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

IN THE APPEAL OF C[redacted]
DONALD A. JAFFA

DOCKET NO. 10-03 670) DATE *September 12, 2016*
) *QLJ*
)

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

THE ISSUES

1. Whether new and material evidence has been received to reopen a claim of entitlement to service connection for sleep apnea.

2. Entitlement to service connection for sleep apnea.

3. Entitlement to service connection for a psychiatric disability, to include depression and posttraumatic stress disorder (PTSD).

4. Entitlement to service connection for diabetes mellitus.

5. Entitlement to service connection for hypertension.

6. Entitlement to service connection for peripheral neuropathy of the upper and lower extremities.

7. Entitlement to service connection for obesity.

8. Entitlement to an increased rating for bilateral hearing loss disability.

9. Entitlement to a total disability rating based on individual unemployability due to service-connected disabilities (TDIU).

REPRESENTATION

Appellant represented by: Adam G. Werner, Attorney

WITNESS AT HEARING ON APPEAL

Appellant

ATTORNEY FOR THE BOARD

S. Layton, Counsel

INTRODUCTION

The Veteran had active service in the Navy from August 1969 to June 1972, in the Army from August 1975 to August 1979, and in the Navy from November 1979 to November 1980. The Veteran has additional reserve service.

These matters come to the Board of Veterans' Appeals (Board) on appeal from multiple rating decisions for the Department of Veterans Affairs (VA) Regional Office (RO) in Los Angeles, California.

An April 2007 rating decision found that new and material evidence sufficient to reopen a previously denied claim for service connection for sleep apnea had not been submitted. That rating decision also continued a 0 percent rating for bilateral hearing loss disability. A June 2009 rating decision denied service connection for

depression, diabetes, hypertension, peripheral neuropathy of the upper and lower extremities, and obesity. That rating decision also denied entitlement to TDIU. A May 2013 rating decision denied service connection for PTSD. A February 2015 rating decision assigned an increased rating of 10 percent for bilateral hearing loss disability, effective June 6, 2014. However, as that increase does not represent a total grant of benefits sought on appeal, the claim for increase remains before the Board. *AB v. Brown*, 6 Vet. App. 35 (1993).

In March 2016, the Veteran testified during a hearing before the undersigned Veterans Law Judge. A transcript of that hearing is of record.

At the Board hearing, the Veteran expressed his belief that the issue of entitlement to an earlier effective date for service connection for a lumbar spine disability was before the Board. A review of the record shows that service connection for a lumbar spine disability was granted by a December 2009 rating decision, which assigned a 10 percent rating, effective August 10, 2006. In January 2010, the Veteran submitted a VA Form 9, Appeal to Board of Veterans' Appeals, in which he expressed disagreement with the assigned effective date for service connection. The RO sent the Veteran a letter in January 2010 informing him that they had accepted his submission as a notice of disagreement with the effective date for service connection. The Veteran submitted an additional VA Form 9 in February 2010 reiterating disagreement with the assigned effective date for service connection. In November 2012, the RO issued a statement of the case concerning the issue of entitlement to an effective date earlier than August 10, 2006, for service connection for degenerative disc disease associated with lumbar stenosis. As Veteran did not submit a timely substantive appeal concerning the issue of the effective date within 60 days of the mailing of the statement of the case, he did not perfect a timely appeal of the issue of entitlement to an effective date earlier than August 10, 2006, for the grant of service connection for a lumbar spine disability, and that issue is not properly before the Board. 38 C.F.R. § 20.302(b) (2015).

The Board additionally notes that service connection for a low back disability was denied in a March 1994 rating decision, and the Veteran has claimed the presence of a clear and unmistakable error (CUE) in that March 1994 rating decision.

Therefore, the issue of whether a clear and unmistakable error exists in a March 1994 rating decision which denied service connection for a low back disability has been raised by the record, 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 issues of entitlement to service connection for a psychiatric disability, an increased rating for a bilateral hearing loss disability, and TDIU are REMANDED to the AOJ.

FINDINGS OF FACT

1. Service connection for sleep apnea was denied in an April 2002 rating decision. That denial was confirmed in a March 2004 rating decision. The Veteran did not perfect an appeal.

2. The evidence received since the April 2002 rating decision is neither cumulative nor redundant, relates to unestablished facts necessary to substantiate the claim, and raises a reasonable possibility of substantiating the claim of entitlement to service connection for sleep apnea.

3. The preponderance of the evidence is against finding that sleep apnea is related to service.

4. The preponderance of the evidence is against finding that diabetes mellitus is related to service.

5. The preponderance of the evidence is against finding that hypertension is related to service.

6. The preponderance of the evidence is against finding that peripheral neuropathy of the lower extremities is related to service.

7. The preponderance of the evidence does not support a finding that the Veteran has a current diagnosis of peripheral neuropathy of the upper extremities.

8. Obesity is a symptom or finding and not a chronic disability for which VA disability benefits may be awarded.

CONCLUSIONS OF LAW

1. The March 2004 rating decision is final. 38 U.S.C.A. §§ 7104, 7105 (West 2014); 38 C.F.R. §§ 3.160(d), 20.1100, 20.1103, 20.1104 (2015).

2. New and material evidence has been received sufficient to reopen the claim of entitlement to service connection for sleep apnea. 38 U.S.C.A. § 5108 (West 2014); 38 C.F.R. § 3.156 (2015).

3. Sleep apnea was not incurred in or aggravated by service. 38 U.S.C.A. §§ 1110, 1131, 1132, 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.102, 3.159, 3.303, 3.304 (2015).

4. Diabetes mellitus was not incurred in or aggravated by service. 38 U.S.C.A. §§ 1110, 1131, 1132, 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.102, 3.159, 3.303, 3.304, 3.309 (2015).

5. Hypertension was not incurred in or aggravated by service. 38 U.S.C.A. §§ 1110, 1131, 1132, 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.102, 3.159, 3.303, 3.304, 3.309 (2015).

6. Peripheral neuropathy of the lower extremities was not incurred in or aggravated by service. 38 U.S.C.A. §§ 1110, 1131, 1132, 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.102, 3.159, 3.303, 3.304 (2015).

7. Peripheral neuropathy of the upper extremities was not incurred in or aggravated by service. 38 U.S.C.A. §§ 1110, 1131, 1132, 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.102, 3.159, 3.303, 3.304 (2015).

8. The criteria for service connection for obesity have not been met. 38 U.S.C.A. §§ 1110, 1131, 1132, 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.102, 3.159, 3.303, 3.304, 3.310 (2015).

