degrees. Bilateral abduction was not lost beyond 10 degrees, bilateral adduction was not limited such that the Veteran cannot cross legs, and bilateral rotation was not limited such that the Veteran cannot toe-out more than 15 degrees. There was no additional loss of range of motion of the hip and thigh following repetitive use testing, but there was less movement than normal, weakened movement, pain on movement, and interference with sitting, standing, and weight-bearing, all bilaterally. Muscle strength testing revealed active movement against some resistance bilaterally for hip flexion, hip abduction, and hip extension. There was no ankylosis of either hip joint. There was no x-ray evidence of arthritis.

The VA examiner indicated that the Veteran was employed full time as a locker room attendant. She reported losing four days from work during the last 12 month period, due to low back pain, right groin pain, and upper abdominal pain. The VA examiner opined that there was no significant general occupational effect, but that the Veteran's injuries prevented her from participating in sports and had a mild effect on her ability to do shopping, exercise, recreation, traveling, feeding, bathing, and dressing. During the May 2014 VA examination, the Veteran reported experiencing increased pain in the right groin when standing on the right foot. She also stated that there was increased pain in the right groin when walking. The VA examiner noted that the Veteran's functional limitations included being able to stand for 15 to 30 minutes, and walking was limited to 30 feet.

Throughout the appeal period, the Veteran did not have right hip ankylosis as required for a rating under Diagnostic Code 5250. The Veteran's extension of the right thigh has been greater than 5 degrees throughout the appeal period, so Diagnostic Code 5251 does not apply. There has also been no limitation of abduction of the right thigh with motion lost beyond 10 degrees, limitation of adduction of the right thigh so that the Veteran cannot cross legs, or limitation of rotation of the right thigh so that the Veteran cannot toe-out more than 15 degrees. Therefore, Diagnostic Code 5253 does not apply. There is no medical evidence of a

flail right hip joint, so Diagnostic Code 5254 does not apply. There is no medical evidence of fracture of the shaft or anatomical neck of the right femur with nonunion, fracture of the surgical neck of the right femur with false joint, or malunion of the right femur with hip disability. Therefore, Diagnostic code 5255 does not apply. 38 C.F.R. § 4.71a (2015).

Although Diagnostic Code 5054 pertains to pain and limitation of the hip, it is applicable after a hip replacement. Here, the evidence does not show that the Veteran had right hip replacement surgery at any period during the appeal. Thus, that Diagnostic Code does not apply. 38 C.F.R. § 4.71a (2015).

Flexion of the right hip was 90 degrees, with pain at 90 degrees, according to the November 2007 VA examination report. However, the May 2014 VA examiner reported that the Veteran's hip flexion ended at 40 degrees, which was also the point where objective evidence of painful motion began. The Board finds that a 10 percent rating is warranted for each hip for the period on appeal as the joints were painful on use. 38 C.F.R. §4.59 (2015). Therefore, a 10 percent rating is warranted for the each hip for the entire appeal period.

The Veteran has described symptoms of painful motion of the lumbar spine, and the May 2014 VA examiner diagnosed the Veteran with lumbar scoliosis. Faulty posture, such as that caused by lumbar scoliosis, can be separately rated as a residual of a pelvic fracture. 38 C.F.R. § 4.67 (2015). However, the Veteran is in receipt of a 40 percent rating under Diagnostic Code 5237. Scoliosis and painful motion of the lumbar spine are contemplated by the rating criteria for Diagnostic Code 5237. Assignment of a separate rating for scoliosis and painful motion of the lumbar spine, secondary to the pelvic fractures, would constitute pyramiding, and is therefore not warranted. 38 C.F.R. § 4.14, 4.67 (2015); *Esteban v. Brown*, 6 Vet. App. 259 (1994).

In a September 2014 VA physical medicine rehabilitation consultation, the Veteran denied numbness of the leg. There was no indication of sciatic neuritis upon neurological examination. Therefore, the Board finds that separate ratings for

neurological residuals of the pelvic fractures are not warranted. 38 C.F.R. § 4.67 (2015).

