BOARD OF VETERANS' APPEALS

FOR THE SECRETARY OF VETERANS AFFAIRS

IN THE APPEAL OF
ROY MONROE
Represented by
Carol J. Ponton, Attorney

SS [redacted]
Docket No. 20-12 958
Advanced on the Docket

DATE: June 9, 2020

ORDER

The Veteran's claim for entitlement to service connection for a right shoulder disability is reopened.

The Veteran's claim for entitlement to service connection for a prostate condition (claimed as prostate cancer and elevated prostate specific antigen (PSA) level) is reopened.

The Veteran's claim for entitlement to service connection for a cardiovascular condition (claimed as heart attack) is reopened.

Entitlement to service connection for peripheral neuropathy of the left lower extremity is granted.

Entitlement to service connection for peripheral neuropathy of the right lower extremity is granted.

Entitlement to an effective date earlier than May 24, 2017 for the grant of service connection for Parkinson's disease, with weakness of the left lower extremity, is denied.

Entitlement to an effective date earlier than May 24, 2017 for the grant of service connection for weakness of the right lower extremity, associated with Parkinson's disease, is denied.

Entitlement to an effective date earlier than May 24, 2017 for the grant of service connection for weakness of the left upper extremity, associated with Parkinson's disease, is denied.

Entitlement to an effective date earlier than May 24, 2017 for the grant of service connection for weakness of the right upper extremity, associated with Parkinson's disease, is denied.

Entitlement to an effective date earlier than May 24, 2017 for the grant of service connection for impairment of the seventh cranial nerve, left, associated with Parkinson's disease, is denied.

Entitlement to an effective date earlier than May 24, 2017 for the grant of service connection for impairment of the seventh cranial nerve, right, associated with Parkinson's disease, is denied.

Entitlement to an effective date earlier than May 24, 2017 for the grant of service connection for impairment of the tenth cranial nerve, left, associated with Parkinson's disease, is denied.

Entitlement to an effective date earlier than May 24, 2017 for the grant of service connection for impairment of the tenth cranial nerve, right, associated with Parkinson's disease, is denied.

Entitlement to an effective date earlier than May 24, 2017 for the grant of service connection for impairment of the eleventh cranial nerve, left, associated with Parkinson's disease, is denied.

Entitlement to an effective date earlier than May 24, 2017 for the grant of service connection for impairment of the eleventh cranial nerve, right, associated with Parkinson's disease, is denied.

Entitlement to an effective date earlier than May 24, 2017 for the grant of Dependents' Educational Assistance is denied.

Entitlement to an effective date earlier than September 10, 2019 for the grant of service connection for loss of sense of smell, associated with Parkinson's disease, is denied.

Entitlement to an effective date earlier than September 10, 2019 for the grant of service connection for constipation, associated with Parkinson's disease, is denied.

Entitlement to an effective date earlier than May 24, 2018 for a right knee strain is denied.

Entitlement to an effective date earlier than September 10, 2019 for right knee instability and subluxation is denied.

Entitlement to a rating in excess of 60 percent disabling for Parkinson's disease with weakness of the left lower extremity is denied.

Entitlement to a rating in excess of 60 percent disabling for weakness of the right lower extremity is denied.

Entitlement to a rating in excess of 40 percent disabling for weakness of the left upper extremity is denied.

Entitlement to a rating in excess of 50 percent disabling for weakness of the right upper extremity is denied.

Entitlement to a compensable disability rating for impairment of the seventh cranial nerve, left, for the period prior to September 10, 2019 is denied.

Entitlement to a compensable disability rating for impairment of the seventh cranial nerve, right, for the period prior to September 10, 2019 is denied

Entitlement to a 10 percent disability rating, but no greater, for impairment of the tenth cranial nerve, left, for the period beginning October 19, 2018, but no earlier, is granted.

Entitlement to a 10 percent disability rating, but no greater, for impairment of the tenth cranial nerve, right, for the period beginning October 19, 2018, but no earlier, is granted.

Entitlement to a rating in excess of 10 percent disabling for impairment of the seventh cranial nerve, left, for the period since September 10, 2019 is denied.

Entitlement to a rating in excess of 10 percent disabling for impairment of the seventh cranial nerve, right, for the period since September 10, 2019 is denied.

Entitlement to a rating in excess of 10 percent disabling for impairment of the tenth cranial nerve, left, for the period since October 19, 2018 is denied.

Entitlement to a rating in excess of 10 percent disabling for impairment of the tenth cranial nerve, right, for the period since October 19, 2018 is denied.

Entitlement to a compensable disability rating for impairment of the eleventh cranial nerve, left is denied.

Entitlement to a compensable disability rating for impairment of the eleventh cranial nerve, right is denied.

Entitlement to a compensable rating for loss of the sense of smell, associated with Parkinson's disease, is denied.

Entitlement to a compensable disability rating for constipation, associated with Parkinson's disease, is denied.

Entitlement to a rating in excess of 10 percent disabling for a right knee strain is denied.

Entitlement to a rating in excess of 20 percent disabling for right knee instability and subluxation is denied.

Entitlement to a separate rating of 10 percent disabling for limitation of extension of the right knee is granted.

REMANDED

Entitlement to service connection for bilateral hearing loss is remanded.

Entitlement to service connection for a cardiovascular condition is remanded.

Entitlement to service connection for a left hand disability, as secondary to a cardiovascular condition, is remanded.

Entitlement to service connection for a right hand disability, as secondary to a cardiovascular condition, is remanded.

Entitlement to service connection for neuropathy of the left upper extremity is remanded.

Entitlement to service connection for neuropathy of the right upper extremity is remanded.

Entitlement to a separate compensable rating for paralysis of the lower radicular group of the left upper extremity is remanded.

Entitlement to a separate compensable rating for paralysis of the lower radicular group of the right upper extremity is remanded.

Entitlement to service connection for a respiratory condition, to include chronic obstructive pulmonary disease (COPD), is remanded.

Entitlement to service connection for a sleep disorder, to include obstructive sleep apnea (OSA), is remanded.

Entitlement to service connection for a right shoulder disability is remanded.

Entitlement to service connection for a prostate condition is remanded.

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

FINDINGS OF FACT

1. Evidence received since the May 2012 denial of the Veteran's claim for entitlement to service connection for a right shoulder disability is both new and material.

2. Evidence received since the May 2012 denial of the Veteran's claim for entitlement to service connection for a prostate condition is both new and material.

3. Evidence received since the May 2012 denial of the Veteran's claim for entitlement to service connection for a cardiovascular condition is both new and material.

4. The Veteran did not file a Notice of Disagreement (NOD) with the May 2012 rating decision initially denying his claim for entitlement to service connection for Parkinson's disease within the prescribed period, or submit new and material evidence within one year of the issuance of notice of that decision.

5. VA received an intent to file a claim, VA Form 21-0966, submitted by the Veteran on May 24, 2018, and he submitted a request to reopen his claim for entitlement to service connection for Parkinson's disease and a claim for entitlement to service connection for a right knee disability in July 2018.

6. VA did not receive a request to reopen the Veteran's claim for entitlement to service connection for Parkinson's disease prior to July 2018.

7. The Veteran was initially granted a total combined disability rating effective May 24, 2017.

8. The Veteran was first diagnosed with loss of his sense of smell due to his Parkinson's disease on September 10, 2019.

9. The Veteran was first diagnosed with constipation due to his Parkinson's disease on September 10, 2019.

10. VA received the Veteran's claim for entitlement to service connection for a right knee disability, associated with his May 24, 2018 intent to file a claim, in July 2018.

11. The Veteran was first diagnosed with instability of his right knee in a September 10, 2019 private examination.

12. The Veteran's Parkinson's disease with weakness of the left lower extremity symptoms did not more nearly approximate complete paralysis of the sciatic nerve during the period on appeal.

13. The Veteran's weakness of the right lower extremity symptoms did not more nearly approximate complete paralysis of the sciatic nerve during the period on appeal.

14. The Veteran's weakness of the left upper extremity symptoms did not more nearly approximate complete paralysis of the upper radicular group during the period on appeal.

15. The Veteran's weakness of the right upper extremity symptoms did not more nearly approximate complete paralysis of the upper radicular group during the period on appeal.

16. The Veteran's impairment of the seventh cranial nerve, left, symptoms for the period prior to September 10, 2019 most nearly approximated mild incomplete paralysis.

17. The Veteran's impairment of the seventh cranial nerve, right, symptoms for the period prior to September 10, 2019 most nearly approximated mild incomplete paralysis.

18. The Veteran's impairment of the tenth cranial nerve, left, symptoms for the period prior to October 19, 2018 most nearly approximated mild incomplete paralysis.

19. The Veteran's impairment of the tenth cranial nerve, right, symptoms for the period prior to October 19, 2018 most nearly approximated mild incomplete paralysis.

20. The Veteran's impairment of the seventh cranial nerve, left, symptoms for the period since September 10, 2019 most nearly approximated moderate incomplete paralysis.

21. The Veteran's impairment of the seventh cranial nerve, right, symptoms for the period since September 10, 2019 most nearly approximated moderate incomplete paralysis.

22. The Veteran's impairment of the tenth cranial nerve, left, symptoms for the period since October 19, 2018 most nearly approximated moderate incomplete paralysis.

23. The Veteran's impairment of the tenth cranial nerve, right, symptoms for the period since October 19, 2018 most nearly approximated moderate incomplete paralysis.

24. The Veteran's impairment of the eleventh cranial nerve, left, symptoms most nearly approximated mild incomplete paralysis for the period on appeal.

25. The Veteran's impairment of the eleventh cranial nerve, right, symptoms most nearly approximated mild incomplete paralysis for the period on appeal.

26. The Veteran exhibited no more than partial loss of his sense of smell during the period on appeal.

27. The Veteran exhibited no more than occasional episodes of abdominal distress during the period on appeal.

28. The Veteran exhibited a limitation of flexion of his right knee to, at most, 60 degrees, with associated functional loss, during the period on appeal.

29. The Veteran exhibited no more than moderate instability and subluxation of his right knee during the period on appeal.

30. The Veteran exhibited a limitation of extension of his right knee to, at most, 10 degrees during the period on appeal.

CONCLUSIONS OF LAW

1. The criteria to reopen the Veteran's claim for entitlement to service connection for a right shoulder disability have been met. 38 U.S.C. §§ 1154(a), 5108, 7105 (2012); 38 C.F.R. §§ 3.156, 20.302, 20.1103 (2019).

2. The criteria for reopening the Veteran's claim for entitlement to service connection for a prostate condition have been met. 38 U.S.C. §§ 1154(a), 5108, 7105; 38 C.F.R. §§ 3.156, 20.302, 20.1103.

3. The criteria for reopening the Veteran's claim for entitlement to service connection for a cardiovascular condition have been met. 38 U.S.C. §§ 1154(a), 5108, 7105; 38 C.F.R. §§ 3.156, 20.302, 20.1103.

4. The criteria for entitlement to service connection for peripheral neuropathy of the left lower extremity, as secondary to Parkinson's disease, have been met. 38 U.S.C. §§ 1110, 5107, 38 C.F.R. §§ 3.102, 3.159, 3.303, 3.310.

5. The criteria for entitlement to service connection for peripheral neuropathy of the right lower extremity, as secondary to Parkinson's disease, have been met. 38 U.S.C. §§ 1110, 5107, 38 C.F.R. §§ 3.102, 3.159, 3.303, 3.310.

6. The criteria for entitlement to an effective date earlier than May 24, 2017 for the grant of service connection for Parkinson's disease with weakness of the left lower extremity have not been met. 38 U.S.C. §§ 5101, 5103, 5103A, 5107, 5110; 38 C.F.R. §§ 3.151, 3.155, 3.159, 3.400.

7. The criteria for entitlement to an effective date earlier than May 24, 2017 for the grant of service connection for weakness of the right lower extremity have not been met. 38 U.S.C. §§ 5101, 5103, 5103A, 5107, 5110; 38 C.F.R. §§ 3.151, 3.155, 3.159, 3.400.

8. The criteria for entitlement to an effective date earlier than May 24, 2017 for the grant of service connection for weakness of the left upper extremity have not been met. 38 U.S.C. §§ 5101, 5103, 5103A, 5107, 5110; 38 C.F.R. §§ 3.151, 3.155, 3.159, 3.400.

9. The criteria for entitlement to an effective date earlier than May 24, 2017 for the grant of service connection for weakness of the right upper extremity have not been met. 38 U.S.C. §§ 5101, 5103, 5103A, 5107, 5110; 38 C.F.R. §§ 3.151, 3.155, 3.159, 3.400.

10. The criteria for entitlement to an effective date earlier than May 24, 2017 for the grant of service connection for impairment of the seventh cranial nerve, left, have not been met. 38 U.S.C. §§ 5101, 5103, 5103A, 5107, 5110; 38 C.F.R. §§ 3.151, 3.155, 3.159, 3.400.

11. The criteria for entitlement to an effective date earlier than May 24, 2017 for the grant of service connection for impairment of the seventh cranial nerve, right, have not been met. 38 U.S.C. §§ 5101, 5103, 5103A, 5107, 5110; 38 C.F.R. §§ 3.151, 3.155, 3.159, 3.400.

