BOARD OF VETERANS' APPEALS

FOR THE SECRETARY OF VETERANS AFFAIRS

IN THE APPEAL OF
MELISSA F. BROWN-LEONARD
Represented by
Matthew D. Hill, Attorney

SS [redacted]
Docket No. 16-09 522

DATE: April 17, 2020

ORDER

Entitlement to service connection for post-traumatic stress disorder (PTSD) is denied.

Entitlement to an effective date earlier than September 17, 2015, for the grant of service connection for major depression disorder with anxiety is denied.

Entitlement to an effective date of February 11, 2009, for limitation of flexion of the left hip is granted.

Entitlement to an effective date of February 11, 2009, for limitation of abduction of the left hip is granted.

Entitlement to a disability rating higher than 30 percent for major depressive disorder with anxiety is denied.

Entitlement to a disability rating higher than 30 percent for left ankle disability is denied.

Entitlement to a 20 percent disability rating for left foot disability is granted.

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

REMANDED

The issue of a disability rating higher than 20 percent for limitation of flexion of the left hip is remanded.

The issue of a disability rating higher than 20 percent for limitation of abduction of the left hip is remanded.

The issue of a disability rating higher than 10 percent for limitation of extension of the left hip is remanded.

FINDINGS OF FACT

1. The Veteran's mental disorder symptoms do not warrant a diagnosis of PTSD.

2. VA received on September 17, 2015, the Veteran's claim for service connection for major depressive disorder with anxiety.

3. From the Veteran's February 10, 2009, separation from service, her left hip disability included functional impairment of motion in multiple directions, including flexion. VA received her claim for service connection for left hip disability on May 19, 2009.

4. From the Veteran's February 10, 2009, separation from service, her left hip disability included functional impairment of motion in multiple directions, including abduction. VA received her claim for service connection for left hip disability on May 19, 2009.

5. The Veteran's major depressive disorder with anxiety has been manifested by depression, anxiety, chronic sleep impairment, decreased motivation, fleeting suicidal ideation, and fleeting hallucinations that occasionally decrease efficiency but do not reduce reliability and productivity.

6. The Veteran's left ankle disability has been manifested by severe limitation of motion, pain, weakness, and limitation of weightbearing that are equivalent to ankylosis, but not to ankylosis in any of the most disabling positions.

7. The Veteran's left foot disability has been manifested by arthritis that interferes with standing and weightbearing and produces moderately severe disability.

8. The Veteran's pain and functional limitations from her disabilities of the left hip, ankle, and foot, and the effects of her major depressive disorder with anxiety, make her unable to secure or follow a substantially gainful occupation.

CONCLUSIONS OF LAW

1. PTSD was not incurred or aggravated in service or as a result of events in service. 38 U.S.C. §§ 1110, 5107 (2012); 38 C.F.R. §§ 3.303, 3.304, 4.130 (2019).

2. The criteria for an effective date earlier than September 17, 2015, for the grant of service connection for major depressive disorder with anxiety have not been met. 38 U.S.C. §§ 5107, 5110 (2012); 38 C.F.R. § 3.400 (2019).

3. The criteria for an effective date of February 11, 2009, for the grant of separate service connection for limitation of flexion of the left hip have been met. 38 U.S.C. §§ 5107, 5110; 38 C.F.R. § 3.400.

4. The criteria for an effective date of February 11, 2009, for the grant of separate service connection for limitation of abduction of the left hip have been met. 38 U.S.C. §§ 5107, 5110; 38 C.F.R. § 3.400.

5. The criteria for disability rating higher than 30 percent for major depressive disorder with anxiety have not been met. 38 U.S.C. §§ 1155, 5107 (2012); 38 C.F.R. Part 4, including §§ 4.1, 4.2, 4.7, 4.10, 4.130, Diagnostic Code 9434 (2019).

6. The criteria for a disability rating higher than 30 percent for left ankle disability have not been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. Part 4, including §§ 4.1, 4.2, 4.7, 4.10, 4.40, 4.45, 4.59, 4.71a, Diagnostic Code 5270 (2019).

7. The criteria for a 20 percent disability rating for left foot disability have been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. Part 4, including §§ 4.1, 4.2, 4.7, 4.10, 4.40, 4.45, 4.59, 4.71a, Diagnostic Codes 5010, 5284 (2019).

8. The criteria for a TDIU have been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. § 4.16 (2019).

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

The Veteran had active service from January 1991 to August 1991, and from January 2008 to February 2009. She also had reserve service.