The Board finds that the evidence supports the assignment of separate 10 percent ratings for the right and left hip disabilities, in place of the current 10 percent rating assigned for a bilateral pelvic disability. The Board finds that the preponderance of the evidence is against the assignment of a rating greater than 10 percent based on limitation of motion or any other applicable rating criteria. *Gilbert v. Derwinski*, 1 Vet. App. 49 (1990); 38 U.S.C.A. § 5107 (West 2014); 38 C.F.R. § 3.102 (2015).

Left Hip Disability

The November 2007 VA examination report indicated that there was no loss of range of motion of the left hip and no painful motion.

In the May 2014 VA examination, the VA examiner noted tenderness on the left pubic bone, and lower sacrocoggygeal area at the left side. Bilateral hip flexion ended at 40 degrees, which was the point where objective evidence of painful motion began. Bilateral hip extension was greater than 5 degrees. Bilateral abduction was not lost beyond 10 degrees, bilateral adduction was not limited such that the Veteran cannot cross legs, and bilateral rotation was not limited such that the Veteran cannot toe-out more than 15 degrees. There was no additional loss of range of motion of the hip and thigh following repetitive use testing, but there was less movement than normal, weakened movement, pain on movement, and interference with sitting, standing, and weight-bearing, all bilaterally. Muscle strength testing revealed active movement against some resistance bilaterally for hip flexion, hip abduction, and hip extension. There was no ankylosis of either hip joint. There was no x-ray evidence of arthritis.

The VA examiner indicated that the Veteran was employed full time as a locker room attendant. She reported losing four days from work during the last 12 month period, due to low back pain, right groin pain, and upper abdominal pain. The VA examiner opined that there was no significant general occupational effect, but that the Veteran’s injuries prevented her from participating in sports and had a mild

effect on her ability to do shopping, exercise, recreation, traveling, feeding, bathing, and dressing. The VA examiner noted that the Veteran's functional limitations included being able to stand for 15 to 30 minutes, and walking was limited to 30 feet.

Throughout the appeal period, the Veteran did not have left hip ankylosis as required for a rating under Diagnostic Code 5250. The Veteran's extension of the left thigh has been greater than 5 degrees throughout the appeal period, so Diagnostic Code 5251 does not apply. There has also been no limitation of abduction of the left thigh with motion lost beyond 10 degrees, limitation of adduction of the left thigh so that the Veteran cannot cross legs, or limitation of rotation of the left thigh so that the Veteran cannot toe-out more than 15 degrees. Therefore, Diagnostic Code 5253 does not apply. There is no medical evidence of a flail left hip joint, so Diagnostic Code 5254 does not apply. There is no medical evidence of fracture of the shaft or anatomical neck of the left femur with nonunion, fracture of the surgical neck of the left femur with false joint, or malunion of the left femur with hip disability, so Diagnostic Code 5255 does not apply.

Although Diagnostic Code 5054 pertains to pain and limitation of the hip, it is applicable after a hip replacement. Here, however, the evidence does not show that the Veteran had left hip replacement surgery at any period during the appeal. Thus, that Diagnostic Code does not apply. 38 C.F.R. § 4.71a (2015).

The May 2014 VA examiner reported that the Veteran's left hip flexion ended at 40 degrees, which was also the point where objective evidence of painful motion began. The Veteran has credibly asserted left hip pain throughout the period on appeal and the examiner noted flareups at the November 2007 examination. Therefore, the Board finds that a separate 10 percent rating for the left hip disability is warranted throughout the appeal period, in place of the current bilateral rating. 38 C.F.R. § 4.59 (2015).

Accordingly, the Board finds that a 10 percent rating, but not higher, is warranted for the Veteran's left hip disability, which with a 10 percent rating for a right hip disability, is assigned in place of the current 10 percent bilateral rating. The

preponderance of the evidence is against the assignment of any higher rating. *Gilbert v. Derwinski*, 1 Vet. App. 49 (1990); 38 U.S.C.A. § 5107 (West 2014); 38 C.F.R. § 3.102 (2015).

Rib Disability

The Veteran has been assigned a 0 percent initial disability rating for fracture of the seventh and eighth ribs. She asserts that a higher rating is warranted.

