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

IN THE APPEAL OF C[redacted]
DAVID A. EMSLEY

DOCKET NO. 13-13 912) DATE *September 21, 2016*
) *QLJ*
)

On appeal from the
Department of Veterans Affairs Medical Center in Gainesville, Florida

THE ISSUE

Entitlement to payment or reimbursement of non-VA medical expenses for an emergency room visit at The Villages Regional Hospital, The Villages, Florida, on October 31, 2012.

(The issues of entitlement to a disability rating greater than 30 percent for an acquired psychiatric disability, to include and adjustment disorder with anxiety (also claimed as posttraumatic stress disorder (PTSD)), and entitlement to a total disability rating based on individual unemployability (TDIU) are the subject of a separate Board decision.)

REPRESENTATION

Appellant represented by: Christopher Loiacono, Agent

WITNESS AT HEARING ON APPEAL

IN THE APPEAL OF C [redacted]
DAVID A. EMSLEY

The Veteran

ATTORNEY FOR THE BOARD

Michael T. Osborne, Counsel

INTRODUCTION

The Veteran had active service from June 1969 to January 1972, including in the Republic of Vietnam from December 1969 to November 1970.

This matter comes before the Board of Veterans' Appeals (Board) on appeal from a February 2012 administrative decision issued by the Department of Veterans Affairs (VA) Medical Center in Gainesville, Florida ("VAMC Gainesville") which denied the Veteran's claim of entitlement to reimbursement of unauthorized medical expenses for an emergency room visit at The Villages Regional Hospital, The Villages, Florida, on October 31, 2012. The Veteran disagreed with this decision in February 2013. He perfected a timely appeal in March 2013. A videoconference Board hearing was held at the VA Regional Office (RO) in St. Petersburg, Florida, in April 2016 before the undersigned Veterans Law Judge and a copy of the hearing transcript has been added to the record.

In May 2015, the Board remanded this matter to the RO for additional development. A review of the claims file shows that there has been substantial compliance with the Board's remand directives. The Board directed that the RO schedule the Veteran for a videoconference Board hearing; as noted above, this hearing occurred in April 2016. *See Stegall v. West*, 11 Vet. App. 268 (1998); *see also Dyment v. West*, 13 Vet. App. 141 (1999) (holding that another remand is not required under *Stegall* where the Board's remand instructions were substantially complied with), *aff'd, Dyment v. Principi*, 287 F.3d 1377 (2002).

FINDINGS OF FACT

1. The Veteran incurred medical expenses for treatment of anxiety/panic attack in the emergency room at The Villages Regional Hospital, The Villages, Florida, on October 31, 2012; prior authorization for such treatment was not given by VA, nor can it be implied.

2. At the time of the Veteran's admission to The Villages Regional Hospital on October 31, 2012, service connection was in effect for adjustment disorder with anxiety (also claimed as PTSD), diabetes mellitus, and tinnitus.

3. The services provided to the Veteran by The Villages Regional Hospital on October 31, 2012, were not rendered in response to a medical emergency.

4. At the time of the Veteran's admission to The Villages Regional Hospital on October 31, 2012, an attempt to use VA beforehand would have been considered reasonable by a prudent layperson due to the non-emergent nature of the Veteran's condition for which he sought treatment.

5. The record evidence shows that, on admission to The Villages Regional Hospital on October 31, 2012, the Veteran was ambulatory and complained of PTSD which had lasted for 2 weeks.

6. The record evidence shows that, at the time of his admission to The Villages Regional Hospital on October 31, 2012, the Veteran was enrolled in the VA health care system.

7. The Veteran is financially liable to The Villages Regional Hospital for the treatment that he received in the emergency room at this facility on October 31, 2012.

8. At the time of his admission to The Villages Regional Hospital on October 31, 2012, the Veteran was not enrolled as a participant in Medicare.

CONCLUSION OF LAW

The criteria for payment or reimbursement for the cost of unauthorized private medical expenses for an emergency room visit at The Villages Regional Hospital, The Villages, Florida, on October 31, 2012, have not been met. 38 U.S.C.A. §§ 1725, 1728, 5107 (West 2014); 38 C.F.R. §§ 3.102, 17.120, 17.121, 17.1000, 17.1001, 17.1002, 17.1005 (2015).

REASONS AND BASES FOR FINDINGS AND CONCLUSION

Before assessing the merits of the appeal, VA's duties under the Veterans Claims Assistance Act of 2000 (VCAA) must be examined. The VCAA provides that VA shall apprise a claimant of the evidence necessary to substantiate his claim for benefits and that VA shall make reasonable efforts to assist a claimant in obtaining evidence unless no reasonable possibility exists that such assistance will aid in substantiating the claim.

The Board notes at the outset that the United States Court of Appeals for Veterans Claims (Court) has not clarified whether the VCAA is applicable to claims involving payment or reimbursement of unauthorized medical expenses. *Cf. Barger v. Principi*, 16 Vet. App. 132 (2002). In *Barger*, the Court held that the VCAA, with its expanded duties to notify and assist claimants, is not applicable to cases involving the waiver of recovery of overpayment claims, pointing out that the statute at issue in such cases was not found in Title 38, United States Code, Chapter 51 (*i.e.*, the laws changed by VCAA). Similarly, the statute at issue in this matter is not found in Chapter 51 and is located in Chapter 17 of Title 38. In *Beverly v. Nicholson*, 19 Vet. App. 394, 403-04 (2005), although not stated explicitly, the Court appeared to assume that the VCAA is applicable to a Chapter 17 claim. The Court also held in *Beverly* that any failure by VA to comply with the VCAA notice requirements in that case constituted non-prejudicial error. *See also Sanders v. Nicholson*, 487 F.3d 881 (Fed. Cir. 2007), *rev'd sub nom., Shinseki v. Sanders*, 129 S. Ct. 1696 (2009) (discussing non-prejudicial error).

Moreover, the provisions of Chapter 17 of 38 U.S.C.A. and 38 C.F.R. contain their own notice requirements. Regulations at 38 C.F.R. §§ 17.120-33 discuss the adjudication of claims for reimbursement of unauthorized medical expenses. According to 38 C.F.R. § 17.124, the claimant has the duty to submit documentary evidence establishing the amount paid or owed, an explanation of the circumstances necessitating the non-VA medical treatment, and "other evidence or statements that are deemed necessary and requested for adjudication of the claim." When a claim for reimbursement of unauthorized medical expenses is disallowed, VA is required to notify the claimant of its reasons and bases for denial, his or her appellate rights, and to furnish all other notifications or statements required by Part 19 of Chapter 38. 38 C.F.R. § 17.132.

Having reviewed the record evidence, and to the extent the VCAA is applicable, the Board finds that VA has satisfied the duties to notify and to assist in this case. In March 2013, VA notified the Veteran of the VCAA and of his and VA's obligations with regard to obtaining evidence. The March 2013 Statement of the Case set forth relevant regulations and explained the reasons and bases for the denial of the Veteran's currently appealed claim. The Veteran's claims file also contains private medical records from The Villages Regional Hospital pertaining to the treatment in question. In summary, the Board finds that there is no evidence of any VA error in notifying or assisting the Veteran which reasonably affects the fairness of this adjudication. *See* 38 C.F.R. § 3.159(c); *see also Bernard v. Brown*, 4 Vet. App. 384, 394 (1993).

Laws and Regulations

In adjudicating a claim for payment or reimbursement of medical expenses, the Board must make an initial factual determination as to whether VA gave prior authorization for non-VA medical care received at a private facility. 38 U.S.C.A. § 1703(a); 38 C.F.R. § 17.54. This is a factual, not a medical, determination. *See Similes v. Brown*, 6 Vet. App. 555, 557 (1994).

When the Veteran receives treatment at a non-VA facility without prior authorization, there are two statutes that allow for him to be paid or reimbursed for the medical expenses incurred for that treatment if required criteria are met. *See* 38 U.S.C.A. §§ 1725 and 1728 (West 2002). Application of either statute generally is dependent on whether the claimant has an adjudicated service-connected disability.

Effective October 10, 2008, the provisions of 38 U.S.C.A. §§ 1725 and 1728 were amended. *See* Veterans' Mental Health and Other Care Improvements Act of 2008, Pub. L. No. 110-387, § 402, 122 Stat. 4110 (2008). This law made various changes to Veteran's mental health care and also addresses other health care related matters. The changes are liberalizing in that they make reimbursement for medical expenses mandatory instead of discretionary, as well as expanding the definition of "emergency treatment" beyond the point of stabilization. Most importantly, the changes apply the more liberal prudent layperson standard for determining whether an actual medical emergency existed under either 38 U.S.C.A. §§ 1725 or 1728.

Effective May 21, 2012, VA amended its regulations regarding payment or reimbursement for emergency services for nonservice-connected conditions in non-VA facilities to conform with amendments made to 38 U.S.C.A. § 1725 by the Expansion of Veteran Eligibility for Reimbursement Act, Pub. L. No. 111-137, 123 Stat. 3495 (2010). Specifically, VA amended 38 C.F.R. §§ 17.1001, 17.1002, 17.1004, and 17.1005 to expand the qualifications for payment or reimbursement to Veterans who receive emergency services in non-VA facilities and to establish accompanying standards for the method and amount of payment or reimbursement. These amendments also state that VA will provide retroactive payment or reimbursement for emergency treatment received by a Veteran in certain circumstances. *See* 77 Fed. Reg. 23,615-23,618 (April 20, 2012).

