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

IN THE APPEAL OF
WILLIE J. HUNT

SS [redacted]

DOCKET NO. 09-41 853) DATE *March 22, 2017*
) *MBJ*
)

On appeal from the
Department of Veterans Affairs Regional Office in Chicago, Illinois

THE ISSUE

Entitlement to a rating in excess of 20 percent for right knee degenerative joint disease (DJD) and residuals of arthrotomy, history of patella injury.

REPRESENTATION

Appellant represented by: Vietnam Veterans of America

ATTORNEY FOR THE BOARD

T. Wishard, Counsel

INTRODUCTION

The Veteran had active military service from February 1969 to February 1971.

This matter comes before the Board of Veterans' Appeals (Board) from a May 2007 rating decision of the Department of Veterans Affairs (VA), Regional Office (RO) in St. Louis, Missouri. Jurisdiction was subsequently transferred to the Chicago, Illinois RO. (The Board notes that at times this matter has been referred to as stemming from a July 2004 rating decision and/or being a claim for an initial increased rating; however, upon further review, the Board finds that it is from a May 2007 claim for an increased rating.)

This matter was previously before the Board in March 2013 when the Board remanded it for further development, July 2013 when the Board again remanded it, March 2014 when the Board granted a rating of 20 percent rating and no higher, and most recently in November 2015 at which time the Board remanded it for further development consistent with an April 2015 Memorandum decision of the United States Court of Appeals for Veterans Claims (Court). It has now returned to the Board for further appellate consideration. The Board finds that there has been substantial compliance with the directives of its remand.

FINDINGS OF FACT

During the entirely of the rating period on appeal, the Veteran's right knee disability has manifested in complaints of symptoms such as pain and instability; objectively, he had significant range of motion, a slightly unstable knee, and no history of recurrent subluxation.

CONCLUSION OF LAW

The criteria for a rating in excess of 20 percent for right knee degenerative joint disease (DJD) and residuals of arthrotomy, history of patella injury, have not been met. 38 U.S.C.A. §§ 1155,5103, 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.159, 3.321, 4.1, 4.3, 4.7, 4.40. 4.45. 4.59, 4.71a, Diagnostic Codes 5010-5263 (2016).

REASONS AND BASES FOR FINDINGS AND CONCLUSION

With respect to the Veteran's claim herein, VA has met all statutory and regulatory notice and duty to assist provisions. See 38 U.S.C.A. §§ 5100, 5102, 5103, 5103A, 5106, 5107, 5126 (West 2014); 38 C.F.R. §§ 3.102, 3.156(a), 3.159, 3.326 (2015); see also *Scott v. McDonald*, 789 F.3d 1375 (Fed. Cir. 2015).

The Board acknowledges that the 2016 VA examination report does not specifically reflect range of motion under passive movement (See *Correia v. McDonald*, 28 Vet. App. 158 (2016); however, the Board finds that a remand to obtain another examination is not warranted. Notably, neither the Veteran nor his representative has alleged that the 2016 VA examination report is inadequate. In addition, and importantly, the Veteran's range of motion would naturally be greater under passive movement (i.e. when it is being moved for him by the physician) than with active motion; thus, the more accurate range of motion upon which to rate the Veteran, and that which could potentially provide him with the highest level of compensation, is the active movement, which is noted in the record. A remand to obtain another examination would serve no useful purpose and would merely delay adjudication of the claim which has now been pending for a decade.

Legal Criteria

Disability evaluations are determined by comparing a Veteran's present symptomatology with criteria set forth in VA's Schedule for Rating Disabilities, which is based on average impairment in earning capacity. 38 U.S.C.A. § 1155; 38 C.F.R. Part 4. When a question arises as to which of two ratings applies under a particular diagnostic code, the higher evaluation is assigned if the disability more closely approximates the criteria for the higher rating. Otherwise, the lower rating will be assigned. 38 C.F.R. § 4.7. After careful consideration of the evidence, any reasonable doubt remaining is resolved in favor of the Veteran. *Id.* § 4.3.

Further, a disability rating may require re-evaluation in accordance with changes in a Veteran's condition. It is thus essential in determining the level of current

impairment that the disability is considered in the context of the entire recorded history. Id. § 4.1. Nevertheless, the present level of disability is of primary concern. *Francisco v. Brown*, 7 Vet. App. 55, 58 (1994). The Board notes 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. *Hart v. Mansfield*, 21 Vet. App. 505 (2007).

