BOARD OF VETERANS' APPEALS

FOR THE SECRETARY OF VETERANS AFFAIRS

WASHINGTON, DC 20038

Date: June 13, 2019 [redacted]

MICHAEL T. FORD
9645 OSPREY LANDING DR
ORLANDO, FL 32832

Dear Appellant:

The Board of Veterans' Appeals (Board) has made a decision in your appeal, and a copy is enclosed.

If your decision contains a	*What happens next*
Grant	The Department of Veterans Affairs (VA) will be contacting you regarding the next steps, which may include issuing payment. Please refer to VA Form 4597, which is attached to this decision, for additional options.
Remand	Additional development is needed. VA will be contacting you regarding the next steps.
Denial or Dismissal	Please refer to VA Form 4597, which is attached to this decision, for your options.

If you have any questions, please contact your representative, if you have one, or check the status of your appeal at http://www.vets.gov.

Sincerely yours,

K. Osborne
Deputy Vice Chairman

Enclosures (1)
CC: Carol J. Ponton, Attorney

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BOARD OF VETERANS' APPEALS

FOR THE SECRETARY OF VETERANS AFFAIRS

IN THE APPEAL OF
MICHAEL FORD [redacted]
Docket No. 16-15 317
REPRESENTED BY
Carol J. Ponton, Attorney

DATE: June 13, 2019

ORDER

New and material evidence having been received, the previously denied claim for service connection for a left knee disability is reopened.

New and material evidence not having been received, the previously denied claim for service connection for a right eye disability is not reopened.

Service connection for sleep apnea is granted.

Service connection for bruxism is denied.

An initial evaluation of 10 percent, and no more, for traumatic brain injury is granted, subject to the laws and regulations governing the award of monetary benefits.

An initial increased evaluation for migraines, evaluated as noncompensable prior to February 1, 2016, and as 30 percent disabling thereafter, is denied.

An increased rating for left ankle sprain, evaluated as noncompensable prior to September 8, 2011, and as 10 percent disabling thereafter, is denied.

IN THE APPEAL OF [redacted]
MICHAEL FORD Docket No. 16-15 317

REMANDED

The claims for service connection for a cervical spine disability, a lumbar spine disability, a right shoulder disability, a right knee disability, a left knee disability, and a neurological disability of the left hand, and for a rating in excess of 50 percent for posttraumatic stress disorder (PTSD) prior to October 9, 2015, are remanded.

FINDINGS OF FACT

1. In a final decision, dated in September 1994, the RO denied a claim for service connection for a left knee disability.

2. The evidence received since the RO's September 1994 decision, which denied service connection for a left knee disability, is new and material and raises a reasonable possibility of substantiating the claim.

3. In a final decision, dated in August 2010, the RO denied a claim for service connection for keratoconus, right eye.

4. The evidence received since the RO's August 2010 decision, which denied service connection for keratoconus, right eye, that was not previously of record and that is not cumulative of other evidence of record, does not raise a reasonable possibility of substantiating the claim.

5. The Veteran has sleep apnea that was caused by a service-connected disability.

6. The Veteran does not have bruxism that is related to his service or to a service connected disability.

7. The Veteran's residuals of a traumatic brain injury are shown to have been productive of mild memory impairment, but not symptoms warranting more than a level "1" in any category under DC 8045.

8. Prior to February 1, 2016, the Veteran's migraines are not shown to have been productive of characteristic prostrating attacks averaging one episode in two months over a several month period.

9. As of February 1, 2016, the Veteran's migraines are shown to cause characteristic prostrating attacks of migraine pain "more frequently than once per month"; his migraines are not shown to have been manifested by very frequent, completely prostrating and prolonged attacks productive of severe economic inadaptability for any distinct period during the course of the appeal.

10. Prior to September 8, 2011, the Veteran's left ankle strain is not shown to have been productive of a moderate limitation of motion, ankylosis, a malunion of the os calcis or astragalus, or astragalectomy.

11. As of September 8, 2011, the Veteran's left ankle sprain is shown to have been productive of subjective complaints of pain, but no more than moderate limitation of motion. Ankylosis, a malunion of the os calcis or astragalus, and astragalectomy, have not been shown or alleged.

CONCLUSIONS OF LAW

1. The criteria to reopen a previously denied claim for a left knee disability have been met. 38 U.S.C. § 5108; 38 C.F.R. § 3.156.

2. The criteria to reopen a previously denied claim for a right eye disability have not been met. 38 U.S.C. § 5108; 38 C.F.R. § 3.156.

3. The criteria for service connection for sleep apnea have been met. 38 U.S.C. § 1131; 38 C.F.R. § 3.310.

4. The criteria for service connection for bruxism have not been met. 38 U.S.C. §§ 1131, 5107; 38 C.F.R. §§ 3.102, 3.159, 3.303, 3.310.

5. The criteria for an initial 10 percent evaluation, and no higher, for service-connected residuals of a traumatic brain injury, have been met. 38 U.S.C. §§ 1155, 5107(b); 38 C.F.R. §§ 3.102, 3.159, 4.7, 4.124a, Diagnostic Code 8045.

6. The criteria for a compensable rating for migraine headaches prior to February 1, 2016, or a rating in excess of 30 percent thereafter, for migraine headaches have not been met. 38 U.S.C. §§ 1155, 5107(b); 38 C.F.R. §§ 3.102, 3.159, 4.7, 4.71a, 4.124a, Diagnostic Code 8100.

7. The criteria for a compensable rating for left ankle sprain prior to September 8, 2011, or in excess of 10 percent thereafter, have not been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 3.102, 3.159, 4.7, 4.40, 4.45, 4.59, 4.71a, Diagnostic Codes 5270, 5271, 5272, 5273, 5274.

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

The Veteran had active service from August 1980 to October 1986.