In general, under 38 U.S.C.A. § 1728, in order to be entitled to payment or reimbursement of medical expenses incurred at a non-VA facility, there must be a showing that three criteria are met:

(a) the care and services rendered were either: (1) for an adjudicated service-connected disability, (2) for a nonservice-connected disability associated with and

held to be aggravating an adjudicated service-connected disability, (3) for any disability of a Veteran who has a total disability, permanent in nature, resulting from a service-connected disability, or (4) for any injury, illness, or dental condition in the case of a Veteran who is participating in a rehabilitation program and who is medically determined to be in need of hospital care or medical services for reasons set forth in 38 C.F.R. § 17.47(i) (*formerly* § 17.48(j) (2000)); and

(b) the treatment was for a medical emergency of such nature that a prudent layperson would have reasonably expected that delay in seeking immediate medical attention would have been hazardous to life or health; and

(c) VA or other Federal facilities were not feasibly available and an attempt to use them beforehand or obtain prior authorization for the services required would not have been reasonable, sound, wise, or practicable, or treatment had been or would have been refused.

See 38 U.S.C.A. § 1728 (West 2002); 76 Fed. Reg. 79069, 70070 (*to be codified at* 38 C.F.R. § 17.120). All three statutory requirements found in 38 U.S.C.A. § 1728 must be met before the reimbursement may be authorized. *See Zimick v. West*, 11 Vet. App. 45, 49 (1998); *Hayes v. Brown*, 6 Vet. App. 66, 68 (1993).

The Veterans Millennium Health Care and Benefits Act, which became effective in May 2000, also provides general authority for reimbursement for the reasonable value of emergency treatment furnished in a non-Department facility to those Veterans who are active Department health-care participants (enrolled in the annual patient enrollment system and recipients of Department hospital, nursing home, or domiciliary care under such system within the last 24-month period) and who are personally liable for such treatment and not eligible for reimbursement under the provisions of 38 U.S.C.A. § 1728. *See* 38 U.S.C.A. § 1725.

To be eligible for reimbursement under this Act, the Veteran has to satisfy all of the following conditions:

(a) The emergency services were provided in a hospital emergency department or a

similar facility held out as providing emergency care to the public;

(b) The claim for payment or reimbursement for the initial evaluation and treatment is for a condition of such a nature that a prudent layperson would have reasonably expected that delay in seeking immediate medical attention would have been hazardous to life or health (this standard would be met if there were an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part);

(c) A VA or other Federal facility/provider was not feasibly available and an attempt to use them beforehand would not have been considered reasonable by a prudent layperson (as an example, these conditions would be met by evidence establishing that a Veteran was brought to a hospital in an ambulance and the ambulance personnel determined that the nearest available appropriate level of care was at a non-VA medical center);

(d) The claim for payment or reimbursement for any medical care beyond the initial emergency evaluation and treatment is for a continued medical emergency of such a nature that the Veteran could not have been safely discharged or transferred to a VA or other Federal facility (the medical emergency lasts only until the time the Veteran becomes stabilized);

(e) At the time the emergency treatment was furnished, the Veteran was enrolled in the VA health care system and had received medical services under authority of 38 U.S.C. Chapter 17 within the 24-month period preceding the furnishing of such emergency treatment;

(f) The Veteran is financially liable to the provider of emergency treatment for that treatment;

(g) The Veteran has no coverage under a health-plan contract for payment or reimbursement, in whole or in part, for the emergency treatment (this condition cannot be met if the Veteran has coverage under a health-plan contract but payment is barred because of a failure by the Veteran or provider to comply with the provisions of that health-plan contract, e.g., failure to submit a bill or medical records within specified time limits, or failure to exhaust appeals of the denial of payment);

(h) The Veteran has no contractual or legal recourse against a third party that could reasonably be pursued for or in part, the Veteran's liability to the provider;

(i) The Veteran is not eligible for reimbursement under 38 U.S.C. § 1728 for the emergency treatment provided (38 U.S.C. § 1728 authorizes VA payment or reimbursement for emergency treatment to a limited group of Veterans, primarily those who receive emergency treatment for a service-connected disability). *See also* 38 C.F.R. § 17.1002.

Failure to satisfy any of the criteria listed above precludes VA from paying unauthorized medical expenses incurred at a private facility. *See* 38 U.S.C.A. § 1725(b); 38 C.F.R. § 17.1002(g). These criteria are conjunctive, not disjunctive; thus, all of the criteria found in 38 U.S.C.A. § 1725 must be met before payment will be authorized. *See Melson v. Derwinski*, 1 Vet. App. 334 (1991) (holding that use of the conjunctive "and" in a statutory provision meant that all of the conditions listed in the provision must be met).

Factual Background and Analysis

The Board finds that the preponderance of the evidence is against finding that the Veteran is entitled to payment or reimbursement of non-VA medical expenses for an emergency room visit at The Villages Regional Hospital, The Villages, Florida, on October 31, 2012. The Veteran seeks payment or reimbursement of unauthorized medical expenses for an emergency room (ER) visit at The Villages Regional Hospital, The Villages, Florida ("TVRH"), on October 31, 2012. The Veteran essentially contends that he was forced to seek emergency treatment at

TVRH for what he feared was a heart attack experienced while he was working. The record evidence does not support his assertions concerning the nature of the alleged medical emergency he was experiencing when he sought treatment at TVRH on October 31, 2012, or that a VA facility was not feasibly available at that time. It shows instead that he sought treatment at TVRH on October 31, 2012, for a non-emergent condition and that a VA facility was feasibly available at that time. The Board notes initially that the Veteran does not contend, and the record evidence does not indicate, that his ER visit at TVRH on October 31, 2012, was "authorized" by VA.

A review of the records obtained by VA from TVRH shows that the Veteran arrived by private car to the ER at this private hospital on October 31, 2012, with complaints of depression, agitation, and PTSD which had lasted for 2 weeks. He was on Abilify, Wellbutrin, and Mirtazapine. He denied any suicidal thoughts. A history of anxiety, PTSD, and panic attacks was noted. The Veteran's mental status was anxious and tearful. He was fully oriented. He received 2 mg of Ativan intravenously. A brain computerized tomography (CT) scan was unremarkable. The Veteran and his family were counseled regarding the diagnosis. The diagnosis was anxiety/panic attacks. The Veteran was discharged in improved and stable condition. The discharge paperwork that the Veteran submitted in support of his claim shows that his discharge date/time was October 31, 2012, at 6:24:17 pm.

A review of the Veteran's VA outpatient treatment records indicates that, no outpatient treatment on October 29, 2012, he "was alert, oriented, and mildly agitated…His overriding agenda for our meeting was to convince me that he has 'severe PTSD' and his [VA compensation] claim needs to be adjusted to take that into account." The Veteran denied suicidal or homicidal ideation although a history of suicidal ideation "some years back" was noted. "There was no evidence of psychosis or a severe mood disorder – what previously appeared as evidence of a manic state was not present today." The VA clinician stated that the Veteran's judgment and insight were impaired. "He told me a variety of untruths…with no understanding that I would find out about these things by reviewing his chart." This clinician also stated that the Veteran "seemed determined to convince me that his

compensation for PTSD should be increased…The Veteran could not restrain himself from returning to his desire for an increase in compensation due to PTSD."

In an Administrative Note dated on November 1, 2012, and included in the Veteran's VA outpatient treatment records, the Veteran's treating psychiatrist stated that the Veteran "came to clinic today as a walk in because he had shortness of breath, went to [the emergency room], and [was] prescribed Ativan…for anxiety attacks." The Veteran apparently came to the walk-in VA clinic "to find out whether he should take [Ativan] or not." The Veteran was not suicidal or homicidal and no panic symptoms were present. Because of the Veteran's "prior drinking history," his treating psychiatrist limited his Ativan and only provided him with 10 tablets.

On VA outpatient treatment on November 5, 2012, the Veteran reported that he "had become so anxious on 10/31 that he called his wife from his job and asked her to take him to the emergency room at The Villages Hospital." He reported being diagnosed as having anxiety and panic attacks after being seen in the ER. The VA clinician stated that the Veteran's "past behavior indicates that, when he experiences panic, he seeks medical attention rather than self-harm." This clinician also stated:

> The Veteran's eye contact and speech were [within normal limits], although he wandered off the topic at times. He complied with my requests to stop discussing whatever he was discussing and either return to the topic at hand or answer a question. He complained of racing thoughts but these were not especially apparent. Long term memory was intact generally but [he] became confused about dates. Affect and mood were tense and anxiety-prone but he could laugh when he recalled certain events. Insight and judgment are limited…In fact, I encountered [the Veteran] in the waiting room upon his release from The Villages Hospital on 10/31 and he had come to the [VA mental health] clinic as a walk-in. His purpose was to check with [his treating psychiatrist] to find out if taking Ativan would conflict with other medications.

In statements on his February 2013 notice of disagreement, the Veteran asserted:

> I was working at The Home Depot and became ill and it was believed I was having a heart attack. Home Depot called an ambulance, and although I told them I didn't have insurance, they told me they would have to take me to the nearest facility, which was The [] Villages Hospital. I was there about 1½ days.

In a March 2013 statement, the Veteran stated:

> At approximately 1745 I was transported from my work to The Villages [Outpatient Clinic] to be seen for an anxiety attack that I was experiencing which had made be debilitated. My wife drove and we arrived to the Clinic at approximately 1800 [hours]. The place was closed down except for some facility maintenance people who advised my wife to take me to the Emergency Room at the Villages Hospital. We arrived at the Villages Hospital at approximately 1820 [hours] where I was immediately administered to by a physician in the Emergency Room. The physician quickly put me on an IV which brought down my blood pressure to a level that was not critical.
>
> I am aware of the requirement to always go to the VA facility for any and all care. In this instance, I was experiencing an extreme anxiety attack which made my wife believe (and I) that I was dying and needed immediate care.

The record evidence clearly shows that the Veteran was enrolled in the VA health care system at the time he sought treatment in the ER at TVRH on October 31, 2012. In fact, it appears that he was seen briefly on that same day following his discharge from the ER when he stopped by a VA walk-in mental health clinic to ask his VA treating psychiatrist if he could take the medication (Ativan) prescribed by the ER treating clinician for his anxiety/panic attack which was treated in the ER. Having reviewed the record evidence, the Board concludes that the Veteran's ER

visit at TVRH on October 31, 2012, was not authorized by VA either explicitly or implicitly. *See* 38 U.S.C.A. § 1703(a); 38 C.F.R. § 17.54; *see also Similes,* 6 Vet. App. at 557.