12. The criteria for entitlement to an effective date earlier than May 24, 2017 for the grant of service connection for impairment of the tenth cranial nerve, left, have not been met. 38 U.S.C. §§ 5101, 5103, 5103A, 5107, 5110; 38 C.F.R. §§ 3.151, 3.155, 3.159, 3.400.

13. The criteria for entitlement to an effective date earlier than May 24, 2017 for the grant of service connection for impairment of the tenth cranial nerve, right, have not been met. 38 U.S.C. §§ 5101, 5103, 5103A, 5107, 5110; 38 C.F.R. §§ 3.151, 3.155, 3.159, 3.400.

14. The criteria for entitlement to an effective date earlier than May 24, 2017 for the grant of service connection for impairment of the eleventh cranial nerve, left, have not been met. 38 U.S.C. §§ 5101, 5103, 5103A, 5107, 5110; 38 C.F.R. §§ 3.151, 3.155, 3.159, 3.400.

15. The criteria for entitlement to an effective date earlier than May 24, 2017 for the grant of service connection for impairment of the eleventh cranial nerve, right, have not been met. 38 U.S.C. §§ 5101, 5103, 5103A, 5107, 5110; 38 C.F.R. §§ 3.151, 3.155, 3.159, 3.400.

16. The criteria for entitlement to an effective date earlier than May 24, 2017 for the grant of Dependents' Educational Assistance have not been met. 38 U.S.C. §§ 5101, 5103, 5103A, 5107, 5110; 38 C.F.R. §§ 3.151, 3.155, 3.159, 3.400.

17. The criteria for entitlement to an effective date earlier than September 10, 2019 for the grant of service connection for partial loss of the sense of smell have not been met. 38 U.S.C. §§ 5101, 5103, 5103A, 5107, 5110; 38 C.F.R. §§ 3.151, 3.155, 3.159, 3.400.

18. The criteria for entitlement to an effective date earlier than September 10, 2019 for the grant of service connection for constipation have not been met. 38 U.S.C. §§ 5101, 5103, 5103A, 5107, 5110; 38 C.F.R. §§ 3.151, 3.155, 3.159, 3.400.

19. The criteria for entitlement to an effective date earlier than May 24, 2018 for the grant of service connection for a right knee strain have not been met. 38 U.S.C. §§ 5101, 5103, 5103A, 5107, 5110; 38 C.F.R. §§ 3.151, 3.155, 3.159, 3.400.

20. The criteria for entitlement to an effective date earlier than September 10, 2019 for the grant of service connection for instability and subluxation of the right knee have not been met. 38 U.S.C. §§ 5101, 5103, 5103A, 5107, 5110; 38 C.F.R. §§ 3.151, 3.155, 3.159, 3.400.

21. The criteria for entitlement to a rating in excess of 60 percent disabling for Parkinson's disease with weakness of the left lower extremity have not been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 4.1, 4.3, 4.7, 4.124a, Diagnostic Code 8520.

22. The criteria for entitlement to a rating in excess of 60 percent disabling for weakness of the right lower extremity have not been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 4.1, 4.3, 4.7, 4.124a, Diagnostic Code 8520.

23. The criteria for entitlement to a rating in excess of 40 percent disabling for weakness of the left upper extremity have not been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 4.1, 4.3, 4.7, 4.124a, Diagnostic Code 8510.

24. The criteria for entitlement to a rating in excess of 50 percent disabling for weakness of the right upper extremity have not been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 4.1, 4.3, 4.7, 4.124a, Diagnostic Code 8510.

25. The criteria for entitlement to a compensable disability rating for impairment of the seventh cranial nerve, left, for the period prior to September 10, 2019 have not been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 4.1, 4.3, 4.7, 4.124a, Diagnostic Code 8207.

26. The criteria for entitlement to a compensable disability rating for impairment of the seventh cranial nerve, right, for the period prior to September 10, 2019 have not been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 4.1, 4.3, 4.7, 4.124a, Diagnostic Code 8207.

27. The criteria for entitlement to a 10 percent disability rating, but no greater, for impairment of the tenth cranial nerve, left, for the period beginning October 19, 2018, but no earlier, have been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 4.1, 4.3, 4.7, 4.124a, Diagnostic Code 8210.

28. The criteria for entitlement to a 10 percent disability rating, but no greater, for impairment of the tenth cranial nerve, right, for the period beginning October 19, 2018, but no earlier, have been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 4.1, 4.3, 4.7, 4.124a, Diagnostic Code 8210.

29. The criteria for entitlement to a rating in excess of 10 percent disability for impairment of the seventh cranial nerve, left, for the period since September 10, 2019 have not been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 4.1, 4.3, 4.7, 4.124a, Diagnostic Code 8207.

30. The criteria for entitlement to a rating in excess of 10 percent disability for impairment of the seventh cranial nerve, right, for the period since September 10, 2019 have not been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 4.1, 4.3, 4.7, 4.124a, Diagnostic Code 8207.

31. The criteria for entitlement to a rating in excess of 10 percent disability for impairment of the tenth cranial nerve, left, for the period since October 19, 2018 have not been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 4.1, 4.3, 4.7, 4.124a, Diagnostic Code 8210.

32. The criteria for entitlement to a rating in excess of 10 percent disability for impairment of the tenth cranial nerve, right, for the period since October 19, 2018 have not been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 4.1, 4.3, 4.7, 4.124a, Diagnostic Code 8210.

33. The criteria for entitlement to a compensable disability rating for impairment of the eleventh cranial nerve, left, have not been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 4.1, 4.3, 4.7, 4.124a, Diagnostic Code 8211.

34. The criteria for entitlement to a compensable disability rating for impairment of the eleventh cranial nerve, left, have not been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 4.1, 4.3, 4.7, 4.124a, Diagnostic Code 8211.

35. The criteria for entitlement to a compensable rating for loss of the sense of smell have not been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 4.1, 4.3, 4.7, 4.87a, Diagnostic Codes 6275-76.

36. The criteria for entitlement to a compensable rating for constipation have not been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 4.1, 4.3, 4.7, 4.114, Diagnostic Code 7319.

37. The criteria for entitlement to a rating in excess of 10 percent disabling for a right knee strain have not been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 4.1, 4.3, 4.7, 4.71a, Diagnostic Code 5260.

38. The criteria for entitlement to a rating in excess of 20 percent disabling for instability and subluxation of the right knee have not been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 4.1, 4.3, 4.7, 4.71a, Diagnostic Code 5257.

39. The criteria for entitlement to a separate 10 percent rating, but no greater, for limitation of extension of the right knee have been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 4.1, 4.3, 4.7, 4.71a, Diagnostic Code 5260.

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

Initially, the Board notes that the Veteran's attorney submitted a statement in April 2020 indicating a March 16, 2020 Higher Level Review appeal request, which was rejected by the Agency of Original Jurisdiction (AOJ) on the basis that the appeal path was not available to rating decisions issued prior to February 19, 2020, should have been accepted as valid. In response to the AOJ's rejection of the Higher Level Review appeal request, the attorney also submitted a NOD utilized by the legacy appeal system.

An overview of the procedural history of the Veteran's instant claims is necessary for the Board's analysis of the propriety of the AOJ's rejection of his Higher Level Review appeal request and of the Board's jurisdiction to adjudicate the matters at issue herein.

The Veteran was granted service connection for Parkinson's disease, with a 30 percent rating, and for a right knee strain, with a 10 percent evaluation, in a September 2018 rating decision. That decision also denied his claims for entitlement to a TDIU and entitlement to service connection for depression, and further denied his request to reopen his claim for entitlement to service connection for a right shoulder disability. VA subsequently received new claims for entitlement to service connection for bilateral peripheral neuropathy, secondary to

herbicide agent exposure, for sleep apnea, and for hearing loss in October 2018. He was denied entitlement to service connection for sleep apnea, for bilateral hearing loss, for peripheral neuropathy of the left lower extremity, for peripheral neuropathy of the right lower extremity, for peripheral neuropathy of the left upper extremity, and for peripheral neuropathy of the right upper extremity in a November 2018 rating decision. The Veteran filed a NOD for both the September 2018 and November 2018 decisions in November 2018. VA also received a claim for special monthly compensation (SMC) based on the need for regular aid and attendance in March 2019, which was then denied in May, September, and December 2019 rating decisions.

On February 11, 2020, the AOJ issued a rating decision granting a 60 percent rating for Parkinson's disease with weakness of the left lower extremity; service connection for weakness of the right lower extremity, with a 60 percent rating; service connection for weakness of left upper extremity, with a 40 percent rating; service connection for weakness of the right upper extremity, with a 50 percent rating; service connection for impairment of the seventh cranial nerve, left, with a noncompensable rating prior to September 10, 2019 and a 10 percent rating thereafter; service connection for impairment of the seventh cranial nerve, right, with a noncompensable rating prior to September 10, 2019 and a 10 percent rating thereafter; service connection for impairment of the tenth cranial nerve, left, with a noncompensable rating prior to September 10, 2019 and a 10 percent rating thereafter; service connection for impairment of the tenth cranial nerve, right, with a noncompensable rating prior to September 10, 2019 and a 10 percent rating thereafter; service connection for impairment of the eleventh cranial nerve, left, with a noncompensable rating; service connection for impairment of the eleventh cranial nerve, right, with a noncompensable rating; service connection for constipation, with a noncompensable rating; service connection for partial loss of the sense of smell, with a noncompensable rating; service connection for right knee instability and subluxation, with a 20 percent rating; entitlement to basic Dependents' Educational Assistance; service connection for depression and sleep impairment, with a 30 percent rating; and entitlement to SMC based on the need for regular aid and attendance. The rating decision also denied the Veteran's claim for entitlement to a TDIU as moot.

The AOJ also issued a corresponding February 11, 2020 Statement of the Case (SOC) which denied the Veteran's claims for entitlement to service connection for a left hand disability, service connection for a right hand disability, service connection for cardiovascular issues, service connection for sleep apnea, service connection for bilateral hearing loss, service connection for peripheral neuropathy of the left lower extremity, service connection for peripheral neuropathy of the right lower extremity, service connection for peripheral neuropathy of the left upper extremity, and service connection for peripheral neuropathy of the right upper extremity. The SOC further denied entitlement to a rating in excess of 60 percent disabling for Parkinson's disease with weakness of the left lower extremity; a rating in excess of 60 percent disabling for weakness of the right lower extremity; a rating in excess of 40 percent disabling for weakness of the left upper extremity; a rating in excess of 50 percent disabling for weakness of the right upper extremity; a compensable rating for impairment of the seventh cranial nerve, left, prior to September 10, 2019 and a rating in excess of 10 percent thereafter; a compensable rating for impairment of the seventh cranial nerve, right, prior to September 10, 2019 and a rating in excess of 10 percent thereafter; a compensable rating for impairment of the tenth cranial nerve, left, prior to September 10, 2019 and a rating in excess of 10 percent thereafter; a compensable rating for impairment of the tenth cranial nerve, right, prior to September 10, 2019 and a rating in excess of 10 percent thereafter; a compensable rating for impairment of the eleventh cranial nerve, right; a compensable rating for impairment of the eleventh cranial nerve, left; a rating in excess of 10 percent disabling for a right knee strain; a rating in excess of 20 percent disabling for instability and subluxation of the right knee; a compensable rating for constipation, and a compensable rating for partial loss of the sense of smell. The SOC additionally denied the Veteran's requests to reopen his claims for entitlement to service connection for a right shoulder disability and for a prostate condition, and denied entitlement to an effective date earlier than May 24, 2018 for the grant of service connection for a right knee strain.

The AOJ sent the Veteran a notice of the February 11, 2020 rating decision in a letter dated March 2, 2020.

The Veteran's attorney submitted a VA Form 9 on March 5, 2020 and indicated that he wished to appeal all of the issues listed on the SOC. The attorney stated that the Veteran should have been entitled to service connection for a left hand disability, for a right hand disability, for a cardiovascular condition, for peripheral neuropathy of the left lower extremity, for peripheral neuropathy of the right lower extremity, for peripheral neuropathy of the left upper extremity, for peripheral neuropathy of the right upper extremity. The attorney also stated that he should have been entitled to increased ratings for Parkinson's disease with weakness of the left lower extremity; for weakness of the right lower extremity; for weakness of the left upper extremity; for weakness of the right upper extremity; for constipation; and for loss of the sense of smell. The attorney further stated that he should have been entitled to increased ratings and earlier effective dates for impairment of the seventh cranial nerve, impairment of the tenth cranial nerve, and impairment of the eleventh cranial nerve.

The Veteran's attorney additionally submitted a concurrent request for a Higher Level Review of his claim for entitlement to SMC based on the need for regular aid and attendance on March 5, 2020.

On March 19, 2020, VA received a request for a Higher Level Review appeal of the Veteran's claims for increased ratings and earlier effective dates for his Parkinson's disease with weakness of the left lower extremity, weakness of the right lower extremity; weakness of the left upper extremity,; weakness of the right upper extremity; impairment of the seventh cranial nerve, left; impairment of the seventh cranial nerve, right; impairment of the tenth cranial nerve, left; impairment of the tenth cranial nerve, right; impairment of the eleventh cranial nerve, left; impairment of the eleventh cranial nerve, right; constipation; and loss of the sense of smell. The attorney also included his claims of entitlement to an increased rating for right knee instability and subluxation, to an earlier effective date for the grant of SMC based on the need for regular aid and attendance and for Dependents' Education Assistance, and for entitlement to a TDIU. The Veteran's attorney did not indicate that he wished to opt-in and withdraw any issue that was part of the legacy appeals system from the SOC.

