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UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

No. 18-1640

LINDA MCCANTS, APPELLANT,

V.

ROBERT L. WILKIE,
SECRETARY OF VETERANS AFFAIRS, APPELLEE.

Before MEREDITH, *Judge*.

MEMORANDUM DECISION

Note: Pursuant to U.S. Vet. App. R. 30(a), this action may not be cited as precedent.

MEREDITH, *Judge*: The appellant, Linda McCants, through counsel appeals a March 14, 2018, Board of Veterans' Appeals (Board) decision that denied entitlement to benefits for ischemic heart disease (IHD), including as secondary to herbicide exposure or to service-connected post-traumatic stress disorder (PTSD), and denied entitlement to a total disability rating based on individual unemployability (TDIU) for her deceased husband, veteran Jerry McCants. Record (R.) at 1-19. This appeal is timely, and the Court has jurisdiction to review the Board's decision pursuant to 38 U.S.C. §§ 7252(a) and 7266(a). Single-judge disposition is appropriate. *See Frankel v. Derwinski*, 1 Vet.App. 23, 25-26 (1990). For the following reasons, the Court will vacate the Board's decision and remand the matters for further proceedings consistent with this decision.

I. BACKGROUND

The veteran served on active duty in the U.S. Navy from September 1962 to August 1966, including service aboard the U.S.S. *Enterprise* stationed in the Gulf of Tonkin off the coast of Vietnam. R. at 573; *see* R. at 6.[1]

A. PTSD and TDIU

A VA regional office (RO) granted the veteran's claim for benefits for PTSD in July 2008 and assigned a 30% disability rating, effective February 12, 2007, the date of the claim. R. at 4748-53. At a hearing before a Board member in November 2011, the veteran reported lapses in judgment, obsessive rituals, and unprovoked irritability with periods of violence. R. at 3934-35. He also stated that he experienced short-term memory loss and flashbacks, R. at 3936, as well as suicidal and homicidal thoughts, R. at 3937-38. The appellant testified to her husband's obsessive behavior and angry outbursts. R. at 3939-40, 3943.

In connection with an appeal of the disability rating assigned for PTSD, the veteran's representative, in May 2013, explicitly raised the issue of TDIU as a result of PTSD. *See* R. at 2915. He also submitted a May 2013 letter from a private clinical psychologist, who opined that the veteran was unable to secure or maintain substantially gainful employment since 2002 because of his PTSD. R. at 1986. The examiner acknowledged the veteran's long work history, but stated that he "appeared to benefit considerably from his supervisor's kindness in allowing him to work alone or w[ith] only one other worker to avoid conflicts and blow-ups[,] for which the veteran was evidently very well known." *Id.* Finally, the examiner wrote:

> The progression of the veteran's symptoms of PTSD such as the anger, irritability, difficulty working with others, and his increasingly marked impairments in task concentration and attention/memory, all support his substantial work deficits related to his PTSD. Interestingly, recent work in the medical area has consistently supported the finding that chronic PTSD can and does lead to a marked and increased likelihood of cardiac illness and events (see attached article as an example). Thus, it could be additionally argued that the veteran's nonservice-

[1] The Board found that the Gulf of Tonkin was not an inland waterway and therefore the veteran was not presumed to have been exposed to herbicides. R. at 5-6. Because the appellant does not challenge the Board's determination that her husband's IHD was not secondary to herbicide exposure, the Court will not determine whether the veteran served in the "Republic of Vietnam" for the purposes of the presumption of exposure to herbicides. *See* 38 U.S.C. § 1116(f) (stating that veterans who served in the "Republic of Vietnam" between January 1962 and May 1975 are entitled to a presumption of exposure to herbicides); *Procopio v. Wilkie*, 913 F.3d 1371, 1375-76 (Fed. Cir. 2019) (holding that "the Republic of Vietnam" for the purposes of section 1116 includes the country's territorial waters, which extend 12 nautical miles from shore). Nevertheless, as explained below, because the Court is remanding the IHD claim on different grounds, the Court will also remand a theory of entitlement based on herbicide exposure in light of the change in the law.