Service Connection

Service connection may be established on a direct basis for a disability resulting from disease or injury incurred in or aggravated by active service. 38 U.S.C. § 1110; 38 C.F.R. § 3.303. Service connection may also be granted for any disease diagnosed after service when all the evidence establishes that the disease was incurred in service. 38 C.F.R. § 3.303(d). In general, service connection requires (1) evidence of a current disability; (2) medical evidence, or in certain circumstances lay evidence, of in-service incurrence or aggravation of a disease or injury; and (3) evidence of a nexus between the claimed in-service disease or injury and the current disability. *See Shedden v. Principi,* 381 F.3d 1163, 1167 (Fed. Cir. 2004).

The United States Court of Appeals for Veterans Claims (Court) has indicated that the Board of Veterans' Appeals (Board) must assess the credibility and weight of all the evidence, including the medical evidence, to determine its probative value, accounting for evidence which it finds to be persuasive or unpersuasive, and providing reasons for rejecting any evidence favorable to the claimant. *See Masors v. Derwinski*, 2 Vet. App. 181 (1992); *Wilson v. Derwinski*, 2 Vet. App. 614, 618

(1992); *Hatlestad v. Derwinski*, 1 Vet. App. 164 (1991); *Gilbert v. Derwinski*, 1 Vet. App. 49 (1990). Equal weight is not accorded to each piece of evidence contained in the record; every item of evidence does not have the same probative value. When there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a claim, the Department of Veterans Affairs (VA) shall give the benefit of the doubt to the claimant. 38 U.S.C. § 5107. To deny a claim on its merits, the evidence must preponderate against the claim. *Alemany v. Brown*, 9 Vet. App. 518, 519 (1996), citing *Gilbert*, 1 Vet. App. at 54.

1. PTSD

The Veteran contends that she has PTSD that resulted from events during active service. She has sought service connection for psychiatric disability under several diagnoses. In January 2013 she sought service connection for PTSD. In a July 2013 rating decision, a VA Regional Office (RO) denied service connection for PTSD. The Veteran appealed that denial. In September 2015 she sought service connection for major depressive disorder with anxiety, claimed as secondary to service-connected disorders of the left ankle, left foot, and left hip. In an October 2017 rating decision, an RO granted service connection for major depressive disorder with anxiety, associated with left ankle pain residual to left calcaneal fracture. That decision resolved the claim for service connection for major depressive disorder with anxiety secondary to pain from physical disorders. She has been found to have a service-connected psychiatric disorder. The psychiatric disorder service connection claim that remains on appeal is her claim for service connection for PTSD remains.

PTSD is a mental disorder that develops due to traumatic experience. It is possible for service connection to be established for PTSD that becomes manifest after separation from service. Service connection for PTSD requires: (1) medical evidence diagnosing the condition in accordance with VA regulations; (2) a link, established by medical evidence, between current symptoms and an in-service stressor; and (3) credible supporting evidence that the claim.

VA considers mental disorders based on the nomenclature in the American Psychiatric Association's Diagnostic and Statistical Manual, Fifth Edition

(DSM-V). 38 C.F.R. § 4.130. Under the DSM-V, factors considered in diagnosing PTSD included exposure to a traumatic event, persistent reexperiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma, alterations in cognitions and moods associated with the trauma, persistent symptoms of increased arousal, persistence of the disturbance for more than one month, and clinically significant distress or impairment in functioning.

The evidence necessary to establish the occurrence of a recognizable stressor during service varies depending on the circumstances of the veteran's service and of the claimed stressor. If the veteran engaged in combat with the enemy, the claimed stressor is related to that combat, and the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran's service, then, in the absence of clear and convincing evidence to the contrary, the veteran's lay testimony alone may establish the occurrence of the claimed in-service stressor. 38 C.F.R. § 3.304(f)(2). Similarly, if a stressor claimed by a veteran is related to the veteran's fear of hostile military or terrorist activity, a VA or VA-contracted psychiatrist or psychologist confirms that the claimed stressor is adequate to support a diagnosis of PTSD, and the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran's service, then, in the absence of clear and convincing evidence to the contrary, the veteran's lay testimony alone may establish the occurrence of the claimed in-service stressor. 38 C.F.R. § 3.304(f)(3).

In general, if a veteran's service and claimed stressors were not under circumstances that provide for his or her lay testimony alone to establish the occurrence of the stressor, the record must contain service records that corroborate the veteran's testimony as to the occurrence of the claimed stressor. *See Zarycki v. Brown,* 6 Vet. App. 91, 98 (1993). If a PTSD claim is based on in-service personal assault, evidence from sources other than the veteran's service records may corroborate the veteran's account of the stressor. 38 C.F.R. § 3.304(f)(5).