The Board notes that the AOJ improperly rejected the Veteran's March 19, 2020 request for a Higher Level Review appeal. Although the February 11, 2020 rating decision was issued prior to the February 19, 2020 enactment of the Appeals Modernization Act (AMA), which controls whether the claims fall under the AMA, is based upon the date that VA issued the notice of the rating decision. *See* 38 C.F.R. § 3.2400.

However, the Board also notes that there were numerous overlapping issues pertaining to the Veteran's VA Form 9 and his request for a Higher Level Review appeal. In fact, all of the appealed issues other than entitlement to an increased rating and earlier effective date for depression with sleep disturbance were present, either implicitly or explicitly, in the February 2020 SOC. The Board notes that under *Fenderson v. West*, 12 Vet. App. 119, 126 (2001), the effective date question is part and parcel of an initial rating being appealed, and does not require separate adjudication. Further, a Veteran is presumed to be seeking the maximum benefit allowed and entitlement to benefits such as Dependents' Educational Assistance are "inferred issues" in the context of an increased rating claim, even if the claimant does not place eligibility for such ancillary benefits at issue. *See* 38 U.S.C. § 1114(s); *Akles v. Derwinski*, 1 Vet. App. 118, 121 (1991); cf. *AB v. Brown*, 6 Vet. App. 35, 38 (1993). Therefore, the denial of entitlement to each of the increased ratings available above those initially assigned by the AOJ in the February 2020 SOC included any issues concerning the effective dates for those ratings and the propriety of the ratings for the respective disabilities for the period on appeal, along with any ancillary benefits related to the Veteran's claims for entitlement to increased ratings.

Accordingly, the Board has jurisdiction over all of the claims for which the Veteran initiated a formal appeal by submitting his March 2020 VA Form 9, and for all of the issues implicitly associated with those claims.

The Board notes that there were issues adjudicated in the February 11, 2020 rating decision which were not a part of the corresponding SOC, and thus jurisdiction was not conveyed to the Board via the filing of a VA Form 9. Specifically, the grant of the Veteran's claims for entitlement to service connection for depression and sleep impairment and entitlement to SMC based on the need for regular aid

and attendance were not addressed in the subject SOC. Thus, the Veteran's election of a Higher Level Review appeal for those issues is applicable and they will be handled separately pursuant to that appeal pathway.

The Board recognizes that the issue of entitlement to an earlier effective date for the grant of Dependents' Educational Assistance was not addressed in the February 11, 2020 SOC; however, the Board notes that entitlement to such benefits is wholly derivative of the assignment of a total disability rating (100 percent). The Board further notes that as an "inferred issue" associated with his increased rating claims currently before the Board, there is a duty to address entitlement to such benefits when reasonably raised by the record. *See Akles, supra*. Additionally, although the issue of entitlement to a TDIU was not addressed in the February 11, 2020 SOC, as discussed in *Rice v. Shinseki*, 22 Vet. App. 447, 454 (2009), an increased rating claim inherently includes a claim for entitlement to a TDIU. *See Rice*, 22 Vet. App. at 454 (when entitlement to TDIU is raised during the appeal of a rating for a disability, it is part of the claim for benefits for the underlying disability). Therefore, the issues of entitlement to an earlier effective date for the grant of Dependents' Educational Assistance and entitlement to a TDIU are also properly before the Board.

The Board notes that while entitlement to an earlier effective date for the grant of SMC based on the need for regular aid and attendance may also be considered along increased rating claims under *Akles*, the Veteran filed a claim for entitlement to such benefits independent of his other claims and also filed a request for a Higher Level Review appeal solely for that issue at the same time he filed his VA Form 9 in response to the February 11, 2020 SOC. Thus, the record indicates that the Veteran wished that issue to be considered separately from the issues listed in the SOC, and the Board will treat that claim as an independent appeal stream which will also be addressed as a Higher Level Review appeal.

New and Material Evidence

In general, rating decisions that are not timely appealed are final. *See* 38 U.S.C. § 7105; 38 C.F.R. § 20.200. From the date of notification of an AOJ decision, a claimant has one year to submit new evidence or to initiate an appeal by filing a

NOD with the decision. In this regard, the decision becomes final if the Veteran does not express disagreement with the decision or if new, material evidence is not associated with the claims file within one year of the mailing of the rating decision to the Veteran. 38 C.F.R. § 20.302.

An exception to this rule is 38 U.S.C. § 5108, which provides that if new and material evidence is presented or secured with respect to a claim which has been disallowed, the Secretary shall reopen the claim and review the former disposition of the claim. The Board must consider the question of whether new and material evidence has been received because it goes to the Board's jurisdiction to reach the underlying claim and adjudicate the claim de novo. *See Jackson v Principi*, 265 F.3d 1366 (Fed. Cir. 2001); *Barnett v. Brown*, 83 F.3d 1380 (Fed. Cir. 1996).

"New" evidence is existing evidence not previously submitted to agency decision makers. "Material" evidence is existing evidence that, by itself or when considered with previous evidence of record, relates to an unestablished fact necessary to substantiate the claim. New and material evidence can be neither cumulative nor redundant of the evidence of record at the time of the last prior denial of the claim sought to be reopened, and must raise a reasonable possibility of substantiating the claim. 38 C.F.R. § 3.156(a). In determining whether evidence is new and material, the "credibility of the evidence is to be presumed." *Justus v. Principi*, 3 Vet. App. 510, 513 (1992).

In order for evidence to be sufficient to reopen a previously disallowed claim, it must be both new and material. If the evidence is new, but not material, the inquiry ends, and the claim cannot be reopened. *See Smith v. West*, 12 Vet. App. 312, 314 (1999). If it is determined that new and material evidence has been submitted, the claim must be reopened. VA may then proceed to evaluate the merits of the claim on the basis of all evidence of record, but only after ensuring that the duty to assist the appellant in developing the facts necessary for the claim has been satisfied. *See Elkins v. West*, 12 Vet. App. 209 (1999).

The threshold for determining whether new and material evidence raises a reasonable possibility of substantiating a claim is "low." *See Shade v. Shinseki*, 24 Vet. App. 110, 117 (2010). Furthermore, consideration is not limited to whether

the newly submitted evidence relates specifically to the reason the claim was last denied, but instead should include whether the evidence could reasonably substantiate the claim were the claim to be reopened, either by triggering the Secretary's duty to assist or through consideration of an alternative theory of entitlement. *Id.* at 118. Additionally, the United States Court of Appeals for the Federal Circuit has noted that new evidence could be sufficient to reopen a claim if it could contribute to a more complete picture of the circumstances surrounding the origin of a claimant's injury or disability, even where it would not be enough to convince the Board to grant a claim. *Hodge v. West*, 155 F.3d 1356, 1363 (Fed. Cir. 1998).

The record reflects that prior to the initiation of the instant claim, the Veteran's claims for entitlement to service connection for a right shoulder disability, for a prostate condition, and for a cardiovascular condition were most recently denied in a May 2012 rating decision. There is no indication that he appealed that decision within the prescribed period. Additionally, there is no indication that new and material evidence was submitted within one year of the issuance of that decision. Therefore, the May 2012 decision became final. 38 U.S.C. § 7105; 38 C.F.R. § 20.1103.

Since the May 2012 decision became final, additional statements and evidence supporting his claims have been associated with the Veteran's file. Particularly, the Board notes that he has continued to report symptoms related to his right shoulder, and noted in a January 2018 VA orthopedic surgery consultation note that he "had a couple of falls landing on his right shoulder." The record indicates that his service-connected disabilities result in instability, and such falls potentially aggravated his right shoulder disability. Additionally, his VA treatment records show that he has continued to show elevated PSA levels throughout the period on appeal and private treatment records indicated that his prostate was enlarged. While there is no indication that he has been diagnosed with prostate cancer, the record does reflect chronic symptoms of a potential abnormality of his prostate. Further, the Veteran has claimed that he experiences pain and swelling of his hands due to a cardiovascular condition and was afforded a VA examination related to his claim in April 2018.

The Board finds that the evidence associated with his claims file after May 2012 decision could potentially affect the outcome of the Veteran's claims and it is both new and material. Accordingly, his claims for entitlement to service connection for a right shoulder disability, a prostate condition, and a cardiovascular condition are reopened.

Service Connection

Service connection may be granted for a disability resulting from a disease or injury incurred in or aggravated by active service. *See* 38 U.S.C. §§ 1110, 1131; 38 C.F.R. § 3.303(a). To establish a right to compensation for a present disability, a veteran must show: (1) the existence of a present disability; (2) in-service incurrence or aggravation of a disease or injury; and (3) a causal relationship between the present disability and the disease or injury incurred or aggravated during service"-the so-called "nexus" requirement. *Holton v. Shinseki*, 557 F.3d 1362, 1366 (Fed. Cir. 2010) (quoting *Shedden v. Principi*, 381 F.3d 1163, 1167 (Fed. Cir. 2004); *see also Davidson v. Shinseki*, 581 F.3d 1313 (Fed.Cir.2009); *Jandreau v. Nicholson*, 492 F.3d 1372 (Fed.Cir.2007).

Service connection may also be granted on a secondary basis for a disability which is proximately due to, or the result of, a service-connected disease or injury. 38 C.F.R. § 3.310(a). Secondary service connection may also be granted for aggravation of a disease or injury by a service-connected disability. *Id.* To establish secondary service connection based on aggravation, the evidence must show an increase in severity of a disease or injury beyond a medically established baseline which is proximately due to or the result of a service-connected disease or injury, and not due to the natural progress of the nonservice-connected condition. 38 C.F.R. § 3.310(b).

VA regulations further provide that certain diseases associated with exposure to herbicide agents may be presumed to have been incurred in service even if there is no evidence of the disease in service, provided the requirements of 38 C.F.R. § 3.307(a)(6) are met. 38 C.F.R. § 3.309(e). A veteran who, during active service, served in the Republic of Vietnam during the period beginning on January 9, 1962, and ending on May 7, 1975, shall be presumed to have been exposed during such

service to an herbicide agent, unless there is affirmative evidence to establish that the Veteran was not exposed to any such agent during that service. 38 C.F.R. § 3.307(a). The term "herbicide agent" means a chemical in an herbicide, including Agent Orange, used in support of the United States and allied military operations in the Republic of Vietnam during the Vietnam era.

If a veteran was exposed to an herbicide agent during active service, the following diseases shall be service-connected if the requirements of 38 C.F.R. § 3.307(a)(6) are met, even though there is no record of such disease during service, provided further that the rebuttable presumption provisions of 38 C.F.R. § 3.307(d) are also satisfied: AL amyloidosis; chloracne or other acneform disease consistent with chloracne; Type 2 diabetes (also known as Type II diabetes mellitus or adult-onset diabetes); Hodgkin's disease; all chronic B cell leukemias; multiple myeloma; non-Hodgkin's lymphoma; Parkinson's disease; early-onset peripheral neuropathy; porphyria cutanea tarda; prostate cancer; respiratory cancers (cancer of the lung, bronchus, larynx or trachea); soft-tissue sarcoma (other than osteosarcoma, chondrosarcoma, Kaposi's sarcoma, or mesothelioma); and ischemic heart disease, (including, but not limited to, acute, subacute, and old myocardial infarction); atherosclerotic cardiovascular disease including coronary artery disease (including coronary spasm) and coronary bypass surgery; and stable, unstable and Prinzmetal's angina), shall be service-connected if the requirements of 38 C.F.R. § 3.307(a)(6) are met, even though there is no record of such disease during service, provided further that the rebuttable presumption provisions of 38 C.F.R. § 3.307(d) are also satisfied. 38 C.F.R. § 3.309(e).

The diseases listed at 38 C.F.R. § 3.309(e) shall have become manifest to a degree of 10 percent or more at any time after service, except that chloracne or other acneform disease consistent with chloracne, porphyria cutanea tarda, and early-onset peripheral neuropathy shall have become manifest to a degree of 10 percent or more within a year after the last date on which the Veteran was exposed to an herbicide agent during active military, naval, or air service. 38 C.F.R. § 3.307(a)(6)(ii).

It is the policy of VA to administer the law under a broad interpretation, consistent with the facts in each case, with all reasonable doubt to be resolved in favor of the

claimant. 38 U.S.C. § 5107; 38 C.F.R. § 3.102. When all of the evidence is assembled, VA is responsible for determining whether the evidence supports the claim or is in relative equipoise, with the appellant prevailing in either event, or whether a fair preponderance of the evidence is against the claim, in which case the claim is denied. *Gilbert v. Derwinski*, 1 Vet. App. 49, 55 (1990).

1. Entitlement to service connection for peripheral neuropathy of the left lower extremity and for peripheral neuropathy of the right lower extremity.

The Veteran contends that he is entitled to service connection for peripheral neuropathy of the left lower extremity and peripheral neuropathy of the right lower extremity, as the conditions are due to herbicide agent exposure and/or due to his service-connected Parkinson's disease.