The fracture of the seventh and eighth ribs is rated by analogy under Diagnostic Code 5299-5297, applicable to removal of the ribs. 38 C.F.R. § 4.71a, Diagnostic Code 5299-5297 (2015). When an unlisted condition is encountered, as with fracture of the ribs, it is permissible to rate under a closely related disease or injury in which not only the functions affected, but the anatomical localization and symptomatology are closely analogous. 38 C.F.R. § 4.20 (2015). Here, fracture of the ribs is analogous in anatomical localization and symptomatology to removal of the ribs, Diagnostic Code 5297. The Board notes that the Veteran has not had any ribs removed.

July 2007 private treatment records note that the Veteran reported occasional abdominal pain.

During the November 2007 VA examination, the Veteran reported symptoms of pain and tenderness on the lower anterior rib cage, and that taking deep breaths, sneezing, or coughing made it hurt more. The VA examiner also indicated that the Veteran experienced pain on the bilateral anterior lower rib cage now and then for no reason. The VA examiner attributed the chest discomfort, described as shortness of breath, chest pain, and bilateral pulmonary contusion, to the Veteran's accident during service. The VA examiner also noted symptoms of dyspnea.

In an October 2013 VA emergency room evaluation, the Veteran denied experiencing symptoms of chest pain, shortness of breath, cough, rib pain, or dyspnea on exertion.

The May 2014 VA examiner also noted that the Veteran had symptoms of tenderness on the bilateral upper anterior abdomen along the lower rib cage. X-ray findings included old healed rib fractures of the left seventh and eighth ribs laterally with associate deformity. The Veteran reported that she had that abdomen pain constantly since her accident during service. She described the pain as 7-8/10 to 10/10. She described the pain as sharp stabbing and sharp shooting. She said it hurt to breathe and sneeze.

Resolving all reasonable doubt in the Veterans favor, the Board finds that the weight of the evidence, both lay and medical, supports a finding that the Veteran's symptoms of abdominal pain and bilateral anterior abdomen tenderness approximate the criteria corresponding to the removal of one rib. Accordingly, a 10 percent rating under DC 5299-5297 is granted. However, the Board finds that the criteria for a higher rating are not met as the symptomatology does not more nearly approximate the removal of two ribs.

Accordingly, the Board finds that the evidence supports the assignment of a 10 percent rating, but not higher, for the Veteran's rib fracture disability. However, the preponderance of the evidence is against the assignment of any higher rating. *Gilbert v. Derwinski*, 1 Vet. App. 49 (1990); 38 U.S.C.A. § 5107 (West 2014); 38 C.F.R. § 3.102 (2015).

Extraschedular Consideration

As to consideration of referral for an extraschedular rating, such consideration requires a three-step inquiry. 38 C.F.R. § 3.321(b)(1) (2015); *Thun v. Peake*, 22 Vet. App. 111 (2008). The first question is whether the schedular rating criteria adequately contemplate the Veteran's disability picture. If the criteria reasonably describe the claimant's disability level and symptomatology, then the claimant's disability picture is contemplated by the rating schedule, the assigned schedular rating is adequate, and no referral is required. If the schedular rating does not contemplate the claimant's level of disability and symptomatology and is found inadequate, then the second inquiry is whether the claimant's exceptional disability picture exhibits other related factors such as those provided by the regulation as

governing norms. If her disability picture meets the second inquiry, then the third step is to refer the case to the Under Secretary for Benefits or the Director of Compensation Service to determine whether an extraschedular rating is warranted.

The Board finds that the symptomatology and impairment caused by the Veteran's low back disability, bilateral hip disabilities, and rib fracture are specifically contemplated by the schedular rating criteria, and no referral for extraschedular consideration is required. The schedular rating criteria specifically provide for ratings based on limitation of motion, including due to pain, stiffness and other orthopedic factors. 38 C.F.R. §§ 4.40, 4.45, 4.59, 4.71a, 4.125a (2015); *see also DeLuca v. Brown*, 8 Vet. App. 202 (1995). The Veteran's bilateral hip, rib, and low back disabilities are manifested by symptoms of limitation of motion, stiffness, painful motion, and pain on standing or running. The Board has additionally considered ratings under alternate schedular rating criteria. 38 C.F.R. § 4.20 (2015); *Schafrath v. Derwinski*, 1 Vet. App. 589 (1995).

