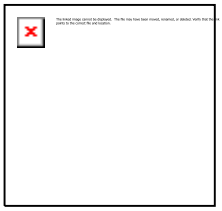

BOARD OF VETERANS' APPEALS
DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON, DC 20420

IN THE APPEAL OF
DAVID M. ALVEREZ [redacted]

DOCKET NO. 13-10 546) DATE *22 FEB 2017*
) *MDP*
)

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

THE ISSUES

1. Entitlement to an initial rating in excess of 30 percent for major depression with posttraumatic stress disorder (PTSD).

2. Entitlement to an initial rating in excess of 30 percent for vertigo.

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

REPRESENTATION

Veteran represented by: Matthew D. Hill, Attorney

ATTORNEY FOR THE BOARD

T. Hal Smith, Counsel

IN THE APPEAL OF [redacted]
DAVID M. ALVEREZ

INTRODUCTION

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

The Veteran served on active duty from May 1987 to August 1990 and May 2006 to October 2010. Pertinent evidence of record is to the effect that the Veteran had additional unverified service in the United States Coast Guard.

These matters are before the Board of Veterans' Appeals (Board) on appeal from January and May 2011 rating decisions of the St. Petersburg, Florida, Regional Office (RO) of the Department of Veterans Affairs (VA). They were remanded by the Board in October 2015 for additional evidentiary development and have now been returned to the Board for further appellate consideration.

The Board also notes that following the issuance of the June 2016 supplemental statement of the case (SSOC) the Veteran submitted additional private treatment records and mental health evaluation report with waiver. The Board concludes that there is no prejudice in proceeding with consideration of this case without affording the RO an opportunity to review the evidence in question as a waiver was provided. *See* 38 C.F.R. § 19.31 (2016).

FINDINGS OF FACT

1. Prior to February 18, 2013, the Veteran's major depression with PTSD was characterized by occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks.

2. From February 18, 2013, the Veteran's major depression with PTSD is characterized by symptoms productive of occupational and social impairment with reduced reliability and productivity.

3. The 30 percent rating in effect for vertigo is the highest schedule rating allowable under the most relevant diagnostic codes (DCs), and no other DC is applicable to his symptoms, to include DC 6205 for Meniere's syndrome.

4. The service-connected disabilities, standing alone, are shown to be of such severity as to effectively preclude all forms of substantially gainful employment.

CONCLUSIONS OF LAW

1. The criteria for an initial disability rating in excess of 30 percent for major depression with PTSD prior to February 18, 2013, are not met. 38 U.S.C.A. §§ 1155, 5107 (West 2014); 38 C.F.R. §§ 3.102, 4.3, 4.130, DC 9411 (2016).

2. The criteria for an initial disability rating of 50 percent for major depression with PTSD are met from February 18, 2013. 38 U.S.C.A. §§ 1155, 5107 (West 2014); 38 C.F.R. §§ 3.102, 4.3, 4.130, DC 9411 (2016).

3. The criteria for an initial disability rating in excess of 30 percent for vertigo have not been met. 38 U.S.C.A. §§ 1155, 5107 (West 2014); 38 C.F.R. §§ 3.102, 4.3, 4.87, DC 6204 (2016).

4. The criteria for a TDIU have been met. 38 U.S.C.A. §§ 1155, 5107 (West 2014); 38 C.F.R. §§ 3.102, 3.340, 4.16 (2016).

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

Duties to Notify and Assist

VA's duty to notify was satisfied by August 2010 and January 2012 letters. *See* 38 U.S.C.A. §§ 5102, 5103, 5013A (West 2014); 38 C.F.R. § 3.159 (2016); *see also Scott v. McDonald*, 789 F.3d 1375 (Fed. Cir. 2015). Moreover, in claims for an increase, the VCAA requirement is generic notice, that is, the type of evidence

needed to substantiate the claims, namely evidence demonstrating a worsening or increase in severity of the disability and the effect that worsening has on employment, as well as general notice regarding how disability ratings and effective dates are assigned. *Vazquez-Flores v. Shinseki*, 580 F.3d 1270 (Fed Cir. 2009).

As for the duty to assist, obtained all available service treatment records (STRs), service personnel records (SPRs), and all pertinent treatment records. These matters were remanded by the Board for further development in October 2015, to include updating the medical evidence on file and obtaining pertinent VA examinations and medical opinion pertaining to the claims. This development was completed. Moreover, neither the Veteran nor his representative has objected to the adequacy of any of the examinations conducted during this appeal. *See Sickels v. Shinseki*, 643 F.3d, 1362, 1365-66 (Fed. Cir. 2011) (holding that although the Board is required to consider issues independently raised by the evidence of record, the Board is still "entitled to assume" the competency of a VA examiner and the adequacy of a VA opinion without "demonstrating why the medical examiners' reports were competent and sufficiently informed"). As such, the Board finds that the October 2015 remand directives were substantially complied with. *See Stegall v. West*, 11 Vet. App. 268, 271 (1998).

In view of the grant of a TDIU herein, any deficiency in the duties to notice or assist are not prejudicial to the Veteran and will not be discussed further.