Although additional evidence has been received that is of record and which has not been reviewed by the Agency of Original Jurisdiction (AOJ), a waiver of AOJ review, received in January 2019, is of record. *See* 38 C.F.R. § 20.1304.

In February 2019, the Veteran withdrew his request for a hearing. *See* 38 C.F.R. § 20.704 (e).

1. New and Material.

The Veteran asserts that new and material evidence has been submitted to reopen claims for service connection for a left knee disability, and a right eye disability.

In September 1994, the RO denied a claim for service connection for a left knee disability. In August 2010, the RO denied a claim for service connection for a right eye disability (keratoconus, right eye). In each case, there was no appeal, and no new and material evidence submitted within a year, and the RO's decisions became final. *See* 38 U.S.C. § 7105(c).

The most recent and final denial of the claims were in September 1994 (left knee), and August 2010 (right eye). Therefore, the Board must determine if new and material evidence has been received since those times. *See* 38 U.S.C. § 5108. When determining whether the evidence is new and material, the specified basis for the last final disallowance must be considered. *See Hodge v. West*, 155 F.3d 1356 (Fed. Cir. 1998). Service connection may be granted for disability resulting from disease or injury incurred in or aggravated by service. 38 U.S.C. § 1131; 38 C.F.R. § 3.303. Service connection may also be granted on the basis of a post-service initial diagnosis of a disease, when "all of the evidence, including that pertinent to service, establishes that the disease was incurred during service." *See* 38 C.F.R. § 3.303 (d).

Congenital or developmental defects, e.g., refractive error of the eyes, as such, are not diseases or injuries within the meaning of applicable legislation and, thus, are not disabilities for which service connection may be granted. 38 C.F.R. § 3.303 (c); *see also* 38 C.F.R. § 4.9; *Beno v. Principi*, 3 Vet. App. 439 (1992). Service connection may be granted for diseases (but not defects) of congenital, developmental or familial origin if the evidence as a whole shows that the manifestations of the disease in service constituted "aggravation" of the disease within the meaning of applicable VA regulations. VAOPGCPREC 82-90; 56 Fed. Reg. 45711 (1990).

VA has recognized that refractive errors include astigmatism, myopia, hyperopia, and presbyopia.

The Board first notes that the RO first denied this claim in September 1994, however, a copy of the RO's September 1994 decision is not of record. It appears that the Veteran's claims file was lost and that it was rebuilt in March 1995. In June 2012, the RO noted that the claim was initially denied in September 1994, and determined that new and material evidence had not been received to reopen the claim. *See also* February 2016 statement of the case.

Left knee.

Since September 1994, the Veteran has submitted additional medical evidence regarding his left knee. Specifically, in September 2013, Dr. L wrote that the

Veteran's problems began approximately in 1981 when he began to seek treatment for knee pain followed by back pain, ankle pain, neck pain, and ultimately his left wrist injury. He stated that it is his opinion that the Veteran's symptoms were more than likely aggravated by the motor vehicle accident in 1985, as the Veteran denied any intermittent injuries since his discharge from the service. He further stated that it is his opinion that these conditions as stated above are all as likely as not directly related to the Veteran's military service "based on his 160 parachuting drops during service."

In his opinion, Dr. L also alluded to a May 2011 opinion from Dr. M (an orthopedic surgeon) who felt that the degree of the Veteran's chondromalacia and knee pain could have been severely exacerbated by his paratrooper training and work activities.

For the purpose of reopening a claim, the credibility of these statements is presumed. When this is done, the evidence of record added since the last final denial raises a reasonable possibility of substantiating the Veteran's claim, and therefore the previously denied claim for service connection for a left knee disability is reopened.

Right Eye.

At the time of the RO's August 2010 decision, the evidence included the Veteran's service treatment records, which showed that he received multiple treatments for visual symptoms, with notations that included CMA (compound myopia, astigmatism). He wore glasses. An April 1983 report notes conjunctivitis OD (right eye). In April 1984, a routine eye examination noted that he did not have any visual complaints or ocular symptoms. The Veteran was noted to have simple myopia and refractive amblyopia OD. The Veteran's separation examination report, dated in October 1986, shows that his that his eyes, ophthalmoscopic examination, pupils, and ocular motility, were clinically evaluated as normal. Corrected distant vision in the right eye was 20/30. A report of medical history, dated in October 1986, shows that the Veteran indicated that he had a history of eye trouble. He stated, "I am in good health except for my (left) ankle and (left) foot, a Morton's neuroma need(s) to be removed."

As for the post-service medical evidence, at the time of the RO's August 2010 decision, VA progress notes showed that in September 2008, the Veteran reported that during service he had an explosion in his face and eye infections (residuals to the eyes from an explosion are not shown in his service treatment records). He was noted to have keratoconus "since 1986," and a history of vision 20/400 OU (both eyes). The impression was keratoconus OU, status post multiple procedures by outside ophthalmologist.

A VA eye examination report, dated in July 2010, showed that the Veteran was noted to have a history of viral eye infections and high astigmatism in the right eye, with measures of corneal shape in the early 1980s suggesting potential keratoconus, which was ultimately diagnosed in the late 1980s. In 2008, the Veteran underwent a surgical procedure (Intacs) in both eyes to attempt to correct corneal irregularities associated with keratoconus. The diagnosis was keratoconus. The examiner concluded that it was less likely as not that the Veteran's right eye condition was caused by, or a result of, his service. The examiner explained that the Veteran has keratoconus, a degenerative corneal condition where the cornea thins and develops irregular astigmatism, and that it is thought to have some hereditary component, but it is also known to be aggravated by things such as ocular allergies and inflammation. In this case, the Veteran had clear signs of keratoconus in the right eye before and during his time in service, however, the signs were mild at the time, and the two or three cases of viral conjunctivitis during service appear to have left no residual issues. During the course of the past decade, the keratoconus had progressed significantly, and the Veteran had sought treatment alternatives, including specialty contact lenses and surgery. Visual acuity was noted to be approximately 20/30 in the right eye at that time, which is about where it was when he entered the service, and before his keratoconus progressed.