The medical records from the Veteran's January 1991 to August 1991 period of active service do not reflect any mental health complaints or treatment. The medical records from her January 2008 to February 2009 period of active service do not reflect any mental health complaints or treatment.

In VA treatment of the Veteran in June 2009 and February 2012, screens for PTSD were negative.

On VA examination in December 2013, the Veteran stated that in service in Kuwait in 2008 to 2009, she experienced fear of hostile military action, including fear of being shot down during helicopter flights. She reported that her duties kept her on call, and she got very limited sleep. She stated that since the Kuwait service she had episodes of awakening in a panic. She related that she was irritable and easily angered. She denied a depressed mood or tearfulness, but reported a lack of energy. She denied nightmares or problems with sleep. She reported constant anxiety. She denied panic attacks. She indicated that she attended sports matches and other large social gatherings.

The examiner reviewed the Veteran's claims file and interviewed the Veteran. The examiner found that the Veteran reported a stressor consistent with causing PTSD. The examiner found that the Veteran did not report intrusive symptoms related to the stressors, nor persistent avoidance of stimuli associated with the stressor. The examiner concluded that the Veteran's symptoms did not meet the criteria for a diagnosis of PTSD.

The Veteran had VA mental health treatment in May and June 2014. She was referred for evaluation of anger, depression, mood instability, and suicidal thoughts. She stated that she awakened in a panic, as though after nightmares. She reported loss of time from work due to ankle and hip problems incurred in the 2005 MVA. She reported that during service in Kuwait she experienced sexual harassment, but did not experience sexual trauma.

In November 2014 the Veteran wrote that the during her service in Kuwait she was in fear for her life during helicopter flights over hostile territory. She stated that she experienced severe, daily, constant sexual harassment from other soldiers. She related that as a result she began to have sleepless nights, severe depression, anxiety, and panic attacks.

In November 2014 the Veteran's spouse, J. L., wrote that the Veteran has told him of stressors during service in Kuwait. He related her report that she flew over hostile areas, felt constantly in fear of dying, and was sexually harassed on a daily

basis. Mr. L. stated that after that service the Veteran's behavior changed, such that she had nightmares, irritability, unprovoked anger, depression, anxiety, and distance from family members.

The claims file contains notes of the Veteran's VA psychotherapy in August and October 2015. The Veteran reported previous mental health treatment in 2014. She stated that left leg pain made her unable to stand for long periods, and had necessitated retirement from her Postal Service job. She reported depression since her return from Kuwait in 2009. She reported poor sleep, and waking from nightmares in a panic. The clinician's impression was recurrent major depressive disorder.

On VA mental disorders examination in January 2016, the Veteran reported chronic depression, sleep disruption, irritability, anxiety, and angry verbal outbursts. The examiner noted that the Veteran had depressed mood, anxiety, and chronic sleep impairment. The examiner provided a diagnosis of an unspecified depressive disorder. The examiner expressed the opinion that it is at least as likely as not that pain from the Veteran's service-connected disorders of the left hip, ankle, and foot contributes to causing her depressive disorder.

In VA mental health treatment of the Veteran in December 2016, a screen for PTSD was negative. In mental health treatment through May 2018, clinicians continued to list a diagnosis of depressive disorder.

In July 2017, private psychologist C. M., Ph. D., reviewed the Veteran's claims file and interviewed the Veteran. Dr. M. was asked to provide an opinion as to the Veteran's mental disorders diagnosis, to include whether the Veteran has PTSD. Dr. M. concluded that the Veteran's psychiatric diagnosis was major depressive disorder. Dr. M. did not find that the Veteran has PTSD.

In screens, treatment, examinations, and evaluations, clinicians have found that the Veteran does not have PTSD. The preponderance of the evidence is against a diagnosis of PTSD. As she does not have a diagnosis of PTSD, the Board denies service connection for PTSD. This denial has no effect on the established service connection for her major depressive disorder with anxiety.

Effective Dates

The assignment of effective dates of awards of VA disability compensation is generally governed by 38 U.S.C. § 5110 and 38 C.F.R. § 3.400. Unless specifically provided otherwise, the effective date of an award based on an original claim for compensation benefits, or a claim reopened after final disallowance, will be the date of receipt of the claim or the date entitlement arose, whichever is later. *See* 38 U.S.C. § 5110(a); 38 C.F.R. § 3.400(b)(2).

2. Effective date for the grant of service connection for major depression disorder with anxiety

On September 17, 2015, an RO received the Veteran's claim for service connection for major depressive disorder with anxiety. In an October 2017 rating decision, the RO granted service connection for major depressive disorder with anxiety. The RO made service connection effective September 17, 2015.