REASONS AND BASES FOR FINDINGS AND CONCLUSION

While the Board must provide reasons and bases supporting this decision, there is no need to discuss, in detail, the evidence submitted by the Veteran or on his behalf. *Gonzales v. West*, 218 F.3d 1378 (Fed. Cir. 2000) (Board must review the entire record, but does not have to discuss each piece of evidence). The analysis below focuses on the most salient and relevant evidence of record. The Veteran should not assume that the Board has overlooked pieces of evidence that are not explicitly discussed. *Timberlake v. Gober*, 14 Vet. App. 122 (2000).

The Board must assess the credibility and weight of all evidence, including the medical evidence, to determine its probative value, accounting for evidence that it finds to be persuasive or unpersuasive, and providing reasons for rejecting any evidence favorable to the Veteran. Equal weight is not given to each piece of evidence contained in the record. Every item of evidence does not have the same probative value. When the evidence is assembled, the Board is responsible for determining whether the evidence supports the claim or is in relative equipoise, with the Veteran prevailing in either event, or whether a preponderance of the evidence is against a claim, in which case the claim is denied. *Gilbert v. Derwinski*, 1 Vet. App. 49 (1990).

Duties to Notify and Assist

VA has a duty to notify a Veteran of the information and evidence necessary to substantiate a claim for VA benefits. 38 U.S.C.A. §§ 5103, 5103A (West 2014);

38 C.F.R. § 3.159 (2015). VA also has a duty to assist Veterans in the development of claims. 38 U.S.C.A. §§ 5103, 5103A (West 2014). Upon receipt of a complete or substantially complete application for benefits, VA is required to notify the claimant and representative, if any, of any information, and any medical or lay evidence, that is necessary to substantiate the claim. 38 U.S.C.A. § 5103(a) (West 2014); 38 C.F.R. § 3.159(b) (2015); *Quartuccio v. Principi*, 16 Vet. App. 183 (2002). Proper notice from VA must inform the claimant of any information and evidence not of record (1) that is necessary to substantiate the claim; (2) that VA will to provide; and (3) that the claimant is expected to provide. The notice should be provided prior to an initial unfavorable decision on a claim by the agency of original jurisdiction. *Mayfield v. Nicholson*, 444 F.3d 1328 (Fed. Cir. 2006); *Pelegrini v. Principi*, 18 Vet. App. 112 (2004).

The notice requirements apply to all five elements of a service-connection claim, including: (1) Veteran status; (2) existence of a disability; (3) a connection between service and the disability; (4) degree of disability; and (5) effective date of the disability. The notice should include information that a disability rating and an effective date for the award of benefits will be assigned if service connection is awarded. *Dingess v. Nicholson*, 19 Vet. App. 473 (2006). Correspondence dated in January 2007 and April 2009 provided all necessary notification to the Veteran.

VA has done everything reasonably possible to assist the Veteran with respect to his claims for benefits. 38 U.S.C.A. § 5103A (West 2014); 38 C.F.R. § 3.1599(c) (2015). The service medical records have been associated with the claims file. All identified and available treatment records have been secured, which includes VA examinations and VA health records. The duty to assist includes, when appropriate, the duty to conduct a thorough and contemporaneous examination of the veteran. *Green v. Derwinski*, 1 Vet. App. 121 (1991). When VA provides an examination, it must ensure that the examination is adequate. *Barr v. Nicholson*, 21 Vet. App. 303 (2007).

The Veteran has been provided with VA examinations in August 2013 and May 2015. The examiners reviewed the claims file and past medical history, and made appropriate diagnoses and opinions consistent with the remainder of the

evidence of record. The Board concludes that the August 2013 and May 2015 VA examination reports are adequate for the purpose of making a decision. 38 C.F.R. § 4.2 (2015); *Barr v. Nicholson*, 21 Vet. App. 303 (2007).

The Board notes that the Veteran has not been scheduled for or provided with a VA examination for the claims of entitlement to service connection for sleep apnea, diabetes, hypertension, and peripheral neuropathy. However, the Board finds that an examination is not necessary to decide those claims due to a lack of credible lay or medical evidence of those disabilities in service or for decades thereafter. In essence, there is no credible lay evidence of a continuity of symptomatology since service, nor is there a competent etiology opinion of record that links the claimed disabilities to service. Therefore, a VA examination is not warranted for those claims.

The Board is satisfied that all relevant facts have been adequately developed to the extent possible and that no further assistance is required to comply with the duty to assist. Accordingly, the Board will proceed with a decision.

New and Material Evidence

Service connection may be granted for a disability resulting from disease or injury incurred in or aggravated by active service. 38 U.S.C.A. §§ 1110, 1131 (West 2014); 38 C.F.R. § 3.303 (2015).

In general, VA rating decisions that are not timely appealed are final. 38 U.S.C.A. § 7105 (West 2014); 38 C.F.R. § 20.1103 (2015). A finally disallowed claim may be reopened when new and material evidence is presented or secured with respect to that claim. 38 U.S.C.A. § 5108 (2015).

New evidence is defined as evidence not previously submitted to agency decision-makers. Material evidence means existing evidence that, by itself or when considered with previous evidence of record, relates to an unestablished fact necessary to substantiate the claim. New and material evidence can be neither cumulative nor redundant of the evidence of record at the time of the last prior final

denial of the claim sought to be reopened, and must raise a reasonable possibility of substantiating the claim. 38 C.F.R. § 3.156(a) (2015).

If new and material evidence is presented or secured with respect to a claim that has been finally denied, the claim will be reopened and decided upon the merits. Once it has been determined that a claimant has produced new and material evidence, the adjudicator must evaluate the merits of the claim in light of all the evidence, both new and old, after ensuring that the VA's statutory duty to assist the appellant in the development of his claim has been fulfilled. 38 U.S.C.A. § 5108 (West 2014); *Elkins v. West*, 12 Vet. App. 209 (1999); *Vargas-Gonzalez v. West*, 12 Vet. App. 321 (1999).

The claim to reopen does not require the submission of new and material evidence as to each previously unproven element of a claim for that claim to be reopened. *Shade v. Shinseki*, 24 Vet. App 110 (2010).

For the purpose of establishing whether new and material evidence has been submitted, the credibility of the new evidence, although not its weight, is presumed. *Justus v. Principi*, 3 Vet. App. 510 (1992).