> connected heart disease may in fact be related in part to the chronic and disabling stress so characteristic of PTSD.

Id.

In August 2013, the Board remanded the veteran's claim for benefits for PTSD and the matter of entitlement to TDIU for a medical examination to determine if his PTSD precluded him from substantially gainful employment. R. at 2911-18. In accordance with the Board remand, in September 2013 the veteran submitted a formal request for TDIU based on PTSD. R. at 2902-03. In his request, he wrote: "Since 1990[,] my service[-]connected PTSD has affected my employment due to irritability, paranoia[,] and depression. My PTSD has made me unable to mix well with other co[-]workers[,] as well as take orders from my superiors." R. at 2903. The veteran underwent a VA PTSD examination in December 2013. R. at 2814-27. The examiner noted symptoms of depressed mood, anxiety, suspiciousness, weekly panic attacks, chronic sleep impairment, mild memory loss, disturbances of motivation and mood, and difficulty in establishing and maintaining relationships. R. at 2825-26. The examiner determined that the veteran's PTSD did not "preclude him from engaging in substantially gainful employment consistent with [h]is education and occupational experience." R. at 2827.

The veteran's private clinical psychologist reviewed the December 2013 VA examination report and offered an addendum opinion in March 2014. R. at 1975-77. The psychologist wrote that the veteran's "anger, irritability, and limited ability to work with others without significant conflict occurring are clearly related to his PTSD, and would, in an ordinary competitive work environment, promptly lead to his quitting or being discharged for cause." R. at 1977. He further opined that, "with very generous job accommodations, similar to that found in Sheltered Employment, [the] veteran could manage his job." *Id.*

The RO subsequently increased the veteran's initial disability rating for PTSD to 50%. R. at 2477-81. The veteran died in July 2015, R. at 503, and the appellant was substituted in his appeal, R. at 2306. The veteran's counsel proceeded to represent the appellant in continuing the appeal. *See* R. at 2307. The same counsel represents the appellant before the Court in this matter.

In May 2016, the Board increased the veteran's initial disability rating for PTSD to 70%. R. at 611-35. In the same decision, the Board remanded the matter of entitlement to TDIU, finding it inextricably intertwined with the remanded matter of entitlement to benefits for IHD. R. at 632.

The RO denied entitlement to TDIU in a June 2017 Supplemental Statement of the Case. *See* R. at 100-02.

Upon return to the Board, the Board again remanded the matter of entitlement to TDIU in August 2017, finding the issue inextricably intertwined with the remanded matter of entitlement to benefits for IHD. R. at 72.

B. IHD

In April 2011, the veteran filed a claim for benefits for IHD. R. at 4015. The RO denied the claim in March 2012. R. at 3848-57. The veteran filed a Notice of Disagreement with that decision, R. at 3711, and ultimately appealed to the Board, R. at 2607. The Board then remanded the claim for benefits for IHD in May 2016 for a medical opinion to determine whether the veteran's IHD was caused or aggravated by his service-connected PTSD. R. at 632-33.

In August 2016, a VA examiner, Adam Berliner, D.O., opined that it was less likely than not that the veteran's IHD was "proximately due to or the result of" his service-connected PTSD. R. at 54. He further stated: "It is less likely as not that the veteran's PTSD contributed significantly to the development of coronary artery disease." R. at 55. Dr. Berliner then explained that the major risk factors for coronary artery disease include a history of smoking, diabetes mellitus, hypertension, family history of coronary artery disease, and hyperlipidemia, while minor risk factors include stress, which he noted "would include symptoms of PTSD." *Id.* He stated that "[i]t would be merely speculative to conclude which risk factors influenced the veteran's coronary artery disease and to what degree such influence had on his coronary artery disease," because the veteran had three of the major risk factors—a history of smoking, diabetes, and hyperlipidemia. *Id.* Dr. Berliner asserted that "[e]ach of these major risk factors are more likely than PTSD to have contributed to coronary artery disease in this veteran and I cannot determine what, if any, influence PTSD had." *Id.*