Increased Ratings – In General

VA has adopted a Schedule for Rating Disabilities (Schedule) to evaluate service-connected disabilities. *See* 38 U.S.C.A. § 1155 (West 2014); 38 C.F.R., Part IV (2016). Disability evaluations assess the ability of the body as a whole, the psyche, or a body system or organ to function under the ordinary conditions of daily life, to include employment. 38 C.F.R. § 4.10 (2016). The percentage ratings in the Schedule represent the average impairment in earning capacity resulting from service-connected diseases and injuries and their residual conditions in civilian occupations. 38 U.S.C.A. § 1155 (West 2014); 38 C.F.R. § 4.1 (2016). The percentage ratings are generally adequate to compensate for considerable loss of

working time from exacerbation or illness proportionate to the severity of the disability. *Id*.

The Schedule assigns DCs to individual disabilities. DCs provide rating criteria specific to a particular disability. If two DCs are applicable to the same disability, the DC that allows for the higher disability rating applies. 38 C.F.R. § 4.7 (2016). Any reasonable doubt regarding the degree of disability is resolved in favor of the claimant. 38 C.F.R. § 4.3 (2016). The Schedule recognizes that a single disability may result from more than one distinct injury or disease; however, rating the same disability or its manifestation(s) under different DCs - a practice known as pyramiding - is prohibited. *Id*.; *see* 38 C.F.R. § 4.14 (2016).

In initial disability rating cases, VA must assess the level of disability from the date of initial application for service connection and determine whether the level of disability warrants the assignment of different disability ratings at different times over the course of the claim, a practice known as "staged ratings." *See Fenderson v. West*, 12 Vet. App. 119, 126 (1999); *see also Hart v. Mansfield*, 21 Vet. App. 505, 509-10 (2007) (holding that staged ratings may be warranted in increased rating claims).

Major Depression with PTSD

As an initial matter, service connection for major depression with PTSD was granted upon rating decision in January 2011. A 30 percent disability rating was assigned, effective October 16, 2010, the day following discharge. The Veteran submitted a timely notice of disagreement (NOD) as to that decision (and others), and this appeal ensued.

Under the general rating formula for the evaluation of mental disorders, 38 C.F.R. § 4.130, Code 9411, PTSD will be rated as follows:

A 30 percent rating is assigned when a veteran's PTSD causes occupational and social impairment with occasional decrease in work efficiency and intermittent periods of 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, or mild memory loss (such as forgetting names, directions, recent events). 38 C.F.R. § 4.130, Diagnostic Code 9411.

A 50 percent rating is assigned when a veteran's PTSD causes 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-term 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; or difficulty in establishing and maintaining effective work and social relationships. *Id.*

A 70 percent evaluation is assigned when a veteran's PTSD causes 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 worklike setting); or an inability to establish and maintain effective relationships.

A 100 percent rating is assigned when a veteran's PTSD causes total occupational and social impairment, due to such symptoms as: gross impairment in thought processes or communication; persistent delusions or hallucinations; grossly inappropriate behavior; danger of hurting self or others; intermittent inability to perform activities of living (including maintenance of minimal hygiene); disorientation to time or place; or, memory loss for names of close relatives, occupation, or own name. *Id.*

The symptoms associated with each rating in 38 C.F.R. § 4.130 (2016) are not intended to constitute an exhaustive list; rather, they serve as examples of the type and degree of the symptoms, or their effects, that would justify a particular rating. *See Mauerhan v. Principi*, 16 Vet. App. 436, 442 (2002). Thus, the evidence considered in determining the level of impairment under 38 C.F.R. § 4.130 (2016) is not restricted to the symptoms provided in the DC. *See id*. VA must consider all symptoms of a claimant's disorder that affect his or her occupational and social impairment. *See Mauerhan* at 443. If the evidence demonstrates that a claimant suffers symptoms or effects that cause occupational or social impairment equivalent to what would be caused by the symptoms listed in the DC, the appropriate, equivalent rating will be assigned. *Id*. In this regard, VA shall consider the frequency, severity, and duration of psychiatric symptoms, the length of remissions, and the claimant's capacity for adjustment during periods of remission. 38 C.F.R. § 4.126 (2016). Although VA considers the level of social impairment, it does not assign an evaluation based solely on social impairment. *Id*.

The Veteran's records include evaluations based on the *American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders (4th ed. 1994) (DSM-IV),* which includes Global Assessment Functioning (GAF) scores. These are based on a scale set forth in the *DSM-IV* reflecting the "psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness." *See Carpenter v. Brown*, 8 Vet. App. 240, 242 (1995); *see also Richard v. Brown*, 9 Vet. App. 266, 267 (1996); *DSM-IV*. According to *DSM-IV*, a score of 61-70 indicates "[s]ome mild symptoms (e.g., depressed mood and mild insomnia OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships." A score of 51-60 indicates "[m]oderate 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)." *Id*. A score of 41-50 indicates "[s]erious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job)." *Id*. A score of 31-40 indicates "[s]ome impairment in reality testing or communication (e.g., speech is at times

illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work)." *Id*. The Court has found that certain scores may demonstrate a specific level of impairment. *See Richard*, 8 Vet. App. At 267 and *Bowling v. Principi*, 15 Vet. App. 1, 14-15 (2001) (observing that a GAF score of 50 indicates serious impairment).

Although an examiner's classification of the level of psychiatric impairment reflected in the assigned GAF score is probative evidence of the degree of disability, such a score is not determinative of the rating assigned by VA in evaluating a psychiatric disorder under the rating criteria. *See* 38 C.F.R. §§ 4.2, 4.126 (2014); VAOPGCPREC 10-95 (March 31, 1995). Rather, VA must take into account all of the claimant's symptoms and resulting functional impairment as shown by the evidence of record in assigning the appropriate rating, and will not rely solely on the examiner's assessment of the level of disability at the moment of examination. *See* 38 C.F.R. § 4.126 (2016).