Painful, unstable, or malaligned joints, due to healed injury, are entitled to at least the minimum compensable rating for the joint. 38 C.F.R. § 4.59 (2016). The factors involved in evaluating, and rating, disabilities of the joints include weakness; fatigability; incoordination; restricted or excess movement of the joint, or pain on movement. Id. § 4.45.

Analysis

The Board has reviewed all of the evidence in the Veteran's claims file, with an emphasis on the medical evidence pertinent to the claims on appeal. Although the Board has an obligation to provide reasons and bases supporting this decision, there is no need to discuss, in detail, the extensive evidence of record. Indeed, the U.S. Court of Appeals for the Federal Circuit has held that the Board must review the entire record, but does not have to discuss each piece of evidence. *Gonzales v. West*, 218 F.3d 1378, 1380-81 (Fed. Cir. 2000). Therefore, the Board will summarize the relevant evidence where appropriate, and the Board's analysis below will focus specifically on what the evidence shows, or fails to show, as to the claim.

The Veteran's right knee disability is currently rated as 20 percent disabling under DC 5010-5262. In the present case, DC 5262 was used to rate the Veteran because VA found it to be the most beneficial DC to the Veteran. However, in its brief to the Court, the Veteran's attorney argued that rating the Veteran under DC 5262 has "no reasonable basis in law and fact because DC 5262 was wholly inapplicable to rate Appellant's knee disability." In its April 2015 Memorandum decision, the Court noted that DC 5262 may not be the appropriate diagnostic code under which to evaluate the Veteran because the evidence does not indicate that he has nonunion or malunion of the fibula and tibia. The Board will consider whether another

diagnostic code is more appropriate to rate the Veteran's disability. However, the Board will not disturb a previous rating under DC 5262 if it is more favorable to the Veteran based on the manifestations of his right knee disability.

This matter stems from the Veteran's May 2006 claim for an increased rating. Nevertheless, the Board will consider the history of the Veteran's disability. The Veteran's VA treatment records show recurrent complaints related to the right knee and treatments including injections for knee pain.

At a June 2004 VA compensation and pension (C&P) examination, the examiner noted that the Veteran complained of chronic knee pain. The Veteran described the right knee pain as constant, brought on by standing for more than five minutes or walking, and reported "infrequent episodes of subluxation or the sensation of the joint giving way." The Veteran stated that he experienced flare-ups of pain two to three times per week and "acute fla[res] of pain" that caused him to stop or curtail his activities over the course of the day. The examiner diagnosed the Veteran with mild degenerative joint disease of the right knee. No locking was reported. The Veteran had an antalgic gait and range of motion of 0 to 125 degrees with pain at the endpoint of flexion. The right knee was stable: medial and lateral collateral ligament testing was normal and anterior and posterior cruciate ligament testing was negative.

A Social Security Administration (SSA) decision granted the Veteran disability benefits due to hypertension and osteoarthrosis from April 2006, with various other disorders noted on the functional capacity assessment.

At a February 2007 VA examination, the examiner noted that the Veteran reported pain on a daily basis brought about by ambulation, prolonged standing, and weather changes. The Veteran also reported that his "knee will give way all the time," but denied having any "locking or catching" symptoms, and stated that his "right knee will become warm, swollen[,] and redden on a regular basis." The Veteran also reported acute flares of pain on a daily basis that cause him to "cease all activity . . . until the acute fla[re] of pain diminishes to the point where he can perform his activities again at a reasonable level of functioning." The examiner noted that the

Veteran uses a knee brace for "support and stability." Although he could independently carry out most of his activities of daily living, the Veteran reported that he sometimes needed his wife to help him with bathing. Examination of the knee showed no effusion, warmth, or erythema. Active range of motion was 0 to 105 degrees with mild crepitus with motion; passively, flexion was slightly increased. Lachman's and anterior drawer testing was negative. The Veteran had an antalgic gait in favor of the right knee. It was noted that his knee would affect his work in that he would have pain from sitting for long periods of time.