The Board found Dr. Berliner's opinion "inadequate for decision making purposes" in August 2017 because Dr. Berliner had "not stated whether the [v]eteran's PTSD aggravated his [IHD], and he ha[d] not provided reasoning as to why an opinion could not be provided without resorting to speculation." R. at 71-72. The Board also determined that Dr. Berliner had "not explained what information would allow for an opinion that did not resort to speculation." R. at 72. Accordingly, the Board remanded the claim for a new medical opinion and directed the

examiner to specifically address an article the appellant had submitted regarding the relationship between PTSD and heart disease. R. at 72-73.

Dr. Berliner provided an addendum opinion in October 2017. He reiterated that "[i]t is less likely as not that the veteran's PTSD contributed significantly to the development of coronary artery disease," and that "[i]t is less likely as not that the veteran's [IHD] was permanently aggravated beyond natural progression by PTSD." R. at 52. Dr. Berliner summarized the article the appellant had submitted as showing "at least mild increased symptom burden, mild increased physical limitation[,] and mildly diminished quality of life in patients with 'stable cardiovascular disease' and a history of PTSD as compared to patients without PTSD." R. at 52-53. He then wrote: "Despite this article's results[,] I stand by my previous decision because the veteran's major risk factors . . . overshadow that of stress associated with PTSD." R. at 53. Dr. Berliner acknowledged that "PTSD is associated with a higher risk of [coronary artery disease (CAD)]," but explained that "this is not equivalent to indicating that the veteran's CAD was at least as likely as not caused or permanently aggravated by PTSD." *Id.* He further stated that, "[i]n this case, diabetes, smoking and hyperlipidemia are 3 factors that very often lead to coronary artery disease, whereas PTSD causes a mildly increased risk of developing the disease or aggravating it," and ultimately concluded that "PTSD did not likely contribute significantly to the development or worsening of this condition." *Id.*

In a December 2017 opinion, VA physician Tiffany Howard, M.D., also determined that it was less likely than not that the veteran's PTSD caused or aggravated his IHD. R. at 50. She explained:

> The major risk factors for [CAD] include history of smoking, diabetes mellitus, hypertension, family history of coronary artery disease[,] and hyperlipidemia. The veteran possessed each of these risk factors. Minor risk factors include ps[y]chological disorders, which would include symptoms of PTSD. It would be merely speculative to conclude which risk factors influenced the veteran's [CAD] and to what degree such influence had on his [CAD]. The veteran had at least 3 major risk factors including diabetes, smoking history[,] and hyperlipidemia. Each of these major risk factors are more likely than PTSD to have contributed to the [CAD] in this veteran. Any association between his CAD and PTSD would be merely speculative, as his major risk factors for the development of this condition far outweigh the minor risk factor.

Id.

Dr. Berliner provided a second addendum opinion in December 2017. R. at 47-49. He stated that it was less likely than not that the veteran's IHD was "proximately due to or the result of" his service-connected PTSD. R. at 48. As rationale, he wrote:

> I have reviewed the November 2009 article . . . submitted [by the veteran] in December 2014. I am aware of the increased risk of cardiovascular disease caused by stress. PTSD is associated with an increased risk of [IHD]. As stated in my previous [] medical opinion[s,] there are numerous risk factors for the development of [IHD]. There are major and minor risk factors. PTSD is a minor risk factor. The veteran had several major risk factors including diabetes, smoking history[,] and hyperlipidemia. Each of these major risk factors are more likely than PTSD to have contributed significantly to the veteran's heart disease. It is less likely as not that the PTSD was a significant contributor to the veteran's heart disease.