The evidence received since the RO's August 2010 decision includes private records showing ongoing treatment for eye symptoms, dated beginning in 2005. This evidence includes notations of keratoconus and anisometropia, and a history of bilateral Intacs and conductive keratoplasty OU.

An affidavit from R. W., O.D., dated in December 2009, shows that she states that she examined the Veteran in early November 1986, and that he was wearing glasses and had problems with his vision. On examination, he had keratoconus in

both eyes, and he was fitted for contact lenses. Unfortunately, she no longer had records of his treatment.

This evidence, which was not of record at the time of the RO's August 2010 decision, which is not cumulative, is "new" within the meaning of 38 C.F.R. § 3.156. However, the Board finds that this evidence is not material. At the time of the RO's August 2010 decision, the Veteran was not shown to have had eye symptoms during service, and there was no competent evidence to show incurrence of a right eye disability during service. Rather, the Veteran was shown to have current findings of refractive error and keratoconus. The submitted evidence shows continued treatment for eye symptoms, which does not warrant a reopening of the claim. *Cornele v. Brown*, 6 Vet. App. 59, 62 (1993). In addition, it does not remedy the missing facts that were not present when the claim was previously denied, as it does not include competent evidence to show that the Veteran has a right eye disability due to his service, to include medical evidence to show that the Veteran has additional disability from aggravation (i.e., a permanent worsening) of a congenital or developmental defect, i.e., mental deficiency during service from a superimposed disease or injury. VAOPGCPREC 82-90; *Shade*. In summary, the new evidence is not material, and does not raise a reasonable possibility of substantiating the claim. Accordingly, the claim for a right eye disability condition is not reopened.

2. Service Connection.

The Veteran asserts that service connection is warranted for sleep apnea, and bruxism.

Service connection may be granted for disability resulting from disease or injury incurred in or aggravated by service. 38 U.S.C. § 1131; 38 C.F.R. § 3.303. Service connection may also be granted on the basis of a post-service initial diagnosis of a disease, when "all of the evidence, including that pertinent to service, establishes that the disease was incurred during service." *See* 38 C.F.R. § 3.303 (d).

Sleep Apnea.

The Veteran asserts that his sleep apnea was either caused or aggravated by his service-connected PTSD.

The Veteran's service treatment records do not contain any complaints, findings or diagnoses shown to be relevant.

In May 2012, a VA examiner diagnosed the Veteran with obstructive sleep apnea, with a date of diagnosis of 2011. The examiner concluded that it was less likely than not that the Veteran's sleep apnea was related to his PTSD, explaining that sleep apnea is a separate entity from his PTSD, and that it is an obstructive process.

In September 2013, the Veteran submitted an opinion from L.G., M.D., in which Dr. L.G. concluded that it is at least as likely as not that the Veteran's sleep apnea was caused by his PTSD. The physician referenced multiple medical studies in support of his conclusion.

VA regulations dictate that if the evidence is in relative equipoise, then the benefit of the doubt must be resolved in the appellant's favor. 38 U.S.C. § 5107 (b). That is the case here. Accordingly, service connection for sleep apnea is granted.

Bruxism.

The Veteran's service treatment records include the Veteran's separation examination report, dated in October 1986, which shows that his that his mouth and throat were clinically evaluated as normal. His teeth were noted to be in good repair. A report of medical history, dated in October 1986, shows that the Veteran indicated that he had a history of severe tooth or gum trouble. He stated, "I am in good health except for my (left) ankle and (left) foot, a Morton's neuroma need(s) to be removed." He stated that he had numerous one-time occurrences on several of his complaints, with no significant history of any, other than Morton's neuroma of the left foot, and left ankle instability.

As for the post-service medical evidence, private treatment records from W.H., D.D.S., dated in 1986, note moderate to heavy sublingual calculus, generalized chronic gingivitis, and a high plaque index. He was noted to have old restorations and new caries, with a history of a number of amalgam and composite restorations.

VA progress notes show that in 2018, the Veteran sought treatment for about a one-year history of an infection of the mandible, with jaw pain. He was noted to have been recommended for full bone grafting done with extractions. There are notations of periapical abscess and irreversible pulpitis, and that he was pending extractions of multiple hopeless teeth.

The Board finds that service connection bruxism is not warranted. The Veteran clearly has some dental problems during service, however, bruxism was not shown, and there is no evidence to show that he had bruxism during service that caused or contributed to a dental disability as defined at 38 C.F.R. § 4.150. There is no competent and probative opinion of record in support of the claim on any basis. Accordingly, service connection on a direct or secondary basis is not warranted. *See* 38 C.F.R. §§ 3.303, 3.310.

With regard to the Veteran's own contentions, although lay persons are competent to provide opinions on some medical issues, *see Kahana v. Shinseki*, 24 Vet. App. 428, 435 (2011), as to the specific issue in this case, it falls outside the realm of common knowledge of a lay person. *See Jandreau v. Nicholson*, 492 F.3d 1372 (Fed. Cir. 2007). Although the Veteran is competent to report the presence of physical symptoms, he has not specifically claimed to have bruxism symptoms on an ongoing basis since his service, and the claimed disability is not the types of condition that is readily amenable to mere lay diagnosis or probative comment regarding its etiology, as the evidence shows that specific findings are needed to properly assess and diagnose such disorder. *Id*. The Board has determined that service connection is not warranted for the claimed disability. Given the foregoing, the Board finds that the medical evidence outweighs the appellant's contentions to the effect that he has the claimed condition due to his service. *Id*.

2. Increased Initial Evaluations.

Traumatic Brain Injury.

In March 2015, the RO granted service connection for a traumatic brain injury, evaluated as noncompensable, with an effective date of December 13, 2013. The Veteran has appealed the issue of entitlement to an initial compensable evaluation.