The Board also finds that the Veteran is not entitled to payment or reimbursement of non-VA medical expenses for an ER visit at TVRH on October 31, 2012, under either applicable statute governing such claims. *See generally* 38 U.S.C.A. §§ 1725, 1728 (West 2014). The Veteran essentially contends that he should be reimbursed for the cost of non-VA medical expenses incurred during this ER visit under at least one of these statutes. The Veteran also essentially contends that his ER visit at TVRH constituted a medical emergency. As noted, the record evidence does not support his assertions regarding his entitlement to reimbursement under either of the governing statutes or his assertions that his ER visit at TVRH was a medical emergency. The evidence shows instead that the Veteran received treatment at the ER at TVRH on October 31, 2012, for a non-emergent medical condition (anxiety/panic attack).

The Board next notes that the Veteran's claim does not meet all three of the criteria set out in 38 U.S.C.A. § 1728 in order for payment or reimbursement to be authorized under this statute. The Board acknowledges that service connection is in effect for an acquired psychiatric disability, to include an adjustment disorder with anxiety (also claimed as PTSD). Thus, the Veteran was treated in the ER at TVRH on October 31, 2012, for symptomatology associated with this service-connected disability. The Veteran also does not contend, and the evidence does not indicate, that this ER visit was for a nonservice-connected disability associated with and held to be aggravating an adjudicated service-connected disability. A review of the claims file demonstrates that the Veteran does not experience a total disability, permanent in nature, resulting from a service-connected disability. The Veteran further is not a participant in a rehabilitation program and has not been medically determined to be in need of hospital care or medical services for reasons set forth in 38 C.F.R. § 17.47(i). *See* 38 U.S.C.A. § 1728(a).

The record evidence also shows that the Veteran's ER visit at TVRH on October 31, 2012, was for a non-emergent condition (anxiety/panic attack). There

is no indication in the medical evidence of record that the Veteran's treatment in the ER at TVRH on October 31, 2012, was for a medical emergency of such nature that a prudent layperson would have reasonably expected that delay in seeking immediate medical attention would have been hazardous to life or health. *Id*. The Board notes in this regard the obvious discrepancy in the Veteran's February and March 2013 statements concerning how he arrived at the ER at TVRH. He suggested in his February 2013 statement that his employer, Home Depot, had called an ambulance and he was transported involuntarily to TVRH even though he apparently advised ambulance personnel that he did not have insurance. The Veteran was somewhat closer to the truth of the matter when he stated in his March 2013 statement that he had called his wife from his job at Home Depot and she had driven him to the ER at TRVH. The facts that the Veteran arrived via private vehicle (rather than in an ambulance) and was ambulatory on arrival at the ER at TRVH on October 31, 2012, are supported by a review of the ER medical records.

The Veteran finally contends that VA or other Federal facilities were not feasibly available and an attempt to use them beforehand or obtain prior authorization for the services required would not have been reasonable, sound, wise, or practicable, or treatment had been or would have been refused. *See* 38 U.S.C.A. § 1728(c). There is no indication that the Veteran actually attempted to call or visit any VA health care facility prior to his admission to the ER at TRVH on October 31, 2012, or, if he had, that he would not have received treatment that same day. The evidence suggests otherwise. It shows that, in fact, the Veteran visited a VA facility immediately following his ER visit at TVRH on October 31, 2012, as his treating VA clinician noted on November 5, 2012, that she had seen the Veteran in the VA walk-in mental health clinic immediately following his discharge from the ER at TVRH when he sought advice from his treating VA psychiatrist about whether he could take the Ativan he had been prescribed in the ER to treat his anxiety/panic attack. The Veteran's assertion in March 2013 that he arrived at a VA facility late in the day and was advised by "some facility maintenance people" to go the ER at TRVH because the VA facility had closed for the day simply is not credible in light of the medical records stating otherwise. *See Bastien v. Shinseki*, 599 F.3d 1301, 1306 (Fed. Cir. 2010) ("The evaluation and weighing of evidence and the drawing

of appropriate inferences from it are factual determinations committed to the discretion of the fact finder.").

The Veteran's timeline of events on October 31, 2012, as described in his March 2013 statement, also is not credible because it is undermined by his own submission of the discharge instructions that he received upon leaving the ER at TRVH. As noted above, these discharge instructions are date stamped at 6:24pm (or 1824 hours Zulu time) which indicates that he was discharged at that time from the ER at TRVH. According to the Veteran's March 2013 statement, he did not arrive at the ER at TRVH until 1820 hours Zulu time "where I was immediately administered to by a physician." It beggars belief that he would have been discharged approximately 4 minutes later from the ER, as the time-stamp on his discharge instructions indicates his time of discharge from the ER was at 1824 hours Zulu time. Thus, the Board finds it reasonable to conclude that the Veteran's March 2013 description of the events which unfolded on October 31, 2012, simply is not credible and is entitled to zero probative value. *Id*.

It is clear from a review of the record evidence that a VA clinic was feasibly available to the Veteran at the time he sought medical treatment on October 31, 2012. Again, it seems reasonable to conclude that the Veteran went to a VA clinic immediately following his discharge from the ER at TRVH in order to obtain advice from his VA treating psychiatrist on whether he could take the medications he had been prescribed in the ER to treat his anxiety/panic attack. This persuasively suggests that a VA facility was feasibly available to the Veteran and he knew it. Thus, the Board concludes that an attempt to use VA or other Federal facilities beforehand or obtain prior authorization for the services required would have been reasonable, sound, wise, or practicable, given the non-emergent condition (anxiety/panic attack) for which the Veteran sought treatment on that date. Because all three statutory requirements under 38 U.S.C.A. § 1728 have not been met, payment or reimbursement is not authorized under this statute. *See* 38 U.S.C.A. § 1728 (West 2002); *see also Zimick*, 11 Vet. App. at 49, and *Hayes*, 6 Vet. App. at 68.

The Board next notes that the Veteran's claim does not meet all of the criteria set out in 38 U.S.C.A. § 1725 in order for payment or reimbursement to be authorized under this statute as well. First, the Board acknowledges that the services provided to the Veteran on October 31, 2012, by TVRH appear to be "emergency services." The medical records received in support of the Veteran's claim for medical expenses reimbursement clearly show that he was treated in the ER at TVRH for anxiety/panic attack on this date. It also is clear from a review of the record evidence that TVRH is "a hospital emergency department or a similar facility held out as providing emergency care to the public." *See* 38 U.S.C.A. § 1725(a). Second, as noted elsewhere, the Veteran's anxiety/panic attack treated on October 31, 2012, by TVRH was not of such nature that a prudent layperson would have reasonably expected that delay in seeking immediate medical attention would have been hazardous to life or health. The record evidence suggests that the Veteran's condition was non-emergent and he might have been seen by a VA clinician at his local VA clinic had he attempted to contact VA before he apparently called his wife from his job at Home Depot and asking her to drive him to the ER at TVRH for the non-emergent condition. *See* 38 U.S.C.A. § 1725(b); *see also* 38 C.F.R. § 17.1005. Third, as also noted elsewhere, the evidence indicates that an attempt to use VA or other Federal facilities beforehand or obtain prior authorization for the services required would have been reasonable, sound, wise, or practicable. There is no indication that treatment had been or would be refused if the Veteran had attempted to use a VA clinic beforehand. *See* 38 U.S.C.A. § 1725(c). Because his medical condition (diagnosed as anxiety/panic attack) was non-emergent at the time he was seen in the ER at TVRH on October 31, 2012, there was no medical emergency of such a nature that the Veteran could not have been safely discharged or transferred to a VA or other Federal facility. *See* 38 U.S.C.A. § 1725(d).

The VHA physician who conducted a second review of the Veteran's claim in February 2013 concluded that his condition was non-emergent. The Veteran clearly was enrolled in the VA health care system and received medical treatment from VA within 24 months of his hospitalization at TVRH on October 31, 2012. *See* 38 U.S.C.A. § 1725(e). And it is undisputed that the Veteran is financially liable to TVRH for payment of the expenses incurred during his ER visit on October 31,

2012. *See* 38 U.S.C.A. § 1725(f). It appears that, at the time of his admission to the ER at TVRH, the Veteran did not have other health care coverage which provides for payment or reimbursement of the charges incurred. The medical expense forms submitted by TVRH to the VAMC seeking payment for the charges incurred by the Veteran when he was seen in the ER at this facility on October 31, 2012, indicate that he was not enrolled in Medicare at the time he sought treatment although his Medicare status is not entirely clear from the record. *See* 38 U.S.C.A. § 1725(g). The Veteran does not contend, and the evidence does not show, that he has no contractual or legal recourse against a third party that could reasonably be pursued for all or in part his liability to the provider. *See* 38 U.S.C.A. § 1725(h). Finally, and as discussed above, the Veteran is not eligible for reimbursement under 38 U.S.C. § 1728 for the emergency treatment provided. *See* 38 U.S.C.A. § 1725(i). In summary, the Board finds that, because all of the criteria outlined in 38 U.S.C.A. § 1725 are not met, VA is precluded from paying unauthorized medical expenses incurred at a private facility. *See also* 38 U.S.C.A. § 1725(b); 38 C.F.R. § 17.1002(g); *Melson*, 1 Vet. App. at 334.