R. at 49. Dr. Berliner provided an identical rationale for his conclusion that it was less likely than not that the veteran's PTSD aggravated his IHD. *See id.*

In January 2018, through her current counsel, the appellant asserted that Dr. Howard provided insufficient rationale and made "contradictory conclusions," because she found it would be "merely speculative to conclude which risk factors influenced the veteran's [IHD]" but then concluded that "the veteran's major risk factors, to include diabetes, smoking history, and hyperlipidemia are more likely than PTSD to have contributed to [his IHD]." R. at 26 (emphasis omitted). She also argued that Dr. Berliner, in his December 2017 opinion, provided an insufficient rationale, because he "acknowledged that PTSD is associated with the increased risk of [IHD]" but concluded that the veteran's "major risk factors for [IHD] are more likely than PTSD to have contributed significantly to [his IHD]" without providing "further explanation, facts, or research . . . to explain why PTSD, still a known risk factor, did not aggravate or contribute to the development of the [v]eteran's [IHD]." *Id.*

C. Board Decision

In March 2018, the Board issued the decision on appeal, denying entitlement to benefits for IHD, including as secondary to service-connected PTSD, and to a total disability rating based on individual unemployability. In denying entitlement to benefits for IHD, the Board found the VA medical opinions adequate, R. at 5, and relied on Dr. Berliner's August 2016 and December 2017 medical opinions, as well as Dr. Howard's December 2017 opinion, which the Board collectively found to be of great probative weight, *see* R. at 8-10. With respect to TDIU, the Board found that "the record as a whole does not support a finding that [the veteran] was unable to obtain

or maintain substantially gainful employment consistent with education and occupational history because of his PTSD." R. at 16. Instead, the Board stated, "the [v]eteran maintained substantially gainful employment for many years before a nonservice-connected cardiac disability rendered him unemployable." *Id.* This appeal followed.

II. ANALYSIS

A. TDIU

On appeal, the appellant argues that the Board erred by relying on the veteran's pre-retirement, pre-claim work history to find that his PTSD did not prevent him from securing or maintaining substantially gainful employment. Appellant's Brief (Br.) at 23-30. She further asserts that the Board failed to account for the favorable 2013 opinion from a private examiner opining that the veteran had been unable to work since 2002 because of his PTSD. *Id.* at 24. The Secretary asserts that the appellant has failed to carry her burden of demonstrating clear error in the Board's decision to deny entitlement to TDIU. Secretary's Br. at 23-28.

TDIU may be assigned to a veteran who meets certain disability percentage thresholds and is "unable to secure or follow a substantially gainful occupation as a result of service-connected disabilities." 38 C.F.R. § 4.16(a) (2018). If a veteran fails to meet the percentage standards set forth in § 4.16(a) but is "unemployable by reason of service-connected disabilities," the matter should be submitted to the Director of the Compensation Service (Director) for extraschedular consideration. 38 C.F.R. § 4.16(b).

Whether a veteran is unable to secure or follow substantially gainful employment is a finding of fact that this Court reviews under the "clearly erroneous" standard. 38 U.S.C. § 7261(a)(4); *Bowling v. Principi*, 15 Vet.App. 1, 6 (2001). A finding of fact is clearly erroneous when the Court, after reviewing the entire evidence, "is left with the definite and firm conviction that a mistake has been committed." *United States v. U.S. Gypsum Co.*, 333 U.S. 364, 395 (1948); *see Gilbert v. Derwinski*, 1 Vet.App. 49, 52 (1990). As with any material issue of fact or law, the Board must provide a statement of the reasons or bases for its determination "adequate to enable a claimant to understand the precise basis for the Board's decision, as well as to facilitate review in this Court." *Allday v. Brown*, 7 Vet.App. 517, 527 (1995); *see* 38 U.S.C. § 7104(d)(1); *Gilbert*, 1 Vet.App. at 56-57.