An April 2002 rating decision denied service connection for sleep apnea. The RO stated that service connection was denied since sleep apnea neither occurred in nor was caused by the Veteran's service. Later, a March 2004 decision, the RO continued the previous denial of service connection for sleep apnea. The RO noted that the Veteran had a diagnosis of sleep apnea, but the evidence did not link the sleep apnea to service.

The Veteran did not perfect an appeal of either the April 2002 or the March 2004 rating decision, and the rating decisions became final. 38 U.S.C.A. §§ 7104, 7105, 7266 (West 2014); 38 C.F.R. § 3.104 (2015).

The evidence added to the claims file subsequent to the March 2004 denial includes additional VA and private treatment records, additional lay statements, and additional statements from the Veteran. In particular, at the March 2016 Board

hearing, the Veteran gave additional details concerning his experiences with sleep deprivation while serving on active duty. He expressed his belief that his current sleep apnea was related to in-service sleep deprivation.

The Veteran's March 2016 Board hearing testimony has a tendency to support the claim, as it provides evidence of a possible in-service incurrence of sleep apnea.

The credibility of the newly submitted evidence is presumed in determining whether or not to reopen a claim. *Justus v. Principi*, 3 Vet. App. 510 (1992). As the Veteran's assertions and medical statements are presumed to be credible for the limited purpose of attempting to reopen a previously denied claim, that evidence raises a reasonable possibility of substantiating the claims. 38 C.F.R. § 3.156(a) (2015). The Board finds that the additional evidence is also material.

Accordingly, as new and material evidence has been received, the claim for service connection for sleep apnea is reopened.

Service Connection

Service connection may be granted for disability caused by disease or injury incurred in or aggravated by active service. 38 U.S.C.A. §§ 1110, 1131 (West 2014); 38 C.F.R. § 3.303 (2015). In order to establish service connection for a claimed disability, there must be (1) medical evidence of a current disability; (2) medical, or in certain circumstances, lay evidence of in-service incurrence or aggravation of a disease or injury; and (3) evidence, generally medical, of a causal relationship between the claimed in-service disease or injury and the current disability. *Hickson v. West*, 12 Vet. App. 247 (1999).

Service connection may also be granted for any disease initially diagnosed after service, when the evidence establishes that the disease was incurred in service. 38 U.S.C.A. § 1113(b) (West 2014); 38 C.F.R. § 3.303(d) (2015); *Cosman v. Principi*, 3 Vet. App. 503 (1992). The disease entity for which service connection is sought must be chronic rather than acute and transitory in nature. For the showing of chronic disease in service, a combination of manifestations must exist

sufficient to identify the disease entity and sufficient observation to establish chronicity at the time, as distinguished from merely isolated findings or a diagnosis including the word chronic. Diabetes mellitus and hypertension are among the chronic diseases listed in 38 C.F.R. § 3.309(a), and service connection for diabetes mellitus and hypertension may be established based on a continuity of symptomatology. Furthermore, service incurrence will be presumed for certain chronic diseases, including diabetes mellitus and hypertension, if manifest to a compensable degree within the year after active service. 38 U.S.C.A. § 1112 (West 2014); 38 C.F.R. §§ 3.307, 3.309 (2015).

A disability that is proximately due to or the result of a service connected disease or injury shall be service connected. When service connection is established for a secondary disability, the secondary disability shall be considered a part of the original disability. 38 C.F.R. § 3.310(a) (2015). Secondary service connection may also be established for a non-service connected disability, which is aggravated by a service-connected disability. In such an instance, the Veteran is compensated for the degree of disability over and above the degree of disability existing prior to the aggravation. 38 C.F.R. § 3.310(b) (2015); *Allen v. Brown*, 7 Vet. App. 439 (1995).

Sleep Apnea

On a Veteran's October 1968 service entry physical examination report, it was noted that the Veteran had a deviated septum. The Veteran indicated on an accompanying Report of Medical History that he had nose trouble. A September 1971 service examination report also indicates that the Veteran had a deviated septum. The Veteran indicated on an accompanying Report of Medical History that he did not experience frequent trouble sleeping.

A May 1972 service separation examination report indicates that the Veteran had a deviated nasal septum. On a May 1972 Report of Medical History, the Veteran indicated that he did not have trouble sleeping.

A March 1975 service entry examination report indicates that the Veteran had a normal nose, sinuses, lungs, and chest. On a March 1975 Report of Medical

History, the Veteran indicated that he did not have frequent trouble sleeping. A July 1979 service separation examination report indicates that the Veteran had a normal nose, sinuses, lungs, and chest. On an accompanying Report of Medical History, the Veteran indicated that he did not have trouble sleeping.

On a November 1979 service entry physical examination report, it was noted that the Veteran had normal nose, sinuses, lungs, and chest. On an accompanying Report of Medical History, the Veteran noted that he did not have trouble sleeping.

A May 1980 service physical examination shows that the Veteran had normal nose, sinuses, mouth and throat, lungs, and chest. On an accompanying Report of Medical History, the Veteran indicated that he did not experience frequent trouble sleeping.

On a Veteran's November 1980 separation from active duty examination, it was noted that the Veteran had a normal nose, sinuses, lungs, and chest.

An August 1981 reserve pre-commissioning physical report shows that the Veteran had normal nose, sinuses, mouth and throat, lungs, and chest. On an accompanying Report of Medical History, the Veteran indicated that he did not experience frequent trouble sleeping.

A January 1983 reserve annual physical report shows that the Veteran had normal nose, sinuses, mouth and throat, lungs, and chest. On an accompanying Report of Medical History, the Veteran indicated that he did not experience frequent trouble sleeping.

A February 1984 reserve annual physical report shows that the Veteran had normal nose, sinuses, mouth and throat, lungs, and chest. On an accompanying Report of Medical History, the Veteran indicated that he did not experience frequent trouble sleeping.

A February 1985 reserve annual physical report shows that the Veteran had a normal nose, sinuses, lungs, and chest. On a February 1985 Report of Medical History, the Veteran indicated that he did not have trouble sleeping.

A May 1988 reserve annual physical report shows that the Veteran had normal nose, sinuses, mouth and throat, lungs, and chest. On an accompanying Report of Medical History, the Veteran indicated that he did not experience frequent trouble sleeping.

A March 1989 reserve annual physical report shows that the Veteran had normal nose, sinuses, mouth and throat, lungs, and chest. On an accompanying Report of Medical History, the Veteran indicated that he did not experience frequent trouble sleeping.

On a February 1996 pre-deployment Report of Medical History, the Veteran indicated that he did not have trouble sleeping.