Additionally, the Veteran has not asserted, and the evidence of record has not suggested, any combined effect or collective impact of multiple service-connected disabilities that create such an exceptional circumstance to make the schedular rating criteria inadequate. Therefore, the Board finds that the Rating Schedule is adequate to rate the Veteran's current disabilities and symptomatology. Therefore, in the absence of exceptional factors, the Board finds that the criteria for submission for assignment of an extraschedular rating pursuant to 38 C.F.R. § 3.321(b)(1) are not met. *Thun v. Peake*, 22 Vet. App. 111 (2008); *Johnson v. McDonald*, 762 F.3d 1362 (Fed. Cir. 2014); *Bagwell v. Brown*, 9 Vet. App. 337 (1996); *Shipwash v. Brown*, 8 Vet. App. 218 (1995).

The Board has considered whether the issue of entitlement to a total disability rating based on individual unemployability (TDIU) due to service-connected disabilities was reasonably raised by the record in this case. *Rice v. Shinseki*, 22 Vet. App. 447 (2009). However, in this case, neither the evidence nor the Veteran suggests unemployability due to the service-connected disabilities. Therefore, entitlement to a TDIU is not considered part of the present appeal.

Earlier Effective Date

Generally, the effective date of an award of disability compensation, in conjunction with a grant of entitlement to service connection, shall be the day following separation from active service or the date entitlement arose if the claim is received within one year of separation from service. Otherwise, the effective date shall be the date of receipt of the claim, or the date entitlement arose, whichever is later. 38 U.S.C.A. § 5110 (West 2014); 38 C.F.R. § 3.400(b)(2)(i) (2015).

A claim means a formal or informal communication in writing requesting a determination of entitlement, or evidencing a belief in entitlement, to a benefit. 38 C.F.R. § 3.1(p) (2015). Where a formal claim has already been allowed, certain submissions will be accepted as an informal claim such as a report of examination or hospitalization by the VA. 38 C.F.R. §§ 3.157(b)(1)-(b)(3) (2015). Furthermore, any communication or action indicating an intent to apply for VA benefits from a claimant or representative may be considered an informal claim provided that informal claim identifies the benefit being sought. 38 C.F.R. § 3.155(a) (2015); *Brannon v. West*, 12 Vet. App. 32 (1998).

As with any claim, when there is an approximate balance of positive and negative evidence regarding any matter material to the claim, reasonable doubt shall be resolved in favor of the claimant. 38 U.S.C.A. § 5107 (West 2014).

In the February 2009 rating decision granting service connection for PTSD, a 50 percent disability rating was assigned effective September 9, 2008, the date the Veteran filed a formal claim for service connection for PTSD. The Board, in a March 2014 decision, denied entitlement to an effective date earlier than September 9, 2008, for the grant of service connection for PTSD. That decision was vacated by the Court in a December 2015 Order, pursuant to a Joint Motion. On remand, the Veteran's representative contends that the effective date of the grant of benefits should be either October 19, 2007, or in July 2008.

On October 19, 2007, VA received the Veteran's VA Form 21-526, Veteran's Application for Compensation and/or Pension. The Veteran's representative claims

that the record before the RO at the time of the February 2008 adjudication of the formal claims raised by the October 2007 submission raised an informal claim for entitlement to service connection for psychological disabilities. In support of that contention, the representative cites the presence of psychiatric diagnoses in the Veteran's service and post-service treatment records, which were of record at the time the February 2008 rating decision was adjudicated. However, the Board finds that those diagnoses in the record before the VA were insufficient to constitute an informal claim. There is no indication that the Veteran intended to file a claim for service connection for PTSD through the mere submission of medical records in support of her formal claims for service connection for non-psychiatric disabilities. 38 C.F.R. § 3.155(a) (2015); *Brannon v. West*, 12 Vet. App. 32 (1998). The mere existence of a diagnosis in the record does not indicate that the Veteran wishes to file a claim for service connection for that disability. The October 2007 claim did not refer to any psychiatric disability or symptom that can be attributed to a psychiatric disability. Therefore, the Board finds that the October 2007 communication does not constitute a claim for service connection for service connection for a psychiatric disability as it does not identify that benefits are being sought for a psychiatric disability.