In an April 2007 VA treatment record, the examining physician noted that the Veteran reported difficulty walking and stated that his "knee pops out on him." In a May 2007 SSA daily living questionnaire, the Veteran reported that he experienced knee swelling and that his "knees give[] out." In July 2007, the Veteran asserted that he experiences "locking of the knee." (See Notice of Disagreement.)

A May 2009 record reflects that the Veteran 10 degrees of genu varum. He had a stable valgus/varus stress test, and stable patella.

At a December 2011 VA examination, the examiner indicated that the Veteran has functional loss and functional impairment of the right knee and lower leg, noting that less movement than normal and pain on movement were contributing factors. The examiner also noted that the Veteran occasionally used a knee brace to alleviate right knee pain and that imaging studies confirmed degenerative or traumatic arthritis. The Veteran had full extension and 80 degrees of flexion with pain at 40 degrees. There was no change after repetition.. There was no tenderness or instability. Strength was 4/5. There was no evidence of a history of recurrent patellar subluxation or dislocation. The meniscus tear and meniscectomy caused frequent episodes of joint pain and DJD. The Veteran reported that he occasionally used a brace. His work activities were not affected by his knee problems because he was retired.

June 2012 correspondence from Dr. V. Cuk reflects that "[d]ue to the diagnosis of Osteoarthritis (bilateral knees) and Gout, [the Veteran] is unable to :stand more than

30 min,. walk more than 2 blocks, no bending or lifting more than 10 lbs. [the Veteran] will only be able to perform light work."

In October 2013, the Veteran underwent another medical examination. The Veteran reported that his right knee had become more painful while standing or walking and that he used a knee brace regularly. He denied flare-ups of pain, recurrent patellar subluxation or dislocation, or pain on palpation of the right knee. The examiner reported that the Veteran has functional loss and functional impairment of the right knee and lower leg, noting that less movement than normal, weakened movement, excess fatigability, pain on movement, interference with sitting, standing, and weight-bearing, and deformity were contributing factors to additional functional loss. The examiner specified that a "painful arthritic knee" was a residual sign and symptom resulting from the Veteran's 1979 right knee meniscectomy.

At the 2013 VA examination, range of motion was 5 degrees of extension to 80 degrees of flexion with pain at 40 degrees. After repetition, flexion decreased to 70 degrees and there was no change in extension. There was no instability, history of subluxation or dislocation, or tenderness. Residuals of the meniscectomy included pain and arthritis. Strength was 4/5. The impact on work was that standing and walking caused knee pain.

A July 2014 VA PTSD examination report reflects that the Veteran walks his dog daily.

A November 2014 VA record reflects that the Veteran reported that he fell on the stairs due to his knees giving out. He also reported that he does not work due to his knees.

VA records in 2015 continue to show complaints of bilateral knee pain and that the Veteran did not want to undergo knee surgery.

A July 27, 2015 Midwest Sports Medicine & Orthopaedic Surgical Specialists, LTD record reflects that the Veteran had varus deformity of the knee, moderate synovitis, no recurvatum, 95 degrees of flexion, minus 5 degrees of extension, flexion past 90

degrees causing significant pain, and a stable knee in full extension. He had full muscle strength of 5/5. There was 5 mm of pseudo-laxity when applying a varus stress in 20 degrees of flexion. Anterior and posterior drawer tests were negative. 2015 records from Osteo Relief Institute reflect complaints of pain of a 10 out of 10 in the knees.

2015 records from Chicago Physician's Group reflect varus angulation deformity of 3 degrees, pain described as moderate to severe, active range of motion from 0 to 90 degrees, and negative posterior and anterior drawers testing. (See October 7, 14, and 28, 2015 records.) An October 7, 2015 report reflects that varus stress was positive for instability on the right; however, it also notes that during knee testing, instability was not noted. A November 19, 2015 record reflects that the Veteran had active range of motion from 0 to 140 degrees and that the motion was "pain-free". The Veteran had been obtaining injections for the knee.

The Veteran underwent another VA examination in June 2016. The report reflects that the Veteran complained of knee pain of a 10 out of 10 with swelling. The Veteran further reported that Synvisc injections did not provide pain relief. The Veteran complained of bilateral buckling and falling going up and down stairs. He reported that his unloader brace for the right knee was broken and that he did not want to wear an elastic compression wrap to the examination. The Veteran denied locking, redness, warmth, numbness, and tingling.