In January 2001, the Veteran received a referral to evaluate probable sleep apnea. A private treatment record from February 2001 shows that the Veteran's medical history and clinical findings were highly suspicious for severe obstructive sleep apnea. Another record contains the Veteran's history of snoring, apnea, and micro sleep attacks. A sleep study was positive for breathing stoppages.

A VA sleep study in October 2006 confirmed a diagnosis of moderate obstructive sleep apnea.

The Veteran has reported that while serving in Germany in 1976, he was housed in a tent on the parade ground with no facilities to shower or shave for six months. He experienced sleep deprivation and stated that his circadian rhythms were permanently altered. He has submitted a lay statement from a fellow serviceman who attested to the conditions during the Veteran's service.

Having carefully reviewed the record regarding this claim, the Board finds that service connection is not warranted for sleep apnea. While the evidence clearly

shows that the Veteran has a current diagnosis of sleep apnea, the persuasive evidence of record weighs against a finding that any currently diagnosed sleep apnea is related to service. Notably, while multiple medical treatment providers have diagnosed sleep apnea, none of the treatment providers of record have provided the necessary nexus between a current diagnosis of sleep apnea and active duty service.

The Board has considered the Veteran's statements and acknowledges that the Veteran is competent to diagnose and report on simple conditions. *Jandreau v. Nicholson,* 492 F.3d 1372 (Fed. Cir. 2007). The Board finds no evidence to refute the Veteran's contention that he experienced difficult living conditions while serving in Germany in 1976, to include sleep deprivation. However, because the absence of documented complaints of apnea or clinical findings related specifically to sleep apnea, the Board concludes that any suggestions by the Veteran of a continuity of symptomatology since service are not credible.

The Board is not relying solely upon a general absence of complaints during service. *Buchanan v. Nicholson,* 451 F. 3d 1331 (Fed. Cir. 2006). Rather, the Board is relying on the fact that periodic physical examinations at the conclusion of the Veteran's periods of active duty and subsequent periods of Reserve duty found no evidence of sleep apnea symptoms. In fact, the Board finds it significant that the Veteran affirmatively stated on Reports of Medical History completed in September 1971, May 1972, March 1975, July 1979, November 1979, May 1980, August 1981, January 1983, February 1984, February 1985, May 1988, March 1989, and February 1996 that he did not experience trouble sleeping. Therefore, the Board finds that suggestions of chronic problems following his periods of active duty are not credible. The Board finds that the statements on periodic examinations during and after active service are more credible than more current statements of trouble sleeping, advanced in conjunction with a claim for benefits.

Accordingly, the Board finds that the preponderance of evidence is against this claim, and entitlement to service connection for sleep apnea 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).

Diabetes Mellitus

A September 1971 service examination report indicates that the Veteran had a normal endocrine system. A urinalysis was essentially negative for sugar and albumin. The Veteran indicated on an accompanying Report of Medical History that he did not experience sugar in his urine. The May 1972 service separation examination report indicates that the Veteran's endocrine system was normal. A urinalysis was essentially negative for sugar. On a May 1972 Report of Medical History, the Veteran noted that he did not have sugar or albumin in his urine.

A March 1975 service entry examination report indicates that the Veteran had a normal endocrine system. A urinalysis was negative for sugar. On a March 1975 Report of Medical History, the Veteran indicated that he did not have sugar in his urine. A July 1979 service separation examination report indicates that the Veteran had a normal endocrine system. A urinalysis was negative for sugar. On an accompanying Report of Medical History, the Veteran stated that he did not experience sugar or albumin in his urine.

On a November 1979 service entry physical examination report, it was noted that the Veteran's endocrine system was normal. A urinalysis was negative for sugar. On an accompanying Report of Medical History, the Veteran indicated that he did not experience sugar or albumin in his urine.

A May 1980 service physical examination shows that the Veteran had a normal endocrine system. A urinalysis was negative for sugar and albumin. On an accompanying Report of Medical History, the Veteran indicated that he did not experience sugar or albumin in his urine.

On a Veteran's November 1980 separation from active duty examination, it was noted that the Veteran had a normal endocrine system. A urinalysis was negative for sugar.

An August 1981 reserve pre-commissioning physical report shows that the Veteran had a normal endocrine system. A urinalysis was negative for sugar. On an accompanying Report of Medical History, the Veteran indicated that he did not experience sugar in his urine.

A January 1983 reserve annual physical report shows that the Veteran had a normal endocrine system. A urinalysis was negative for sugar. On an accompanying Report of Medical History, the Veteran indicated that he did not experience sugar in his urine.

A February 1984 reserve annual physical report shows that the Veteran had a normal endocrine system. A urinalysis was negative for sugar. On an accompanying Report of Medical History, the Veteran indicated that he did not experience sugar in his urine.

A February 1985 reserve annual physical report shows that the Veteran had a normal endocrine system. A urinalysis was negative for sugar. On an accompanying Report of Medical History, the Veteran indicated that he did not experience sugar in his urine.

On a February 1987 Report of Medical History, the Veteran indicated that he did not experience sugar in his urine.

A May 1988 reserve annual physical report shows that the Veteran had a normal endocrine system. A urinalysis was negative for sugar. On an accompanying Report of Medical History, the Veteran indicated that he did not experience sugar in his urine.

A March 1989 reserve annual physical report shows that the Veteran had a normal endocrine system. A urinalysis was negative for sugar. On an accompanying Report of Medical History, the Veteran indicated that he did not experience sugar or albumin in his urine.

A February 1996 reserves pre-deployment medical examination report shows that the Veteran had a normal endocrine system. A urinalysis was negative for sugar. On an accompanying Report of Medical History, the Veteran indicated that he did not experience sugar or albumin in his urine.

A medical treatment record from March 2007 shows that the Veteran had impaired fasting glucose. Another treatment record from May 2007 shows that the Veteran was recently diagnosed with diabetes mellitus.

A medical problem list in a January 2008 medical record contains a diagnosis of diabetes mellitus. Diabetes Mellitus was listed as a diagnosis in a September 2008 medical treatment record.

An October 2009 private treatment record shows that the Veteran had a three-year history of diabetes mellitus.

Having reviewed the evidence pertaining to this claim, the Board has determined that service connection on a presumptive basis for diabetes mellitus is not warranted. As the evidence is negative for signs, symptoms, or diagnoses of diabetes to a compensable level during the Veteran's first post-service year, service connection for diabetes cannot be granted on a presumptive basis. 38 C.F.R. §§ 3.307, 3.309 (2015).