In December 2017 the Veteran submitted a notice of disagreement (NOD) with the effective date the RO assigned for service connection for major depressive disorder with anxiety. The Veteran has not submitted argument as to what effective date is warranted, or why. Before September 17, 2015, a claim for service connection for major depressive disorder with anxiety was not received, and entitlement to service connection for that disorder did not arise. The record does not provide any basis for an earlier effective date. The Board denies the claim.

3. Effective date for the grant of service connection for limitation of flexion of the left hip

The Veteran appealed the January 12, 2016, effective date that an RO assigned for the grant of separate service connection for limitation of flexion of her left hip. Many sources of evidence address both her appeal for an earlier effective date for service connection for limitation of left hip flexion and her appeal for an earlier effective date for service connection for limitation of left hip abduction. The Board is relating in this section information that applies to both claims.

The Veteran was in a motor vehicle accident (MVA) in 2005. She sustained left hip injuries including acetabular fracture. Treatment included surgery. After her 2008 to 2009 active service period she sought service connection for aggravation of her left hip disability during that service period. The RO ultimately granted service connection for her left hip disability on that basis.

The history of the assignment of disability ratings for the Veteran's left hip disability is relevant to some of the effective date issues on appeal. VA assigns disability ratings by evaluating the extent to which a veteran's service-connected disability adversely affects his ability to function under the ordinary conditions of daily life, including employment, by comparing his symptomatology with the criteria set forth in the VA Schedule for Rating Disabilities. 38 U.S.C. § 1155; 38 C.F.R. Part 4, including §§ 4.1, 4.2, 4.10. In determining the current level of impairment, the disability must be considered in the context of the whole recorded history, including service medical records. 38 C.F.R. § 4.2. If two disability ratings are potentially applicable, the higher rating will be assigned if the disability picture more nearly approximates the criteria required for that rating. Otherwise, the lower rating will be assigned. 38 C.F.R. § 4.7.

The Court has held that, at the time of the assignment of an initial rating for a disability following an initial award of service connection for that disability, separate ratings can be assigned for separate periods of time based on the facts found, a practice known as staged ratings. *Fenderson v. West,* 12 Vet. App. 119, 126 (1999). The Court also has held that a claimant may experience multiple distinct degrees of disability that might result in different levels of compensation from the time the claim for an increased rating was filed until a final decision is made. *See Hart. v. Mansfield,* 21 Vet. App. 505 (2007).

When evaluation of a musculoskeletal disability is based on limitation of motion, that evaluation must include consideration of impairment of function due to such factors as pain on motion, weakened motion, excess fatigability, diminished endurance, or incoordination. 38 C.F.R. §§ 4.40, 4.45, 4.59; *see DeLuca v. Brown*, 8 Vet. App. 202 (1995). Evaluation of joints that have painful motion also should include consideration of whether there is pain on both active and passive motion, consideration of whether there is pain with and without weightbearing, and

comparison of the range of motion to that of any opposite undamaged joint. 38 C.F.R. § 4.59; *see Correia v McDonald,* 28 Vet. App. 158 (2016).

If a claim for direct service connection is received within one year after separation from service, service connection is effective the day following separation from service. 38 U.S.C. § 5110(b)(1); 38 C.F.R. § 3.400(b)((2)(i). The Veteran was separated from her 2008 to 2009 active service period on February 10, 2009. On May 19, 2009, an RO received her claim for service connection for a left hip disability. In a July 2013 rating decision, the RO granted service connection for degenerative joint disease of the left hip. The RO made service connection effective February 11, 2009, the day after her separation from service. The RO assigned a disability rating based on 38 C.F.R. § 4.71a, Diagnostic Code 5010, for traumatic arthritis, and Diagnostic Code 5251, for limitation of extension of the hip.

In July 2014 the Veteran submitted an NOD with the disability rating the RO assigned for degenerative joint disease of the left hip. She argued that a VA medical examination in 2013 did not adequately address the range of motion and pain in that hip.

On January 12, 2016, the Veteran had another VA examination of her left hip. In a February 2016 rating decision, an RO continued service connection for left hip degenerative joint disease. The RO granted separate service connection and separate disability ratings for limitation of flexion of the left hip, under Diagnostic Code 5252, and for limitation of abduction of the left hip, under Diagnostic Code 5253. The RO made service connection for each of the added disabilities effective January 12, 2016.