Initially, the Board indicated that the issue of entitlement to TDIU has been pending since 2008.[2] R. at 3. The Board then reviewed the evidence of record relating to the veteran's work history, including his statements that he stopped working in 2002, as well as the private and VA medical evidence related to his ability to work. R. at 12-15. The Board found the private opinions outweighed by other evidence of record because they "do not provide sufficient rationale to support the finding that each of the [v]eteran's employers was a sheltered or marginal employer." R. at 15. The Board emphasized that, "[m]ost recently, the [v]eteran worked for an employer with no particular ties of friendship that might result in unusual accommodation or leeway, and performed successfully," and that "he only left this employment because of his nonservice-connected cardiac disability." R. at 15-16. The Board noted that, at a December 2013 VA examination, the veteran reported that, in his most recent employment, "he got along well with his co-workers, meaning an unusual degree of isolation was not needed or requested." R. at 16. Accordingly, the Board concluded:

> [T]he record as a whole does not support a finding that [the veteran] was unable to obtain or maintain substantially gainful employment consistent with [his] education and occupational history because of his PTSD. On the contrary, [he] maintained substantially gainful employment for many years before a nonservice-connected cardiac disability rendered him unemployable.

Id.

As this discussion reflects, the Board relied on the veteran's ability to work before his retirement in 2002 and its finding that his retirement was due to a nonservice-connected medical condition. That discussion, however, does not address whether his service-connected PTSD rendered him unemployable *during the period on appeal*, and the Board did not explain why the veteran's employment history prior to his retirement in 2002—more than 6 years before the Board indicated the eligibility period for TDIU began, R. at 3—was more probative than the more recent evidence of his current ability to perform substantially gainful employment. Further, the Board discounted the private examiner's opinion because it found that the examiner mischaracterized the nature of the veteran's previous employment—prior to 2002—as having been sheltered. But, the Board did not address in its analysis the private examiner's opinions that the veteran's PTSD symptoms would have severely affected his ability to work *since 2002*. *See* R. at 1977, 1986. The

[2] The Board stated that TDIU was "part and parcel" of an appeal of the 2008 assignment of a PTSD rating but was not listed as a separate issue by the Board until 2013. R. at 3.

Board's reasons or bases for denying TDIU are therefore inadequate and remand is necessary. *See* 38 U.S.C. § 71041(d)(1); *Allday*, 7 Vet.App. at 527.

B. IHD

The appellant argues that, in denying entitlement to benefits for IHD, the Board "misinterpreted and misapplied the law, applied a standard higher than that which the law requires, failed to ensure that the duty to assist was satisfied, and provided inadequate reasons or bases." Appellant's Br. at 14. She contends that the Board relied on VA medical opinions reflecting that the veteran's PTSD was not a "significant" contributor to his IHD, even though the law does not specify a level of contribution required for secondary service connection. *Id.* at 14-16. She asserts that the VA opinions are inadequate for this reason as well. *Id.* at 16-18. The appellant alleges additional inadequacies in the VA medical opinions: (1) the Board previously found the August 2016 VA opinion inadequate and did not explain its reliance on that decision to deny the claim; (2) the December 2017 VA opinion is based on speculation; and (3) all VA examiners failed to properly address whether the veteran's IHD was aggravated by his PTSD. *Id.* at 18-23. The Secretary requests that the Court decline to address the appellant's challenges to the adequacy of the VA medical opinions because she raises them for the first time on appeal. Secretary's Br. at 9-12. Beyond that, the Secretary disputes the appellant's arguments and urges the Court to affirm this portion of the Board decision. *Id.* at 12-23.

To begin, the Court is not persuaded that it should decline to address all the appellant's arguments regarding the sufficiency of the VA medical opinions. *See Maggitt v. West*, 202 F.3d 1370, 1377-78 (Fed. Cir. 2000) (holding that this Court has jurisdiction to hear arguments presented to it in the first instance, provided that it otherwise has jurisdiction over the claim, and the Court has discretion to consider, refuse to hear, or remand arguments presented to it in the first instance). The Court concludes that, as the appellant argues, Reply Br. at 1-4, her January 2018 arguments to the Board sufficiently encompass the arguments she raises on appeal with respect to the 2017 opinions, as discussed below. *See* R. at 26-29. Further, because the Board previously found the August 2016 examination to be inadequate but apparently relied on it in the decision on appeal, the Court will exercise its discretion to hear arguments as to that examination that were not raised during the proceedings before the Board in 2018. *See Maggitt*, 202 F.3d at 1377-78; Appellant's Reply Br. at 2 (arguing that, because the August 2016 examination had already been deemed inadequate, it was not necessary to challenge that examination below). The Court will not