The Board finds that the preponderance of evidence is against a finding that the Veteran's diabetes was caused or aggravated by active service, to include as a result of sleep deprivation. The Veteran has sought medical treatment from numerous physicians, both through the VA and privately. However, the Board finds that there competent evidence of record does not support a finding that relates diabetes to service. Therefore, as there is no competent evidence linking a currently diagnosed disability to service, the claim must be denied on a direct basis.

The Board acknowledges the Veteran's contentions that he experiences diabetes symptoms as a result of sleep deprivation during active duty. The Veteran can attest to factual matters of which he had first-hand knowledge. *Washington v.*

Nicholson, 19 Vet. App. 362 (2005). However, while the Veteran is competent to report what comes to him through his senses, he does not have medical expertise to provide an opinion on the etiology of diabetes mellitus. The etiology of diabetes presents a complex medical question as there is no observable cause and effect relationship. *Layno v. Brown*, 6 Vet. App. 465 (1994). Significantly, the Veteran's in-service urinalyses were all found to be normal, and post-service urinalyses were also normal for multiple years. While the Board has considered the Veteran's contentions regarding the presence of symptoms, the Board ultimately places more probative weight on the objective laboratory findings and observations of the VA and private medical professionals, who have the medical training and knowledge to perform and interpret the necessary medical tests. In addition, the Veteran has not submitted any competent medical evidence that supports a finding that diabetes is due to service.

While the Veteran submitted an April 2016 letter from a private physician that states that to some extent his long term sleep deprivation while he was serving in the army could contribute/exaggerate some of the disease he has at this time, in particular diabetes mellitus. The Board finds that opinion is speculative and does not show that it is at least as likely as not that any diabetes is related to service. *Bostain v. West*, 11 Vet. App. 124 (1998); *Obert v. Brown*, 5 Vet. App. 30 (1993) (medical opinion expressed in terms of may also implies may or may not and is too speculative to establish medical nexus); *Warren v. Brown*, 6 Vet. App. 4 (1993) (doctor's statement framed in terms such as could have been is not probative); *Tirpak v. Derwinski*, 2 Vet. App. 609 (1992) (may or may not language by physician is too speculative).

Accordingly, the Board finds that the preponderance of the evidence is against the claim for service connection for diabetes mellitus, and 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).

Hypertension

On a Veteran's October 1968 service entry physical examination report, a blood pressure reading of 126/84 was noted. A September 1971 service examination report indicates that the Veteran's vascular system was normal. The Veteran indicated on an accompanying Report of Medical History that he did not experience high or low blood pressure.

A May 1972 service separation examination report indicates that the Veteran had a normal vascular system. On a May 1972 Report of Medical History, the Veteran noted that he did not have high or low blood pressure.

A March 1975 service entry examination report indicates that the Veteran had a normal vascular system. A blood pressure reading of 130/70 was recorded. On a March 1975 Report of Medical History, the Veteran indicated that he did not have high or low blood pressure.

The service medical records show blood pressures of 110/60 in May 1975, 102/58 in February 1976, 124/82 in March 1976, 100/60 in August 1976, 118/70 in March 1977, 108/78 in December 1977, 112/70 in April 1978, 90/60 in July 1978, 102/64 in July 1978, and 116/76 in May 1979.

A July 1979 service separation examination report indicates that the Veteran had a normal vascular system. On an accompanying Report of Medical History, the Veteran indicated that he did not experience high or low blood pressure.

On a November 1979 service entry physical examination report, it was noted that the Veteran's vascular system was normal. A blood pressure reading of 106/70 was recorded. On an accompanying Report of Medical History, the Veteran indicated that he did not experience high or low blood pressure.

A May 1980 service physical examination shows that the Veteran had a normal vascular system. On an accompanying Report of Medical History, the Veteran indicated that he did not experience high or low blood pressure.

On a November 1980 separation from active duty physical, it was noted that the Veteran had a normal vascular system.

An August 1981 reserve pre-commissioning physical report shows that the Veteran had a normal vascular system. On an accompanying Report of Medical History, the Veteran indicated that he did not experience high or low blood pressure.

A February 1984 reserve annual physical report shows that the Veteran had a normal vascular system. On an accompanying Report of Medical History, the Veteran indicated that he did not experience high or low blood pressure.

A December 1984 reserve annual physical report shows that the Veteran had a normal vascular system. A blood pressure reading of 102/62 was recorded. On an accompanying Report of Medical History, the Veteran indicated that he did not experience high or low blood pressure.

A February 1985 reserve annual physical report shows that the Veteran had a normal vascular system. A blood pressure reading of 118/76 was recorded. On an accompanying Report of Medical History, the Veteran indicated that he did not experience high or low blood pressure.

On a February 1987 Report of Medical History, the Veteran indicated that he did not have high or low blood pressure.

A May 1988 reserve annual physical report shows that the Veteran had a normal vascular system. A blood pressure reading of 110/66 was recorded. On an accompanying Report of Medical History, the Veteran indicated that he did not experience high or low blood pressure.

A March 1989 reserve annual physical report shows that the Veteran had a normal vascular system. A blood pressure reading of 96/70 was recorded. On an accompanying Report of Medical History, the Veteran indicated that he did not experience high or low blood pressure.

The service medical records show blood pressure readings of 128/76 in October 1994; 123/72, 122/66, and 108/74 in November 1994; 126/84 in January 1996. Another January 1996 treatment record contains a blood pressure reading of 120/74. The Veteran was advised to stop smoking and lose weight.

A February 1996 reserve pre-deployment medical examination report shows that the Veteran had a normal heart and vascular system. His blood pressure was 120/74. On an accompanying Report of Medical History, the Veteran indicated that he did not experience high or low blood pressure.

In May 1996, a blood pressure reading of 123/78 was recorded. A treatment record from July 1996 contains a blood pressure reading of 126/72. In January 2001, a blood pressure reading of 122/80 was recorded.

In March 2007, the Veteran received a diagnosis of hypertension.

A medical problem list in a January 2008 medical record contains a diagnosis of systemic and essential hypertension. Hypertension was listed as a diagnosis in a September 2008 medical treatment record.

Having reviewed the evidence pertaining to this claim, the Board has determined that service connection on a presumptive basis for hypertension is not warranted. As the evidence is negative for signs, symptoms, or diagnoses of hypertension to a compensable level during the Veteran's first post-service year, service connection for hypertension cannot be granted on a presumptive basis. 38 C.F.R. §§ 3.307, 3.309 (2015).