The Board recognizes that the Veteran disagrees with this determination and notes in this regard that he is competent to provide evidence and argument about what he experienced. The Veteran has asserted that he thought he was experiencing a heart attack prior to being transported to the ER at TVRH on October 31, 2012. With respect to these assertions, the Board notes that, although he is competent to report what he experienced, his assertions simply are not credible because they are not supported by the medical evidence of record. As discussed above, despite the Veteran's assertions in his February 2013 statement, he was not transported to the ER via ambulance and was not hospitalized for "about 1½ days" at TVRH following his admission to the ER. The evidence shows instead that, at best, he was in the ER for a few hours before being discharged and immediately went to the VA clinic to ask his VA treating psychiatrist whether he could take the Ativan he had been prescribed by the clinicians who had treated him in the ER. There is no indication in the record evidence that the Veteran ever experienced a heart attack on the way to the ER at TVRH or was hospitalized for any length of time at this facility following his visit to the ER. Given the foregoing, the Board concludes that the Veteran's lay assertions regarding his medical condition while being transported

to the ER and on admission to the ER at TVRH, although competent, are not credible. *See generally Layno v. Brown*, 6 Vet. App. 465 (1994), *Barr v. Nicholson*, 21 Vet. App. 303 (2007), and *Buchanan v. Nicholson*, 451 F.3d 1331 (Fed. Cir. 2006). The Board observes that no medical professional has indicated that the Veteran's ER visit at TVRH on October 31, 2012, was under emergent circumstances. The evidence suggests instead that the Veteran's condition was non-emergent when he sought treatment at a private facility on October 31, 2012. And, as discussed above, after reviewing the record evidence, the Board finds that a prudent layperson would not consider the situation that the Veteran faced on October 31, 2012, to be emergent. While the Board is sympathetic to the Veteran, it is bound by the relevant statutes and regulations and is without authority to grant benefits simply because it might perceive the result to be equitable. *See* 38 U.S.C.A. §§ 503, 7104 (West 2014); *Harvey v. Brown*, 6 Vet. App. 416, 425 (1994).

ORDER

Entitlement to payment or reimbursement of non-VA medical expenses for an emergency room visit at The Villages Regional Hospital, The Villages, Florida, on October 31, 2012, is denied.

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DEBORAH W. SINGLETON
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).

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

IN THE APPEAL OF C [redacted]
DAVID A. EMSLEY

DOCKET NO. 11-18 592) DATE *September 21, 2016*
) *QLJ*
)

On appeal from the
Department of Veterans Affairs Regional Office in St. Petersburg, Florida

THE ISSUES

1. Entitlement to a disability rating greater than 30 percent for an adjustment disorder with anxiety (also claimed as posttraumatic stress disorder (PTSD)).

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

(The issue of entitlement to payment or reimbursement of non-VA medical expenses for an emergency room visit at The Villages Regional Hospital, The Villages, Florida, on October 31, 2012, is the subject of a separate Board decision.)

REPRESENTATION

Appellant represented by: Christopher Loiacono, Agent

WITNESS AT HEARING ON APPEAL

The Veteran

ATTORNEY FOR THE BOARD

Michael T. Osborne, Counsel

INTRODUCTION

The Veteran had active service from June 1969 to January 1972, including in the Republic of Vietnam from December 1969 to November 1970.

This matter comes before the Board of Veterans' Appeals (Board) on appeal from a January 2010 rating decision issued by the Department of Veterans Affairs (VA) Regional Office (RO) in St. Petersburg, Florida, which denied the Veteran's claim for a disability rating greater than 30 percent for an adjustment disorder with anxiety (also claimed as posttraumatic stress disorder). The Veteran disagreed with this decision in February 2010. He perfected a timely appeal in June 2011. A Travel Board hearing was held at the RO in April 2016 before the undersigned Veterans Law Judge and a copy of the hearing transcript has been added to the record.

The Board notes that, in a May 2013 rating decision, the RO denied, in pertinent part, the Veteran's claims of entitlement to a disability rating greater than 20 percent for diabetes mellitus, a disability rating greater than 10 percent for tinnitus, special monthly compensation based on the loss of use of a creative organ, entitlement to service for ischemic heart disease, and entitlement to service connection for erectile dysfunction. The Veteran disagreed with this decision in August 2013. As such, these issues were previously remanded by the Board to the AOJ in May 2015. The Board specifically directed the AOJ to issue a Statement of the Case (SOC) to the Veteran and his agent on these 5 claims. *See Manlincon v.*

West, 12 Vet. App. 238, 240-241 (1999) (finding that, where claimant files notice of disagreement and RO has not issued SOC, issue must be remanded to RO for SOC). Accordingly, the Board's May 2015 remand directives concerning these 5 claims are incorporated by reference.

This appeal was processed using the Virtual VA (VVA) and Virtual Benefits Management System (VBMS) paperless claims processing systems. Accordingly, any future consideration of this appellant's case should take into consideration the existence of these electronic records.

The Board notes that, in *Rice v. Shinseki*, the Court held that a TDIU claim cannot be considered separate and apart from an increased rating claim. *See Rice v. Shinseki*, 22 Vet. App. 447 (2009). Instead, the Court held that a TDIU claim is an attempt to obtain an appropriate rating for a service-connected disability. The Court also found in *Rice* that, when entitlement to a TDIU is raised during the adjudicatory process of the underlying disability, it is part of the claim for benefits for the underlying disability.

Also, the record in this case indicates that the Veteran has asserted that he is not employable solely by reason of his service-connected acquired psychiatric disability, to include adjustment disorder with anxiety (also claimed as PTSD), diabetes mellitus, and tinnitus. Since these matters are inextricably intertwined, the issue of entitlement to TDIU is addressed in the REMAND portion of the decision below and is REMANDED to the AOJ. VA will notify the Veteran if further action is required.

FINDING OF FACT

The record evidence shows that the Veteran's service-connected adjustment disorder with anxiety (also claimed as PTSD) is manifested by, at worst, complaints of depression, irritability, hypervigilance, anxiety, and difficulty sleeping.

CONCLUSION OF LAW

The criteria for a disability rating greater than 30 percent for an adjustment disorder with anxiety (also claimed as PTSD) have not been met. 38 U.S.C.A. §§ 1155, 5107 (West 2014); 38 C.F.R. §§ 4.1, 4.2, 4.7, 4.130, Diagnostic Code (DC) 9440 (2015).

REASONS AND BASES FOR FINDING AND CONCLUSION

Before assessing the merits of the appeal, VA's duties under the Veterans Claims Assistance Act (VCAA) must be examined. The VCAA provides that VA shall apprise a claimant of the evidence necessary to substantiate his claim for benefits and that VA shall make reasonable efforts to assist a claimant in obtaining evidence unless no reasonable possibility exists that such assistance will aid in substantiating the claim.

In letters issued in October 2009, April 2012, and in April 2013, VA notified the Veteran of the information and evidence needed to substantiate and complete his claim, including what part of that evidence he was to provide and what part VA would attempt to obtain for him. *See* 38 U.S.C.A. § 5103(a); 38 C.F.R. § 3.159(b)(1); *Quartuccio v. Principi*, 16 Vet. App. 183, 187 (2002). These letters informed the Veteran to submit medical evidence showing that his acquired psychiatric disability had worsened. The Veteran also was informed of when and where to send the evidence. After consideration of the contents of these letters, the Board finds that VA has satisfied substantially the requirement that the Veteran be advised to submit any additional information in support of his claim. *See Pelegrini v. Principi*, 18 Vet. App. 112 (2004).

The Court previously held that to satisfy the first *Quartuccio* element for an increased compensation claim, section 5103(a) compliant notice must meet a four-part test laid out in *Vazquez-Flores v. Peake*, 22 Vet. App. 37 (2008). The United States Court of Appeals for the Federal Circuit (Federal Circuit) overruled *Vazquez-Flores* in part, striking the claimant-tailored and "daily life" notice elements. *See*

Vazquez-Flores v. Shinseki, 580 F.3d 1270 (Fed. Cir. 2009). Following the Federal Circuit's decision, the Court subsequently issued an opinion incorporating those surviving portions of the first *Vazquez-Flores* decision, namely that VA must notify the claimant that 1) to substantiate a claim, the claimant must provide, or ask VA to obtain, medical or lay evidence demonstrating a worsening or increase in severity of the disability, 2) a disability rating will be determined by applying relevant Diagnostic Codes, which typically provide for a range in severity of a particular disability from noncompensable to as much as 100 percent (depending on the disability involved), based on the nature of the symptoms of the condition for which disability compensation is being sought, their severity and duration, and their impact upon employment, and 3) provide examples of the types of medical and lay evidence that the claimant may submit (or ask VA to obtain) that are relevant to establishing entitlement to increased compensation, and must also notify the claimant that to substantiate such a claim the claimant should provide or ask the Secretary to obtain medical or lay evidence demonstrating a worsening or increase in severity of the disability and the effect that worsening has on the claimant's employment. *See Vazquez-Flores v. Shinseki*, 24 Vet. App. 94, 107 (2010) (*Vazquez-Flores III*). For the following reasons, the Board finds that the elements of the *Vazquez-Flores* test that remain under *Vazquez-Flores III* either have been met in this case or that any error in not providing such notice is not prejudicial to the Veteran.

The first and third elements were met by the VCAA notice letters issued during the pendency of this appeal. These letters informed the Veteran that he needed to provide information showing his service-connected disability had worsened. He was informed that such evidence could be a statement from his doctor or lay statements describing what individuals had observed about his disability. He was told that he needed to provide VA information as to where he had received medical treatment, or that he could send VA any pertinent treatment records. Examples of evidence needed to support the claim were provided, including laboratory tests, examinations, and statements from other individuals who could describe from their knowledge and personal observations the manner in which his disability had worsened. He also was informed of what evidence VA would obtain on his behalf and what he needed to do to help VA process his claim. The Veteran also has

submitted personal statements and lay statements from others with respect to his service-connected disability. As the Board finds the Veteran had actual knowledge of the requirement to show worsening of the disability and the variety of the medical and lay evidence which could support his claim, any failure to provide him with adequate notice as to the first and third *Vazquez-Flores* elements is not prejudicial.