The STRs show that the Veteran was treated during service for psychiatric complaints. Major depression was diagnosed. During service, he sustained a severe infection of the left leg which involved multiple surgeries including antibiotics which resulted in balance problems thought to be due to ototoxicity from medications. He underwent mental health examination for VA in September 2010 shortly prior to his discharge. The Veteran reported sleep problems with a history of nightmares. He typically awoke every two hours with anxiety and pain. He had experienced problems with depression and anxiety ever since undergoing surgery in 2006. He indicated that hypervigilance had irritated his wife and negatively impacted his marriage. He was on medication for his psychiatric symptoms, and felt that it adequately controlled his anger and irritability. On examination, his mood and affect appeared to be congruent and appropriate to the current situation. His abstract reasoning, concentration, and long and short term memory were all within normal limits. There was no indication of any thought disorder or paranoia, but the Veteran did report that when he became extremely stressed or depressed, he could hear vague auditory hallucinations, such as hearing his name shouted. The Veteran admitted to suicidal ideation and as a result had removed the guns from his

home. He denied any risk for acting upon these thoughts and feelings at present. The diagnoses were major depression and PTSD. The GAF score was 54.

The Veteran was discharged from service due to major depressive disorder (MDD) and various musculoskeletal diagnoses.

Subsequently dated records include a May 2011 private report by a clinical psychologist. At that time, the Veteran indicated that his mood was depressed. He denied experiencing hallucinations or delusions, but reported a low energy level and had complaints associated with his associated vertigo (e.g., headaches, dizziness, and loss of balance). He was on medication for his psychiatric symptoms, but he did not use alcohol or drugs for self-medication. Socially, he had friends and denied difficulty getting along with them or with supervisors when he was employed. On evaluation, the Veteran was alert and oriented times three. He denied any history of hallucinations or delusions. His mood was mildly depressed with an appropriate affective quality. His concentration capacity appeared adequate, and he had a basic grasp of concepts. His foresight appeared intact, and he had a basic grasp of anticipating the consequences of his own and other people's behaviors. His long-term memory appeared adequate, and his vocabulary, word usage, and ability to conceptualize suggested a man of above average intellectual functioning. The diagnoses were MDD and PTSD. The Veteran's GAF score was 70. In the past year, his score was also 70. As for functional assessment, the private clinical psychologist opined that the ramifications of the Veteran's mild depression mildly impaired his ability to perform not only complex and detailed tasks, but simple and repetitive ones as well. He also suspected that the Veteran's mild depression might mildly impair his ability to maintain regular attendance and perform work activities on a consistent basis. His history and interview behavior did not suggest impairment with respect to his ability to interact with coworkers or the general public. He did demonstrate some mild concentration lapses and described possible moderate impairment regarding his ability to perform activities of daily living and some difficulty in doing chores. He had been working as a design and production manager and had been working full-time for the past two weeks and was doing reasonably well.

A VA record from December 2011 reflects that the Veteran was apparently no longer employed as he related that while he had worked in emergency management during service; and he speculated that he might go back to school as he did not think he could work in that field anymore. His GAF score was 60.

Upon VA mental health examination in May 2012, it was noted that his psychiatric diagnosis was of MDD. It was also noted that the Veteran was unemployed at that time. When asked to summarize the level of the Veteran's occupational and social impairment, the examiner checked the following report entry option: "Occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or; symptoms controlled by medication." It was noted that he was getting a second divorce and that he had been accused of domestic violence. He now had a girlfriend. He also had several close friends. He had attended college the previous semester and took three classes. He had not received his grades yet. He had not worked since 2011. He had sought a reduced schedule to accommodate his MDD symptoms. When his symptoms increased, he quit. He had looked for subsequent work without success. The examiner noted that the Veteran experienced depressed mood and mild memory loss. The Veteran reported that he enjoyed cooking with his girlfriend and was attending a seafood festival. He noted that his energy fluctuated and he was distracted at times. He denied any suicidal ideation or homicidal ideation. He was alert and oriented and had no evidence of remote memory impairment. His GAF score was 65.

VA records in June 2012 show that the Veteran was referred for neuropsychological evaluation to examine complaints of distractibility and memory difficulty. These problems had started after suffering necrotizing fasciitis in 2009. He reported difficulty with spatial orientation and difficulty with performing simply and complex math problems. He was occasionally distractible and had mild difficulty remembering to complete projects but multitasking was generally intact. He reported no problems with reasoning, judgment, or problem solving abilities. He also reported no difficulty recalling conversations and appointments. He reported some problems with anger and frustration tolerance, noting that he had had more problems dealing with stress and managing his reaction to stress over the past three

years. He tried to avoid stress provoking situations and conversational topics. He was independent with all activities of daily living but occasionally missed taking his medications due to memory lapse. He had been treated for depression and anxiety in the past and continued to be seen for such. He also experienced sleep difficulty due to racing thoughts, chronic lethargy, and motivation difficulties.

Additional VA records dated in July 2012 reflect that his sleep problems continued unless he took his medication (trazodone). His depression continued as did his irritability. He hoped to obtain a job. The examiner noted that the Veteran seemed a bit calmer and less stressed or intense than he had on some past visits. The diagnoses were recurrent, moderate MDD and PTSD. His GAF score was 70.