Upon examination in 2016, the Veteran had flexion from 0 to 90 degrees and extension from 140 to 90 degrees. Essentially, as noted by the examiner, the Veteran had a decreased range of flexion of 50 degrees (i.e. he could move his leg from 0 to 90 degrees, and if it was at 140 degrees, he could move it back to 90 degrees.) It was noted that he had decreased range of motion of 50 degrees. Pain on the examination was noted to cause functional loss. The Veteran was able to perform repetitive use testing without additional loss in range of motion. It was noted that the Veteran had weakened movement due to muscle or peripheral nerve injury, swelling, disturbance of locomotion, and interference with standing. He had strength of 4 out of 5. The Veteran had no history of recurrent subluxation, no history of lateral instability, and no history of recurrent effusion. On joint stability

testing, he had abnormal anterior and posterior instability which was 1+. Other testing was normal. The report specifically notes that he had normal lateral stability.

Legal Analysis

The Veteran's traumatic arthritis is currently rated under DC 5010-5262. 38 C.F.R. § 4.27. DC 5262 considers impairment of the tibia and fibula. In the Memorandum Decision, the Court found that the Board failed to provide an adequate statement of its reasons and bases as to why DC 5262 was selected to rate the Veteran's disability. Historically, the Veteran's service treatment records note he sustained a severely bruised patella with a minor amount of internal hemorrhage in October 1970. He was ordered to light duty and was told to ice it and wrap it for 1 week. During a November 1993 VA examination, the Veteran reported that in November 1970 he had fallen while playing basketball, landing on the right side of the leg. He reported to the examiner that he was casted "on the whole right leg, arthrotomy was done on the lateral malleolar area of the right leg." The examiner noted, "[a]pparently, he was casted for a long time because he was shipped back stateside with the cast, which was removed."

Service treatment records show that in December 1970 he sustained an injury to the *left* leg after twisting the *left* ankle while playing basketball. He was on crutches for a week, then placed in a short leg cast and evacuated (from Vietnam) to a naval hospital in Japan for further evaluation. His service personnel records show he was transferred to Japan on January 17, 1971, and was then transferred back to the United States on January 21, 1971. Records from the naval hospital show that an X-ray revealed a small avulsion fracture of the left distal tibia and no new cast was needed. He was discharged to limited duty for 4 weeks. His February 1971 separation examination revealed normal clinical evaluation of the lower extremities.

The 1993 examiner noted that the Veteran reported that "[h]is condition did not improve any. He was deteriorating with pain and weakness of the right ankle, knee all the time. . . . In 1979 he had medial arthrotomy on the right knee due to torn ligaments and cartilage." During the examination, "[h]e could not put weight on the

right leg. He put weight on the left leg steadily." The examiner noted a scar on the right knee "where the arthrotomy was done in 1979 and "[o]n the right ankle lateral malleolar area is a scar from arthrotomy, secondary to removal of a chipped bone fracture in this area." The examiner found that the "left knee and left ankle has no orthopedic deficit."

A June 2004 VA examiner noted a medical history that included a pre-service knee injury while playing football, an in-service knee injury playing basketball, and right knee surgery in 1971 after leaving service "for cartilage medial aspect scar." The Veteran reported to the examiner that he "was in [a] cast [for a] couple of months" in service and that there were no records of the 1971 knee surgery for cartilage repair. The examiner found the Veteran's current problems with the right knee at least as likely as not "related to his initial injury . . . in . . . service[]." Based on that finding, service connection was awarded in 2004 for degenerative joint disease and residual arthrotomy, right knee, history of patella injury. A 10 percent rating was assigned under DC 5003.

Thereafter, in a May 2007 rating decision, a higher, 20 percent rating was awarded under DC 5010-5262 based on findings reflective of moderate functional limitation.

As an initial matter, the Board finds that the Veteran's statements with respect to the origin, progression, and current severity of his right knee disability lack credibility. This is so because his statements as to the etiology, progression, and severity of his right knee are inconsistent with the other evidence of record. For example, the Veteran's account to the 1993 VA examiner of a cast on the whole right leg in service and surgery (arthrotomy) in the right malleolar area in service is inconsistent with the service treatment records. The contemporaneous evidence of record, his service treatment records, show that the right leg was never casted in service and no surgical procedures were performed on the either lower extremity. These records show a short cast for a short time on the *left* leg. Further, his report to the 2004 VA examiner that he was in a right leg cast for a couple of months conflicts with the service treatment records which show that when he was evaluated in January 1971, less than a month after his initial injury, his *left* leg cast was

removed; he had an X-ray "out of plaster"; and the subsequent orders were that "no new cast was needed."