In April 2016, the Veteran filed an NOD with the effective dates of the grants of service connection for limitation of flexion and limitation of abduction of the hip. She argued that the effective dates should be based on the date of the claim for service connection for left hip disability. In an informal telephone conference in June 2017, she contended that the effective dates for service connection for limitations of flexion and abduction of the left hip should be the same as the effective date for service connection for left hip disability, that is, February 11, 2009.

On VA examination in February 2010, the Veteran reported severe left hip pain intermittently, four or five times a week, and left hip numbness intermittently. She used a cane frequently. Left hip x-rays showed hardware in the joint. Testing showed limitation of extension, flexion, and abduction of the left hip. On VA examination in February 2013, testing of the left hip showed pain and weakness with extension. With flexion there was limitation and weakness. With abduction there was weakness.

The 2010 examination provides evidence that, from the 2009 separation from service, disability of the left hip included functional impairment with extension, flexion, and abduction. Separate service connection and ratings for each type of impairment are warranted from the day after her 2009 separation from service. The Board grants an effective date of February 11, 2009, for service connection for limitation of flexion of the left hip.

4. Effective date for the grant of service connection for limitation of abduction of the left hip

The Veteran appealed the January 16, 2016, effective date that an RO assigned for the grant of separate service connection for limitation of flexion of her left hip. As noted above, from separation from service in 2009, disability of the left hip included functional impairment with extension, flexion, and abduction. Separate service connection and ratings for each type of impairment are warranted from the day after her 2009 separation from service. The Board grants an effective date of February 11, 2009, for service connection for limitation of abduction of the left hip.

Increased Ratings

5. Major depressive disorder with anxiety

The Veteran appealed the initial 30 percent rating an RO assigned for her major depressive disorder with anxiety. The RO granted service connection and assigned the rating effective September 17, 2015. The Veteran contends that the effects of her major depressive disorder with anxiety warrant a rating higher than 30 percent.

VA evaluates mental disorders under a General Formula for Mental Disorders (General Formula). 38 C.F.R. § 4.130. Under that formula, a noncompensable (0 percent) rating is assigned when a mental condition has been formally diagnosed, but symptoms are not severe enough to either require continuous medication, or to interfere with occupational and social functioning.

A 10 percent rating is assigned when mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of occasional stress, or symptoms controlled by medication cause occupational and social impairment.

A 30 percent rating is assigned when symptoms such as depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment, or mild memory loss (such as forgetting names, directions, or recent events), cause occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and normal conversation).

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

A 70 percent rating is assigned when symptoms such as suicidal ideation; obsessional rituals which interfere with routine activities; intermittently illogical, obscure, or irrelevant speech; near-continuous panic or depression affecting the ability to function independently, appropriately and effectively; impaired impulse control (such as unprovoked irritability with periods of violence); spatial disorientation; neglect of personal appearance and hygiene; difficulty in adapting to stressful circumstances (including work or a worklike setting); or inability to establish and maintain effective relationships cause occupational and social

impairment with deficiencies in most areas, such as work, school, family relations, judgment, thinking, or mood.

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

The Board must conduct a "holistic analysis" that considers all associated symptoms, regardless of whether they are listed as criteria. *Bankhead v. Shulkin*, 29 Vet. App. 10, 22 (2017). The Board must determine whether unlisted symptoms are similar in severity, frequency, and duration to the listed symptoms associated with specific disability percentages. Then, the Board must determine whether the associated symptoms, both listed and unlisted, caused the level of impairment required for a higher disability rating. *Vazquez-Claudio v. Shinseki*, 713 F.3d 112, 114-118 (Fed. Cir. 2013).

The Veteran's claims file contains VA treatment records dated through 2018. She has had VA mental health treatment fairly regularly from 2014 forward. From 2014 she has reported depression, anhedonia, anxiety, sleep impairment, irritability. She has indicated having crying spells and angry verbal outbursts. She has related fleeting suicidal ideation, without intention or plan. She has reported hallucinations in which she falsely senses a person nearby. Clinicians have noted tearfulness and depressed and anxious moods. Clinicians have observed logical thought and speech, normal judgment, and normal memory. From 2014 clinicians have prescribed antidepressant and sleep medications.

On VA mental disorders examination in January 2016, the examiner reviewed the Veteran's claims file and interviewed the Veteran and her spouse. The examiner noted that the Veteran had depressed mood, anxiety, and chronic sleep impairment. The Veteran's spouse stated that the Veteran's depression made her distant, which diminished her relationship with their two school-aged children. The Veteran related irritability and angry verbal outbursts. She reported that she sometimes

hallucinated a person walking by. She reported that in August 2015 she medically retired from Postal Service employment. She stated that she maintained contact with her parents and siblings. In assessing the severity and effects of the Veteran's disability, the examiner marked the box for the criteria for a 30 percent rating, occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks, although generally functioning satisfactorily, with routine behavior, self-care, and normal conversation.