In February 2013, Dr. Guilford met with the Veteran and wrote that while he had numerous health problems, the main one was his vertigo. At the evaluation, the Veteran was appropriately dressed, had proper hygiene, and was cooperative. The Veteran reported being depressed all of the time, and described experiencing auditory hallucinations when he was under extreme stress. He was in contact with some friends, but stated that he was mostly concerned with his children's well-being at that point. As for daily functioning, the Veteran reported that such varied day to day. Some days, he did not do much other than chores around the house. He sometimes helped his sons (ran errands such as picking up materials and helped obtain bids for their construction business). If he did too much, he experienced back problems, and he said that his vertigo was quite impairing. His anxiety increased when he did not feel well. He also had memory problems. On examination, he was depressed and had sleep problems. He sometimes had an anxiety attack. He was alert and fully oriented. His insight and judgment were within normal limits. Thought content was normal and the Veteran was fully alert and oriented. He was not suicidal, but sometimes had thoughts of such. His prognosis was extremely guarded.

When examined at a private facility in May 2013, Dr. Taitt opined that the Veteran's psychological symptoms had worsened during service after he suffered a life threatening illness (necrotizing fasciitis). He felt that his mental health problems had increased particularly the last two months. His symptoms included

anxiety, irritability, mood swings, easy startle, autonomic hyperactivity, insomnia, poor concentration, and forgetfulness. The Veteran reported trouble starting and finishing simple self-care and household tasks and reported intermittent inability to provide self-care. On examination, his affect was reactive, and his mood was dysphoric, anxious, and irritable. He had had suicidal ideation as recently as three weeks earlier, and he had attempted suicide on one occasion in the past, although prior to the period on appeal. His energy level was low, and his appetite was poor. His weight fluctuated, and he reported a recent 50 pound weight loss. His concentration was poor, and he was easily distracted. He was forgetful of facts and events. His insight was limited, and his judgment was intact. The Veteran was noted to be living with his girlfriend of multiple years. His GAF score was 50 at the time of this exam and for the past 12 months. Dr. Taitt concluded that the Veteran had severe psychological problems.

Upon VA examination in January 2016, when requested to summarize the Veteran's level of occupational and social impairment with regards to all mental diagnoses, the examiner checked the box which stated: "Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks, although generally functioning satisfactorily, with normal routine behavior, self-care and conversation. He had attended college, but had not obtained a degree. He had been a firefighter during service. He had been married twice and now had a girlfriend. He had two children from each marriage. Activities that he enjoyed included woodworking, eating out, going to movies, reading, and using the computer. He had a history that included one suicide attempt (overdosed on pills) in 2008 (prior to the appeal period). He became argumentative when asked about domestic abuse allegations against him. He said that he no longer worked. He sometimes laughed sarcastically and was evasive during the interview. In answering some questions, he was vague.

In a private report dated in October 2016, Dr. Mangold suggested that the Veteran had been unemployable since he last worked full time in 2010. Dr. Mangold summarized the medical evidence of record in detail. In a portion of the report labeled "Discussion," he stated that he believed that the Veteran's limitations of social and occupational functioning as a result of his service-connected MDD with

PTSD rendered him unable to secure or follow a substantially gainful occupation since he last worked full time in 2010 and continued through the present date. In coming to this conclusion, consideration was given to the fact that the Veteran was medically discharged to his service-connected mental health condition and that there was no evidence in the record that he had had significant remissions or any sustained improvement since discharge. Dr. Mangold opined that the VA examination findings from 2010 and 2012 were not consistent with the GAF scores assigned. Specifically, as the Veteran had entertained thoughts of suicide, the GAF score should have been between 41-50 upon exam in 2010. Moreover, the 2012 VA GAF score of 65 represented relatively mild symptoms. As the Veteran exhibited problems with family relationships (divorce with allegations of domestic violence). He was also having problems at work due to increased depression. Thus his GAF score should have been assessed between 41-50. At the 2016 examination, the Veteran's anger and evasiveness resulted from his PTSD.

As noted on the title page, the issue before the Board is entitlement to an initial rating in excess of 30 percent for major depression with PTSD. In the decision below, the Board increases the 30 percent rating for this disorder to 50 percent, effective the date of a private examination on February 18, 2013. Thus, the discussion below is why a rating in excess of 30 percent is not warranted prior to that date and why a rating of 50 percent, but not higher, is warranted as of that date forward.

In an October 2015 remand decision, the Board requested additional development to include a contemporaneous mental health examination. At the time of the October 2015 remand, it was noted that the Veteran's representative contended that the most recent VA compensation examinations, in 2010 and 2012, were not sufficient for rating purposes in that the symptoms that were noted do not correspond with the Global Assessment of Functioning (GAF) scores that were assigned. It was asserted that the Veteran described symptoms of depression, memory loss, anxiety, panic attacks, auditory hallucinations, "visions" and suicidal ideation. As well as leaving his employment when his request to reduce his work hours was not accepted, it was also pointed out that the Veteran was twice divorced and had been

subject to domestic violence allegations. As such, it was argued, he had significant social and occupational impairment.

In January 2017, the Veteran's representative submitted a long argument in support of the Veteran's claim for a psychiatric rating in excess of 30 percent. The representative argued that the findings at the 2016 VA examination failed to provide thorough analysis and rationale. It was suggested that the examiner did not comment on the consistency of the GAF scores assigned in 2010 and 2012. The representative argued that a 70 percent rating was warranted back to the date of separation from service.