As to the second element of *Vazquez-Flores* notice, the Board acknowledges that the Veteran was not provided notice that a disability rating would be determined by application of the ratings schedule and relevant diagnostic codes based on the extent and duration of the signs and symptoms of his disability and their impact on his employment. *See Vazquez-Flores III*, 24 Vet. App. at 107. The Veteran received a statement of the case in May 2011 addressing his claim. Specific VCAA notice to the Veteran of the ratings schedule to be applied to the symptomatology of his disability is unnecessary in light of repeated correspondence sent to the Veteran by the AOJ describing the Rating Schedule and applying the relevant regulations to his claim. The Board finds that the Veteran was on constructive notice of the existence and function of the Ratings Schedule. The Board further finds that any error in the third element of *Vazquez-Flores* notice is not prejudicial. In summary, the Board concludes that the Veteran was notified and aware of the evidence needed to substantiate his claim, as well as the avenues through which he might obtain such evidence, and of the allocation of responsibilities between himself and VA in obtaining such evidence.

As will be explained below in greater detail, the evidence does not support granting an increased rating for an acquired psychiatric disability. Because the Veteran was fully informed of the evidence needed to substantiate his claim, any failure of the AOJ to notify the Veteran under the VCAA cannot be considered prejudicial. *See Bernard v. Brown*, 4 Vet. App. 384, 394 (1993). The claimant also has had the opportunity to submit additional argument and evidence and to participate meaningfully in the adjudication process. *Mayfield v. Nicholson*, 444 F.3d 1328 (Fed. Cir. 2006).

With respect to the timing of the notice, the Board points out that the Court held that a VCAA notice, as required by 38 U.S.C.A. § 5103(a), must be provided to a claimant before the initial unfavorable agency of original jurisdiction decision on a claim for VA benefits. *See Pelegrini,* 18 Vet. App. at 112. Here, all appropriate notice was issued prior to the currently appealed rating decision; thus, this notice was timely. Because the Veteran's increased rating claim is being denied in this decision, any question as to the appropriate disability rating or effective date is moot and there can be no failure to notify the Veteran. *See Dingess,* 19 Vet. App. at 473. And any defect in the timing or content of the notice provided to the Veteran has not affected the fairness of the adjudication. *See Mayfield,* 444 F.3d at 1328.

The Board also finds that VA has complied with the VCAA's duty to assist by aiding the Veteran in obtaining evidence and affording him the opportunity to give testimony before the Board. It appears that all known and available records relevant to the issue on appeal have been obtained and associated with the Veteran's claims file; the Veteran has not contended otherwise. Pursuant to the duty to assist, VA must obtain "records of relevant medical treatment or examination" at VA facilities. 38 U.S.C.A. § 5103A(c)(2). All records pertaining to the conditions at issue are presumptively relevant. *See Moore v. Shinseki*, 555 F.3d 1369, 1374 (Fed. Cir. 2009); *Golz v. Shinseki*, 590 F.3d 1317 (Fed. Cir. 2010). In addition, where the Veteran "sufficiently identifies" other VA medical records that he or she desires to be obtained, VA also must seek those records even if they do not appear potentially relevant based upon the available information. *Sullivan v. McDonald*, 815 F.3d 786, 793 (Fed. Cir. 2016) (citing 38 C.F.R. § 3.159(c)(3)). The Veteran's electronic paperless claims files in VVA and in VBMS have been reviewed. The Veteran's complete Social Security Administration (SSA) records also have been obtained and associated with the claims file. Information from SSA indicates that the Veteran is not currently received Social Security disability as his claim was denied by SSA.

In *Bryant v. Shinseki,* 23 Vet. App. 488 (2010), the Court held that 38 C.F.R. § 3.103(c)(2) requires that the Veterans Law Judge (VLJ) who conducts a hearing fulfill two duties to comply with the above regulation. These duties consist of (1) the duty to fully explain the issues and (2) the duty to suggest the submission of

evidence that may have been overlooked. In March 2016, the Federal Circuit ruled in *Dickens v. McDonald*, 814 F.3d 1359 (Fed. Cir. 2016), that a *Bryant* hearing deficiency was subject to the doctrine of issue exhaustion as laid out in *Scott*, 789 F.3d at 1375. Because the Veteran has not raised a potential *Bryant* problem in this appeal, no further discussion of *Bryant* is necessary.

The Veteran also has been provided with VA examinations which address the current nature and severity of his acquired psychiatric disability. 38 U.S.C.A. § 5103A(d); 38 C.F.R. § 3.159(c)(4). Given that the pertinent medical history was noted by the examiners, these examination reports set forth detailed examination findings in a manner which allows for informed appellate review under applicable VA laws and regulations. Thus, the Board finds the examinations of record are adequate for rating purposes and additional examination is not necessary regarding the claim adjudicated in this decision. *See also* 38 C.F.R. §§ 3.326, 3.327, 4.2. In summary, VA has done everything reasonably possible to notify and to assist the Veteran and no further action is necessary to meet the requirements of the VCAA.

Increased Rating for Acquired Psychiatric Disability

Laws and Regulations

In general, disability evaluations are assigned by applying a schedule of ratings that represent, as far as can be determined, the average impairment of earning capacity. 38 U.S.C.A. § 1155; 38 C.F.R. § 4.1. Separate diagnostic codes identify the various disabilities and the criteria that must be met for specific ratings. The regulations require that, in evaluating a given disability, the disability be viewed in relation to its whole recorded history. 38 C.F.R. § 4.2; *see also Schafrath v. Derwinski*, 1 Vet. App. 589 (1991).

Where an increase in the level of a service-connected disability is at issue, the primary concern is the present level of disability. *See Francisco v. Brown*, 7 Vet. App. 55 (1994). In *Hart v. Mansfield*, 21 Vet. App. 505 (2007), the Court held that "staged" ratings are appropriate for an increased rating claim when the factual findings show distinct time periods where the service-connected disability exhibits

symptoms that would warrant different ratings. The evidence of a factually ascertainable increase warranting a staged increased rating need not itself demonstrate that the scheduler criteria for an increased rating are met if additional later evidence otherwise satisfies the scheduler criteria. *See Swain v. McDonald*, 27 Vet. App. 219, 224-25 (2015).

The Veteran's service-connected adjustment disorder with anxiety (also claimed as PTSD) currently is evaluated as 30 percent disabling effective August 29, 2006, under 38 C.F.R. § 4.130, DC 9440 (chronic adjustment disorder). *See* 38 C.F.R. § 4.130, DC 9440 (2015). A 30 percent rating is assigned under DC 9440 for chronic adjustment disorder manifested by occupational and social impairment with an occasional decrease in work efficiency and intermittent periods of an inability to perform occupational tasks (although generally functioning satisfactorily with routine behavior, self-care, and conversation normal) due to such symptoms as depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment, and mild memory loss (such as forgetting names, directions, recent events).

A 50 percent rating is assigned under DC 9440 for chronic adjustment disorder manifested by occupational and social impairment with reduced reliability and productivity due to such symptoms as flattened affect, circumstantial, circumlocutory, or stereotyped speech, panic attacks more than once a week, difficulty in understanding complex commands, impairment of short- and long-term memory (e.g., retention of only highly learned material, forgetting to complete tasks), impaired judgment, impaired abstract thinking, disturbances of motivation and mood, and difficulty in establishing and maintaining effective work and social relationships.

A 70 percent rating is assigned under DC 9440 for chronic adjustment disorder manifested by occupational and social impairment with deficiencies in most areas, such as work, school, family relations, judgment, thinking or mood due to such symptoms as suicidal ideation, obsessional rituals which interfere with routine activities, speech intermittently illogical, obscure, or irrelevant, near-continuous panic or depression affecting the ability to function independently, appropriately,

and effectively, impaired impulse control (such as unprovoked irritability with periods of violence), spatial disorientation, neglect of personal appearance and hygiene, difficulty in adapting to stressful circumstances (including work or a work-like setting), or an inability to establish and maintain effective relationships.

A 100 percent rating is assigned under DC 9440 for chronic adjustment disorder manifested by total occupational and social impairment due to such symptoms as gross impairment in thought process or communication, persistent delusions or hallucinations, grossly inappropriate behavior, persistent danger of hurting self or others, intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene), disorientation to time or place, and memory loss for names of close relatives, own occupation, or own name. *Id.*

In *Mauerhan v. Principi,* 16 Vet. App. 436 (2002), the Court held that the symptoms listed in the General Rating Formula for Mental Disorders are not an exhaustive list, and instead are only examples of the type and degree of the symptoms, or their effects, that would justify a certain rating. In *Vazquez-Claudio v. Shinseki,* 713 F. 3d 112 (Fed. Cir. 2013), the Federal Circuit held that a Veteran may qualify for a specific disability rating under 38 CFR § 4.130 only by demonstrating the particular symptoms associated with that percentage, or others of similar frequency, severity, and duration.

The Global Assessment of Functioning (GAF) is a scale reflecting the psychological, social, and occupational functioning on a hypothetical continuum of mental-health illness. *See Richard v. Brown,* 9 Vet. App. 266, 267 (1996), citing the Diagnostic and Statistical Manual of Mental Disorders (4th ed.1994). A GAF score of 41 to 50 is defined as denoting serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifter) or any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job). A score of 51 to 60 is defined as indicating moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) or moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers). *See Carpenter v. Brown*, 8 Vet. App. 240, 242-244 (1995).

Factual Background and Analysis

On VA mental disorders examination in August 2008, the Veteran's complaints included depression and increased alcohol consumption. He had been married to his second wife for 26 years. His wife reported in a letter that the Veteran "is irritable and has anger outbursts." The Veteran had positive relationships with 2 adult children from his prior marriage and 1 child from his current marriage. He also had 2 close friends who lived out of state. Mental status examination of the Veteran showed he was clean, neatly groomed, appropriately and casually dressed, unremarkable psychomotor activity and speech, full orientation, unremarkable thought process and content, no delusions, hallucinations, inappropriate behavior, obsessive/ritualistic behavior, panic attacks, suicidal or homicidal thoughts, fair impulse control with no episodes of violence, an ability to maintain minimum personal hygiene, a normal memory, and no problems with activities of daily living. The Veteran's GAF score was 60, indicating moderate symptoms. The diagnoses included mixed adjustment disorder with anxiety and depressed mood.