The Veteran's traumatic brain injury with headaches has been evaluated as 10 percent disabling under 38 C.F.R. § 4.124a, Diagnostic Code (DC) 8045.

Under DC 8045, there are three main areas of dysfunction that may result from TBIs and have profound effects on functioning: cognitive (which is common in varying degrees after a TBI), emotional/behavioral, and physical. Each of these areas of dysfunction may require evaluation. DC 8045.

Cognitive impairment is defined as decreased memory, concentration, attention, and executive functions of the brain. Executive functions are goal setting, speed of information processing, planning, organizing, prioritizing, self-monitoring, problem solving, judgment, decision making, spontaneity, and flexibility in changing actions when they are not productive. Not all of these brain functions may be affected in a given individual with cognitive impairment, and some functions may be affected more severely than others. In a given individual, symptoms may fluctuate in severity from day to day. Cognitive impairment should be evaluated under the table titled "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified."

Subjective symptoms may be the only residual of a TBI or may be associated with cognitive impairment or other areas of dysfunction. Evaluate subjective symptoms that are residuals of a TBI, whether or not they are part of cognitive impairment, under the subjective symptoms facet in the table titled "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified." However, separately evaluate any residual with a distinct diagnosis that may be evaluated under another diagnostic code, such as migraine headache or Meniere's disease, even if that diagnosis is based on subjective symptoms, rather than under the "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified" table.

Evaluate emotional/behavioral dysfunction under § 4.130 (Schedule of ratings-mental disorders) when there is a diagnosis of a mental disorder. When there is no diagnosis of a mental disorder, evaluate emotional/behavioral symptoms under the criteria in the table titled "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified."

Evaluate physical (including neurological) dysfunction based on the following list, under an appropriate diagnostic code: motor and sensory dysfunction, including pain of the extremities and face; visual impairment; hearing loss and tinnitus; loss of sense of smell and taste; seizures; gait, coordination, and balance problems; speech and other communication difficulties, including aphasia and related disorders, and dysarthria; neurogenic bladder; neurogenic bowel; cranial nerve dysfunctions; autonomic nerve dysfunctions; and endocrine dysfunctions.

The preceding list of types of physical dysfunction does not encompass all possible residuals of a TBI. For residuals not listed here that are reported on an examination, evaluate under the most appropriate diagnostic code. Evaluate each condition separately, as long as the same signs and symptoms are not used to support more than one evaluation, and combine under § 4.25 the evaluations for each separately rated condition. The evaluation assigned based on the "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified" table will be considered the evaluation for a single condition for purposes of combining with other disability evaluations.

Consider the need for special monthly compensation for such problems as loss of use of an extremity, certain sensory impairments, erectile dysfunction, the need for aid and attendance (including for protection from hazards or dangers incident to the daily environment due to cognitive impairment), being housebound, etc. Evaluation of Cognitive Impairment and Subjective Symptoms: the table titled "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified" contains 10 important facets of a TBI related to cognitive impairment and subjective symptoms. It provides criteria for levels of impairment for each facet, as appropriate, ranging from 0 to 3, and a 5th level, the highest level of impairment, and labeled "total." However, not every facet has every level of severity. The Consciousness facet, for example, does not provide for an impairment level other than "total," since any level of impaired consciousness would be totally disabling. Assign a 100- percent evaluation if "total" is the level of evaluation for one or more facets. If no facet is evaluated as "total," assign the overall percentage evaluation based on the level of the highest facet as follows: 0 = 0 percent; 1 = 10 percent; 2 = 40 percent; and 3 = 70 percent. For example, assign a 70 percent evaluation if 3 is the highest level of evaluation for any facet.

The table titled "Evaluation Of Cognitive Impairment And Other Residuals of TBI Not Otherwise Classified" provides the following evaluations:

Impairment of memory, attention, concentration, executive functions are assigned numerical designations as follows: (0) No complaints of impairment of memory, attention, concentration, or executive functions; (1) A complaint of mild loss of memory (such as having difficulty following a conversation, recalling recent conversations, remembering names of new acquaintances, or finding words, or often misplacing items), attention, concentration, or executive functions, but without objective evidence on testing; (2) Objective evidence on testing of mild impairment of memory, attention, concentration, or executive functions resulting in mild functional impairment; (3) Objective evidence on testing of moderate impairment of memory, attention, concentration, or executive functions resulting in moderate functional impairment; and (Total) Objective evidence on testing of severe impairment of memory, attention, concentration, or executive functions resulting in severe functional impairment.

Impairment of judgment is assigned numerical designations as follows: (0) Normal; (1) Mildly impaired judgment - For complex or unfamiliar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision; (2) Moderately impaired judgment - For complex or unfamiliar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision, although has little difficulty with simple decisions; (3) Moderately severely impaired judgment - For even routine and familiar decisions, occasionally unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision; and (Total) Severely impaired judgment - For even routine and familiar decisions, usually unable to identify, understand, and weigh the alternatives, understand the consequences of choices, and make a reasonable decision. For example, unable to determine appropriate clothing for current weather conditions or judge when to avoid dangerous situations or activities.

Impairment of social interaction is assigned numerical designations as follows: (0) Social interaction is routinely appropriate; (1) Social interaction is occasionally

inappropriate; (2) Social interaction is frequently inappropriate; and (3) Social interaction is inappropriate most or all of the time.

Impairment of orientation is assigned numerical designations as follows: (0) Always oriented to person, time, place, and situation; (1) Occasionally disoriented to one of the four aspects (person, time, place, situation) of orientation; (2) Occasionally disoriented to two of the four aspects (person, time, place, situation) of orientation or often disoriented to one aspect of orientation; (3) Often disoriented to two or more of the four aspects (person, time, place, situation) of orientation; and (Total) Consistently disoriented to two or more of the four aspects (person, time, place, situation) of orientation.