Treatment and examination records show that the Veteran's major depressive disorder with anxiety has been manifested by symptoms associated with a 30 percent rating, such as depressed mood, anxiety, and chronic sleep impairment. She has had symptoms associated with a 50 percent rating, such as disturbances of motivation and mood. She also had had symptoms that are not listed with a specific rating, such as fleeting hallucinations.

The Board notes that the Veteran has expressed suicidal ideation, which is contemplated by the 70 percent criteria and is similar to persistent danger of self-harm, which is contemplated by the 100 percent criteria. *Bankhead v. Shulkin*, 29 Vet. App. 10, 19 (2017). However, the severity, frequency, and duration of the Veteran's suicidal ideation has not risen to the level contemplated by the 70 percent or 100 percent disability ratings. She has reported only fleeting suicidal ideation, without intention or plan.

The Board concludes that the Veteran's symptoms did not cause the level of impairment required for a disability rating of 50 percent or higher. Her symptoms have not produced occasional decrease in efficiency in work or home tasks. Her impairment has not reached the level of reduction of reliability and productivity. Her symptoms more closely approximated the symptoms associated with a 30 percent rating, and resulted in a level of impairment that most closely approximated the level of impairment associated with a 30 percent rating.

The preponderance of the evidence weighs against finding that the severity, frequency, and duration of the Veteran's symptoms resulted in the level of impairment required for a 50 percent rating. The criteria for a 50 percent or higher rating are not met. The Board denies the appeal for a rating higher than 30 percent.

6. Left ankle disability

The Veteran appealed the initial 30 percent rating assigned for her left ankle disability. The disability had onset with an MVA in 2005. She sustained calcaneal fracture and underwent surgery. An RO granted service connection based on aggravation of the disability during the Veteran's 2008 to 2009 active service period. The RO described the disability as residual ankle pain due to the fracture, status post repair surgery.

The left ankle disability has been rated under 38 C.F.R. § 4.71a, Diagnostic Code 5270. Under that Diagnostic Code, ankylosis of an ankle is rated at 30 percent if it is in plantar flexion, between 30 degrees and 40 degrees, or in dorsiflexion between 0 degrees and 10 degrees. A higher, 40 percent rating is assigned if ankylosis is in plantar flexion at more than 40 degrees, in dorsiflexion at more than 10 degrees, or with abduction, adduction, inversion, or eversion deformity.

In VA treatment in June 2009, the Veteran wore an air cast on her left ankle. On VA examination in February 2010, she had had a gel foam ankle brace, a heel cushion, and a cane to minimize weightbearing on her left lower extremity. She had an antalgic gait, with poor propulsion. She used one cane, and walked slowly. Her left ankle had 3/5 muscle strength. Motion was limited to 5 degrees of plantar flexion and 5 degrees of dorsiflexion.

On VA examination in February 2013, the Veteran had a gel foam ankle brace, a heel cushion, and a cane to minimize weightbearing on her left lower extremity. She reported daily stiffness and intermittent pain in her left ankle. She related that the pain was treated with prescription and nonprescription medications. She stated that the symptoms worsened with any weightbearing. She reported that she was limited to fifteen to twenty minutes of standing and one block of walking. She said that left ankle and hip stiffness caused difficulty walking up inclines. She stated that she rode a stationary bike for exercise. The examiner found that motion of the ankle was limited to 10 degrees of plantar flexion and 10 degrees of dorsiflexion, with pain and weakness on motion in both directions. Muscle strength was 3/5 on plantar flexion and 3/5 on dorsiflexion. The left ankle disability disturbed locomotion and interfered with sitting, standing, and weightbearing. The examiner

found that function of her left lower extremity was not so impaired that it would be equally well served by amputation with a prosthesis.

On VA examination in January 2016, the Veteran wore a rigid foot and ankle brace on her left ankle, which she regularly used. She also regularly used a walker and a lift on her left shoe. Her ankle pain was treated with prescription medication. She stated that ankle pain was worse with prolonged standing or walking. The examiner found that motion of the ankle was limited to 5 degrees of plantar flexion and 5 degrees of dorsiflexion. There was pain on both of those motions and pain with weightbearing. Muscle strength was 4/5 on plantar flexion and 4/5 on dorsiflexion. The examiner found that function of her left lower extremity was not so impaired that it would be equally well served by amputation with a prosthesis.