Further impacting his credibility are statements by VA psychiatrists that the Veteran is not a reliable historian. A VA psychiatrist in 2012 (Dr. K.P.) found that the Veteran has made statements that are "quite unbelievable" and has often contradicted himself with regard to his service-connected mental health disability. In October 2013, Dr. K.P. again found that the Veteran had "many inconsistencies" in his statements. It was noted that while competent, he was an unreliable historian and frequently contradicted himself. Thus, the Veteran has been clinically found to be less than accurate when reporting symptoms related to a service-connected disability.

The Court found that the Board has failed to articulate a reason to evaluate the Veteran's disability under DC 5262 in its earlier decision and noted that a prerequisite for the application of DC 5262 "is evidence of either nonunion or malunion of the tibia and fibula." Simply put, the Board continues to evaluate the Veteran's knee disability under DC 5262 and does not disturb the previous rating under DC 5262 because it is more favorable to the Veteran.

DC 5262 provides ratings for impairment of the tibia or fibula, assigning ratings for malunion of the tibia and fibula with "knee or ankle disability" or nonunion of the tibia and fibula with loose motion, requiring a brace. 38 C.F.R. § 4.71a. Thus, the requirement of knee or ankle "disability" under Diagnostic Code 5262 is broad enough to encompass symptoms including limitation of motion due to pain as well as instability. The U.S. Court of Appeals for Veterans Claims (Court) has held that the regulatory definition of "disability" is the "impairment of earning capacity resulting from such diseases or injuries and their residual conditions." *Hunt v. Derwinski*, 1 Vet. App. 292, 296 (1991). Thus, the requirement of knee or ankle "disability" under Diagnostic Code 5262 is broad enough to encompass all symptoms, including pain, limitation of motion, stiffness, and instability. The other requirement under Diagnostic Code 5262 is that there be malunion or nonunion of the tibia and fibula. The only evidence of record suggesting involvement of the tibia and fibula are the Veteran's statements to the 1993 VA examiner. As

discussed above, the Veteran did sustain a tibia fracture in service; however, the service treatment records are clear that the fracture involved his *left* tibia, not his right.

DCs 5257 and 5262 overlap by providing ratings based, at least in part, on symptoms of instability and subluxation. Likewise, DCs 5260/61 for limitation of knee motion also overlap with DC 5262, as the 20 percent rating currently in effect contemplates a "moderate" level of knee or ankle disability, arguably encompassing any limited motion.

The critical element in permitting the assignment of several ratings under various DCs is that none of the symptomatology for any one of the disabilities is duplicative or overlapping with the symptomatology of the other disability. *See Esteban v. Brown*, 6 Vet. App. 259, 261-62 (1994); *see also* 38 C.F.R. § 4.14. The Veteran's right knee disability has been manifested by instability and limited motion (and additional right knee symptoms such as pain). If instability associated with the malunited fracture is rated under DC 5257, or the limited motion is rated under DC 5260/61, then, to avoid pyramiding, the separate rating under DC 5262 could not be continued, as to do so would compensate the Veteran twice for the overlapping symptomatology of instability or limited motion. See 38 C.F.R. § 4.14; *Esteban*, 6 Vet. App. at 261-62.

DC 5262 has provided the Veteran with a higher rating than that provided under DC 5259, which only allows for a 10 percent rating, in combination with DC 5257, as his instability symptoms only warrant a separate 10 percent rating, at most.

As noted above, a higher rating under DC 5262 is not applicable because the Veteran does not have nonunion or malunion of the tibia and fibula or marked disability of the right knee. The Veteran contends that his knee warrants a 30 percent rating under DC 5262 for marked disability. (See January 2017 brief). The Board finds that based on the evidence noted above, the Veteran’s right knee does not equate with a marked or severe disability. In this regard, the Board has considered that the Veteran retains a significant range of motion of the knee, has only slight instability, and does not have genu recurvatum. The Board finds that the

evidence of record, when taken as a whole, is against a finding that the Veteran is entitled to a rating in excess of 20 percent for his right knee under DC 5262 for any period on appeal.