Impairment of motor activity (with intact motor and sensory system) is assigned numerical designations as follows: (0) Motor activity normal; (1) Motor activity normal most of the time, but mildly slowed at times due to apraxia (inability to perform previously learned motor activities, despite normal motor function); (2) Motor activity mildly decreased or with moderate slowing due to apraxia; (3) Motor activity moderately decreased due to apraxia; and (Total) Motor activity severely decreased due to apraxia.

Impairment of visual spatial orientation is assigned numerical designations as follows: (0) Normal; (1) Mildly impaired - Occasionally gets lost in unfamiliar surroundings, has difficulty reading maps or following directions. Is able to use assistive devices such as GPS (global positioning system); (2) Moderately impaired - Usually gets lost in unfamiliar surroundings, has difficulty reading maps, following directions, and judging distance. Has difficulty using assistive devices such as GPS; (3) Moderately severely impaired - Gets lost even in familiar surroundings, unable to use assistive devices such as GPS; and (Total) Severely impaired. May be unable to touch or name own body parts when asked by the examiner, identify the relative position in space of two different objects, or find the way from one room to another in a familiar environment.

Subjective symptoms are assigned numerical designations as follows: (0) Subjective symptoms that do not interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples are: mild or occasional headaches, mild anxiety; (1) Three or more subjective symptoms that

mildly interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples of findings that might be seen at this level of impairment are: intermittent dizziness, daily mild to moderate headaches, tinnitus, frequent insomnia, hypersensitivity to sound, hypersensitivity to light; and (2) Three or more subjective symptoms that moderately interfere with work; instrumental activities of daily living; or work, family, or other close relationships. Examples of findings that might be seen at this level of impairment are: marked fatigability, blurred or double vision, headaches requiring rest periods during most days.

Neurobehavioral effects are assigned numerical designations as follows: (0) One or more neurobehavioral effects that do not interfere with workplace interaction or social interaction. Examples of neurobehavioral effects are: Irritability, impulsivity, unpredictability, lack of motivation, verbal aggression, physical aggression, belligerence, apathy, lack of empathy, moodiness, lack of cooperation, inflexibility, and impaired awareness of disability. Any of these effects may range from slight to severe, although verbal and physical aggression are likely to have a more serious impact on workplace interaction and social interaction than some of the other effects; (1) One or more neurobehavioral effects that occasionally interfere with workplace interaction, social interaction, or both but do not preclude them; (2) One or more neurobehavioral effects that frequently interfere with workplace interaction, social interaction, or both but do not preclude them; and (3) One or more neurobehavioral effects that interfere with or preclude workplace interaction, social interaction, or both on most days or that occasionally require supervision for safety of self or others.

Impairment of communication is assigned numerical designations as follows: (0) Able to communicate by spoken and written language (expressive communication), and to comprehend spoken and written language; (1) Comprehension or expression, or both, of either spoken language or written language is only occasionally impaired. Can communicate complex ideas; (2) Inability to communicate either by spoken language, written language, or both, more than occasionally but less than half of the time, or to comprehend spoken language, written language, or both, more than occasionally but less than half of the time. Can generally communicate complex ideas; (3) Inability to communicate either by spoken language, written language, or both, at least half of the time but

not all of the time, or to comprehend spoken language, written language, or both, at least half of the time but not all of the time. May rely on gestures or other alternative modes of communication. Able to communicate basic needs; and (Total) Complete inability to communicate either by spoken language, written language, or both, or to comprehend spoken language, written language, or both. Unable to communicate basic needs.

Impairment of consciousness is assigned numerical designations as follows: Total - Persistently altered state of consciousness, such as vegetative state, minimally responsive state, coma. *See* 38 C.F.R. § 4.124a, DC 8045.

Note (1): There may be an overlap of manifestations of conditions evaluated under the table titled "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified" with manifestations of a co-morbid mental or neurologic or other physical disorder that can be separately evaluated under another diagnostic code. In such cases, do not assign more than one evaluation based on the same manifestations. If the manifestations of two or more conditions cannot be clearly separated, assign a single evaluation under whichever set of diagnostic criteria allows the better assessment of overall impaired functioning due to both conditions. However, if the manifestations are clearly separable, assign a separate evaluation for each condition.

Note (2): Symptoms listed as examples at certain evaluation levels in the table are only examples and are not symptoms that must be present in order to assign a particular evaluation.

Note (3): "Instrumental activities of daily living" refers to activities other than self-care that are needed for independent living, such as meal preparation, doing housework and other chores, shopping, traveling, doing laundry, being responsible for one's own medications, and using a telephone. These activities are distinguished from "Activities of daily living," which refers to basic self-care and includes bathing or showering, dressing, eating, getting in or out of bed or a chair, and using the toilet.

Note (4): The terms "mild," "moderate," and "severe" TBI, which may appear in medical records, refer to a classification of TBI made at, or close to, the time of

injury rather than to the current level of functioning. This classification does not affect the rating assigned under Diagnostic Code 8045.

As for the history of the disability at issue, the Veteran's service treatment records show that in December 1985, the Veteran reported recurrent headaches, and a history of being in a motor vehicle accident in June 1985, without a concussion, and with a negative CT (computerized tomography) scan and no permanent sequalae to date.

The medical evidence dated during the time period in issue includes a VA TBI DBQ, dated in February 2015; this report indicates that the examination was performed on February 2, 2015. This report shows that the Veteran complained of symptoms that included short-term memory loss, a decreased sense of smell and taste, and infrequent dizziness and vertigo, poor attention, and insomnia. The report notes the following: there was a complaint of mild memory loss, attention, concentration or executive functions, but without objective evidence on testing. Judgment, motor activity, visual spatial orientation, and consciousness, were normal. Social interaction was routinely appropriate. He was always oriented to person, time, place and situation. There were subjective symptoms that did not interfere with work, instrumental activities of daily living, or work, family, or other close relationships. There were one or more neurobehavioral effects that do not interfere with workplace interaction or social interaction. He is able to communicate by spoken and written language, and to comprehend spoken and written language. A CT of the head showed no acute intercranial hemorrhage or mass effect, and no gross infarct. Functional impact was noted to consist of headache symptoms. The diagnosis was TBI.