The Board has carefully reviewed the evidence of record and finds that the weight of the evidence is against the assignment of an initial disability rating in excess of 30 percent for the service-connected major depression with PTSD for the period prior to February 18, 2013. For the initial rating period up to that date, the Board finds that the Veteran's service-connected PTSD was productive of occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks due to symptoms such as chronic sleep impairment with nightmares, depression, anxiety, hypervigilance, mild memory loss, and reduced motivation. During this time, the Veteran's GAF scores, when considering his depression/PTSD alone ranged to 60-70 in December 2011, May 2012, and July 2012. As such, during the course of his appeal, the assigned GAF scores connote mild to moderate symptoms. While the GAF scores are not dispositive, they do carry weight, as it represents a medical professional's best guess as to the Veteran's psychiatric impairment at the time of the examination.

Dr. Mangold suggested in October 2016 that the Veteran had experienced severe psychiatric symptoms since service, and suggested that the severity of his symptoms during this time was more severe than what was suggested by the medical reports generated during that time. He suggested that in reviewing the 2010 and examination reports, he felt that the Veteran's self-report of the magnitude of his symptoms at that time was more severe than what was documented in the reports. He added that the Veteran met the criteria for a 70 percent rating at that time, adding that the Veteran's psychiatric symptoms had prevented him from completing

a normal workday and workweek without interruptions from psychologically based symptoms; perform at a consistent pace without an unreasonable number and length of rest periods; attend work regularly; or accept supervision and interact appropriately with co-workers and the general public.

Similarly, Dr. Taitt argued that the Veteran's psychiatric symptomatology had been severe since discharge from active duty. He suggested that a retroactive determination finds that the global assessment of functioning of May of 2012 was 50, based on the Veteran's self-report. Yet, Dr. Taitt's next sentence contradicts his assertion, as he wrote that over the past two months, the Veteran had experienced *unusually* severe symptoms with persistent danger of hurting himself due to frequent suicidal. Yet, while the Veteran was experiencing *unusually* severe symptoms Dr. Truitt assigned a GAF of 50, the same as he suggested was appropriate more than a year earlier when the Veteran was presumably not experiencing *unusually* severe symptoms. Here, the Board chooses to accept the opinion of the medical professionals who spoke with the Veteran contemporaneously with the examination reports as they were in the best position to evaluate the Veteran's psychiatric state prior to February 2013.

As an initial point, it is not just the GAF scores that suggest that a rating in excess of 30 percent is not warranted during the initial part of the appeal. Rather, the symptomatology reported during that time includes interaction with co-workers and friends, no impulse control issues, and independence with all activities of daily living. Prior to 2013, when asked to quantify the Veteran's psychiatric symptomatology, the examiners found that the symptoms most closely equated with a 30 percent rating. That is, having interviewed the Veteran, the medical professionals contemporaneously found how they felt he was impacted by his psychiatric symptomatology. Conversely, while Dr. Mangold suggests that based on an interview of the Veteran in 2016 that he was worse than rated from 2010-2012, the fact remains that he did not have the benefit of meeting with the Veteran during that time. Here, the Board puts significant weight on the contemporaneous medical findings from prior to February 2013 and for that reason finds a rating in excess of 30 percent is not warranted.

The treatment records generated prior to 2013 noted that the Veteran was, for example in 2011, able to grasp concepts, and his psychiatric symptoms was found to only mildly impair his ability to work. He was not noted to have most, if not all, of the symptoms identified as commensurate with a psychiatric rating of 50 percent or higher. Moreover, even to the extent that symptoms such as memory problems were present, they were not shown to so impact his social and occupational functioning as to cause reduced reliability and productivity.

As summarized above in the relevant medical evidence, his psychiatric symptoms remained essentially the same throughout the period prior to February 2013. Considering the above, the Board finds that that the PTSD related symptoms more nearly approximate the symptoms considered by a 30 percent disability rating which is currently in effect prior to February 18, 2013. *See* 38 C.F.R. § 4.130, DC 9411 (2016). As the weight of the evidence is against the appeal for a higher initial rating in excess of 30 percent for the period prior to February 18, 2013, the appeal for a higher initial rating for PTSD must be denied. 38 U.S.C.A. §§ 1155 (West 2014); 38 C.F.R. §§ 4.3, 4.7, § 4.130, DC 9411 (2016).

Several private opinions have been advanced to suggest that the assigned GAF scores were incorrect and inaccurately underrepresented the Veteran's symptoms. However, the Board notes that the scores that are in question were not assigned by a single medical professional, but rather constituted the opinions of a series of medical professionals who had the benefit of interviewing and treating the Veteran contemporaneously with the provision of those assessments. This would suggest that those medical professionals were in the best position to address how the Veteran's psychiatric symptoms were impacting him at the time of the examinations.

As supported by the increase in the Veteran's psychiatric rating, it is clear from the evidence of record that the Veteran's psychiatric symptomatology did increase in severity during the course of his appeal.

As already noted above, however, the Board has concluded that a 50 percent disability rating is warranted for major depression with PTSD from February 18,

2013. This increased rating is based on findings made at a private psychiatric examination on that date which is corroborated by additional private reports that were generated in May 2013 and January 2016. Of note, the May 2013 evaluation report specifically noted that the Veteran's symptoms had increased in the previous two months, supporting the assignment of a higher rating in February 2013.