Considering other DCs related to the knee, the Board finds that a rating under DC 5256 is not warranted because the evidence reflects that the Veteran does not have ankylosis. Moreover, a rating under DC 5258 for dislocated semilunar cartilage with frequent episodes of locking, pain, and effusion is not warranted. The evidence does not support a finding that the Veteran has had dislocated semilunar cartilage during the rating period on appeal. Thus, a rating under DC 5258 is not warranted. DC 5263 is not applicable because the Veteran does not have genu recurvatum.

The Board has thus considered the remaining diagnostic codes for the knee; 5257, 5259, 5260, and 5261 as an alternate basis for rating the Veteran's right knee.

Under DC 5257 for other impairment of the knee, a 10 percent rating would be warranted for recurrent subluxation or lateral instability. The Board acknowledges the Veteran's complaints of instability and that he has reported wearing a brace at times and using a cane. While the Veteran may have a subjective feeling of what he considers to be "giving way" or "instability", instability may be observable on diagnostic testing. Lateral instability has not been reproduced, or even observed, by the VA examiners.

The Board finds, however, that a separate rating under DC 5257 is warranted if DC 5262 were not for consideration. While numerous VA examinations affirmatively show that the Veteran does not have lateral instability the record does contain some evidence of instability in the knee. In this regard, the Board has also considered the private records in evidence. As noted above, a July 27, 2015 private record reflects 5mm of pseudo-laxity. Further, although a 2015 record from Chicago Physician's Group reflects that during knee testing, instability was not noted, the same document also reflects that varus stress was positive on the right for instability. The Board has also considered the 2016 VA examination report which notes "1+" anterior and posterior instability. The pre-printed examination report contained 4

possible results: normal; 1+ (0-5 millimeters); 2+ (5-10 millimeters); and 3+ (10-15 millimeters). In the context of this scale, the Board finds that the July 2015 (private medical record) and June 2016 (VA examination) abnormal findings, taken together, more nearly approximate to the criteria of "slight" used under Diagnostic Code 5257 (with 2+ (5-10 millimeters) more nearly corresponding to “moderate” and 3+ (10-15 millimeters more nearly corresponding to “severe”).

The Board has also considered that the Veteran’ has reported *infrequent* episodes of subluxation (June 2004 examination, April 2007 VA record), although he has not been found to have recurrent subluxation and he has also denied it (*See* December 2011 VA examination report, October 2013 VA examination report, June 2016 VA examination report). In addition, while the Veteran has reported that his knee has “popped out”, the kneecap has been found to be clinically stable upon examination. No examiner has found upon objective testing that the patella is dislocated or has a history of recurrent subluxation. (e.g. See May 2009 VA record which notes stable patella.) Accordingly, there is slight instability demonstrated and a separate 10 percent rating would be warranted for the right knee as an alternative to the current 20 percent rating under DC 5262. However, also based on these results, the Board finds no basis to assign any higher rating.

The Board has considered whether a 10 percent rating under DC 5257 in combination with one or more other DCs might result in a higher rating than the current 20 percent rating under DC 5262. In its April 2015 Memorandum Decision, the Court noted that the Board had not previously sufficiently explained whether the Veteran is entitled to a rating under DC 5260 for limitation of motion. The Board finds that he is not because his range of motion, even considering any functional loss caused by pain, does not warrant a higher or separate rating. Quite simply, while he may have pain and/or weakness, he still has enough function of his knee that he is able to have flexion and extension to a level which does not warrant a compensable rating.

The Board has considered DC 5260 (limitation of flexion). As noted above, the Veteran has degenerative joint disease. The Veteran has been found to consistently not have flexion limited to 60 degrees or less. Notably, he had flexion to 125

degrees with pain at 125 degrees (June 2004), to 105 degrees (February 2007), to 80 degrees (December 2011), to 80 degrees with pain at 40 degrees(October 2013, to 95 degrees with pain past 90 degrees (July 2015), to 90 degrees and to 140 degrees (November 2015), and to 90 degrees (June 2016).