On July 7, 2008, the VA received a letter from the Veteran. In this letter, she noted that "I also don't remember a lot of things I do, even the same day," and "[m]y job had to print out special instructions for me to close out the computer step by step because I am unable to remember day to day. "

The Board finds that the Veteran's July 7, 2008, statement constituted an informal claim for service connection for a psychiatric disability. The July 7, 2008, statement described symptoms of memory impairment, the etiology of which is documented in and supported by the medical evidence of record. It can reasonably be interpreted as an attempt to seek service connection for the disability that caused the symptoms described. That communication was received more than one year following separation from service, as the Veteran separated from service on July 2, 2007. Therefore, the Board finds that the proper effective date for the award of service connection for PTSD is July 7, 2008, the date of receipt of the claim.

Accordingly, the Board finds that an effective date of July 7, 2008, but not earlier, is warranted for service connection for PTSD. The Board finds that the preponderance of the evidence is against the assignment of any earlier effective date. *Gilbert v. Derwinski*, 1 Vet. App. 49 (1990); 38 U.S.C.A. § 5107 (West 2014); 38 C.F.R. § 3.102 (2015).

ORDER

Entitlement to an initial disability rating in excess of 40 percent for a low back disability is denied.

Entitlement to an initial disability rating of 10 percent for a right hip disability, as a residual of pelvic fractures, in place of the current 10 percent rating for a bilateral pelvic disability, for the entire appeal period is granted.

Entitlement to an initial disability rating of 10 percent for a left hip disability, as a residual of pelvic fractures, in place of the current 10 percent rating for a bilateral pelvic disability, for the entire appeal period is granted.

Entitlement to an initial disability rating of 10 percent, but not higher, for fracture of the seventh and eighth ribs is granted.

Entitlement to an effective date of July 7, 2008, but not earlier, for service connection for PTSD is granted.

REMAND

The Veteran's May 2014 VA examination indicated that there may be a muscle injury associated with the service-connected pelvic and rib fractures. Specifically, the May 2014 VA examination report indicated that muscle strength testing revealed active movement against some resistance bilaterally for hip flexion. Deep tendon reflexes were "hyperactive without clonus" for the bilateral knees.

The VA examiner also noted tenderness on lower sacrococgygeal area at the left side and the bilateral upper anterior abdomen along the lower rib cage. Muscle injuries as a residual of pelvic fractures must be considered under 38 C.F.R. § 4.67. The Veteran has not received a VA examination that specifically looks at the nature and etiology of any possible muscle injuries as a residual of the service-connected pelvic fractures. Therefore, a remand is necessary to obtain the appropriate VA examination.

Accordingly, the case is REMANDED for the following action:

> 1. Schedule the Veteran for a VA examination to determine the nature and severity of any muscle injuries related to or as a result of the service-connected pelvic fractures. The examiner must review the claims file, and the report should not that review. After reviewing the record and obtaining a complete medical history from the Veteran, the examiner should offer an opinion as to whether it is as least as likely as not (50 percent or greater probability) that there is a current muscle injury related to or caused by the Veteran's service-connected pelvic fractures. The examiner is asked to discuss the symptoms of muscle injury that are found in the May 2014 VA examination report. The examiner should provide a detailed rationale for the opinions offered.
>
> 2. Then, readjudicate the claim. If any decision is adverse to the Veteran, issue a supplemental statement of the case and allow the applicable time for response. Then, return the case to the Board.

The Veteran has the right to submit additional evidence and argument on the matter the Board has remanded. *Kutscherousky v. West*, 12 Vet. App. 369 (1999).

This claim must be afforded expeditious treatment. The law requires that all claims that are remanded by the Board or the United States Court of Appeals for Veterans Claims for additional development or other appropriate action must be handled in an expeditious manner. 38 U.S.C.A. §§ 5109B, 7112 (West 2014).

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Harvey P. Roberts
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).