A VA PTSD examination report, dated in March 2015, shows that the Veteran had complaints similar to those noted in the February 2015 TBI DBQ. On examination, motor activity was calm. The Veteran was cooperative, with normal speech, and normal attention and concentration, and recent and remote memory. Thought process was normal, linear and goal-oriented. He was orientated to person, place, situation, and date.

An October 2015 VA PTSD DBQ notes that the Veteran reported memory issues, with findings that included mild memory loss, and spatial disorientation.

A November 2017 VA PTSD DBQ includes findings of mild memory loss, and spatial disorientation.

VA progress notes show that the findings tended by be consistent with those noted in the March 2015 VA PTSD DBQ, although there were multiple findings of distracted attention; the Veteran repeatedly reported having problems with short-term memory. *See e.g.*, VA progress notes, dated in December 2013, April, June July, September, and October of 2014, January 2015, and February 2018.

Private treatment reports dated between 2011 and 2013 show that the Veteran was found to be alert and oriented times three (person, place, and time), with pressured speech and cognition that was within normal limits.

The Board first notes that the Veteran's headaches, and psychiatric symptoms, have been rated separately. *See* 38 C.F.R. § 4.124a, Diagnostic Code 8045.

The Board finds that the criteria for an initial 10 percent evaluation have been met. The February 2015 VA examination report shows that there were complaints of mild memory loss. Thus level "1" impairment is shown for this facet. VA progress notes, dated beginning in December 2013, similarly show that the Veteran repeatedly complained of memory symptoms. Under the circumstances, the Board finds that the criteria for a 10 percent evaluation are shown to have been met as of the effective date for service connection, i.e., December 13, 2013. To this extent, the appeal is granted.

An initial evaluation in excess of 10 percent is not warranted. The findings in the February 2015 VA TBI DBQ have been discussed. There are no findings that warrant more than a "1" level of impairment in any facet of cognitive impairment, nor are the findings in any of the other medical evidence to show that the Veteran has more than a "1" level of impairment in any facet of cognitive impairment. Given the foregoing, there is no basis to find that the Veteran's symptoms exceed level "1" impairment in any category. Therefore, the criteria for an initial evaluation in excess of 10 percent under 38 C.F.R. § 4.124a, DC 8045 is not warranted.

Headaches.

In March 2015, the RO granted service connection for migraines, evaluated as noncompensable, with an effective date of December 13, 2013. The Veteran appealed the issue of entitlement to an initial compensable evaluation.

In February 2016, the RO increased the Veteran's evaluation to 30 percent, with an effective date of February 1, 2016. Since this increase did not constitute a full grant of the benefit sought, the increased initial evaluation issue remains in appellate status. *AB v. Brown*, 6 Vet. App. 35, 39 (1993).

Under Diagnostic Code 8100, a 10 percent rating is warranted for migraines with characteristic prostrating attacks averaging one episode in 2 months over the last several months.

Where migraine headaches occur with characteristic prostrating attacks occurring on an average of once a month over the last several months, a 30 percent disability rating is appropriate. *Id*.

Migraine headaches with very frequent, completely prostrating and prolonged attacks productive of severe economic inadaptability warrant a maximum schedular 50 percent disability rating. *Id*.

The words "slight," "moderate" and "severe" as used in the various diagnostic codes are not defined in the VA Schedule for Rating Disabilities. Rather than applying a mechanical formula, the Board must evaluate all of the evidence, to the end that its decisions are "equitable and just." 38 C.F.R. § 4.6. It should also be noted that use of terminology such as "severe" by VA examiners and others, although an element of evidence to be considered by the Board, is not dispositive of an issue. All evidence must be evaluated in arriving at a decision regarding an increased rating. 38 C.F.R. §§ 4.2, 4.6.

The rating criteria do not define "severe economic inadaptability;" however, nothing in Diagnostic Code 8100 requires the Veteran to be completely unable to work in order to qualify for a 50 percent rating. *See Pierce v. Principi*, 18 Vet. App. 440 (2004). The Secretary has conceded that the term "productive of economic adaptability" could be read as either "producing" or "capable of producing." *Id*. at 445.

The United States Court of Appeals for Veterans Claims ("Court") has stated that given the use by Congress of the conjunctive "and" in a statute, all of the requirements must be met before funds could be allocated or authorized. *See Malone v. Gober*, 10 Vet. App. 539 (1997).

Prior to February 1, 2016.

A VA headaches DBQ, dated in September 2014, shows that the Veteran complained of four headaches per week, lasting four to six hours, with nausea, sensitivity to light and sound, changes in vision. His symptoms were noted to last less than one day. He preferred to be in dark, quiet rooms when he had headaches. On examination, it was noted that he did not have characteristic prostrating attacks of migraine or non-migraine headache pain. The diagnosis was migraine, including migraine variants.

A VA TBI DBQ, dated in February 2015, shows that the Veteran complained of 15 to 17 headaches per month, that rated a 7 on a scale of one to ten, lasting four to eight hours, with sensitivity to light and loud noise, blurred vision, dizziness, nausea and vomiting. He complained that he could not function during his headaches. On examination, he was noted to have mild or occasional headaches.

VA progress notes show that beginning in 2013, there are multiple complaints of headaches. Reports, dated in October and December of 2014, show that he reported having 13 to 18 headaches per month, lasting three to eight hours. In February 2015, he reported having "several" headaches per month. In April 2015, he reported being headache-free. In May 2015, he reported that his migraines had returned to December 2014 levels. A brain CT found no acute intracranial process was demonstrated. *See also* May 2014 brain CT. A May 2015 MRI of the head was unremarkable. In August 2015, the Veteran reported experiencing approximately six episodes of headaches a month.