The Board finds that the preponderance of the evidence is against a finding that hypertension was caused or aggravated by active service, to include as a result of sleep deprivation. The Veteran has sought medical treatment from numerous physicians, both through VA and privately. None of the medical treatment providers alluded to any possible connection between the Veteran's hypertension and active service, to include sleep deprivation. Therefore, as there is no competent

medical evidence linking a currently diagnosed disability to service, this claim must be denied on a direct basis.

The Board acknowledges the Veteran's contentions that he experiences hypertension symptoms as a result of sleep deprivation from the time he was on active duty. The Veteran can attest to factual matters of which he had first-hand knowledge. *Washington v. Nicholson*, 19 Vet. App. 362 (2005). However, while the Veteran is competent to report what comes to him through his senses, he does not have medical expertise to render an opinion on the diagnosis or etiology of hypertension. The etiology of hypertension presents a complex medical question as there is no observable cause and effect relationship. *Layno v. Brown*, 6 Vet. App. 465 (1994). Significantly, the Veteran's in-service blood pressure readings are not elevated, and the Veteran himself indicated on multiple Reports of Medical History that he did not have high or low blood pressure. While the Board has considered the Veteran's contentions regarding the presence of symptoms and a connection between sleep deprivation and elevated blood pressure, the Board ultimately places more probative weight on the objective laboratory findings and observations of the VA and private medical professionals, who have the medical training and knowledge to perform and interpret the necessary medical tests.

Accordingly, the Board finds that the preponderance of the evidence is against the claim for service connection for hypertension and 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).

Peripheral Neuropathy of the Lower Extremities

A September 1971 service examination report shows that the Veteran was neurologically normal. The Veteran indicated on an accompanying Report of Medical History that he did not experience neuritis or paralysis. A May 1972 service separation examination report indicates that the Veteran had a normal neurological system. On a May 1972 Report of Medical History, the Veteran noted that he did not experience neuritis or paralysis.

A March 1975 service entry examination report indicates that the Veteran was neurologically normal. On a March 1975 Report of Medical History, the Veteran indicated that he did not experience neuritis or paralysis.

On a November 1979 service entry physical examination report, it was noted that the Veteran was neurologically normal. On an accompanying Report of Medical History, the Veteran indicated that he did not experience neuritis or paralysis. A July 1979 service separation examination report also indicates that the Veteran was neurologically normal. On an accompanying Report of Medical History, the Veteran indicated that he did not experience neuritis or paralysis.

A May 1980 service physical examination shows that the Veteran had a normal neurologic system. On an accompanying Report of Medical History, the Veteran indicated that he did not experience neuritis or paralysis.

On a Veteran's November 1980 separation from active duty physical, it was noted that the Veteran had a normal neurological system.

An August 1981 reserve pre-commissioning physical report shows that the Veteran was neurologically normal. On an accompanying Report of Medical History, the Veteran indicated that he did not experience neuritis or paralysis.

A January 1983 reserve annual physical report shows that the Veteran was neurologically normal. On an accompanying Report of Medical History, the Veteran indicated that he did not experience neuritis or paralysis.

A February 1984 reserve annual physical report shows that the Veteran was neurologically normal. On an accompanying Report of Medical History, the Veteran indicated that he did not experience neuritis or paralysis.

A February 1985 reserve annual physical report shows that the Veteran was neurologically normal. On an accompanying Report of Medical History, the Veteran indicated that he did not experience neuritis or paralysis.

On a February 1985 Report of Medical History, the Veteran indicated that he did not experience neuritis or paralysis.

A May 1988 reserve annual physical report shows that the Veteran was neurologically normal. On an accompanying Report of Medical History, the Veteran indicated that he did not experience neuritis or paralysis.

A March 1989 reserve annual physical report shows that the Veteran was neurologically normal. On an accompanying Report of Medical History, the Veteran indicated he did not experience neuritis or paralysis.

A February 1996 reserve pre-deployment medical examination report shows that the Veteran was neurologically normal. On an accompanying Report of Medical History, the Veteran indicated that he did not experience neuritis or paralysis.

A medical problem list in a January 2008 medical record contains a diagnosis of diabetic peripheral neuropathy.

A December 2008 examination report found symptoms consistent with intermittent neurogenic claudication.

A private treatment record from October 2010 shows the presence of constant neuropathy in the plantar surface of both of the Veteran's feet.

A private treatment record from April 2012 contains the Veteran's complaints of numbness in the feet since early 2000. It was noted that the Veteran believed that most of his symptoms were due to lumbar pathology. The diagnoses given were diabetic peripheral polyneuropathy and lumbar radiculopathy.

On VA examination in October 2015, diagnoses of radiculopathy of the lower extremities, and left foot drop were given. The examiner indicated that the Veteran's left foot drop was a progression of the paralysis of the sciatic nerve and its branches.

At a March 2016 Board hearing, the Veteran remarked that his lower limb polyneuropathy was a subsequent event stemming from spinal stenosis because of nerve damage.

In a February 2015 decision, service connection for radiculopathy of the left lower extremity, was granted with a rating of 20 percent. Service connection for radiculopathy of the right lower extremity, was granted with a disability rating of 10 percent, effective June 6, 2014.

Having reviewed the evidence pertaining to this claim, the Board has determined that service connection for peripheral neuropathy of the lower extremities is not warranted. Although the Veteran has a current diagnosis of peripheral neuropathy of the lower extremities, there is no medical evidence of record indicating that the Veteran's peripheral neuropathy was caused or aggravated by active duty service. The Veteran has sought medical treatment from numerous physicians, both through the VA and privately and no competent opinion relating peripheral neuropathy of the lower extremities to active service is of record. . Therefore, as there is no medical evidence linking a currently diagnosed disability to service, this claim must be denied on a direct basis.

The record suggests that the Veteran seeks benefits for neurologic symptoms attributable to his lower back. The Board emphasizes that service connection has already been granted for radiculopathy of the bilateral lower extremities, which appears to account for neurologic symptoms secondary to the service-connected low back disability. The present denial of service connection for peripheral neuropathy of the bilateral lower extremities in no way impacts the prior award of service connection for radiculopathy secondary to the service-connected low back disability.