In September 2017 the Veteran had a VA physical therapy consultation for left ankle and foot disabilities. A clinician noted contractures of her Achilles, flexor hallucis longus (FHL), and flexor digitorum longus (FDL) tendons. Her left ankle was not in ankylosis.

The Veteran's left ankle disability has not included ankylosis. To address pain, weakness, and limitations on weightbearing it has been evaluated as comparable to ankylosis. Examination and treatment records have not shown disability equivalent to an even more disabling position of ankylosis. The disability picture has not met or approximated the criteria for a rating higher than 30 percent. The Board denies a rating higher than 30 percent.

7. Left foot disability

The Veteran appealed the initial 10 percent rating that the RO assigned for her left foot disability, described as degenerative joint disease (DJD). The disability had onset with the 2005 MVA, which caused calcaneal fracture and required surgery. An RO granted service connection based on aggravation of the disability during her 2008 to 2009 active service period.

The left foot disability has been rated under 38 C.F.R. § 4.71a, Diagnostic Code 5010. Under that Code, traumatic arthritis is rated based on the limitation of motion of the affected joints. For foot disabilities, the rating schedule provides

criteria for rating several specific foot disorders, including flatfoot, weak foot, claw foot, metatarsalgia, hallux valgus, hammer toe, and malunion of tarsal or metatarsal bones. *See* Diagnostic Codes 5276-5283. Other foot injuries are evaluated as 10 percent disabling if moderate, 20 percent if moderately severe, and 30 percent if severe. 38 C.F.R. § 4.71a, Diagnostic Code 5284.

On VA examination in February 2010, the Veteran reported that her left foot had stiffness daily and severe pain about two times per week. She stated that the symptoms were aggravated with any weightbearing. She reported fatigability and reduced endurance with weightbearing. She had a heel cushion for that foot. She was limited to fifteen to twenty minutes of standing and one block of walking. She took medication for pain in that foot and other musculoskeletal areas. The examiner noted swelling and tenderness of the left foot, with pes planus, and the weightbearing line over or medial to the great toe. X-rays showed a healed calcaneal fracture, and arthritic changes of the talonavicular joint. The Veteran's gait was antalgic and unsteady, with poor propulsion.

On VA examination in February 2013, the Veteran reported that she regularly used an ankle and foot brace, a cane, and a lift in her left shoe. The examiner noted that the Veteran walked with a moderate limp. the examiner found that the Veteran had DJD of the left foot. The examiner noted earlier x-ray findings of arthritis in the subtalar and talonavicular joints. The examiner characterized the foot arthritis as moderately severe.

On VA examination in January 2016, the Veteran reported daily severe pain in her left foot with prolonged activity. She stated that she regularly used pain medication, a brace, a shoe lift, and a shoe insert with a nerve stimulator. The examiner found that the foot had pain on movement and pain with and without weightbearing. The examiner found that the left foot disability interfered with standing and walking. The examiner evaluated the foot disability as flatfoot, and did not evaluate it as arthritis.

The 2013 VA examiner found that the effects of the Veteran's left foot arthritis were moderately severe. That finding is consistent with a 20 percent rating under Diagnostic Code 5284. Other VA examiners evaluated the foot disability based on pes planus. Her left foot sustained fracture and other traumatic injuries in the 2005

MVA, and then underwent aggravation in the 2008 and 2009 service period. Evaluation based on arthritis following traumatic injury is at least as relevant as evaluation based on flatfoot. Considering the interference with standing, and severe pain with prolonged weightbearing, the disability picture more nearly approximates the criteria for no more than a 20 percent rating under Diagnostic Code 5284. The Board grants that rating.

8. TDIU

The Veteran contends that her service-connected disabilities make her unemployable. VA regulations allow for the assignment of a TDIU when a veteran is unable to secure or follow a substantially gainful occupation as a result of service-connected disabilities, and the veteran has certain combinations of disability ratings for service-connected disabilities. If there is only one such disability, that disability must be ratable at 60 percent or more. If there are two or more disabilities, they must merit a combined rating of at least 70 percent, with one condition rated at least 40 percent. 38 C.F.R. § 4.16(a). For the purpose of one 60 percent rating or one 40 percent rating, disabilities that will be considered as one disability include disabilities of the extremities, disabilities resulting from a common etiology or single accident, and disabilities affecting a single system, such as the orthopedic system. The Veteran's orthopedic disabilities of the left hip, ankle, and foot have ratings that combine to more than 40 percent. Her combined rating is at least 70 percent. Her ratings meet the criteria at 38 C.F.R. § 4.16(a). A TDIU is warranted if her service-connected disabilities make her unable to secure or follow a substantially gainful occupation.