consider the remainder of the appellant's arguments as to the 2017 opinions, because the appellant, who was represented below by current counsel, did not raise the same or similar arguments to the Board. *See Scott v. McDonald*, 789 F.3d 1375, 1377 (Fed. Cir. 2015) (quoting *United States v. L.A. Tucker Truck Lines, Inc.*, 344 U.S. 33, 37 (1952)).

Under certain circumstances, and as part of its duty to assist claimants, VA must provide a medical examination or opinion. *See* 38 U.S.C. § 5103A(d). "[O]nce the Secretary undertakes the effort to provide an examination [or opinion,] . . . he must provide an adequate one." *Barr v. Nicholson*, 21 Vet.App. 303, 311 (2007). A medical examination or opinion is adequate "where it is based upon consideration of the veteran's prior medical history and examinations," *Stefl v. Nicholson*, 21 Vet.App. 120, 123 (2007), "describes the disability, if any, in sufficient detail so that the Board's 'evaluation of the claimed disability will be a fully informed one,'" *id.* (quoting *Ardison v. Brown*, 6 Vet.App. 405, 407 (1994)) (internal quotation marks omitted), and "sufficiently inform[s] the Board of a medical expert's judgment on a medical question and the essential rationale for that opinion," *Monzingo v. Shinseki*, 26 Vet.App. 97, 105 (2012) (per curiam). The law does not impose any reasons-or-bases requirements on medical examiners and the adequacy of medical reports must be based upon a reading of the report as a whole. *Id.* at 105-06.

"Whether a medical [examination or] opinion is adequate is a finding of fact, which the Court reviews under the 'clearly erroneous' standard." *D'Aries v. Peake*, 22 Vet.App. 97, 104 (2008) (per curiam). The Board must adequately explain its conclusions regarding the adequacy of a medical examination or opinion. *See* 38 U.S.C. § 7104(d)(1); *Allday*, 7 Vet.App. at 527; *Gilbert*, 1 Vet.App. at 56-57.

The Board found that the record contains "three negative medical opinions," which it found of "greater probative value" than the only favorable evidence of record—the medical treatise article the appellant submitted—"because the article provides general statements, while the medical opinions are based upon the specific facts of the [v]eteran's case." R. at 10. The Board acknowledged the appellant's argument that Dr. Howard's opinion was contradictory because, as the Board characterized it, she first stated that "it would be merely speculative to conclude which risk factors influenced the [IHD] and to what degree, before stating that the [v]eteran's major risk factors[—diabetes, smoking, and hyperlipidemia—]were *more likely* [emphasis added] to have contributed than PTSD." R. at 9 (second brackets in original). The Board rejected this argument

because it did not find the general statement that it was speculative to conclude "exactly" which factors influenced the veteran's IHD contradictory to "a finding that the minor risk factor of PTSD was generally less likely to influence the [v]eteran's heart disease than the major risk factors in his medical history." R. at 9-10. However, as the appellant argues, the Board previously found inadequate Dr. Berliner's August 2016 opinion that had provided a nearly identical rationale as that used by Dr. Howard in December 2017, Appellant's Br. at 20 (citing R. at 71-72), and the Board provided no explanation for why it now found that rationale to be sufficient.

Similarly, as the appellant also argues, Appellant's Br. at 18-20, the Board did not explain why it apparently relied on Dr. Berliner's August 2016 opinion, despite having found that opinion inadequate in August 2017. *See* R. at 71-72; *see also* R. at 8-9 (summarizing the August 2017 medical opinion, omitting reference to Dr. Berliner's October 2017 opinion,[3] and summarizing Dr. Howard's and Dr. Berliner's December 2017 opinions), 10 (stating that the record contains "three negative medical opinions").