Next the Board has considered DC 5261 (limitation of extension). The Veteran had full extension (December 2011), limited to 5 degrees (October 2013), limited to 5 degrees (noted as minus five degrees which the Board, in giving the benefit to the Veteran, interprets as limited to five degrees) (July 2015), and to 0 degrees (November 2015, June 2016). The Veteran does not have extension limited to 10 degrees, which would warrant a compensable rating.

In determining, the Veteran's overall functioning, the Board has considered the factors espoused in *DeLuca v. Brown*, 8 Vet. App. 202 (1995), the Veteran's reported symptoms, to include during flare-ups, the clinical records, and the VA examination reports. As noted above, the Board has found that the Veteran is not a credible historian with respect to his right knee. The Board has also considered the evidence of pain on range of motion testing and during use. Pain alone is not sufficient to warrant a higher rating, as pain may cause a functional loss, but pain itself does not constitute functional loss. *Mitchell v. Shinseki*, 25 Vet. App. 32, 36-38 (2011). Rather, pain must affect some aspect of "the normal working movements of the body" such as "excursion, strength, speed, coordination, and endurance," in order to constitute functional loss. Id at 43; *see* 38 C.F.R. § 4.40. The Veteran's pain has not been shown by competent credible evidence to cause a limitation of motion or other functional loss which would warrant a higher rating. Even with consideration that the Veteran’s pain begins at 40 degrees (e.g. December 2011), he still had extension to 80 degrees, and importantly, flexion limited to 40 degrees would not provide the Veteran with a rating higher than his current 20 percent evaluation.

The Board has also considered DC 5259 (cartilage , semilunar, removal of, symptomatic). The Veteran’s statements indicate that he had a right knee meniscectomy following service; however, his statements have been inconsistent. He reported to one examiner in 1993 that the right knee surgery was in 1979 and he

reported to another examiner in 2004 that the right knee surgery was in 1971. Assuming, arguendo, that these statements are correct (the Board notes that the 2003 VA examiner found a right knee scar on clinical evaluation), the maximum rating under DC 5259 is 10 percent. A rating under DC 5259 in addition to the 10 percent rating under DC 5257 would still not result in a higher evaluation for the knee. As noted above, any symptoms considered under DC 5259 would be compensated under DC 5262 which allows for his disability to be evaluated as "slight", "moderate", or "marked". As the Veteran is already getting a rating of 20 percent for his symptoms, another rating of 10 percent under DC 5259 for those same symptoms is not permitted.

The preponderance of the evidence is against a higher rating for the Veteran's right knee at any time, either under DC 5262 or, alternately, under a combination of DCs, to include DC 5257 and 5259. As DC 5262 does afford him a higher rating than the application of other diagnostic codes, as explained above, the Board will continue with its application.

Other considerations

The Veteran's various knee complaints, including pain, limited motion, and instability, are contemplated by the schedular criteria based on their level of severity. Hence, referral for consideration of an extra-schedular rating is not warranted. *Thun v. Peake*, 22 Vet. App. 111 (2008). Any right or left knee symptom of the Veteran's would be considered under the appropriate Diagnostic Code. Notably, DCs 5262 allows for symptoms to be compensated without requiring a specific symptom. Thus, the Board finds that the rating criteria reasonably allow for consideration of the Veteran's symptoms.

Under *Johnson v. McDonald*, 762 F.3d 1362 (Fed. Cir. 2014), a veteran may be awarded an extra-schedular rating based upon the combined effect of multiple disorders in an exceptional circumstance where the evaluation of the individual entities fails to capture all the service-connected disabilities experienced. The Veteran, for the time period on appeal, is in receipt of service connection for numerous disabilities. All of the pertinent symptoms and manifestations have been

evaluated by the appropriate diagnostic codes. *See Mittleider v. West*, 11 Vet. App. 181 (1998). Accordingly, this is not a case involving an exceptional circumstance in which extra-schedular consideration may be required to compensate the Veteran for a disability that can be attributed only to the combined effect of multiple entities.

The Board is cognizant of the ruling of the Court in *Rice v. Shinseki*, 22 Vet. App. 447 (2009), in which the Court held that a claim for a total rating based on individual unemployability due to service-connected disability, either expressly raised by the Veteran or reasonably raised by the record, involves an attempt to obtain an appropriate rating for a disability and is part of the claim for an increased rating. The Veteran is in receipt of a 100 percent combined rating from February 10, 2008; nevertheless, the Board has considered whether the Veteran was unable to maintain substantial gainful employment due solely to his right knee disability during this appeal.