On VA outpatient treatment in October 2008, the Veteran stated, "I am doing better." He denied "any hopeless or helpless feeling[s] and anger control problems" and "the presence of active psychosis (auditory and/or visual hallucination and delusion). He reported good sleep. He also denied suicidal or homicidal ideation. Mental status examination of the Veteran showed he was casually dressed, full orientation, good personal hygiene, no abnormal psychomotor activity, good eye contact, clear speech, and a goal-oriented and logical thought process. The Veteran's GAF score was 55, indicating moderate symptoms. The diagnoses included PTSD.

In August 2009, the Veteran's complaints included "a lot of stress and frustration from unemployment and financial hardship." He denied feeling angry, hopeless, or the presence of active psychosis, and reported fair sleep. Mental status examination of the Veteran, his GAF score, and the diagnoses were unchanged from October 2008.

In September 2009, the Veteran's complaints included increased irritability, easy anger, and more nightmares and vigilance. The Veteran reported that he was "just overwhelmed from financial hardship which makes him more depressed." He reported good sleep and denied any active psychosis or current suicidal or homicidal ideation. Mental status examination of the Veteran was unchanged. The Veteran's GAF score and diagnoses were unchanged from October 2008.

A November 2009 VA discharge summary included in the Veteran's VA outpatient treatment records indicates that he was hospitalized at a VA Medical Center for several days in October and November 2009 for mood stabilization and alcohol detoxification. The Veteran's complaints included intrusive thoughts, nightmares, flashbacks, feeling numb, isolation, irritability, hyperarousal, and "anger issues." He reported experiencing suicidal thoughts before being hospitalized. He was "requesting help to stop using alcohol." The Veteran tolerated the detoxification process well. The Veteran's GAF score at discharge was 50, indicating serious symptoms. The discharge diagnoses included substance-induced mood disorder.

On subsequent VA outpatient treatment later in November 2009, the Veteran's complaints included nightmares and vigilance. He denied feeling hopeless or helpless, active psychosis (auditory or visual hallucinations or delusions), or current suicidal or homicidal ideation. He reported fair sleep. Mental status examination of the Veteran showed he was clean, neatly groomed, appropriately and casually dressed, unremarkable psychomotor activity and speech, full orientation, unremarkable thought process and content, no delusions, hallucinations, inappropriate behavior, obsessive/ritualistic behavior, panic attacks, suicidal or homicidal thoughts, fair impulse control with no episodes of violence, an ability to maintain minimum personal hygiene, a normal memory, and no problems with activities of daily living. The Veteran's GAF score was 55. The diagnoses included PTSD.

On VA mental disorders examination in January 2010, the Veteran's complaints included mild depression and mild/moderate anxiety. He reported sleeping 3-5 hours a night and napping 1-2 times per week for 30 minutes. Although he had been married to his second wife for 25 years, he stated that they did not sleep

together "due to his violent nightmares. He has generally positive relationships with his two sons from his first marriage. He has a close relationship with his daughter from his current marriage. He has 3-4 close friends who live in Pennsylvania." Mental status examination of the Veteran showed he was clean, neatly groomed, appropriately and casually dressed, unremarkable psychomotor activity and speech, full orientation, unremarkable thought process and content, no delusions, hallucinations, obsessive/ritualistic behavior, panic attacks, homicidal or suicidal ideation, fair impulse control with no episodes of violence, normal memory, and no problems with activities of daily living. The Veteran's GAF score was 60. The VA examiner stated that the Veteran's mixed adjustment disorder with anxiety and depressed mood included "relatively mild hypervigilance and irritability." The Axis I diagnoses included mixed adjustment disorder with anxiety and depressed mood.

On VA outpatient treatment in August 2010, the Veteran's complaints included increased nightmares, hypervigilance, and irritability. Mental status examination of the Veteran showed he was well groomed, no psychomotor agitation or retardation, normal speech, a goal-directed thought process with no flight of ideas, no suicidal ideation, homicidal ideation, hallucinations, or delusions, and full orientation. The Axis I diagnoses included depression, not otherwise specified, by history, and PTSD by history. The Veteran was advised to restart medication for depression and to add prazosin for nightmares.

In December 2010, the Veteran's complaints included feeling sad. He reported improved sleep to 6 hours per night "with decreased nightmares." He also reported getting along better with others, feeling slightly less hypervigilant, and "decreased intrusive thoughts and flashbacks." He was "less intensely" sad. He denied any suicidal or homicidal ideation. Mental status examination of the Veteran and the Axis I diagnoses were unchanged.

In January 2011, the Veteran's complaints included hypervigilance, a startle response, and getting in to physical fights with others. He also complained of occasional nightmares and reported avoiding crowds. He also reported feeling less depressed. He denied any suicidal or homicidal ideation and there was no psychosis

present. The Veteran's GAF score was 50. Mental status examination of the Veteran and the Axis I diagnoses were unchanged.

In July 2011, the Veteran's complaints included "having 'more panic episodes' since being terminated from work" for minor reasons. He reported that his supervisors "are trying to make him quit." He also reported that his depression had increased since he was terminated from his prior job. He had an occasional passive death wish but denied any suicidal or homicidal ideation. There were no symptoms of psychosis. Mental status examination of the Veteran and the Axis I diagnoses were unchanged. The Veteran was advised to start taking venlafaxine XR 75 mg every morning for depression and PTSD and to continue his other medications.

The Veteran reported to a private emergency room (ER) in October 2012 with complaints of "dizziness [and] lots of thoughts going through my head." He denied any thoughts of suicide. A history of anxiety, PTSD, and panic attacks was noted. Mental status examination of the Veteran showed he was alert, oriented, cooperative, and anxious. The diagnosis was anxiety/panic attack.

On VA outpatient treatment in August 2013, the Veteran's complaints included nightmares, occasional intrusive memories, hypervigilance, a startle response, and occasionally avoiding crowds. He stated, "Things didn't work out in Florida…[M]y wife decided that she didn't want me around and I was almost ready to commit suicide, but then I thought about my family and I couldn't do it." He also stated that he had waved his gun in front of his wife "threatening to commit suicide. [The Veteran] states that he realized [that] he couldn't do it, gave his guns to his brother, and moved back to [Pennsylvania] to be near [his] son 2 months ago." He had been drinking heavily although he had cut back his drinking recently. He also reported feeling less depressed with no current suicidal or homicidal ideation. Mental status examination of the Veteran showed he was well groomed, good eye contact, no psychomotor agitation or retardation, normal speech, goal-directed thought process, no hallucinations or delusions, full orientation, and good insight/judgment. The Veteran's GAF score was 50. The Axis I diagnoses included depression, not otherwise specified, by history and PTSD by history.

In October 2013, no new complaints were noted. The Veteran reported travelling to Pennsylvania to help his friend and having "a good time with him." He was looking for another job for additional income and "feels down and depressed" due to unemployment but was not suicidal. The Veteran "seems to be able to maintain his normal[] daily function." He denied any homicidal ideation. He reported good sleep. Mental status examination of the Veteran showed he was casually dressed, good hygiene, full orientation, no abnormal psychomotor movement, good eye contact, clear speech, goal-oriented thoughts, no hallucinations or delusions, and fair impulse control. The Veteran's GAF score was 48, indicating serious symptoms. The Axis I diagnoses included PTSD.

In January 2014, no new complaints were noted. The Veteran stated that he was doing better and had less stress and depression. He denied any suicidal or homicidal ideation or active psychosis. Mental status examination of the Veteran, his GAF score, and the Axis I diagnoses were unchanged.

The Veteran contacted VA's Suicide Hotline on April 18, 2014, after having an argument with his wife "which triggered his PTSD; Veteran states he is feeling shaky and anxious." He reported putting a gun to his head the previous summer but not pulling the trigger because of his children and grandchildren. "Veteran states his reason for living is for his grandchildren. Veteran reports he does not have any access to guns and or weapons." The Veteran also reported difficulty sleeping and his sleep medications were not helping. A Suicide Prevention Case Manager (SPCM) later contacted the Veteran's wife that same day and she reported that the Veteran "has been acting strangely. Veteran has been angry and yelling off and on this week. Veteran took a ride with his daughter last night and [his] wife said [that] he told [his] daughter 'weird things' but wife did not know what these things were. Veteran said he would kill his daughter if she told his wife." When the Veteran's wife got home, she found the Veteran in his closet and he spoke to the SPCM. The SPCM stated, "Veteran said he was in the closet because he was scared of 'everything.' Veteran then began to make seemingly irrelevant comments about telling 'Trish' everything and that he has his pen and notes." The Veteran stated that he had been off of his medications for 1 week. The SPCM contacted local law enforcement and requested a wellness check on the Veteran. Law enforcement

subsequently contacted the SPCM and reported that, after conducting a wellness check on the Veteran, they determined that he was safe and did not need to be hospitalized involuntarily for his own safety. The SPCM requested a mental health evaluation for the Veteran as soon as possible.

On VA outpatient treatment on April 21, 2014, the Veteran reported a recent psychiatric hospitalization for anxiety. He also reported recent flashbacks after his niece was involved in a car accident. The VA clinician stated that the Veteran "seems to be much calmer today" with no suicidal or homicidal ideation and "shows good and strong family attachment." Mental status examination of the Veteran showed he was casually dressed, good hygiene, full orientation, no abnormal psychomotor movement, good eye contact, clear speech, goal-oriented thought process, no hallucinations or delusions, and fair impulse control. The Veteran's GAF score was 48. The Axis I diagnoses included PTSD. The Veteran was advised to restart Abilify 5 mg "and increase to 10 mg daily for PTSD and anger issues." He also was advised to restart outpatient therapy.

On April 30, 2014, the Veteran reported a recent psychiatric hospitalization for aggressive behavior. "[H]is wife called police and reported that he threatened to hurt/kill her, he denies his intention, but admits he said, 'I could kill you' because she was pushing me constantly." The Veteran's medication was adjusted while he was hospitalized and he had no current suicidal or homicidal ideation. He reported fair sleep and denied the presence of active psychosis. He was living with his spouse. Mental status examination of the Veteran, his GAF score, and the Axis I diagnoses were unchanged.