The Board acknowledges the Veteran's contentions that he experiences peripheral neuropathy of the lower extremities as a result of active duty. The Veteran can attest to factual matters of which he had first-hand knowledge. *Washington v. Nicholson*, 19 Vet. App. 362 (2005). However, while the Veteran is competent to report what comes to him through his senses, he does not have medical expertise to

provide an opinion on the diagnosis or etiology of peripheral neuropathy. The etiology of peripheral neuropathy presents a complex medical question as there is no observable cause and effect relationship. *Layno v. Brown*, 6 Vet. App. 465 (1994). Significantly, the Veteran has current diagnoses of peripheral neuropathy and radiculopathy, and he has not been shown to have the necessary medical training to be able to attribute specific symptoms to separate diagnoses. The Board ultimately places more probative weight on the objective laboratory findings and observations of VA and private medical professionals, who have the medical training and knowledge to perform and interpret the necessary medical tests.

This decision also denies service connection for diabetes mellitus. Therefore, any claim that peripheral neuropathy is secondary to diabetes mellitus must fail. Secondary service connection cannot be granted where the primary disability is not service-connected. 38 C.F.R. § 3.310 (2015).

Accordingly, the Board finds that the preponderance of the evidence is against the claim for service connection for peripheral neuropathy of the lower extremities, and 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).

Peripheral Neuropathy, Bilateral Upper Extremities

The service medical records and subsequent medical treatment records are negative for signs of or a diagnosis of peripheral neuropathy of the bilateral upper extremities.

At a March 2016 hearing, the Veteran specified that he did not have upper extremity polyneuropathy. He stated that VA had added that claim without the Veteran actually requesting service connection for upper extremity polyneuropathy.

The Board finds that service connection for peripheral neuropathy of the upper extremities is not warranted. Peripheral neuropathy of the upper extremities has not been identified at any point during the period on appeal by any competent evidence of record.

Significantly, the Veteran himself said at the March 2016 Board hearing that he did not have peripheral neuropathy of the upper extremities. No other competent evidence of record demonstrates that the Veteran has peripheral neuropathy of the upper extremities. Therefore, the requirement that there be current disability has not been met. Congress has specifically limited entitlement to service-connected benefits to cases where there is a current disability. In the absence of proof of a present disability, there can be no valid claim. *Brammer v. Derwinski*, 3 Vet. App. 223 (1992).

Accordingly, the Board finds that service connection is not available for peripheral neuropathy of the upper extremities, as there is no current diagnosis of peripheral neuropathy of the upper extremities. As the preponderance of the evidence is against the claim, 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).

Obesity

Based on a thorough review of the record, the Board finds that the preponderance of the evidence is against the claim for service connection for obesity. Obesity is not a disability for VA purposes.

Obesity is a finding or symptom and not a disability in and of itself for which VA compensation benefits are payable. The Board notes that a symptom, without a diagnosed or identifiable underlying malady or condition, does not, in and of itself, constitute a disability for which service connection may be granted. *Sanchez-Benitez v. West*, 13 Vet. App. 282 (1999); 61 Fed. Reg. 20,440 (1996) (although Veteran is competent to describe symptoms of pain, pain, alone, without a sufficient factual showing that the pain is derived from the in-service injury is not a disability).

Congress specifically limits entitlement for service-connected disease or injury to cases where those incidents have resulted in a disability. In the absence of proof of

a present disability there can be no valid claim. *Brammer v. Brown*, 3 Vet. App. 223 (1992); *Rabideau v. Derwinski*, 2 Vet. App. 141 (1992).

Service connection can only be granted for a disability resulting from disease or injury. 38 U.S.C.A. § 1110 (West 2014). Obesity is a finding that manifests itself only in examination and is not a disability for which service connection can be granted. Therefore, service connection for weight gain is not warranted.

In sum, the evidence demonstrates that the Veteran is not entitled to service connection for obesity as that does not represent a disability for which service connection can be granted. As the preponderance of the evidence is against the claim, 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).

ORDER

New and material evidence has been received to reopen a claim for service connection for sleep apnea and to that extent only, the appeal is granted.

Entitlement to service connection for sleep apnea is denied.

Entitlement to service connection for diabetes mellitus is denied.

Entitlement to service connection for hypertension is denied.

Entitlement to service connection for peripheral neuropathy of the upper and lower extremities is denied.

Entitlement to service connection for obesity is denied.

REMAND

The Veteran seeks service connection for a psychiatric disability, to include depression and PTSD.

A September 1971 service examination report indicates that the Veteran was psychiatrically normal. The Veteran indicated on an accompanying Report of Medical History that he did not experience depression or nervousness. A May 1972 service separation examination report indicates that the Veteran was psychiatrically normal. On a May 1972 Report of Medical History, the Veteran noted that he did not experience depression or excessive worry.

A March 1975 service entry examination report indicates that the Veteran was psychiatrically normal. On a March 1975 Report of Medical History, the Veteran indicated that he did not have depression or excessive worry. A July 1979 service separation examination report indicates that the Veteran was psychiatrically normal. On an accompanying Report of Medical History, the Veteran indicated that he did not experience depression, excessive worry, or nervous trouble of any sort.

On a November 1979 service entry physical examination report, it was noted that the Veteran was psychiatrically normal. On an accompanying Report of Medical History, the Veteran indicated that he did not experience depression or nervous trouble of any sort.

A May 1980 service physical examination shows that the Veteran was psychiatrically normal. On an accompanying Report of Medical History, the Veteran indicated that he did not experience depression, excessive worry, or nervous trouble of any sort.

On a Veteran's November 1980 separation from active duty physical, it was noted that the Veteran was psychiatrically normal.

An August 1981 reserve pre-commissioning physical report shows that the Veteran was psychiatrically normal. On an accompanying Report of Medical History, the

Veteran indicated that he did not experience depression, excessive worry, or nervous trouble of any sort.

A January 1983 reserve annual physical report shows that the Veteran was psychiatrically normal. On an accompanying Report of Medical History, the Veteran indicated that he did not experience depression, excessive worry, or nervous trouble of any sort.

A February 1984 reserve annual physical report shows that the Veteran was psychiatrically normal. On an accompanying Report of Medical History, the Veteran indicated that he did not experience depression, excessive worry, or nervous trouble of any sort.

A February 1985 reserve annual physical report reflect that the Veteran was psychiatrically normal. On an accompanying Report of Medical History, the Veteran indicated that he did not experience depression, excessive worry, or nervous trouble of any sort.

On a February 1985 Report of Medical History, the Veteran indicated that he did not experience depression, excessive worry, or nervousness.

In 1988, the Veteran was investigated by the Naval Criminal Investigative Service (NCIS). His record was reviewed by a doctor attached to NCIS, and that doctor gave the Veteran a diagnosis of dependent personality.