In an April 2018 VA neurology outpatient note, the treating clinician noted increased gait unsteadiness and falls, likely worsened by peripheral neuropathy and poor postural reflexes.

In a June 2018 VA neurology outpatient note, the treating clinician indicated that the Veteran's neuropathy was about the same, and that he had burning pain in his feet.

In an October 2018 VA examination, the examiner indicated that the Veteran had a diagnosis of bilateral peripheral neuropathy of the lower extremities. He claimed that he felt like he was "walking on water balloons" and that his feet hurt all the time. He stated that the onset was approximately one year before the examination. The examiner documented that he experienced moderate constant pain of both the left and right lower extremities. The examiner opined that the Veteran's peripheral neuropathy was less likely than not due to his herbicide agent exposure, but did not provide an opinion as to whether his neuropathy was associated with his Parkinson's disease.

In a May 2017 private electrodiagnostic study report, the Veteran's private physician indicated that the Veteran had motor-sensory polyneuropathy, primarily of an axonal type.

In an October 2018 VA neurology return note, the treating clinician indicated that the Veteran had neuropathy in both feet, with burning pain that was worse when he went to bed.

In a January 2019 VA neurology outpatient note, the treating clinician stated that the Veteran's neuropathy was of unclear significance, and that his neuropathy labs had been unremarkable. The treating clinician indicated that the etiology of his condition was unclear, but small fiber neuropathy was suspected given his burning pain.

In an April 2019 VA neurology note, the treating clinician stated that an EMG and nerve conduction study showed no electrophysiological evidence of polyneuropathy.

In a July 2019 VA neurology outpatient note, the treating clinician diagnosed the Veteran with likely small fiber neuropathy.

In the September 2019 private DBQ concerning Parkinson's disease, the Veteran's physician stated that he had neuropathy in both of his feet.

An October 2019 private treatment record, the Veteran's private clinician noted a past medical history of bilateral neuropathy of his feet.

In a January 2020 medical opinion, the Veteran's private physician opined that the Veteran's neuropathy was "much more likely than not" related to his Parkinson's disease. The physician cited studies showing a link between the development of neuropathy and Parkinson's disease, and noted that Parkinson's disease was, by definition, a disease that attacked and destroyed the body's nervous system, and therefore caused neuropathy.

Accordingly, the Board finds that the preponderance of the evidence is in favor of a finding that the Veteran's peripheral neuropathy of the left lower extremity and of the right lower extremity is due to his Parkinson's disease. Although a VA nerve conduction testing did not show signs of polyneuropathy, testing by the Veteran's private physician showed the presence of neuropathy, and both VA and private

physicians have diagnosed him with neuropathy. Therefore, entitlement to service connection for peripheral neuropathy of the left lower extremity and entitlement to service connection for peripheral neuropathy of the right lower extremity are warranted.

Earlier Effective Dates

Generally, the effective date for the grant of service connection for a disease or injury is the day following separation from active duty or the date entitlement arose if a claim is received within one year after separation from service. Otherwise, the effective date is the date of receipt of claim, or date entitlement arose, whichever is later. The effective date of an award based on a claim reopened after final adjudication shall be fixed in accordance with the facts found, but shall not be earlier than the date of receipt of application therefor. 38 U.S.C. § 5110; 38 C.F.R. § 3.400.

A pending claim is an application, formal or informal, which has not been finally adjudicated. 38 C.F.R. § 3.160(c). The pending claims doctrine provides that a claim remains pending in the adjudication process if VA fails to act on it. *Norris v. West*, 12 Vet. App. 413, 422 (1999).

The Court discussed the case law and regulations regarding the scope of a veteran's claim in *DeLisio v. Shinseki*, 25 Vet. App. 45 (2011). In relevant part, the Court stated that a claim for VA benefits requires "(1) an intent to apply for benefits, (2) an identification of the benefits sought, and (3) a communication in writing." *Brokowski v. Shinseki*, 23 Vet. App. 79, 84 (2009). However, a claimant is not required in filing a claim for benefits to identify a precise medical diagnosis or the medical cause of his condition; rather, he sufficiently files a claim for benefits "by referring to a body part or system that is disabled or by describing symptoms of the disability." *Id*. at 86. This is because a claimant is not expected to have medical expertise and generally "is only competent to identify and explain the symptoms that he observes and experiences." *Clemons v. Shinseki*, 23 Vet. App. 1, 5 (2009); *see also Jandreau v. Nicholson*, 492 F.3d 1372, 1376-77 (Fed. Cir. 2007) (noting general competence of laypersons to testify as to symptoms but not medical diagnosis).

Effective on March 24, 2015, a specific claim in the form prescribed by VA must be filed in order for benefits to be paid or furnished to any individual under the laws administered by VA. *See* 79 Fed. Reg. 57660 (Sept. 25, 2014). A veteran, or other eligible persons listed in 38 C.F.R. § 3.155 (a), who indicates a desire to file for benefits by a communication or action that does not meet the standards of a complete claim is considered a request for an application form for benefits under 38 C.F.R. § 3.150(a). 38 C.F.R. § 3.155(a). Upon receipt of such a communication or action, VA shall notify the claimant of the information necessary to complete the application or form prescribed by the Secretary.

However, prior to March 24, 2015, a "claim" was defined broadly to include a formal or informal communication in writing requesting a determination of entitlement or evidencing a belief in entitlement to a benefit. 38 C.F.R. § 3.1(p); *Brannon v. West*, 12 Vet. App. 32, 34 35 (1998); *Servello v. Derwinski*, 3 Vet. App. 196, 199 (1992). Any communication indicating an intent to apply for a benefit under the laws administered by the VA may be considered an informal claim provided it identifies, but not necessarily with specificity, the benefit sought. *See* 38 C.F.R. § 3.155(a) (2015). To determine when a claim was received, the Board must review all communications in the claims file that may be construed as an application or claim. *See Quarles v. Derwinski*, 3 Vet. App. 129, 134 (1992).

Upon receipt of an informal claim prior to March 24, 2015, if a formal claim had not been filed, the AOJ would forward an application form to the claimant for execution. If the AOJ received a complete application from the claimant within one year from the date it was sent, then the AOJ would consider it filed as of the date of receipt of the informal claim. 38 C.F.R. § 3.155 (2015).

2. **Entitlement to an effective date earlier than May 24, 2017 for the grants of service connection for Parkinson's disease with weakness of the left lower extremity; weakness of the right lower extremity; weakness of the left upper extremity; weakness of the right upper extremity; impairment of the seventh cranial nerve, left; impairment of the seventh cranial nerve, right; impairment of the tenth cranial nerve, left; impairment of the tenth cranial nerve, right; impairment of the eleventh cranial nerve, left; impairment of the**

eleventh cranial nerve, right, and the grant of entitlement to Dependents' Educational Assistance.

The Veteran contends he is entitled to an effective date earlier than May 24, 2017 for the grants of service connection for Parkinson's disease with weakness of the left lower extremity; weakness of the right lower extremity; weakness of the left upper extremity; weakness of the right upper extremity; impairment of the seventh cranial nerve, left; impairment of the seventh cranial nerve, right; impairment of the tenth cranial nerve, left; impairment of the tenth cranial nerve, right; impairment of the eleventh cranial nerve, left; impairment of the eleventh cranial nerve, right, partial loss of the sense of smell; constipation and the grant of entitlement to Dependents' Educational Assistance, as he was diagnosed with Parkinson's disease, and all associated conditions, prior to May 24, 2017 and the disease is presumed to be due to Agent Orange exposure.

An effective date of an award of benefits based on liberalizing laws is assigned in accordance with the facts found, but is typically no earlier than the effective date of the change. 38 U.S.C. § 5110(g); 38 C.F.R. § 3.114. If the claim is reviewed based on a request from the claimant or by VA initiative more than one year from the date the liberalizing law became effective, the effective date for the award of benefits will be one-year prior to the date of review, if the Veteran met all the requirements for eligibility. 38 C.F.R. § 3.114 (a)(2).

The holdings in the *Nehmer* cases established an exception to 38 C.F.R. § 5110(g), in that "*Nehmer* class members" could be assigned earlier effective dates than the date of the law and regulations that established presumptive service connection for a "covered herbicide disease." *See* 38 C.F.R. § 3.816(c)(2); *see also Nehmer v. United States Veterans Administration*, 712 F. Supp. 1404 (N.D. Cal. 1989) (Nehmer I); *Nehmer v. United States Veterans Administration*, 32 F. Supp. 2d. 1175 (N.D. Cal. 1999) (Nehmer II*); Nehmer v. Veterans Administration of the Government of the United States*, 284 F.3d 1158 (9th Cir. 2002) (Nehmer III).

A *Nehmer* class member is defined as a Vietnam veteran who has been diagnosed with a disorder presumptively associated with herbicide exposure. An earlier effective date may apply if a *Nehmer* class member was denied compensation for

such disorder between September 25, 1985 and May 3, 1989; or if there was a claim for benefits pending before VA between May 3, 1989 and the effective date of the applicable liberalizing law. *See* 38 C.F.R. § 3.816(c). In these situations, the effective date of the award will be the later of the date such claim was received by VA or the date the disability arose. 38 C.F.R. § 3.816(c)(1), (c)(2). Parkinson's disease was included as a presumptive herbicide exposure related disease under 38 C.F.R. § 3.309(e), which was made effective by VA as of August 31, 2010.

Looking to the claims file, the first communication VA received from the Veteran expressing an intent to file a claim of service connection for Parkinson's disease was received on September 29, 2010. The AOJ ultimately denied entitlement to service connection for Parkinson's disease in a May 2012 rating decision, on the basis that the Veteran did not have a current diagnosis of Parkinson's disease. As noted above, he did not appeal that decision and it became final.

VA subsequently received the Veteran's intent to file a claim on May 24, 2018 and his request to reopen his claim for entitlement to service connection for Parkinson's disease on July 11, 2018. He was eventually granted entitlement to service connection for Parkinson's disease in a September 2018 rating decision and assigned a 30 percent rating, effective May 24, 2018. After appealing that decision, he was granted entitlement to separate ratings for weakness of his left lower extremity; weakness of his right lower extremity; weakness of his left upper extremity; weakness of his right upper extremity; impairment of his seventh cranial nerve, left; impairment of the seventh cranial nerve, right; impairment of the tenth cranial nerve, left; impairment of the tenth cranial nerve, right; impairment of the eleventh cranial nerve, left; and impairment of the eleventh cranial nerve, right, all as associated with Parkinson's disease, and assigned an effective date of May 24, 2017 for each condition. He was also granted entitlement to Dependents' Educational Assistance based on a total combined disability rating, effective May 24, 2017.

The Board considered whether the Veteran is entitled to earlier effective dates for his conditions associated with his Parkinson's disease under 38 C.F.R. § 3.816. Although the Veteran is a *Nehmer* class member and Parkinson's disease is a covered herbicide disease, the evidence does not show: (1) VA denied

compensation for Parkinson's disease in a decision issued between September 25, 1985 and May 3, 1989; or (2) a claim for disability compensation for Parkinson's disease was either pending before VA on May 3, 1989 or was received by VA between May 3, 1989 and the effective date of the regulation establishing a presumption of service connection for Parkinson's disease, which was August 31, 2010. Further, there is no indication from the record that the VA received a request to reopen his claim for entitlement to service connection for Parkinson's disease prior to May 24, 2018 or a request for service connection for Parkinson's disease prior to September 29, 2010, on either a formal or informal basis. Nor is there any indication that the Veteran was diagnosed with Parkinson's disease or exhibited symptoms objectively due to Parkinson's disease during his service or within one year of his separation from service.

While the Board is sympathetic to the Veteran's contention that he is entitled to an earlier effective date, the Board is bound by statute and VA regulations. The Board considered the Veteran's claim that he was entitled to an earlier effective date both through the liberalizing means set out for *Nehmer* class members and through standard means; however, the preponderance of the evidence is against a finding that the Veteran is entitled to an effective date earlier than May 24, 2017 for the respective conditions associated with his Parkinson's disease on any basis.

Accordingly, entitlement to the grant of service connection for Parkinson's disease prior to May 24, 2017 is not warranted. Therefore, entitlement to an effective date earlier than May 24, 2017 is not warranted for the grant of service connection for Parkinson's disease with weakness of the left lower extremity; weakness of the right lower extremity; weakness of the left upper extremity; weakness of the right upper extremity; impairment of the seventh cranial nerve, left; impairment of the seventh cranial nerve, right; impairment of the tenth cranial nerve, left; impairment of the tenth cranial nerve, right; impairment of the eleventh cranial nerve, left; or impairment of the eleventh cranial nerve, right.

Additionally, as the effective date for the Veteran's entitlement to Dependents' Educational Assistance is dependent on the date that he was found to be totally disabled, and as the combined rating for the disabilities discussed above are responsible for the May 24, 2017 effective date for the grant of Dependents'

Educational Assistance, entitlement to an effective date earlier than May 24, 2017 for the grant of Dependents' Educational Assistance is not warranted.