In July 2014, the Veteran reported no new complaints and "thinks his current [medications] are helping with his PTSD symptoms but he feels very tired all the time." The Veteran denied any suicidal or homicidal ideation. "[H]is relationship with his wife is getting slightly better than before." A depression screen was negative. A PTSD screen was positive. The Veteran's GAF score and his Axis I diagnoses were unchanged.

In October 2014, the Veteran reported "that he is the most stable today than he has been in years. [He] is enjoying his family and recently travelled with his spouse up north to see his [grandchildren]. [The] Veteran has cut back greatly on alcohol intake and he and [his] spouse enjoy being tog[e]ther." Mental status examination of the Veteran showed he was casually dressed, good hygiene, full orientation, no abnormal psychomotor movement, good eye contact, clear speech, goal-oriented thought process, no hallucinations or delusions, and fair impulse control. The assessment was anxiety.

In December 2014, the Veteran stated, "I am doing so much better. I have my family back around me for [the] first time in years. I am coping better with my PTSD symptoms." He reported fair sleep and denied any signs of active psychosis or current suicidal or homicidal ideation. Mental status examination of the Veteran and the assessment were unchanged.

In March 2015, the Veteran reported no new complaints although it was noted that he "continues to struggle with chronic PTSD symptoms [and] he thinks he is doing OK with [his] current medication." He reported fair sleep and no feeling of hopelessness or being overwhelmed. He also denied any signs of active psychosis or current suicidal or homicidal ideation. Mental status examination of the Veteran was unchanged. The Veteran's GAF score was 48. The Axis I diagnoses included PTSD.

The Veteran was admitted briefly to an inpatient psychiatric unit at a VA Medical Center in May 2015 for complaints of homicidal ideation towards his daughter's ex-boyfriend. The Veteran stated that he had been doing very well since his last hospitalization in 2009. The attending VA psychiatrist reviewed a psychiatric consult which noted:

> [The Veteran] reports that he has been having intermittent [homicidal ideation] towards his daughter's ex-boyfriend since Friday. He reports he has a plan to sneak up on him and hit him on the head with a blunt object until he is dead. He states that he found out on Friday that the ex-boyfriend was physically abusive towards his daughter.

> He expresses that the ex-boyfriend has been harassing his daughter and he needs to be stopped. Furthermore, the police got involved with the situation as the ex-boyfriend tried to break into the [Veteran's] home where [his] daughter is currently staying. The [Veteran] reports that he has a bad temper, and he has a 'short fuse.' He expresses that he 'loses it' over minor things at times.

The Veteran stated that the stress related to the problems with his daughter's ex-boyfriend had exacerbated his PTSD symptoms, including recurrent intrusive thoughts, nightmares, flashbacks, irritability, and hypervigilance. The Veteran was seeing an outpatient therapist regularly. He denied any history of suicide attempts or suicidal ideation. He had a strong social support system and no access to firearms. Mental status examination of the Veteran showed he was in hospital pajamas, good eye contact, appropriate grooming, full orientation, slight psychomotor agitation, normal speech, no suicidal or homicidal ideation, no ideas of reference, no delusions or hallucinations, a goal-oriented thought process, fair insight, impulsive, and fair judgment and reliability. The assessment included PTSD, intermittent explosive disorder, and a history of generalized anxiety disorder. The Veteran stated that he did not want to change his medications. He was discharged home 3 days later.

A post-hospitalization follow up telephone call 7 days after his discharge in May 2015 indicates that the Veteran reported that he was doing very well and had no hostility. Mental status examination of the Veteran showed a linear, rational, and goal-directed thought process, clear speech, reported sleeping problems, and no suicidal ideation, homicidal ideation, or hallucinations.

On VA outpatient treatment in June 2015, the Veteran stated, "I am ok now." His hospitalization for homicidal ideation was noted although the Veteran denied taking any action against his daughter's ex-boyfriend. It was noted that no medication changes were made during this hospitalization and the Veteran was discharged after 3 days. The Veteran had no current anger. He reported getting good sleep. He denied any active psychosis (hallucinations or delusions) or suicidal or homicidal ideation. He was living with his spouse. Mental status examination of the Veteran

showed he was casually dressed, full orientation, no abnormal psychomotor movement, good eye contact, clear speech, goal-oriented thought process, and good impulse control, judgment, and insight. The Veteran's GAF score was 48. The Axis I diagnoses included PTSD. The Veteran was advised to continue taking his current medications although his Ambien was lowered to 5 mg for insomnia because of its sedating effects.

On private psychiatric evaluation in April 2016, the Veteran's complaints included PTSD, anxiety, anger, nightmares, memory problems, feeling like "giving up, and suicidal ideas." The Veteran reported experiencing auditory hallucinations "as manifest[ed] by 'someone is trying to talk to me.'" Mental status examination of the Veteran showed posture and bearing within normal limits, "no signs of undue restlessness or inattention," psychomotor activity within normal limits, productive and spontaneous speech, "evidence for depression, anxiety, and hopelessness, as well as for suicidal ideation but without an active plan or intent," reported auditory hallucinations, no delusions or obsessions, no flight of ideas, goal-directed thoughts, impulse control and judgment within normal limits, and full orientation. The Veteran's GAF score was 40, indicating some impairment in reality testing or communication or major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood. The Axis I diagnosis was PTSD with psychotic features. The private psychiatrist concluded that the Veteran "has significantly impaired social functioning."

The Board acknowledges that the Veteran's psychiatric disability has been variously diagnosed, to include an adjustment disorder, anxiety and PTSD, by VA and private clinicians during the pendency of this appeal. Nevertheless, the Board finds that the psychiatric symptoms manifested by the Veteran during the course of this appeal, which were attributed to various Axis I psychiatric diagnoses are attributable to the diagnosis of an acquired psychiatric disability, to include adjustment disorder with anxiety (also claimed as PTSD), for rating purposes. *See Mittleider v. West*, 11 Vet. App. 181, 182 (1998) (finding the benefit of the doubt applies to determinations of whether a symptom should be attributed to a service-connected condition).

The Veteran contends that his service-connected acquired psychiatric disability, to include adjustment disorder with anxiety (also claimed as PTSD), is more disabling than currently evaluated. The record evidence does not support his assertions. It shows instead that this disability is manifested by, at worst, complaints of depression, irritability, hypervigilance, anxiety, and difficulty sleeping. It also suggests that the Veteran's continued drinking of alcohol to excess exacerbated his psychiatric symptomatology, despite being advised repeatedly to cut back or discontinue drinking alcohol by multiple VA clinicians.

The Board acknowledges that the Veteran was hospitalized briefly on 2 separate occasions in 2009 and in 2015 during the pendency of this appeal for symptoms which he attributes to his service-connected acquired psychiatric disability. The record evidence shows that the Veteran's 2009 hospitalization was for mood stabilization and alcohol detoxification. Immediately following this hospitalization, the Veteran denied feeling hopeless or helpless, active psychosis (auditory or visual hallucinations or delusions), or current suicidal or homicidal ideation on subsequent outpatient treatment. He also reported fair sleep. Mental status examination of the Veteran showed he was clean, neatly groomed, appropriately and casually dressed, unremarkable psychomotor activity and speech, full orientation, unremarkable thought process and content, no delusions, hallucinations, inappropriate behavior, obsessive/ritualistic behavior, panic attacks, suicidal or homicidal thoughts, fair impulse control with no episodes of violence, an ability to maintain minimum personal hygiene, a normal memory, and no problems with activities of daily living. The Veteran's GAF score was 55, indicating only moderate symptoms. Although the Veteran subsequently was hospitalized in 2015 for homicidal ideation towards his daughter's abusive ex-boyfriend, he was seeing an outpatient therapist regularly. He also denied any history of suicide attempts or suicidal ideation at his 2015 hospitalization and had a strong social support system and no access to firearms. Mental status examination of the Veteran showed good eye contact, appropriate grooming, full orientation, slight psychomotor agitation, normal speech, no suicidal or homicidal ideation, no ideas of reference, no delusions or hallucinations, a goal-oriented thought process, fair insight, impulsive, and fair judgment and reliability. The Veteran also stated that he did not want to change his medications. A VA clinician subsequently noted that no medication changes had been made during this

hospitalization and the Veteran himself denied taking any action against his daughter's abusive ex-boyfriend when questioned by his VA treating clinician at a subsequent outpatient treatment visit. Critically, a post-hospitalization follow up telephone call 7 days after his discharge in May 2015 indicates that the Veteran reported that he was doing very well and had no hostility. Mental status examination of the Veteran showed a linear, rational, and goal-directed thought process, clear speech, reported sleeping problems, and no suicidal ideation, homicidal ideation, or hallucinations. Having reviewed the record evidence of the Veteran's brief hospitalizations in 2009 and in 2015, and while this evidence indicates that the Veteran's judgment was impaired in the moment, the outpatient therapy and mental status evaluations also show that the Veteran had insight into his issues, which did not indicate deficiencies in the areas of judgment and thinking that would rise to a level higher than the 30 percent already assigned.