Specifically, as of the February 13, 2013, report forward, an increase in the severity of the Veteran's major depression and PTSD symptoms is indicated. From that date forward, suicidal thoughts were noted. The examiner at this examination found that Veteran's prognosis was extremely guarded. Moreover, his GAF scores had decreased indicating serious symptoms (an increase in severity from mild to moderate symptoms).

While it has been determined that a 50 percent rating is warranted from February 13, 2013, a higher rating of 70 percent is not demonstrated. Specifically, for example, for the period from February 13, 2013, the Veteran does not show occupational and social impairment with deficiencies in most areas such as work, school, family relations judgment, or mood due to such as 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.

While the Veteran may have experienced periodic suicidal ideation, a symptom that may be associated with a 70 percent rating, the fact remains that it is impact of the symptom on the Veteran's social and occupational functioning that is the critical component for analysis. Here, even as the Veteran may have experienced periodic suicidal ideation, it was not shown to ever result in a plan during the course of the appeal. Similarly, the Veteran was noted to be involved with his son's business, and he reported enjoying woodworking, eating out, and going to movies at his 2016 VA examination. Such pursuits, as well as his familial and social relationships, do not align with the inability to establish and maintain effective relationships (i.e. a symptom commensurate with a 70 percent rating). Here, the Board simply does not believe the criteria for a psychiatric rating in excess of 50 percent have been met during the course of the Veteran's appeal.

In *Thun v. Peake*, 22 Vet. App. 111, 115-16 (2008), the United States Court of Appeals for Veterans Claims (Court) set forth a three-step inquiry for determining whether a veteran is entitled to an extraschedular rating. First, as a threshold issue, the Board must determine whether the veteran's disability picture is contemplated by the rating schedule. If so, the rating schedule is adequate and an extraschedular referral is not necessary. If, however, the veteran's disability level and symptomatology are not contemplated by the rating schedule, the Board must turn to the second step of the inquiry, that is whether the veteran's exceptional disability picture exhibits other related factors such as those provided by the regulation as "governing norms." These include marked interference with employment and frequent periods of hospitalization. Third, if the first and second steps are met, then the case must be referred to the VA Under Secretary for Benefits or the Director of the Compensation and Pension Service to determine whether, to accord justice, a veteran's disability picture requires the assignment of an extraschedular rating.

The evidence of record does not reflect that the Veteran's disability picture is so exceptional as to not be contemplated by the rating schedule. There is no unusual clinical picture presented, nor is there any other factor which takes the Veteran's PTSD outside the usual rating criteria. The rating criteria for the Veteran's currently assigned 30 percent rating prior to February 18, 2013, and 50 percent thereafter, specifically contemplate his symptoms, including suicidal ideation, depression, and difficulty adapting to stressful circumstances. Moreover, the Board must consider ***any*** additional psychiatric symptoms that the Veteran exhibits, even if they are not specifically identified in the rating criteria. *See Mauerhan*, *supra*. In so doing, VA necessarily considers all of the Veteran's psychiatric symptomatology within the confines of the schedular rating that is assigned. Thus, the Board finds that the Veteran's disability picture is adequately contemplated by the rating schedule. As the threshold issue under *Thun* is not met, any further consideration of governing norms or referral to the appropriate VA officials for extraschedular consideration is not necessary.

In short, the evidence does not support the proposition that the Veteran's service-connected major depression with PTSD presents such an exceptional or unusual

disability picture as to render impractical the application of the regular schedular standards and to warrant the assignment of an extraschedular rating under 38 C.F.R. § 3.321 (b)(1) (2016). Thus, referral of this issue to the appropriate VA officials for consideration of an extraschedular evaluation is not warranted.

Vertigo

Historically, service connection was established for vertigo upon rating decision in January 2011. The grant was based on STRs which showed inservice treatment for dizziness due to ototoxicity and VA examination (conducted while on active duty) which continued to show a diagnosis of vertigo. On examination, the Veteran continued to have problems with balance. Initially, a 10 percent rating was assigned, effective from October 16, 2010, the date following discharge. The DC code used was 6204 which is used to evaluate peripheral vestibular disorders.

Upon VA examination for vertigo in August 2010, it was noted that the Veteran had a history of dizziness and intermittent vertigo with sudden head movements and changes in position. The Veteran exhibited a poor tandem walk, falling mostly to the left. He watched the floor when he walked in order to maintain his balance. At a subsequent examination in September 2010, he was unable to tandem walk due to imbalance.

VA records show that the Veteran continued to be seen for vertigo in 2011 through 2013. *(See* Veteran's virtual folder.) In January 2012, he experienced daily symptoms associated with vertigo. He used a cane for ambulation.

When examined by VA in May 2012, physical examination was positive for Romberg's test and a normal gait. The examiner noted that the results of this exam were inadequate for evaluation purposes. It is noted that in June 2012, he walked independently and did not appear to have difficulty with gait or balance. There were no episodes of falling and no indication of motor difficulty in his upper extremities.

Upon independent medical examination in February 2013, it was noted that the Veteran suffered from daily positional vertigo. He lost his balance about twice per day. Examination showed a positive Romberg's test. He became unsteady when going from a siting to a standing position. Attempted heel to toe walking resulted in his almost falling. His gait was normal.