3. **Entitlement to an effective date earlier than September 10, 2019 for the grants of partial loss of the sense of smell and constipation.**

The Veteran contends that he is entitled to an effective date earlier than September 10, 2019 for the grants of service connection for partial loss of the sense of smell and service connection for constipation, as he the conditions manifested prior to September 10, 2019.

In a Disability Benefits Questionnaire (DBQ) dated September 10, 2019, the Veteran's private physician indicated that he experienced a partial loss of his sense of smell due to his Parkinson's disease or its treatment. The physician also indicated that he experienced constipation due to the slowing of his gastrointestinal tract or secondary to his Parkinson's medications.

However, the record does not otherwise indicate that the Veteran reported a loss of his sense of smell or that he experienced constipation due to his Parkinson's disease or its treatment. In a September 2018 VA examination, the examiner documented that the Veteran did not report a loss of his sense of smell or any constipation. Additionally, in numerous VA treatment records, the treating clinicians noted that he did not report constipation.

While the Veteran's partial loss of his sense of smell and constipation are associated with his Parkinson's disease, and in theory could have a disability rating effective the date that his other Parkinson's disease-related conditions became effective (i.e., May 24, 2017), the evidence of record first show reports of a loss of his sense of smell and of constipation in the DBQ dated September 10, 2019. Therefore, the preponderance of the evidence is against a finding that entitlement to service connection for partial loss of his sense of smell or for constipation first arose prior to September 10, 2019, and entitlement to an earlier effective date is not warranted for either condition.

4. **Entitlement to an effective date earlier than May 24, 2018 for the grant of service connection for a right knee strain and to an effective date earlier than September 10, 2019 for the grant of service connection for instability and subluxation of the right knee.**

The Veteran contends that he is entitled to an effective date earlier than May 24, 2018 for the grant of service connection for a right knee strain and to an effective date earlier than September 10, 2019 for the grant of service connection for instability and subluxation of the right knee, as the conditions had their onset prior to their respective effective dates.

The record reflects that VA first received a claim from the Veteran for entitlement to service connection for a right knee disability on July 11, 2018, and that the claim was associated with his May 24, 2018 intent to file submission. Because the preponderance of the evidence of record is against a finding that the Veteran filed a claim for entitlement to service connection for a right knee disability prior to May 24, 2018 on either a formal or informal basis, and is also against a finding that he exhibited objective symptoms of a chronic right knee disability within the context of 38 C.F.R. § 3.309(a) during his active duty service or within one year of his separation from service, entitlement to an effective date earlier than May 24, 2018 is not warranted for the Veteran's right knee strain or his instability and subluxation of the right knee.

In a September 2018 VA examination, the examiner documented that the Veteran did not have a history of recurrent subluxation or lateral instability of his right knee, and his right knee was normal on joint stability testing. The record does not otherwise indicate that the Veteran reported or was diagnosed with either instability or subluxation of his right knee prior to a private examination on September 10, 2019.

Accordingly, the preponderance of the evidence is against a finding that entitlement to service connection for instability and subluxation of the right knee arose prior to September 10, 2019, and entitlement to an effective date earlier than September 10, 2019 for the grant of service connection for the condition is not warranted.

Increased Rating

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

Pertinent regulations do not require that all cases show all findings specified by the Rating Schedule, but that findings sufficiently characteristic to identify the disease and the resulting disability and coordination of rating with impairment of function. 38 C.F.R. § 4.21. Therefore, the Board has considered the potential application of various other provisions of the regulations governing VA benefits, whether or not they were raised by the Veteran, in reaching its decision. *Schafrath v. Derwinski*, 1 Vet. App. 589, 595 (1991).

In considering the severity of a disability, it is essential to trace the medical history of the veteran. 38 C.F.R. §§ 4.1, 4.2, 4.41. Consideration of the whole-recorded history is necessary so that a rating may accurately reflect the elements of any disability present. 38 C.F.R. § 4.2; *Peyton v. Derwinski*, 1 Vet. App. 282 (1991). Although the regulations do not give past medical reports precedence over current findings, the Board is to consider a veteran's medical history in determining the applicability of a higher rating for the entire period in which the appeal has been pending. *Powell v. West*, 13 Vet. App. 31, 34 (1999).

Where entitlement to compensation has already been established and an increase in the disability rating is at issue, it is the present level of disability that is of primary concern. *Francisco v. Brown*, 7 Vet. App. 55 (1994). Nevertheless, the Board acknowledges that a claimant may experience multiple distinct degrees of disability that might result in different levels of compensation from the time the increased rating claim was filed until a final decision is made. *Hart v. Mansfield*, 21 Vet. App. 505 (2007). When adjudicating an increased rating claim, the

relevant time period for consideration is the time period one year before the claim was filed. *See* 38 C.F.R. § 3.400(o); *Hart*, 21 Vet. App. at 509.

The Board must also assess the competence and credibility of lay statements and testimony. *Barr v. Nicholson*, 21 Vet. App. 303, 308 (2007). In increased rating claims, a veteran's lay statements alone, absent a negative credibility determination, may constitute competent evidence of worsening, at least with respect to observable symptoms. *See Vazquez-Flores v. Shinseki*, 24 Vet. App. 94, 102 (2010), rev'd on other grounds by *Vazquez-Flores v. Shinseki*, 580 F.3d 1270, 1277 (Fed. Cir. 2009).

In evaluating disabilities of the musculoskeletal system, consideration must be given to functional loss, including due to weakness and pain, affecting the normal working movements of the body in terms of excursion, strength, speed, coordination, and endurance. 38 C.F.R. § 4.40. With respect to disabilities of the joints, it must be considered whether there is less movement or more movement than normal, weakened movement, excess fatigability, incoordination, and pain on movement, as well as swelling, deformity, or atrophy of disuse. 38 C.F.R. § 4.45.

These provisions thus require a determination of whether a higher rating may be assigned based on functional loss of the affected joint on repeated use as a result of the above factors, including during flare-ups of symptoms, beyond any limitation reflected on one-time measurements of range of motion. *DeLuca v. Brown*, 8 Vet. App. 202, 206 07 (1995). However, a higher rating based on functional loss may not exceed the highest rating available under the applicable diagnostic code(s) pertaining to range of motion. *See Johnston v. Brown*, 10 Vet. App. 80, 85 (1997).

In determining if a higher rating is warranted on this basis, pain itself does not constitute functional loss. Similarly, painful motion alone does not constitute limited motion for the purposes of rating under diagnostic codes pertaining to limitation of motion. However, pain may result in functional loss if it limits the ability to perform normal movements with normal excursion, strength, speed, coordination, or endurance, as provided in §§ 4.40 and 4.45. Functional loss due to pain is to be rated at the same level as functional loss caused by some other factor that actually limited motion. *Mitchell v. Shinseki*, 25 Vet. App. 32 (2011).

The intent of the Rating Schedule is to recognize actually painful, unstable or misaligned joints, due to healed injury, as entitled to at least the minimum compensable rating for the joint. 38 C.F.R. § 4.59. As such, painful motion should be considered to determine whether a higher rating is warranted on such basis, whether or not arthritis is present. *See Burton v. Shinseki*, 25 Vet. App. 1.

The Board notes that neither the Rating Schedule nor the regulations provide definitions for descriptive words such as "mild," "moderate," "moderately severe," and "severe." *Sellers v. Wilkie*, 30 Vet. App. 157 (2018) ("DC 8520 does not define 'mild,' 'moderate,' 'moderately severe,' or 'severe,' or generally associate those terms with specific symptoms"). It should also be noted that use of terminology such as "mild" and "moderate" by VA examiners or other physicians, although an element of evidence to be considered by the Board, is not dispositive of an issue. Rather than applying a mechanical formula, the Board must instead evaluate all of the evidence to the end that its decisions are "equitable and just." 38 C.F.R. § 4.6.

As such, the Board will analyze the evidence of record to determine the Veteran's current levels of disability. Although the Board has an obligation to provide reasons and bases supporting its decision, there is no obligation to discuss, in detail, the extensive evidence of record. *Gonzales v. West*, 218 F.3d 1378, 1380-81 (Fed. Cir. 2000) (holding that the Board must review the entire record, but does not have to discuss each piece of evidence). Therefore, the Board will summarize the relevant evidence where appropriate, and the Board's analysis will focus specifically on what the evidence shows, or fails to show, as it relates to the Veteran's claims.

5. **Entitlement to increased ratings for Parkinson's disease with weakness of the left lower extremity, for weakness of the right lower extremity, for weakness of the left upper extremity, and for weakness of the right upper extremity.**

The Veteran contends that he is entitled to increased ratings for Parkinson's disease with weakness of the left lower extremity, for weakness of the right lower extremity, for weakness of the left upper extremity, and for weakness of the right

upper extremity, as his respective symptoms for each of the conditions more nearly approximated the criteria for a higher rating.

The Veteran is currently rated as 60 percent disabled for Parkinson's disease with weakness of the left lower extremity and 60 percent disabled for weakness of the right lower extremity under Diagnostic Code 8004-8520, and as 40 percent disabled for weakness of the left upper extremity and 50 percent disabled for weakness of the right upper extremity under Diagnostic Code 8510.

Hyphenated diagnostic codes are used when a rating requires use of an additional rating criteria to identify the basis for the evaluation assigned. *See* 38 C.F.R. § 4.71a. Diagnostic Code 8004 contains the rating criteria for paralysis agitans, Diagnostic Code 8510 contains the rating criteria for paralysis of the upper radicular group, and Diagnostic Code 8520 contains the rating criteria for paralysis of the sciatic nerve. *See* 38 C.F.R. § 4.124a.

Diagnostic Code 8004 provides for a minimum rating of 30 percent for paralysis agitans. *Id*. Paralysis agitans is also known as Parkinson's disease. Dorland's Illustrated Medical Dictionary 972 (26th ed. 1990). The minimum rating is the only rating provided for under Diagnostic Code 8004. If, however, there are identifiable residuals that can be rated under a separate diagnostic code and the combined disability rating resulting from these residuals exceeds 30 percent, the separate ratings will be assigned in place of the minimum rating assigned under Diagnostic Code 8004. VA should also analyze individual symptoms under the appropriate diagnostic code for that bodily system. *See Id.*

Under Diagnostic Code 8510, a 40 percent rating is warranted for severe incomplete paralysis of the upper radicular group for the minor extremity, a 50 percent rating is warranted for severe incomplete paralysis of the upper radicular group for the major extremity, a 60 percent rating is warranted for complete paralysis of the upper radicular group of the minor extremity, with all shoulder and elbow movements lost or severely affected and hand and wrist movements not affected, and a 70 percent rating is warranted for complete paralysis of the upper radicular group for the major extremity. *Id.*

Under Diagnostic Code 8520, a 60 percent rating is warranted for severe incomplete paralysis of the sciatic nerve with marked muscular atrophy and an 80 percent rating is warranted for complete paralysis of the sciatic nerve, where the foot dangles and drops, there is no active movement possible of the muscles below the knee, and flexion of the knee is weakened or (very rarely) lost. *Id.*

In an April 2018 VA examination, the examiner noted that the Veteran experienced difficulty with walking, balance, and using his hands. The examiner indicated that he exhibited mild stooped posture, balance impairment, bradykinesia, loss of automatic movements, and speech changes. The examiner further indicated that the Veteran exhibited a mild tremor of the right and left upper extremities and mild muscle rigidity and stiffness of the bilateral upper and bilateral lower extremities.

In a June 2018 VA neurology outpatient note, the Veteran reported that he had chronic sensory loss on his right side, and was told that he may have had a small stroke in the past.

In a September 2018 VA examination, the Veteran indicated that his hand tremors had worsened. The examiner noted that he exhibited slowness of movements (gait and hands), rigidity, stooped posture, small handwriting which progressed to an inability to write, an falls with postural instability. The examiner noted that he had difficulty with walking, balance, and using his hands. The examiner further indicated that he exhibited mild stooped posture, balance impairment, bradykinesia, and loss of automatic movements. The examiner documented that he also exhibited mild tremor of the bilateral upper extremities and mild muscle rigidity and stiffness of the bilateral upper and bilateral lower extremities.

In an October 2018 VA peripheral nerves examination, the Veteran showed normal strength, reflexes, and sensation of the bilateral upper and bilateral lower extremities on testing. The examiner did indicate that he exhibited mild incomplete paralysis of the sciatic nerve bilaterally.

In a July 2019 VA neurology outpatient note, the Veteran reported that he felt his shaking had become worse, especially when eating, and that it was equal in both hands. He noted that he could eat, but spilled a lot, and that he was still struggling

with postural instability. He stated that he fell approximately four times per week, mostly backward, and indicated that he also felt stiff/rigid sometimes. He claimed that he spent most of his time alone and did things like watching television and taking care of things around his house. He noted that it was becoming harder to take care of things like doing laundry and folding it, and indicated that he still cooked for himself with a crockpot. The treating clinician documented that his primary symptoms included rigidity with some mild resting tremor, and indicated that his essential tremor caused the most distress, though functionally no major hinderance. The clinician stated that his tremor seemed to be persistent and was brought on when he used or reached for things. The clinician noted that he had some trouble with feeding himself and drinking out of a cup, and that he had to use both hands. The Veteran indicated that his condition was affecting his quality of life, and noted that he tried physical therapy but could not tolerate it due to his shaking.