Reports from a private health care provider in Orlando, Florida, show that the Veteran was noted to have a history of migraine headaches, but that he denied experiencing routine headaches in April 2011 and December 2013. In February 2015, he complained of 18 headaches per month.

The Board finds that, prior to February 1, 2016, an initial compensable evaluation is not warranted for the Veteran's service-connected migraines. The most probative evidence indicates the Veteran's migraine headaches were not productive of characteristic prostrating attacks. *See* September 2014 VA headache DBQ. Thereafter, a VA examiner characterized the Veteran's headaches as mild or occasional. *See* February 2015 VA TBI DBQ. His complaints have varied widely over time, with some reports that he denied experiencing routine headaches. There is no evidence to show that any health care provider characterized his headaches as prostrating, and the evidence is insufficient to show that his headaches were of such severity and frequency to warrant a compensable evaluation. In summary, there is insufficient evidence to show that the Veteran experienced headaches manifested by characteristic prostrating attacks occurring on an average of once a month over several months, and the Board finds that the criteria for an initial compensable evaluation under DC 8100 were not met prior to February 1, 2016, and the claim is denied to that extent.

As of February 1, 2016.

A VA headache DBQ, dated February 1, 2016, submitted by the Veteran shows the following: The Veteran complained of 14 headaches per month, half of which were "very intense and prostrating." His headaches were accompanied by sensitivity to sound and light, nausea, and lasted less than one day. He had characteristic prostrating attacks of migraine pain "more frequently than once per month." His ability to work was impacted when he had intense headaches.

VA progress notes show that in November 2017, the Veteran reported that he had less intense and frequent headaches, but that he still experienced explosive head syndrome in approximately 50 percent of his headaches. In December 2017, the Veteran reported experiencing about 15 headaches per month. Beginning in 2018, the Veteran reported having headaches, to include headaches associated with medication for erectile dysfunction. In February 2018, he reported having less intense and less frequent headaches.

With regard to the Veteran's employment history, VA progress notes show that in June 2011, the Veteran reported that he had last worked six years earlier. A private psychiatric evaluation, by E.T., M.D., dated in August 2011, shows that the

Veteran reported that he was unemployed, and that he had last worked five years earlier. It does not appear that the Veteran has been employed since that time.

The Board finds that the criteria for an evaluation of 30 percent have not been met. As discussed *supra*, there is evidence that his headaches are frequent, and that at times they are prostrating. However, the evidence is insufficient to show that the Veteran's headaches are "very frequent, completely prostrating and prolonged," or that they are productive of severe economic inadaptability. *Malone*. The evidence indicates that the Veteran has not worked since about 2006, and there is no objective evidence to show time lost from work due to headaches. In summary, there is insufficient objective medical or other evidence to show that the Veteran's headaches are of such frequency and severity to meet the criteria for an evaluation in excess of 30 percent under DC 8100. Accordingly, the preponderance of the evidence is against an evaluation in excess of 30 percent at any time during the course of the appeal.

Left Ankle.

The Veteran asserts that he is entitled to a rating in excess of 10 percent for his left ankle strain.

In August 2011, the Veteran filed his claim for a compensable rating.

In June 2012, the RO increased the Veteran's rating for left ankle sprain to 10 percent, with an effective date of September 8, 2011.

Under DC 5271, a 10 percent rating is warranted for a moderate limitation of ankle motion. A 20 percent rating is warranted for a marked limitation of ankle motion.

In addition, the following diagnostic codes are also relevant to the claim:

Under 38 C.F.R. § 4.71a, DC 5270, a 20 percent rating is warranted for ankylosis of the ankle, in plantar flexion less than 30 degrees.

Under 38 C.F.R. § 4.71a, DC 5272, ankylosis of a subastragalar or tarsal joint, or of the ankle itself, in poor weightbearing position, warrants a 20 percent evaluation.

Under 38 C.F.R. § 4.71a, DC 5273, a 20 percent rating is warranted for Os calcis or astragalus, malunion of, with marked deformity.

Under 38 C.F.R. § 4.71a, DC 5274, a 20 percent rating is warranted for: Astragalectomy.

The standardized description of joint measurements is provided in Plate II under 38 C.F.R. § 4.71. Normal dorsiflexion of the ankle is from 0 to 20 degrees. Normal plantar flexion of the ankle is from 0 to 45 degrees.

In *Mitchell v. Shinseki*, 25 Vet. App. 32 (2011), the Court clarified that there is a difference between pain that may exist in joint motion as opposed to pain that actually places additional limitation of the particular range of motion. The Court specifically discounted the notion that the highest disability ratings are warranted under DCs 5261 and 5261 where pain is merely evident as it would lead to potentially "absurd results." *Id*. at 10 - 11.

Functional loss due to pain is rated at the same level as functional loss where motion is impeded. *See Schafrath v. Derwinski*, 1 Vet. App. 589, 592 (1991). Pursuant to 38 C.F.R. § 4.59, painful motion should be considered limited motion, even though a range of motion may be possible beyond the point when pain sets in. *See Powell v. West*, 13 Vet. App. 31, 34 (1999).

VA has recognized that moderate limitation of ankle motion is present when there is less than 15 degrees dorsiflexion or less than 30 degrees plantar flexion, while marked limitation of motion is demonstrated when there is less than 5 degrees dorsiflexion or less than 10 degrees plantar flexion.

A VA ankle examination report, dated in May 2012, shows that the left ankle had dorsiflexion to 10 degrees, with pain at the extreme of motion (i.e., at 10 degrees), and plantar flexion to 40 degrees, with pain at the extreme of motion (i.e., at 40 degrees).