In a March 2013 rating decision, the Veteran's disability rating of 10 percent for vertigo was increased to 30 percent from October 16, 2010.

The Board remanded the claim for an increased rating for vertigo in October 2015. At that time, it was noted that the Veteran's representative had argued that the Veteran's disability would be more properly rated under the provisions of Meniere's syndrome (DC 6205) instead of peripheral vestibular disorders (DC 6204). The Board notes that Meniere's syndrome rating included the combination of disabilities for tinnitus and hearing loss as well as vertigo, and that the service connection was in effect for left ear hearing loss. Thus, it was necessary to ascertain whether the service-connected tinnitus and hearing loss might be associated with the service-connected vertigo and whether a diagnosis of Meniere's disease was appropriate.

Following examination of the Veteran and his claims file, it was a VA examiner's opinion in January 2016 that the Veteran's diagnosis was not more appropriately classified as Meniere's syndrome, explaining that the medical records showed the etiology of the Veteran's vertigo was ototoxic drugs and multi-organ failure. While the cause of Meniere's disease was unknown, generally, the symptoms included onset of fullness in one ear with tinnitus in that ear with a true spinning sensation that had an onset and an offset. This symptom was not described subjectively, and there was no objective evidence in the record of this symptom complex. The examiner indicated that Meniere's syndrome was a condition that was thought to arise from abnormal fluid and ion homeostasis in the inner ear. Meniere's syndrome referred to presentation of the typical set of symptoms with an idiopathic etiology (that is, cause unknown). The examiner further noted that Meniere's disease was associated with endolymphatic hydrops with distortion and distention of the membranous, endolymph-containing portions of the labyrinthine system.

Although most patients had no identifiable other underlying otologic disease, multiple potential caused of endolymphatic hydrops had been proposed. It was unclear whether excess fluid built up in the endolymphatic spaces of the inner ear. Several theories had been proposed, but all remained unproved. Lack of a single etiologic theory for Meniere's syndrome might reflect underlying clinical and genetic heterogeneity.

It is noted in this case that the Veteran's current disability rating of 30 percent for vertigo pursuant to DC 6204 is the highest schedular rating for the disability. As pointed out by the representative, however, if it is found that Meniere's syndrome (endolymphatic hydrops) is found to be part of the service-connected disability, DC 6205 may be used to award a higher rating.

Under DC 6204, contemplating peripheral vestibular disorders, a 10 percent rating is warranted for manifestation of occasional dizziness, and a maximum 30 percent rating is warranted when there is dizziness and occasional staggering. 38 C.F.R. § 4.87, DC 6204 (2016). A note provides that objective findings supporting the diagnosis of vestibular disequilibrium are required before a compensable evaluation can be assigned under this code. Hearing impairment or suppuration shall be separately rated and combined. *Id*.

Under DC 6205, contemplating Meniere's syndrome (endolymphatic hydrops), a 30 percent rating is warranted for hearing impairment with vertigo less than once a month, with or without tinnitus and a 60 percent rating is warranted for hearing impairment with attacks of vertigo and cerebellar gait occurring from one to four times a month, with or without tinnitus. A 100 percent rating is warranted for hearing impairment with attacks of vertigo and cerebellar gait occurring more than once weekly, with or without tinnitus. 38 C.F.R. § 4.87, DC 6205 (2016). A note provides that Meniere's syndrome can be evaluated either under these criteria or by separately evaluating vertigo as a peripheral vestibular disorder, hearing impairment, and tinnitus, whichever method results in a higher overall evaluation. But a combined evaluation for hearing impairment, tinnitus, or vertigo with an evaluation under DC 6205 is inappropriate. *Id*.

As noted above, it was a VA examiner's opinion in January 2016 that Meniere's syndrome was not part and parcel of the Veteran's service-connected disability. Therefore, the use of the diagnostic code for Meniere's disease is not for application. Thus, an initial rating in excess of 30 percent is not warranted.

In considering the appropriate disability rating, the Board has also considered the Veteran's statements regarding the severity of his vertigo. *See Gabrielson and Gilbert, supra.* While the Veteran is competent to report symptoms because this requires only personal knowledge as it comes to him through his senses, he is not competent (meaning that he has not been shown to have the medical training or expertise) to determine whether the Diagnostic Code for Meniere's disease is appropriate in this situation. *See Jandreau v. Nicholson*, 492 F. 3d 1372 (Fed. Cir. 2007).

As before when discussing the Veteran's claim for an increased rating for his mental health disorder, the Board has also considered the potential application of other various provisions in this claim regarding an increased rating for vertigo, including 38 C.F.R. § 3.321 (b)(1) (2016), for exceptional cases where schedular evaluations are found to be inadequate. In short, the evidence does not support the proposition that the Veteran's service-connected vertigo presents such an exceptional or unusual disability picture as to render impractical the application of the regular schedular standards and to warrant the assignment of an extraschedular rating under 38 C.F.R. § 3.321 (b)(1) (2016). Thus, referral of this issue to the appropriate VA officials for consideration of an extraschedular evaluation is not warranted.

TDIU

It is the established policy of VA that all Veterans who are unable to secure and follow a substantially gainful occupation by reason of service-connected disabilities shall be rated totally disabled. 38 C.F.R. § 4.16 (2016). A finding of total disability is appropriate "when there is present any impairment of mind or body which is sufficient to render it impossible for the average person to follow a substantially gainful occupation." 38 C.F.R. §§ 3.340(a)(1), 4.15 (2016).