In a September 2019 DBQ regarding entitlement to SMC based on the need for regular aid and attendance, the Veteran's private physician noted that he could feed himself but had difficulty cutting food, pouring drinks, and holding a cup or glass. The physician indicated that he was unable to prepare his own meals, as he was weak, especially on the right side, and his hands shake. The physician stated that he needed help opening his medication bottles and getting his medication out, and that he had to have his daughter write checks for him due to his shaking. The physician indicated that he used a cane to walk and was stooped over, and that he had to use both hands to shave because he was too shaky for the fine movements and had a weak grip. The physician noted that he also could not use shirts with buttons and needed a handrail in the bathroom. The physician documented that his balance was bad, that he often fell backward, that he had problems with his right and left knees, and that he had neuropathy in both feet. The physician indicated that he could drive short distances, but needed someone with him, and he stayed at home on a typical day.

In a September 2019 DBQ regarding Parkinson's disease, the Veteran's private physician documented that he had a mild stooped posture, moderate to severe balance impairment, moderate bradykinesia, moderate loss of automatic movements, severe limited movement and tremor of his right upper extremity,

moderate tremor of his left upper extremity, moderate to severe tremor of his right lower extremity, and moderate to severe tremor of his left lower extremity. The physician noted that he had severe muscle rigidity and stiffness of his right upper extremity, mild muscle rigidity and stiffness of his left upper extremity, severe muscle rigidity and stiffness of his right lower extremity and mild muscle rigidity and stiffness of his left lower extremity. The physician indicated that he had "a very difficult time" writing, picking up objects, holding items, turning a key, walking, keeping his balance, preparing meals, feeding himself, pouring liquids, drinking from a cup, fine movements, and driving. The physician stated that he was unable to button shirts, used a handrail in the bathroom, and used a cane or held onto furniture for balance. The physician indicated that he could walk less than one block, and that he was right hand dominant, but now had to use his left hand.

Accordingly, the Board finds that the preponderance of the evidence is against a finding that the Veteran exhibited symptoms most nearly approximating complete paralysis of either the upper radicular group or sciatic nerve during the period on appeal. While the record reflects that his Parkinson's disease symptoms resulted in stiffness and weakness of his bilateral upper extremities and bilateral lower extremities, there is no indication that either all shoulder and elbow movements were lost or severely affected, with hand and wrist movements not affected, or that either of his feet dangled or dropped, with no active movement possible of the muscles below the knee and flexion of the knee weakened. Therefore, entitlement to neither a rating in excess of 60 percent disabling for Parkinson's disease with weakness of the left lower extremity, a rating in excess of 60 percent disabling for weakness of the right lower extremity, a rating in excess of 40 percent disabling for weakness of the left upper extremity, nor a rating in excess of 50 percent disabling for weakness of the right upper extremity is warranted under Diagnostic Codes 8510 or 8520, respectively.

However, the Board notes that the medical evidence of record frequently indicates that the Veteran's Parkinson's disease affected the functionality of his hands, particularly his right hand, and thus potentially brings a rating under Diagnostic Code 8512, for paralysis of the lower radicular group, into consideration. The Board also notes that the Veteran currently has a claim for loss of use of his hands

and loss of use of his feet pending before the AOJ. Since it is somewhat unclear from the record as to the extent of the loss of use of his hands due to his Parkinson's disease, and therefore unclear what the appropriate analogous rating under Diagnostic Code 8512 would be, or if any of the symptoms described in the evidence of record were already considered in evaluating his ratings under Diagnostic Code 8510, the Board finds that remand is necessary to determine if a separate rating under Diagnostic Code 8512 is appropriate. Accordingly, that issue will be addressed in the remand portion of this decision.

6. **Entitlement to increased ratings for impairment of the seventh cranial nerves, left and right; for impairment of the tenth cranial nerves, left and right; and for impairment of the eleventh cranial nerves, left and right.**

A. Prior to September 10, 2019.

The Veteran contends that he is entitled to increased ratings for impairment of the seventh cranial nerves, left and right; for impairment of the tenth cranial nerves, left and right; and for impairment of the eleventh cranial nerves, left and right, for the period prior to September 10, 2019. He is currently rated as noncompensably disabled for each condition, under Diagnostic Code 8207, Diagnostic Code 8210, and Diagnostic Code 8211, respectively.

Under Diagnostic Code 8207, a 10 percent rating is warranted for moderate incomplete paralysis of the seventh cranial nerve, a 20 percent rating is warranted for severe incomplete paralysis of the seventh cranial nerve, and a 30 percent rating is warranted for complete paralysis of the seventh cranial nerve. 38 C.F.R. § 4.124a. Evaluation under Diagnostic Code 8207 is dependent upon the relative loss of innervation of the facial muscles. *Id.*

Under Diagnostic Code 8210, a 10 percent rating is warranted for moderate incomplete paralysis of the tenth cranial nerve, a 20 percent rating is warranted for severe incomplete paralysis of the tenth cranial nerve, and a 30 percent rating is warranted for complete paralysis of the tenth cranial nerve. *Id*. Evaluation under Diagnostic Code 8210 is dependent upon the extent of sensory and motor loss to organs of voice respiration, pharynx, fauces, and tonsils. *Id.*

Under Diagnostic Code 8211, a 10 percent rating is warranted for moderate incomplete paralysis of the eleventh cranial nerve, a 20 percent rating is warranted for severe incomplete paralysis of the eleventh cranial nerve, and a 30 percent rating is warranted for complete paralysis of the eleventh cranial nerve. *Id*. Evaluation under Diagnostic Code 8211 is dependent on the loss of motor function of the tongue. *Id.*

In a December 2017 VA neurology consultation note, the treating clinician noted that the Veteran had a vocal tremor and voice changes. The clinician indicated that on examination of his cranial nerve function, his visual fields were normal, his extraocular movements were intact, his pupils were normal, his facial sensation was normal, his facial symmetry was normal, his tongue midline was normal, and his shoulder shrug was normal. The clinician further indicated that he exhibited normal sensation response to light touch, pin prick, temperature, position, and vibration bilaterally.

In an April 2018 VA neurology outpatient note, the treating clinician noted that the Veteran's cranial nerves (II to XII) were intact bilaterally.

In an April 2018 VA examination, noted that the Veteran had a minimal problem with drooling and a soft, monotone type tremulous voice. The examiner indicated that he displayed a mild loss of automatic movements (such as blinking, leading to fixed gaze, typical Parkinson's facies) and mild speech changes (monotone, slurring words, soft or rapid speech). The examiner documented that he did not have difficulty chewing or swallowing

In a September 2018 VA examination, the examiner noted that the Veteran had a minimal problem with drooling and a soft, monotone type tremulous voice. The examiner indicated that he displayed a mild loss of automatic movements (such as blinking, leading to fixed gaze, typical Parkinson's facies) and mild speech changes (monotone, slurring words, soft or rapid speech). The examiner documented that he did not have difficulty chewing or swallowing.

In an October 2018 VA neurology return note, the treating clinician stated that the Veteran's voice tremor had become worse, described as hoarse with tremors, and

he was harder to understand. The clinician documented that his facial movement was symmetric (testing the seventh cranial nerve) and his shoulder shrug was symmetric (testing the eleventh cranial nerve), but his tenth cranial nerve was difficulty to visualize. The clinician also indicated that the Veteran had decreased sensation to light touch on the right side of his face.

In a January 2019 VA neurology outpatient note, the treating clinician stated that the Veteran's voice tremor had become worse, described as hoarse with tremors, and he was harder to understand. The clinician documented that his facial movement was symmetric (testing the seventh cranial nerve) and his shoulder shrug was symmetric (testing the eleventh cranial nerve), but his tenth cranial nerve was difficulty to visualize. The clinician also indicated that the Veteran had decreased sensation to light touch and pin prick on the right side of his face.

In a July 2019 VA neurology outpatient note, the Veteran reported that he was still able to eat and chew food, with no episodes of choking. The treating clinician indicated that his voice tremor had become worse, described as hoarse with tremors, and he was harder to understand. The treating clinician further noted that his fauces was somewhat masked. The clinician documented that his facial movement was symmetric (testing the seventh cranial nerve) and his shoulder shrug was symmetric (testing the eleventh cranial nerve), but his tenth cranial nerve was difficulty to visualize.

In the September 10, 2019 DBQ concerning Parkinson's disease, the Veteran's private examiner indicated that he had moderate speech changes, with a raspy voice. The physician documented that he had moderate loss of automatic movements (such as blinking, leading to fixed gazes, typical Parkinson's facies), and noted that he did not report any difficulty with chewing or swallowing.

Accordingly, the Board finds that the preponderance of the evidence is against a finding that the Veteran exhibited more than mild impairment of his left or right seventh cranial nerve prior to September 10, 2019. In the April and September 2018 VA examinations, the examiner indicated that he had mild loss of automatic movements (such as blinking, leading to fixed gaze, typical Parkinson's facies). The record does not otherwise reflect that he exhibited more severe symptoms of

impairment of the seventh cranial nerve prior to the indication from his private physician in the September 10 2019 DBQ that his loss of automatic movements was moderate, with cranial nerve testing during VA treatment consistently indicating that the function of his seventh cranial nerve was normal. Therefore, entitlement to a compensable rating for impairment of the left or right seventh cranial nerve for the period prior to September 10, 2019 is not warranted.

The Board further finds that the preponderance of the evidence is in favor of a finding that the Veteran exhibited moderate impairment of his left and right tenth cranial nerves as of October 19, 2018, but no earlier. In the April and September 2018 VA examinations, the examiner indicated that the Veteran exhibited mild speech changes (monotone, slurring words, soft or rapid speech). While his private physician specifically documented that his speech changes were moderate in the September 2019 DBQ, the treating clinician in the October 19, 2018 VA neurology outpatient note indicated that the Veteran's voice tremor had become worse. This is the first instance after the September 2018 VA examination indicating an increase in the severity of his impairment of the left or right tenth cranial nerve. However, the record does not otherwise indicate that he exhibited more than moderate symptoms of impairment of his left or right tenth cranial nerve during the period prior to September 10, 2019. Therefore, entitlement to a rating in excess of 10 percent disabling for the period from October 19, 2018 to September 10, 2019 is not warranted for either the right or left tenth cranial nerve.

The Board also finds that the preponderance of the evidence is against a finding that the Veteran exhibited more than mild impairment of either his left or right eleventh cranial nerve during the period prior to September 10, 2019. The April and September 2018 VA examinations and the September 2019 DBQ all indicated that the Veteran did not have difficulty chewing or swallowing, and his VA treatment records also generally indicate that the function of his tenth cranial nerves were normal during the period prior to September 10, 2019. Therefore, entitlement to a compensable rating for impairment of either the left or right eleventh cranial nerve is not warranted for the period prior to September 10, 2019.

B. Since September 10, 2019.

The Veteran contends that he is entitled to increased ratings for impairment of the seventh cranial nerves, left and right; for impairment of the tenth cranial nerves, left and right; and for impairment of the eleventh cranial nerves, left and right, for the period since September 10, 2019. He is currently rated as 10 percent disabled for both his left and right seventh cranial nerves under Diagnostic Code 8207, as 10 percent disabled for both his left and right tenth cranial nerves under Diagnostic Code 8210, and as noncompensably disabled for both his left and right eleventh cranial nerves under Diagnostic Code 8211 during that time.

The Board finds that the evidence of record since the September 10, 2019 DBQ does not indicated an increase in severity of the Veteran's level of impairment of either the left or right seventh cranial nerve, tenth cranial nerve, or eleventh cranial nerve. His VA and private treatment records since that time do not reflect any relevant symptoms in addition to those listed prior to September 10, 2019, and do not note that any of the relevant symptoms for the respective conditions worsened. Therefore, entitlement to a rating in excess of 10 percent disabling for impairment of the seventh cranial nerves, left and right; entitlement to a rating in excess of 10 percent disabling for impairment of the tenth cranial nerves, left and right; or entitlement to a compensable rating for impairment of the eleventh cranial nerves, left and right, for the period since September 10, 2019 is not warranted.

7. **Entitlement to increased ratings for constipation and for partial loss of the sense of smell.**

The Veteran contends that he is entitled to increased ratings for his constipation and partial loss of the sense of smell associated with his Parkinson's disease, as his symptoms of the respective conditions more nearly approximate the criteria for higher ratings. He is currently rated as noncompensably disabled for his constipation under Diagnostic Code 1399-7319, and as noncompensably disabled for his partial loss of the sense of smell under Diagnostic Code 6275.

Under Diagnostic Code 6275, a 10 percent rating is warranted for complete loss of the sense of smell. 38 C.F.R. § 4.87a.

Diagnostic Code 7399 is a general code for disabilities of the digestive system. Diagnostic Code 7319 provides the rating criteria for irritable colon syndrome (spastic colitis, mucous colitis, etc.). 38 C.F.R. § 4.114.