June 2012 correspondence from Dr. V. Cuk, with regard to court-ordered community service hours, reflects his opinion that due to the Veteran's bilateral knee osteoarthritis and gout, the Veteran is unable to stand for more than 30 minutes or walk more than two blocks, and he cannot bend or lift more than 10 pounds. Dr. V. Cuk found that the Veteran was only able to perform light work. However, Dr. Cuk did not separate the Veteran's service-connected right knee disability from his nonservice-connected left knee disability and his nonservice-connected gout. Thus, the opinion lacks significant probative value. In addition, it did not indicate that the Veteran was unable to perform any type of substantial gainful employment, but merely noted that his work was limited to light work.

July 2012 correspondence from a VA nurse reflects that the Veteran reported that he had to quit his job as a bus driver because he was taken to jail four times for assaulting passengers, and was fired on another occasion for assaulting his supervisor. An October 2012 VA mental health note reflects that the Veteran reported that he retired because he was afraid he would not be able to control his rage.

The October 2013 VA examination report reflects that the Veteran's ability to work is impacted because standing and walking provoke bilateral knee pain. However, it does not indicate that he was unable to maintain substantial gainful employment due to his right knee disability.

A July 2014 VA PTSD examination report reflects that the Veteran reported that he has not worked since age 62 due to "bad knees". The Veteran reported that he had been a bus driver for more than a decade. However, as noted above July and October 2012 records reflect that the Veteran reported that he left his employment due to mental health issues. The evidence does not support a finding that his right knee disability alone prevented him from substantial gainful employment.

While the Veteran's right knee disability may cause limitations with regard to sitting, standing, and walking, it has not been shown by the competent evidence of record to prevent substantial gainful employment for any period on appeal. thus, a TDIU is not warranted. Moreover, discussion of entitlement to special monthly compensation is not warranted as the Veteran does not have a disability rated as 100 percent disabling (or TDIU) plus another disability rated as 60 percent disabling.

ORDER

Entitlement to a rating in excess of 20 percent for right knee degenerative joint disease (DJD) and residuals of arthrotomy, history of patella injury is denied.

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M.C. GRAHAM
Veterans Law Judge, Board of Veterans' Appeals

YOUR RIGHTS TO APPEAL OUR DECISION

The attached decision by the Board of Veterans' Appeals (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. Your local VA office will implement the Board'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. Please note that if you file a Notice of Appeal with the Court and a motion with the Board at the same time, this may delay your appeal at the Court because of jurisdictional conflicts. If you file a Notice of Appeal with the Court ***before*** you file a motion with the Board, the Board will not be able to consider your motion without the Court's permission or until your appeal at the Court is resolved.

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 Board 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 Board to reconsider any part of this decision by writing a letter to the Board clearly explaining why you believe that the Board 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 your letter be as specific as possible. A general statement of dissatisfaction with the Board decision or some other aspect of the VA claims adjudication process will not suffice. If the Board 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:

Litigation Support Branch
Board of Veterans' Appeals
P.O. Box 27063
Washington, DC 20038

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 Board to vacate any part of this decision by writing a letter to the Board 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 on the previous page for the Litigation Support Branch, 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 on the previous page for the Litigation Support Branch, 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 Board, 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: If you hire an attorney or agent to represent you, a copy of any fee agreement must be sent to VA. The fee agreement must clearly specify if VA is to pay the attorney or agent directly out of past-due benefits. See 38 C.F.R. 14.636(g)(2). If the fee agreement provides for the direct payment of fees out of past-due benefits, a copy of the direct-pay fee agreement must be filed with the agency of original jurisdiction within 30 days of its execution. A copy of any fee agreement that is not a direct-pay fee agreement must be filed with the Office of the General Counsel within 30 days of its execution by mailing the copy to the following address: Office of the General Counsel (022D), Department of Veterans Affairs, 810 Vermont Avenue, NW, Washington, DC 20420. See 38 C.F.R. 14.636(g)(3).

The Office of the 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 the General Counsel. See 38 C.F.R. 14.636(i); 14.637(d).