"Substantially gainful employment" is that employment "which is ordinarily followed by the nondisabled to earn their livelihood with earnings common to the particular occupation in the community where the veteran resides." *Moore v. Derwinski*, 1 Vet. App. 356, 358 (1991). "Marginal employment shall not be considered substantially gainful employment." 38 C.F.R. § 4.16(a) (2016). The Court noted the following standard announced by the United States Eighth Circuit Court of Appeals in *Timmerman v. Weinberger*, 510 F.2d 439, 442 (8th Cir. 1975):

It is clear that the Claimant need not be a total 'basket case' before the courts find that there is an inability to engage in substantial gainful activity. The question must be looked at in a practical manner, and mere theoretical ability to engage in substantial gainful employment is not a sufficient basis to deny benefits. The test is whether a particular job is realistically within the physical and mental capabilities of the Claimant. *Moore*, 1 Vet. App. at 359.

As noted above, a claim for a total disability rating based upon individual unemployability "presupposes that the rating for the [service-connected] condition is less than 100%, and only asks for TDIU because of 'subjective' factors that the 'objective' rating does not consider." *Vettese v. Brown*, 7 Vet. App. at 34-35.

In *Hatlestad v. Derwinski*, 1 Vet. App. 164 (1991), the Court referred to apparent conflicts in the regulations pertaining to individual unemployability benefits. Specifically, the Court indicated there was a need to discuss whether the standard delineated in the controlling regulations was an "objective" one based on the average industrial impairment or a "subjective" one based upon the veteran's actual industrial impairment. In a pertinent precedent decision, the VA General Counsel concluded that the controlling VA regulations generally provide that veterans who, in light of their individual circumstances, but without regard to age, are unable to secure and follow a substantially gainful occupation as the result of service-connected disability shall be rated totally disabled, without regard to whether an average person would be rendered unemployable by the circumstances. Thus, the criteria include a subjective standard. It was also determined that

"unemployability" is synonymous with inability to secure and follow a substantially gainful occupation. VAOPGCPREC 75-91 (Dec. 27, 1991).

In determining whether unemployability exists, consideration may be given to the Veteran's level of education, special training and previous work experience, but not to his age or to any impairment caused by non-service-connected disabilities. 38 C.F.R. §§ 3.341, 4.16, 4.19 (2016).

A total disability rating for compensation may be assigned, where the schedular rating is less than total, when the disabled person is, in the judgment of the rating agency, unable to secure or follow a substantially gainful occupation as a result of service-connected disabilities, provided that, if there is only one such disability, this disability shall be ratable at 60 percent or more. If there are two or more disabilities, there shall be at least one disability ratable at 40 percent or more and the combined rating must be 70 percent or more. 38 C.F.R. § 4.16(a) (2016).

Pursuant to 38 C.F.R. § 4.16(b), when a Claimant is unable to secure and follow a substantially gainful occupation by reason of service-connected disabilities, but fails to meet the percentage requirements for eligibility for a total rating set forth in 38 C.F.R. § 4.16(a), such case shall be submitted for extraschedular consideration in accordance with 38 C.F.R. § 3.321 (2016).

Social Security Administration (SSA) records dated in 2015 reflect that the Veteran was awarded total disability benefits based on medical conditions to include both service connected and nonservice-connected conditions. The service-connected conditions included degenerative disc disease (DDD) of the lumbar spine; degenerative joint disease (DJD) of the knees and ankles, bilateral carpal tunnel syndrome, necrotizing fasciitis, vertigo and depression with PTSD. Nonservice-connected conditions included two myocardial infarctions. It was noted that he had not worked since July 11, 2011. His educational background included completion of high school. The Veteran also took college classes during the course of his appeal.

The Board has considered the award and its supporting evidence but, given the different standards utilized by VA and SSA, is not bound by that determination. *See Collier v. Derwinski*, 1 Vet. App. 413, 417 (1991) (although VA is required to consider the SSA's findings, the Board is not bound by the findings of disability and/or unemployability made by other agencies, including SSA). Hence, the Board will render an independent unemployability based on a comprehensive review of the record.

The Veteran currently meets the percentage rating standards for TDIU (two or more disabilities with at least one disability ratable at 40 percent or more with a combined rating of 70 percent or more.

As discussed above in detail, the Board found that there had been increased severity in the Veteran's service-connected depression with PTSD as of private examination on February 18, 2013. It is also noted that upon vertigo examination in February 2013, it was opined that the Veteran's vertigo alone made him unemployable. Moreover, as noted above, although not binding on VA, it is noted that SSA awarded the Veteran benefits primarily based on his various service-connected benefits. The psychiatric evaluations have also concluded that the Veteran could not obtain or maintain substantially gainful employment as a result of his service connected disabilities.

In light of the medical evidence, the Board finds that the Veteran is unemployable due solely to his service-connected disabilities. The criteria for TDIU have been met. 38 C.F.R. § § 3.340, 3.431, 4.16 (2016).

ORDER

An initial rating in excess of 30 percent for major depression with PTSD for the period prior to February 18, 2013, is denied.

An initial rating of 50 percent, but no higher, for major depression with PTSD is granted from February 18, 2013, subject to the laws and regulations governing the award of monetary benefits.

A rating in excess of 30 percent for vertigo is denied.

A TDIU is granted, subject to the laws and regulations governing the award of monetary benefits.

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MATTHEW W. BLACKWELDER
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).