Under Diagnostic Code 7319, a noncompensable rating is warranted for mild symptoms, such as disturbances of bowel function with occasional episodes of abdominal distress; a 10 percent rating is warranted for moderate symptoms, such as frequent episodes of bowel disturbance with abdominal distress; and a 30 percent rating is warranted for severe symptoms, such as diarrhea, or alternating diarrhea and constipation, with more or less constant abdominal distress. *Id.*

As noted above, prior to September 10, 2019, the record does not indicate that the Veteran reported symptoms of either constipation or loss of the sense of smell. In the September 2019 DBQ concerning Parkinson's disease, his private physician documented that he exhibited partial loss of the sense of smell and constipation that was, at times, severe.

Accordingly, the Board finds that the preponderance of the evidence is against a finding that the Veteran exhibited complete loss of his sense of smell or symptoms related to his constipation that manifested more than occasional episodes of abdominal distress. Aside from the September 2019 DBQ, the record does not otherwise indicate that the Veteran reported a loss of his sense of smell, including in April and September 2018 VA examinations related to Parkinson's disease. Additionally, the record does not indicate that he reported experiencing constipation or abdominal distress outside of the September 2019 DBQ, and instead shows multiple reports of no constipation or abdominal distress. Although the September 2019 examiner indicated that his symptoms could be severe, there is no indication he experienced such symptoms with any regular frequency. Therefore, entitlement to a compensable rating for either the Veteran's loss of the sense of smell or a compensable rating for his constipation is not warranted.

8. **Entitlement to increased ratings for a right knee strain and for instability and subluxation of the right knee, and entitlement to a separate compensable rating for limitation of extension of the right knee.**

The Veteran contends that he is entitled to increased ratings for a right knee strain and for instability and subluxation of his right knee, as his symptoms more nearly approximate the criteria for a higher rating. He is currently rated as 10 percent disabled for a right knee strain under Diagnostic Code 5260 and as 20 percent disabled for instability and subluxation of his right knee under Diagnostic Code 5257.

The Board notes that in addition to his current ratings related to his right knee, separate compensable ratings may also be awarded for additional disability of the knee not compensated under Diagnostic Codes 5257 and 5260. The Board further notes that the record does not reflect the presence of ankylosis of the right knee, a semilunar cartilage condition, impairment of the tibia and fibula, or genu recurvatum at any point during the relevant period, and accordingly an analysis of the ratings for those conditions will not be discussed at length herein.

In VAOPGCPREC 23-97, the VA General Counsel interpreted that a veteran who has arthritis and instability of the knee may be rated separately under Diagnostic Codes 5003 and 5257, provided that a separate rating is based upon additional disability. Subsequently, in VAOPGCPREC 9-98, the VA General Counsel further explained that, if a veteran has a disability rating under Diagnostic Code 5257 for instability of the knee, and there is also x-ray evidence of arthritis, a separate rating for arthritis could also be based on painful motion under 38 C.F.R. § 4.59.

The General Counsel has also directed that separate ratings are available if a particular knee disability causes both compensable (10 percent) limitation of extension (Diagnostic Code 5261) and compensable limitation of flexion (Diagnostic Code 5260) of the same joint. Specifically, where a veteran has both a compensable limitation of flexion and a compensable limitation of extension of the same leg, the limitations must be rated separately to adequately compensate for functional loss associated with injury to the leg. VAOPGCPREC 9-04.

In *Lyles v. Shulkin*, 29 Vet. App. 107 (2017), the Court held that, as a matter of law, separate ratings are not precluded for limitation of motion (Diagnostic Codes 5003, 5260 and 5261), meniscal disability (Diagnostic Codes 5258 and 5259) and instability (Diagnostic Code 5257).

Under Diagnostic Code 5257, a 20 percent rating is warranted for moderate recurrent subluxation or lateral instability, and a 30 percent rating is warranted for severe recurrent subluxation or lateral instability. *Id.*

Under Diagnostic Code 5260, a 10 percent rating is warranted if flexion is limited to 45 degrees, a 20 percent rating is warranted if flexion is limited to 30 degrees, and the maximum 30 percent rating is warranted if flexion is limited to 15 degrees. 38 C.F.R. § 4.71a, Diagnostic Code 5260. Normal range of motion of the knee is up to 140 degrees flexion. 38 C.F.R. § 4.71, Plate II. *Id.*

Under Diagnostic Code 5261, a 10 percent rating is warranted if extension is limited to 10 degrees, a 20 percent rating is warranted if extension is limited to 15 degrees, a 30 percent rating is warranted if extension is limited to 20 degrees, a 40 percent rating is warranted if extension is limited to 30 degrees, and a 50 percent rating is warranted if extension is limited to 45 degrees. *Id.*

In a September 2018 VA examination, the examiner diagnosed the Veteran with a right knee strain. The Veteran reported he had experienced a chronic aching sensation since 2008 and noted that he did not have surgery on his knee. He did not report flare-ups of his right knee symptoms, but claimed that he did experience functional loss consisting of limitation to walking no more than 50 feet and standing no more than 20 minutes. He further stated that he could not run or squat, and noted that he used a cane constantly to help take the pressure off of his knee. The examiner documented that the range of motion for his right knee was all normal. The examiner indicated that he exhibited pain on flexion and extension, but it did not result in functional loss. The examiner noted that there was pain on weight-bearing, passive motion, and active motion, but not with nonweight-bearing. The examiner listed that there was no additional functional loss or loss of range of motion after repetitive use testing. The examiner indicated that the examination was medically consistent with the Veteran's statements describing

functional loss with repeated use over time, and documented that pain limited his functional ability. The examiner noted that he displayed a disturbance of locomotion for his right knee, but indicated that joint stability testing of his right knee was normal and that he did not have a history of recurrent subluxation or lateral instability.

A February 2019 primary care follow-up visit note indicated that the Veteran experienced "[m]ore pain in his back, knees, legs, [and] shoulders," and noted that he was "[n]ot stable to ambulate well."

In a September 2019 private examination, the examiner indicated that by 2018, the Veteran was experiencing a constant, aching pain in his right knee. The examiner noted that he indicated he was limited to walking 50 feet and standing no longer than 20 minutes, and that he was unable to run or squat. He further stated that he used a cane to take pressure off of his knee and also assist with his Parkinson's disease. The examiner documented that he experienced flare-ups and had increased pain, which could cause him to lose sleep, limited his ability to bend his knees and climb stairs, and hurt when he walked. The examiner listed functional loss of less movement than normal in the right knee and pain on movement of the right knee. The examiner noted a disturbance in locomotion and stated that he was unable to climb ladders, run, or squat, that he had pain when climbing stairs, and that he could not stand in place for approximately 10 minutes without pain in his knees.

The examiner documented a range of motion for the Veteran's right knee of 60 degrees of flexion and 10 degrees of extension. The examiner indicated that there was pain with all ranges of motion and that it was not possible to do repetitive testing due to pain. The examiner stated that there was generalized tenderness and pain on palpation at the medical joint line, lateral joint line, patella, and suprapatellar area. The examiner noted objective evidence of crepitus in his right knee and pain on weight-bearing. The examiner documented that he had normal muscle strength and did not have muscle atrophy, and indicated that he had a history of moderate recurrent subluxation of his right knee, moderate instability of his right knee, and recurrent effusion. Joint stability testing was abnormal for his right knee. The examiner noted that the he experienced chronic pain and stated

that he experienced pain, weakness, fatigability, and/or incoordination. The examiner claimed that he had limitations in squatting, kneeling, bending, sitting, walking, and standing, due to the chronic pain in his right knee.

In a March 2020 VA outpatient preventive health and patient education note, the Veteran reported chronic pain in the back of his right knee, but stated that the pain was acceptable and did not need to be addressed at that visit.

Accordingly, the Board finds that the preponderance of the evidence is against a finding that the Veteran's right knee strain symptoms more nearly approximated limitation of flexion of his right knee to 30 degrees or less. He exhibited the most limited range of motion at the September 2019 private examination, where he was measured with 60 degrees of flexion. The board notes that flexion limited to 60 degrees normally warrants a noncompensable rating; however, the evidence shows that the Veteran had functional loss due to pain in his knee. Therefore, when considering the standard set out in *DeLuca*, the assignment of the next higher 10 rating, for limitation of flexion to 45 degrees, reflects consideration of the level of impairment and functional loss that he experiences in addition to his limited range of motion.

The Board also finds that the preponderance of the evidence is against a finding that the Veteran's right knee exhibited severe instability during the period on appeal. In the September 2019 private examination, the examiner indicated that he had a history of moderate subluxation of his right knee and moderate instability of his right knee. Other than the September 2019 examination report, the record does not reflect that the Veteran had subluxation or instability of his right knee, including in a September 2018 VA examination, and subsequent records do not note that he reported problems related to instability or subluxation of his right knee. While the February 2019 VA treatment record indicated that he was not stable to ambulate well, the treating clinician listed additional disabilities seemingly contributing to this instability, and the record generally reflects that he experienced instability in association with his Parkinson's disease symptoms. Therefore, entitlement to a rating in excess of 20 percent disabling for instability and subluxation of the Veteran's right knee is not warranted.

Finally, the Board notes that the September 2019 private examiner documented that the Veteran's right knee had a limited range of extension, to 10 degrees. Based on this limitation, the Veteran is entitled to a separate compensable rating for limitation of extension under Diagnostic Code 5261, in accordance with *Lyles, supra*.

REASONS FOR REMAND

1. **Entitlement to service connection for bilateral hearing loss is remanded.**

The Veteran contends that he is entitled to service connection for bilateral hearing loss, as the condition had its onset during his active duty military service. The record reflects that he was most recently afforded a VA examination in October 2018; however, the Board finds that an additional examination is necessary on remand to clarify the nature and etiology of the Veteran's condition.

In the October 2018 examination, the examiner indicated that the Veteran had normal hearing bilaterally, but noted that was only because it was not possible to release him without selecting a diagnosis. The examiner stated that the Veteran's acoustic testing results were not reliable, and it was not possible to provide an opinion without resorting to speculation. The examiner documented that the test results were strongly suggestive of a non-organic hearing loss/hearing loss component.

The Board notes that while the Veteran's service treatment records note hearing loss on multiple examinations during his active duty service, presumptive service connection for hearing loss as a chronic condition is only available for sensorineural hearing loss as an "other organic disease of the nervous system." *See* 38 C.F.R. § 3.3089(a). Thus, as it is unclear whether he has a current diagnosis of an organic disease of the nervous system, and an additional examination is necessary to clarify the nature and etiology of his hearing loss.

2. **Entitlement to service connection for a cardiovascular condition is remanded.**

The Veteran contends that he is entitled to service connection for a cardiovascular condition, as the condition is due to his exposure to herbicide agents and/or due to his Parkinson's disease. The record indicates that the Veteran was most recently afforded a VA examination concerning his claim in April 2018; however, the Board finds that an addendum opinion is necessary on remand which clarifies that rationale for the examiner's opinion.

In the April 2018 VA examination, the Veteran claimed that his heart "sometimes [did] not beat [r]ight," and that it was "either too fast or too slow." He further reported that he experienced pain, stiffness, and swelling of his hands. The examiner stated that there was no objective evidence of a cardiovascular issue, to include ischemic heart disease. The examiner diagnosed him with Dupuytren's contractures and arthritis of his hands. The examiner opined that his claimed hand condition was not incurred in, caused by, or aggravated by his service. The examiner noted that his diagnosed conditions were not presumed to be associated with herbicide agent exposure.

In a January 2018 VA nursing telephone note, the Veteran reported that he was experiencing lower and upper extremity swelling.

In a July 2019 VA neurology outpatient note, the treating clinician indicated that the etiology of his Parkinson's disease was suspected to be vascular, versus idiopathic.

Accordingly, the Board finds that remand for an addendum opinion is necessary. In the April 2018 examination, the examiner did not address whether there was a vascular component to the Veteran's Parkinson's disease or hand symptoms. As the record indicates that there may be a vascular involvement with the development of his Parkinson's disease, and as he frequently complained of swelling in his hands and feet, an opinion is necessary which addresses if the Veteran has a cardiovascular disability related to his Parkinson's disease and/or

treatment thereof and the nature and etiology of his claimed bilateral hand disability.

3. **Entitlement to service connection for peripheral neuropathy of the left upper extremity and peripheral neuropathy of the right upper extremity, and for entitlement to a separate compensable rating for impairment of the left lower radicular group and impairment of the right lower radicular group are remanded.**

The Veteran contends that he is entitled to service connection for peripheral neuropathy of the left upper extremity and for peripheral neuropathy of the right upper extremity. Additionally, as discussed above, the evidence of record indicates that the Veteran may be potentially entitled to separate compensable ratings for impairment of the left lower radicular group and the right lower radicular group. The Board finds that further clarification is needed concerning the nature and etiology of the Veteran's symptoms associated with his left and right hands.

In a December 2017 VA neurology consultation note, the treating clinician noted that the Veteran could no longer eat or write with his right hand.

In a January 2018 VA physical therapy consultation note, the Veteran reported that he experienced dull numbness in his hands.

In an April 2018 VA orthopedic surgery note, the treating clinician noted that the Veteran was being re-evaluated for shoulder pain, and stated that his neuropathy was a contributing factor.