With regard to the issue of aggravation, the appellant argued below that, in his December 2017 opinion, Dr. Berliner failed to provide an adequate rationale for concluding that PTSD did not aggravate the veteran's IHD. R. at 29. On appeal, she contends that Dr. Berliner did not properly address the issue of aggravation, because the examiner's reasoning focused on causation. Appellant's Br. at 21-22. Although the Secretary points out that Dr. Berliner stated that it was less likely than not that the veteran's PTSD aggravated his IHD, Secretary's Br. at 16, he does not point to, and the Court's review of the decision does not reveal, any analysis by the Board as to whether the examiner's reasoning was sufficient to support an aggravation opinion. *See* R. at 46 (Dr. Berliner's December 2017 opinion, referring to the "development of" heart disease, to heart disease "caused by" stress, and to risk factors "contribut[ing] significantly" to heart disease); *see also El-Amin v. Shinseki*, 26 Vet.App. 136, 140-41 (2013) (holding that examinations that focus solely on causation are insufficient for the purposes of determining whether one condition aggravated another). The Court's review is frustrated by the Board's failure to make the necessary

[3] The Secretary asserts that any inadequacy in Dr. Berliner's August 2016 opinion was cured by his October 2017 opinion, Secretary's Br. at 12-13, but the Board did not refer to the October 2017 opinion at all in the decision on appeal. *See Martin v. Occupational Safety & Health Review Comm'n*, 499 U.S. 144, 156 (1991) ("[A]gency 'litigating positions' are not entitled to deference when they are merely appellate counsel's 'post hoc rationalizations' for agency action, advanced for the first time in the reviewing court."); *Evans v. Shinseki*, 25 Vet.App. 7, 16 (2011) ("[I]t is the Board that is required to provide a complete statement of reasons or bases, and the Secretary cannot make up for its failure to do so.").

factual findings in the first instance. *See Hensley v. West*, 212 F.3d 1255, 1263 (Fed. Cir. 2000) ("[A]ppellate tribunals are not appropriate fora for initial fact finding"); *see also* 38 U.S.C. § 7261(c).

Remand is thus necessary for the Board to reassess the adequacy of the medical opinions of record. Given this disposition, the Court will not now address the remaining arguments and issues raised by the appellant.[4] *See Quirin v. Shinseki*, 22 Vet.App. 390, 395 (2009) (noting that "the Court will not ordinarily consider additional allegations of error that have been rendered moot by the Court's opinion or that would require the Court to issue an advisory opinion"); *Best v. Principi*, 15 Vet.App. 18, 20 (2001) (per curiam order). On remand, the appellant is free to submit additional evidence and argument on the remanded matters, including the specific arguments raised here on appeal, and the Board is required to consider any such relevant evidence and argument. *See Kay v. Principi*, 16 Vet.App. 529, 534 (2002) (stating that, on remand, the Board must consider additional evidence and argument in assessing entitlement to the benefit sought); *Kutscherousky v. West*, 12 Vet.App. 369, 372-73 (1999) (per curiam order). The Court reminds the Board that "[a] remand is meant to entail a critical examination of the justification for the decision," *Fletcher v. Derwinski*, 1 Vet.App. 394, 397 (1991), and the Board must proceed expeditiously, in accordance with 38 U.S.C. § 7112.

III. CONCLUSION

After consideration of the parties' pleadings and a review of the record, the Board's March 14, 2018, decision is VACATED and the matters are REMANDED for further proceedings consistent with this decision.

DATED: May 21, 2019

Copies to:

Zachary M. Stolz, Esq.

VA General Counsel (027)

[4] As noted above, the appellant does not challenge the Board's determination that the veteran's IHD was not secondary to herbicide exposure. The Court nevertheless has jurisdiction over this issue. *See Pederson v. McDonald*, 27 Vet.App. 276, 283 (2015) (en banc). Because the Court is remanding the appellant's claim for benefits for IHD, the Board must also address the theory of entitlement to benefits based on herbicide exposure in light of *Procopio*, 913 F.3d at 1375-76.