Entitlement to a TDIU depends on the impact of a veteran's service-connected disabilities on his ability to secure and follow substantially gainful employment, in light of factors such as his work history, education, and vocational training. 38 C.F.R. § 4.16.

Before and after the Veteran's 2008 and 2009 active service period, she worked for the United States Postal Service, in mail distribution. She has reported that her left hip, ankle, and foot disabilities considerably limited her capacity for standing or walking, caused great difficulty performing that job, and ultimately necessitated retiring from that job in 2015. In her December 2015 claim for a TDIU, she

indicated that, before she retired, she was working sixteen hours per week. In a May 2017 statement, the Veteran's spouse reported that her left hip, ankle, and foot disabilities made her unable to stand for more than a couple of minutes, and necessitated frequent changes of position when she was sitting. He stated that the severe limitations on her capacity for physically activity made her feel worthless and caused her to cry. In July 2017, private psychologist Dr. M. evaluated the Veteran. Dr. M. concluded that the Veteran's pain and limitations from her left hip, ankle, and foot disabilities cause her major depressive disorder. Dr. M. expressed the opinion that the Veteran's major depressive disorder would at least as likely as not preclude her from successfully securing and following substantially gainful employment.

There is persuasive evidence that the Veteran's left hip, ankle, and foot disabilities, and her major depressive disorder, make her unable to secure or follow a substantially gainful occupation. The Board grants a TDIU.

REASONS FOR REMAND

1. Ratings for limitation of flexion of the left hip

The Board is remanding this issue for review following a decision on intertwined issues. The Veteran appealed an initial 20 percent rating that an RO assigned, effective January 16, 2016, for limitation of flexion of her left hip. In the present decision, above, the Board has granted an earlier effective date, February 11, 2009, for that disability. That grant necessitates action by the RO to assign a disability rating for limitation of flexion for the period from February 11, 2009, through January 15, 2016. The Veteran's appeal of the rating from January 16, 2016, is intertwined with the rating for the earlier period. The Board is remanding the rating appeal for the later period for the RO to review in conjunction with assigning a review for the later period.

2. Ratings for limitation of abduction of the left hip

The Board is remanding this issue for review following a decision on intertwined issues. The Veteran appealed an initial 20 percent rating that an RO assigned,

effective January 16, 2016, for limitation of abduction of her left hip. In the present decision, above, the Board has granted an earlier effective date, February 11, 2009, for that disability. That grant necessitates action by the RO to assign a disability rating for limitation of abduction for the period from February 11, 2009, through January 15, 2016. The Veteran's appeal of the rating from January 16, 2016, is intertwined with the rating for the earlier period. The Board is remanding the rating appeal for the later period for the RO to review in conjunction with assigning a review for the later period.

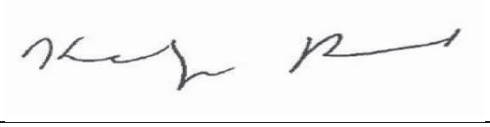
3. Ratings for limitation of extension of the left hip

The Board is remanding this issue for following a decision on intertwined issues. The Veteran appealed an initial 10 percent rating that an RO assigned, effective February 11, 2009, for degenerative joint disease of the left hip. The RO rated that disability based on limitation of extension of the hip. Later, the RO granted separate service connection for limitation of flexion of the hip and for limitation of abduction of the hip. The Board granted earlier effective dates for service connection for limitation of flexion of the hip and for limitation of abduction of the hip. The rating appeals are intertwined. The evidence regarding all of the functional limitations of the Veteran's left hip must be considered in assigning ratings for each disability for each appealed period. The Board is remanding the issue of the rating for limitation of extension for review in conjunction with the other ratings.

The matters are REMANDED for the following action:

> 1. Effectuate the Board's grants of an effective date of February 11, 2009, for service connection for limitation of flexion of the left hip, and an effective date of February 11, 2009, for service connection for limitation of abduction of the left hip. Review the record and assign disability ratings for the following: (a) limitation of flexion, from February 11, 2009, and from January 16, 2016; (b) limitation of abduction, from February 11, 2009, and from January 16, 2016; and (c) limitation of extension, from February 11, 2009, forward.

2. Then review the expanded claims file. In any of the remanded claims is not granted to the Veteran's satisfaction, issue a supplemental statement of the case and afford the Veteran and her representative an opportunity to respond. Then return the case to the Board for appellate review, if otherwise in order.



K. PARAKKAL
Veterans Law Judge
Board of Veterans' Appeals

Attorney for the Board K. J. Kunz, 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).