The Board finds that the claim must be denied. Prior to September 8, 2011, private treatment records, dated between May and July of 2011, show complaints of left ankle pain and instability. The findings included synovitis, possibly secondary to

gait alteration, with good muscle tone and strength, and minimal laxity. Ankle alignment was normal. The Veteran was provided with a prescription for an ankle brace. Sensory examination was grossly intact. X-rays were noted not to show fracture or degenerative changes.

There is no evidence to show that the Veteran's left ankle was productive of a moderate limitation of motion, ankylosis, a malunion of the os calcis or astragalus, or astragalectomy. Accordingly, a compensable rating is not warranted.

As of September 8, 2011, the only specific findings as to the range of motion in the left ankle show that it had dorsiflexion to no less than 10 degrees, and plantar flexion to no less than 40 degrees. There is no competent evidence to show ankylosis of the left ankle. The Board therefore finds that the evidence is insufficient to show ankylosis of the left ankle, or a marked limitation of left ankle motion, as required for an increased rating under DC's 5270, 5271, and 5272. In addition, there is no medical evidence of record to show that the Veteran's left ankle is productive of a malunion of the os calcis or astragalus, or astragalectomy, to warrant a rating in excess of 10 percent under DC's 5273 or 5274.

A higher evaluation is not warranted for functional loss. *See* 38 C.F.R. §§ 4.40 and 4.45; *DeLuca v. Brown*, 8 Vet. App. 202 (1995); VAGCOPPREC 9-98, 63 Fed. Reg. 56704 (1998).

The May 2012 VA examination report shows the following: The Veteran reported that he constantly used a brace. There was no additional limitation of motion following repetitive use testing. The examiner indicated that there was no functional loss or functional impairment. Strength on dorsiflexion and plantar flexion was 4/5. There was no laxity, ankylosis, or astragalectomy. The examiner stated that the impact on ability to work was that the Veteran would have difficulty walking or weightbearing for prolonged periods. A February 2015 VA DBQ shows that the Veteran reported that he walked for exercise. VA progress notes, dated in 2018, include multiple notations that his gait was within normal limits.

When the range of motion findings, and the evidence showing functional loss are considered, to include the findings (or lack thereof) pertaining to neurologic deficits, muscle strength, and muscle atrophy, the Board finds that when the ranges

of motion in the left ankle are considered together with the evidence of functional loss due to ankle pathology, the evidence does not support a conclusion that the loss of motion in the left ankle more nearly approximates the criteria for a rating in excess of 10 percent, even with consideration of 38 C.F.R. §§ 4.40 and 4.45.

Conclusion.

For all increased rating claims, the Veteran is competent to report his physical and neurological symptoms, as these observations come to him through his senses. *Layno v. Brown*, 6 Vet. App. 465, 469 (1994). The Board also acknowledges the Veteran's belief that his symptoms are of such severity as to warrant increased ratings. However, disability ratings are made by the application of a schedule of ratings which is based on average impairment of earning capacity as determined by the clinical evidence of record. The examinations also took into account the Veteran's competent (subjective) statements with regard to the severity of his disabilities. The Board therefore finds that, to the extent that the claims have been denied, the medical findings, which directly address the criteria under which the disabilities are evaluated, are more probative than the Veteran's assertions as to the severity of his disabilities. *Jandreau v. Nicholson*, 492 F.3d 1372, 1376 (Fed. Cir. 2007).

To the extent that the claims have been denied, the Board considered the benefit-of-the-doubt rule; however, as the preponderance of the evidence is against the appellant's claims, such rule is not for application. 38 U.S.C. § 5107 (b); *Gilbert v. Derwinski*, 1 Vet. App. 49 (1990).

REASONS FOR REMAND

1. The claims for service connection for a cervical spine disability, a lumbar spine disability, a right shoulder disability, a right knee disability, a left knee disability, and a neurological disability of the left hand, are remanded.

On remand, the Veteran should be afforded an examination, and etiological opinions should be obtained. *McLendon v. Nicholson*, 20 Vet. App. 79 (2006).

2. **The claim for an increased rating for service-connected posttraumatic stress disorder (PTSD) evaluated as 50 percent disabling for the period from November 15, 2010 to October 9, 2015, is remanded.**

In March 2019, the Veteran's representative raised the issue of entitlement to an earlier effective date for service connection for PTSD. *See* notice of disagreement (VA Form 21-0958), received in March 2019. The Veteran's claim for an earlier effective date for service connection for PTSD is considered to be "inextricably intertwined" with the issue being remanded, and these issues must be decided together. *See Tyrues v. Shinseki*, 23 Vet. App. 166, 178 (2009).

The matters are REMANDED for the following action:

> 1. Afford the Veteran a VA examination to determine whether it is at least as likely as not (50 percent or greater probability) that the Veteran has a cervical spine disability, a lumbar spine disability, a right shoulder disability, a right knee disability, a left knee disability, and/or a neurological disability of the left hand, that either began during or was otherwise caused by his military service? Why or why not? In so doing, the examiner should consider the Veteran's receipt of the parachute badge (requiring at least 5 jumps, including at least one with a full load), and service with the 82nd airborne.
>
> 2. Take all appropriate action on the raised claim of entitlement to an earlier effective date for service connection for PTSD.
>
> 3. When appropriate, adjudicate the claim for an increased rating for service-connected PTSD, evaluated as 50 percent disabling for the period from November 15, 2010 to October 9, 2015.

IN THE APPEAL OF [redacted]
MICHAEL FORD Docket No. 16-15 317

MATTEW W. BLACKWELDER
Veterans Law Judge
Board of Veterans' Appeals

ATTORNEY FOR THE BOARD T.S.E., Counsel

The Board's decision in this case is binding only with respect to the instant matter decided. This decision is not precedential, and does not establish VA policies or interpretations of general applicability. 38 C.F.R. § 20.1303.

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

CONTINUED ON NEXT PAGE

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).