The remaining record evidence shows that, although the Veteran continues to complain of problems related to his acquired psychiatric disability, including hypervigilance, irritability, and occasional difficulty sleeping, these symptoms are treated adequately by his current medication regimen and do not support the assignment of an increased rating for this disability. For example, although the Veteran was seen regularly on an outpatient basis by his therapist, his GAF scores generally showed moderate to serious symptoms attributable to his service-connected acquired psychiatric disability. The Board acknowledges here that he Veteran contacted VA's Suicide Hotline in April 2014 after reportedly threatening to commit suicide. Further investigation of his reported suicidal threat by local law enforcement indicated that the Veteran was considered safe (and not a risk to himself) and he was not hospitalized. The Veteran's psychiatric medications subsequently were increased on VA outpatient treatment several days later when it was noted that he "seems to be much calmer today" with no suicidal or homicidal ideation and "shows good and strong family attachment." Mental status examination of the Veteran showed he was casually dressed, good hygiene, full orientation, no abnormal psychomotor movement, good eye contact, clear speech, goal-oriented thought process, no hallucinations or delusions, and fair impulse control. The Veteran himself subsequently reported in June 2014 that his relationship with his wife was improving. He also reported in October 2014 that he

was the most stable that he had been "in years" and was surrounded by his family. He also stated that he "has cut back greatly on alcohol intake and he and [his] spouse enjoy being tog[e]ther." This report from the Veteran again persuasively suggests that his excessive drinking exacerbated his psychiatric symptomatology and his symptoms improved when he voluntarily reduced his drinking. Finally, in December 2014, the Veteran stated, "I am doing so much better. I have my family back around me for [the] first time in years. I am coping better with my PTSD symptoms." In the same way, the reports from the Veteran indicates that he sees himself getting better, and as being more socially active. Moreover, when the Veteran reported his thoughts of suicide or homicide, the VA outpatient treatment and examination reports showed, again, that he had insight into his behavior at the time, and was able to understand the inappropriateness of his thoughts and behavior, strongly suggesting that the Veteran had no intention to cause harm to himself or others.

The Board acknowledges here that, on private outpatient psychiatric evaluation in April 2016, the Veteran complained of suicidal ideation, and although suicidal ideation is one of the factors for a 70 percent rating for PTSD under the General Rating Formula, the remainder of the Veteran's evaluation in April 2016 suggests that an increased rating for his service-connected acquired psychiatric disability is not warranted. *See* 38 C.F.R. § 4.130, DC 9440. For example, mental status examination of the Veteran in April 2016 showed posture and bearing within normal limits, "no signs of undue restlessness or inattention," psychomotor activity within normal limits, productive and spontaneous speech, no delusions or obsessions, no flight of ideas, goal-directed thoughts, impulse control and judgment within normal limits, and full orientation. Although the private clinician who saw the Veteran in April 2016 indicated that the Veteran "has significantly impaired social functioning," the basis for this conclusion is not clear from a review of this evidence. This clinician did not discuss whether the Veteran continued to live with his wife or his relationships with his children, although contemporaneous VA outpatient treatment records showed that his relationship with his wife had improved and he had good relationships with his children from his current and former marriages. In other words, this April 2016 private psychiatric evaluation does not suggest that the overall disability picture presented by the Veteran's

service-connected acquired psychiatric disability more nearly approximates the rating criteria for a rating higher than 30 percent. *See also* 38 C.F.R. § 4.7.

The Court has held that the Board is free to assess medical evidence and is not compelled to accept a physician's opinion. *Wilson v. Derwinski*, 2 Vet. App. 614 (1992). A medical opinion based upon an inaccurate factual premise is not probative. *Reonal v. Brown*, 5 Vet. App. 458, 461 (1993). A bare conclusion, even one reached by a medical professional, is not probative without a factual predicate in the record. *Miller v. West*, 11 Vet. App. 345, 348 (1998). A bare transcription of lay history, unenhanced by additional comment by the transcriber, does not become competent medical evidence merely because the transcriber is a medical professional. *LeShore v. Brown*, 8 Vet. App. 406, 409 (1995). The Court also has held that the value of a physician's statement is dependent, in part, upon the extent to which it reflects "clinical data or other rationale to support his opinion." *Bloom v. West*, 12 Vet. App. 185, 187 (1999). Thus, a medical opinion is inadequate when it is unsupported by clinical evidence. *Black v. Brown*, 5 Vet. App. 177, 180 (1995). The April 2016 private psychiatric evaluation does not appear be supported by "clinical data or other rationale." Accordingly, the Board finds that the April 2016 private psychiatric evaluation is less than probative on the issue of whether the Veteran is entitled to an increased rating for his service-connected acquired psychiatric disability. The Veteran also has not identified or submitted any evidence demonstrating his entitlement to a disability rating greater than 30 percent for his service-connected acquired psychiatric disability, to include an adjustment disorder with anxiety (also claimed as PTSD). In summary, the Board finds that a disability rating greater than 30 percent for an acquired psychiatric disability is not warranted.

Extraschedular

The Board must consider whether the Veteran is entitled to consideration for referral for the assignment of an extraschedular rating for his service-connected acquired psychiatric disability. 38 C.F.R. § 3.321; *Barringer v. Peake*, 22 Vet. App. 242, 243-44 (2008) (noting that the issue of an extraschedular rating is a component

of a claim for an increased rating and referral for consideration must be addressed either when raised by the Veteran or reasonably raised by the record).

An extraschedular evaluation is for consideration where a service-connected disability presents an exceptional or unusual disability picture with marked interference with employment or frequent periods of hospitalization that render impractical the application of the regular schedular standards. *Floyd v. Brown*, 9 Vet. App. 88, 94 (1996). An exceptional or unusual disability picture occurs where the diagnostic criteria do not reasonably describe or contemplate the severity and symptomatology of the Veteran's service-connected disability. *Thun v. Peake*, 22 Vet. App. 111, 115 (2008).

If there is an exceptional or unusual disability picture, then the Board must consider whether the disability picture exhibits other factors such as marked interference with employment and frequent periods of hospitalization. *Id*. at 115-116. When those two elements are met, the appeal must be referred for consideration of the assignment of an extraschedular rating. Otherwise, the schedular evaluation is adequate, and referral is not required. 38 C.F.R. § 3.321(b)(1); *Thun*, 22 Vet. App. at 116.

The Board finds that the schedular evaluation assigned for the Veteran's service-connected acquired psychiatric disability, as well as for his service-connected diabetes mellitus and tinnitus, is not inadequate in this case. Additionally, the diagnostic criteria adequately describe the severity and symptomatology of the Veteran's service-connected disabilities, to include his acquired psychiatric disability. The Veteran has not presented evidence that his service-connected psychiatric disability, or the combined effect of his service-connected disabilities, has resulted in unique disability that is not already addressed by the rating criteria. This is especially true because the 30 percent rating currently assigned for the Veteran's psychiatric disability, as well as the 20 percent rating for diabetes mellitus and the 10 percent rating for tinnitus, recognizes that the Veteran industrial capabilities are impaired from loss of working time from exacerbations proportionate to that level of disability. 38 C.F.R. § 4.1. And, although the Veteran was hospitalized briefly on 2 occasions in 2009 and in 2015 (as discussed above),

he has not been hospitalized frequently during the appeal period for treatment of his service-connected acquired psychiatric disability, or for any other service-connection condition. As his symptomatology is contemplated by the regular rating standards, 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. *See Bagwell v. Brown*, 9 Vet. App. 337 (1996); *Shipwash v. Brown*, 8 Vet. App. 218, 227 (1995).

ORDER

Entitlement to a disability rating greater than 30 percent for an acquired psychiatric disability, to include an adjustment disorder with anxiety (also claimed as PTSD), is denied

REMAND

The Board notes that, in *Rice v. Shinseki*, the Court held that a TDIU claim cannot be considered separate and apart from an increased rating claim. *See Rice v. Shinseki*, 22 Vet. App. 447 (2009). Instead, the Court held that a TDIU claim is an attempt to obtain an appropriate rating for a service-connected disability. The Court also found in *Rice* that, when entitlement to a TDIU is raised during the adjudicatory process of the underlying disability, it is part of the claim for benefits for the underlying disability.

The record in this case also indicates that the Veteran has asserted that he is not employable solely by reason of his service-connected acquired psychiatric disability, to include an adjustment disorder with anxiety (also claimed as PTSD), diabetes mellitus, and tinnitus. The Veteran has submitted a completed VA Form 21-8940 and information from at least one of his former employers has been obtained by the AOJ.

Given the Veteran's argument concerning the impact of his service-connected diabetes mellitus and tinnitus on his unemployability, and because his increased

rating claims for diabetes mellitus and tinnitus are the subjects of a prior May 2015 Board Remand, which has been incorporated by reference herein, the Board finds that his TDIU claim is inextricably intertwined with these claims. *See Harris v. Derwinski*, 1 Vet. App. 180, 183 (1991) (holding that two issues are inextricably intertwined when they are so closely tied together that a final Board decision on one issue cannot be rendered until the other issue has been considered). Thus, adjudication of the issue of TDIU must be deferred.

Accordingly, the case is REMANDED for the following actions:

1. Per the instructions contained in the May 2015 Board Remand, furnish a Statement of the Case to the Veteran and his representative on the issues of entitlement to a disability rating greater than 20 percent for diabetes mellitus, entitlement to a disability rating greater than 10 percent for tinnitus, entitlement to special monthly compensation based on loss of use of a creative organ, entitlement to service connection for ischemic heart disease, and entitlement to erectile dysfunction. A copy of the statement of the case should be associated with the claims file. Any or all of the issues listed above should be returned to Board for appellate consideration, if the Veteran perfects a timely appeal and specifically identifies the issue or issues in which he intends to pursue on appeal.

2. Review the Veteran's claims file to ensure that all development requested in this REMAND has been completed. If not, then take necessary corrective action.

3. Review all evidence received since the last prior adjudication and readjudicate the issue of TDIU, to include consideration of 38 C.F.R. § 4.16(a)-(b). If the determination remains adverse to the Veteran, then the

> AOJ should issue a Supplemental Statement of the Case that contains notice of all relevant actions taken, including a summary of the evidence and applicable law and regulations considered pertinent to this issue. An appropriate period of time should be allowed for response by the Veteran and his representative. Thereafter, the case should be returned to the Board for further appellate consideration, if in order.

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 of Veterans' Appeals or by the United States Court of Appeals for Veterans Claims for additional development or other appropriate action must be handled in an expeditious manner. *See* 38 U.S.C.A. §§ 5109B, 7112 (West 2014).

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DEBORAH W. SINGLETON
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).