A May 1988 reserves annual physical report shows that the Veteran was psychiatrically normal. On an accompanying Report of Medical History, the Veteran indicated that he did not experience depression, excessive worry, or nervous trouble of any sort.

On a March 1989 Report of Medical History, the Veteran indicated that he did not experience depression, excessive worry, or nervous trouble of any sort.

A February 1996 reserve pre-deployment medical examination report shows that the Veteran was psychiatrically normal. On an accompanying Report of Medical History, the Veteran indicated that he did not experience nervous trouble or depression.

According to a June 2011 treatment record, the Veteran received a diagnosis of PTSD in 1986. The note indicates that the Veteran was never treated and was not currently getting mental health treatment. The Veteran's appearance was normal; his mood was deemed to be euthymic, and his affect was normal. The treatment provider discussed PTSD with the Veteran and determined that no referral was needed for psychologic care.

A June 2012 treatment record indicates that the Veteran got regular psychologic care. A new referral for PTSD treatment was requested.

A June 2012 clinic note shows that the Veteran met all the criteria for PTSD. A primary diagnosis of major depressive disorder and a secondary diagnosis of PTSD were given.

An October 2013 treatment record contains diagnoses of chronic PTSD and chronic major depression.

A June 2015 letter from R.N.K., Ph.D., shows that the Veteran received a diagnosis of PTSD in 2012. Dr. K. also described three possible stressors.

On VA PTSD examination in October 2015, the examiner diagnosed PTSD. The Veteran reported a stressor of being in a destroyer and a ship blowing up. The Veteran described in detail how the ship rose and dropped in the water as the alarms went off. Another stressor described occurred in November 1970 when the Veteran was flying on a plane outside of Wright Air Force Base in Ohio. A terrible storm occurred, and the airplane was struck by lightning twice. The Veteran reported urinating and defecating due to intense fear at the time. As a third stressor, the Veteran reported that in November 1978, he was serving as a duty sergeant when he got a call that three individuals had crossed a safety zone into a missile launch area.

The Veteran stated that he and two subordinates got their weapons and drove to the towers. He reported that a BMW was exiting the area and fired on them. According to the Veteran, the next day, the German FBI found the BWM with 50 to 60 rounds shot into the vehicle. The Veteran stated that the incident was classified due to the presence of nuclear weapons in Germany. The examiner found that all three reported stressors were adequate to support the diagnosis of PTSD.

The examiner opined that the Veteran's PTSD was at least as likely as not incurred in or caused by his service. The examiner specified that the Veteran reported and exhibited symptoms consistent with a diagnosis of PTSD, with depressive symptoms as part of the diagnosis. The examiner referred to the intelligence summary of psychological functioning from April 17, 1988, which described emotional distress that may be indicative of an anxiety disorder. The examiner also noted that the Veteran had been in mental health treatment through Medicare, Tricare, the Wounded Warrior Program, and VA for PTSD.

Although a VA examiner has provided a diagnosis of PTSD and has linked that diagnosis to three in-service stressors, the in-service stressors have not been verified or corroborated. On remand, attempts should be made to verify the Veteran's claimed stressors.

Concerning the claim for an increased rating for hearing loss, the most recent VA audiological examination evaluating the severity of the Veteran's service-connected bilateral hearing loss disability is dated in February 2015. During the March 2016 hearing, the Veteran specifically testified that his hearing has worsened since that examination. The Veteran's representative also suggested that the Veteran's hearing loss disability has worsened since the last VA examination. To ensure that the record shows the current severity of bilateral hearing loss disability on appeal, a more contemporaneous examination is warranted, with findings responsive to all applicable rating criteria.

The Veteran's claim for a TDIU is inextricably intertwined with the claims for service connection for a psychiatric disability and increased rating for hearing loss. Where a claim is inextricably intertwined with another claim, the claims must be

adjudicated together. *Harris v. Derwinski*, 1 Vet. App. 180 (1991). Therefore, further consideration of the claim for a TDIU must be deferred.

Accordingly, the case is REMANDED for the following action:

> 1. With any necessary authorization from the Veteran, obtain any outstanding medical records. All attempts to locate the records must be documented in the record.
>
> 2. Then, compile all information, specifically including the information provided by the Veteran at the September 2015 Board hearing, and submit that information to the United States Army and Joint Services Records Research Center (JSRRC). Any response received from that organization is to be associated with the claims folder. JSRRC should be requested to make an attempt to verify events related to the Veteran's claims:
>
> (a) While serving aboard a ship, fumes detonated in the ship's boiler, injuring all personnel in the engineering spaces and causing the ship to "bounce" in the water.
>
> (b) In November 1970 when the Veteran was flying aboard a VP-91 P-3A aircraft from NAS Moffett Field to Wright Patterson AFB, a terrible storm occurred, and the airplane was struck by lightning twice.
>
> (c) In November of 1978, an assault team of Baader-Meinhof Terrorists crossed the double fence line of the Nike-Hercules launching-area of the Alpha Battery 2/1 ADA, 32nd AADCOM, USAREUR, located at McCully Barracks, Wackenheim, Germany, and entered the Missile Mating structure and attempted to

> remove a nuclear warhead from one of the missiles, but were fired upon by United States servicemen. According to the Veteran, the incident was documented by Army CID, 32nd AADCOM, local German Police, and the German Federal Kriminal Polizei.

3. Then, review the record and make specific determinations whether any of the claimed stressor events have been verified. In reaching that determination, any credibility questions raised by the record should be addressed. The Veteran should be notified of those determinations and provided the opportunity to respond.

4. Then, schedule the Veteran for a VA audiology examination with an audiologist to determine the current level of severity of the hearing impairment. The examiner must review the claim file and should note that review in the report. The examiner should elicit from the Veteran all complaints associated with the service-connected bilateral haring loss disability, to include any associated functional impairment. Audiometric testing and speech discrimination testing should be performed, including the Maryland CNC test. The examiner is requested to review all pertinent records associated with the claims file and to comment on the severity of the bilateral hearing loss. If test results are considered invalid or an inaccurate depiction of the severity of the Veteran's hearing loss, that conclusion should be explained in detail why valid and reliable audiometric data could not be obtained.

5. Then, readjudicate the claims. 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 appellant has the right to submit additional evidence and argument on the matter or matters 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).

_____

Harvey P. Roberts
Veterans Law Judge, Board of Veterans' Appeals

YOUR RIGHTS TO APPEAL OUR DECISION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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