Accordingly, the Board finds that an addendum opinion is necessary which addresses the nature and etiology of any currently diagnosed hand condition, and which opines on the degree of limitation of function of the Veteran's hands due to his Parkinson's disease and/or another hand condition. The Board notes that there are numerous instances within the record indicating that the Veteran does not have normal use of his hands, and the criteria set out in Diagnostic Code 8510 specifically notes that no hand or wrist impairment is considered. Further, the opinions of record concerning the Veteran's claims of peripheral neuropathy of his

bilateral upper and bilateral lower extremities do not specifically address whether any evidence of peripheral neuropathy is present for his upper extremities.

4. **Entitlement to service connection for a respiratory condition is remanded.**

The Veteran contends that he is entitled to service connection for a respiratory condition, as the condition is due to herbicide agent exposure and/or asbestos exposure during his active duty military service. The record does not indicate that he has been afforded a VA examination concerning his condition.

Under *McClendon v. Nicholson*, 20 Vet. App. 79, 81 (2006), a VA medical examination must be provided when there is (1) competent evidence of a current disability or persistent or recurrent symptoms of a disability, and (2) evidence establishing that an event, injury, or disease occurred in service or establishing certain diseases manifesting during an applicable presumptive period for which the claimant qualifies, and (3) an indication that the disability or persistent or recurrent symptoms of a disability may be associated with the veteran's service or with another service-connected disability, but (4) insufficient competent medical evidence on file for the Secretary to make a decision on the claim. See 38 U.S.C. § 5103A (d)(2); 38 C.F.R. § 3.159 (c)(4)(i). The third prong, which requires that the evidence of record "indicate" that the claimed disability or symptoms "may be" associated with the established event, is a low threshold. *McClendon*, 20 Vet. App. at 83.

The record reflects that the Veteran has a current diagnosis of COPD and he is presumed to have been exposed to herbicide agents during his active duty military service. He has also indicated that he was exposed to asbestos in association with his duties during his military service. While COPD is not a condition that is presumed to due to herbicide agent exposure under 38 C.F.R. § 3.309(e) (which does include respiratory cancers), service connection may still be possible through on a direct basis. *See Stefl v. Nicholson*, 21 Vet. App. 120 (2007) (holding that the availability of presumptive service connection for some conditions based on exposure to Agent Orange does not preclude direct service connection for other non-presumptive conditions based on exposure to Agent Orange).

Although the record indicates that the Veteran has an extensive smoking history, there is no evidence specifically addressing the nature and etiology of his respiratory condition. Therefore, an examination is necessary on remand to determine if his respiratory condition was caused by his exposure to herbicide agents and/or asbestos, or otherwise caused or aggravated by his active duty military service or a service-connected disability.

5. **Entitlement to service connection for a sleep disorder is remanded.**

The Veteran contends that he is entitled to service connection for a sleep disorder, as the condition is related to his active duty military service. The record does not reflect that he has been afforded a VA examination related to his claim.

The record shows that the Veteran has a current diagnosis of OSA, and as discussed above, he claims to have respiratory problems associated with his exposure to herbicide agents and/or asbestos. The Board also notes that the Veteran appears to have developed OSA after he manifested symptoms of Parkinson's disease. Additionally, an October 2018 VA neurology return note stated that, "[h]is issues with sleep could be related to OSA or worsening neuropathy that flares at night."

Accordingly, the Board finds that the Veteran should be afforded a VA examination on remand to determine the nature and etiology of any current sleep disorder, to include OSA. *See McClendon, supra.*

6. **Entitlement to a right shoulder disability is remanded.**

The Veteran contends that he is entitled to service connection for a right shoulder disability, as the condition is due to or aggravated by a service-connected disability. The record does not indicate that he has been afforded a VA examination in relation to his claim.

As discussed above, the record indicates that the Veteran experienced numerous falls associated with instability resulting from his Parkinson's disease, and contributed to by his right knee disabilities. In some of these instances, the

medical evidence of record specifically indicates that he hurt his shoulder during the fall. However, it is unclear from the record if the Veteran has a current right shoulder disability that is due to or aggravated by any such fall, or otherwise due to or aggravated by his Parkinson's disease.

Accordingly, an addendum opinion is necessary on remand which addresses whether the Veteran has a current right shoulder disability that is due to a service-connected disability. *See McClendon, supra*.

7. **Entitlement to a prostate condition is remanded.**

The Veteran contends that he is entitled to service connection for a prostate condition, as the condition is due to his exposure to herbicide agents during his active duty military service. The record reflects that the Veteran was provided a VA examination concerning his claimed prostate condition in January 2012; however, the Board finds that a new examination is necessary to determine whether the Veteran's chronic symptoms are indicative of a current prostate disability.

As noted above, the Veteran has displayed a consistently elevated PSA level and his private treatment records have noted that his prostate was enlarged. The Board notes that the January 2012 examination only addressed whether the Veteran had prostate cancer as a result of his exposure to herbicide agents, and did not discuss any other potential prostate issues.

Therefore, an examination is necessary on remand which discusses the nature and etiology of any currently diagnosed prostate condition. *See McClendon, supra*.

8. **Entitlement to a TDIU is remanded.**

The Veteran claims that he is entitled to a TDIU, as he is unable to obtain and maintain substantially gainful employment as a result of his service-connected disabilities. The Board notes that the Veteran has a combined 100 percent rating throughout the period on appeal. While this renders the issue of entitlement to a TDIU based on the combined effect of multiple disabilities moot, it does not make the issue of entitlement to a TDIU irrelevant. *See Locklear v. Shinseki*, 24 Vet.

App. 311, 314 n.2 (2011) (finding entitlement to TDIU mooted from the effective date of a 100 percent schedular disability rating); see also *Herlehy v. Principi*, 15 Vet. App. 33, 35 (2001) (finding a request for TDIU moot where 100 percent schedular rating was awarded for the same period).

The Board notes that VA has a "well-established" duty to maximize a claimant's benefits. *See Buie v. Shinseki*, 24 Vet. App. 242, 250 (2011); *AB v. Brown*, 6 Vet. App. 35, 38 (1993). This duty to maximize benefits includes a requirement that VA assess all of a claimant's disabilities to determine whether any combination of disabilities establishes entitlement to SMC under 38 U.S.C. § 1114. *See Bradley v. Peake*, 22 Vet. App. 280, 294 (2008) (finding that SMC "benefits are to be accorded when a veteran becomes eligible without need for a separate claim" and remanding, pursuant to VA's duty to maximize benefits, for VA to determine whether the Veteran's posttraumatic stress disorder, rated 70 percent disabling, would entitle him to TDIU and, therefore, to SMC).

Indeed, as noted in *Bradley*, VA must consider a TDIU claim despite the existence of a schedular total rating and award SMC under 38 U.S.C. § 1114(s) if VA finds the separate disability supports a TDIU rating independent of the other 100 percent disability rating. *See* Bradley, 22 Vet. App. at 294.

Special monthly compensation is payable where the veteran has a single service-connected disability rated as 100 percent and (1) has additional service-connected disability or disabilities independently ratable at 60 percent, separate and distinct from the 100 percent service-connected disability and involving different anatomical segments or bodily systems, or (2) is permanently housebound by reason of service-connected disability or disabilities. This requirement is met when the veteran is substantially confined as a direct result of service-connected disabilities to his or her dwelling and the immediate premises or, if institutionalized, to the ward or clinical areas and it is reasonably certain that the disability or disabilities and resultant confinement will continue throughout his or her lifetime. 38 U.S.C. § 1114(s); 38 C.F.R. § 3.350(i).

Subsection 1114(s) requires that a disabled veteran whose disability level is determined by the ratings schedule must have at least one disability that is rated at

100 percent in order to qualify for the special monthly compensation provided by the statute. Under the law, subsection 1114(s) benefits are not available to a veteran whose 100 percent disability rating is based on multiple disabilities, none of which is rated at 100 percent disabling.

The Court has held that although a TDIU may satisfy the "rated as total" element of section 1114(s), TDIU based on multiple underlying disabilities cannot satisfy the section 1114(s) requirement of "a service-connected disability" because that requirement must be met by a single disability. The Court declared, however, if a veteran were awarded a TDIU based on multiple underlying disabilities and then later receives a schedular disability rating for a single, separate disability that would, by itself, create the basis for an award of a TDIU, that the order of the awards was not relevant to the inquiry as to whether any of the disabilities alone would render the veteran unemployable and thus entitled to a TDIU rating based on that condition alone. *Buie v. Shinseki*, 24 Vet. App. 242, 250 (2010).

While the current evidence of record indicates that the combined effects of his Parkinson's disease results in a total disability rating, the Board notes that he does not currently have another separate and distinct disability rated as at least 60 percent disabling. As he could theoretically be granted entitlement to a TDIU for one of his claims being remanded even though he is not otherwise awarded a 60 percent rating for any such disability, the issue of entitlement to a TDIU is inextricably intertwined with those, and must likewise be remanded. *See Harris v. Derwinski*, 1 Vet. App. 180 (1991) (two issues are "inextricably intertwined" when they are so closely tied together that a final decision on one issue cannot be rendered until a decision on the other issue has been rendered).

The matters are REMANDED for the following action:

> 1. After any newly obtained evidence has been associated with the claims file, schedule the Veteran for an examination with an appropriately qualified examiner to determine the nature and etiology of his bilateral hearing loss. The entire claims file, including a copy of this remand, must be made available to the examiner and the

examination report must reflect that such review was completed.

The examiner is asked to provide an opinion as to whether it is at least as likely as not (i.e., a 50 percent or greater probability) that any currently diagnosed bilateral hearing loss is related to the Veteran's military service, to include as manifesting during his active duty military service. The examiner should specifically discuss his service treatment records noting evidence of hearing loss and discuss whether the Veteran has sensorineural hearing loss or other type of hearing loss.

The examiner is advised that the Veteran is competent to report symptoms, treatment, and injuries observable to a layperson. *Jandreau v. Nicholson*, 492 F.3d 1372, 1377 (Fed. Cir. 2007). The examiner is also reminded that the absence of documented treatment in service or thereafter is not fatal to a service connection claim, and the absence of evidence in the service treatment records is an insufficient basis, by itself, for a negative opinion. *See Ledford v. Derwinski*, 3 Vet. App. 87, 89 (1992). Thus, the examiner is to consider the totality of the record, and not just the absence of clinical treatment, in weighing the Veteran's statements asserting symptomatology.

The examiner must provide a comprehensive rationale for all opinions expressed and discuss relevant evidence where appropriate. If the examiner cannot provide the requested opinion without resorting to speculation, it must be so stated, and the examiner must provide the reasons why an opinion would require speculation. The examiner must indicate whether there was any further need for information or testing necessary to make a determination. The examiner must indicate whether an

opinion could not be rendered due to limitations of knowledge in the medical community at large and not those of the particular examiner.

2. After associating any newly obtained evidence with the claims file, provide a copy of the file, including a copy of this remand, to an appropriately qualified examiner for an opinion regarding the nature and etiology of any currently diagnosed cardiovascular disorder. The examiner should review the entire claims file and should indicate that such review was completed in the opinion report. If deemed appropriate, the examiner should contact the Veteran for additional information or examination.

The examiner is asked to provide an addendum opinion to the April 2018 opinion as to whether it is at least as likely as not (i.e., 50 percent or greater probability) that any currently diagnosed cardiovascular disorder, is related to his active duty military service, to include as due to herbicide agent exposure. In providing the requested opinion, the examiner should consider all relevant evidence of record, including both medical and lay evidence, citing to specific evidence where appropriate. The examiner should specifically discuss the Veteran's statements concerning his abnormal heart rates and recurrent swelling of his hands.

The examiner is advised that the Veteran is competent to report symptoms, treatment, and injuries observable to a layperson. *Jandreau v. Nicholson*, 492 F.3d 1372, 1377 (Fed. Cir. 2007). The examiner is also reminded that the absence of documented treatment in service or thereafter is not fatal to a service connection claim, and the absence of evidence in the service treatment records is an

insufficient basis, by itself, for a negative opinion. *See Ledford v. Derwinski*, 3 Vet. App. 87, 89 (1992). Thus, the examiner is to consider the totality of the record, and not just the absence of clinical treatment, in weighing the Veteran's statements asserting symptomatology.

The examiner must provide a comprehensive rationale for all opinions expressed. If the examiner cannot provide the requested opinion without resorting to speculation, it must be so stated, and the examiner must provide the reasons why an opinion would require speculation. The examiner must indicate whether there was any further need for information or testing necessary to make a determination. The examiner must indicate whether an opinion could not be rendered due to limitations of knowledge in the medical community at large and not those of the particular examiner.

3. After associating any newly obtained evidence with the claims file, provide a copy of the file, including a copy of this remand, to an appropriately qualified examiner for an opinion regarding the nature and etiology of any current disability of his hands, to include peripheral neuropathy of the upper extremities. The examiner should review the entire claims file and should indicate that such review was completed in the opinion report. If deemed appropriate, the examiner should contact the Veteran for additional information or examination.

The examiner is asked to provide an addendum opinion to the October 2018 opinion as to whether it is at least as likely as not (i.e., 50 percent or greater probability) that the Veteran has a current diagnosis of peripheral neuropathy of the left or right upper extremity which is

related to his active duty military service, to include as caused or aggravated by his Parkinson's disease. If possible, the examiner should also opine on the level of impairment that the Veteran experiences in each radicular group of his upper extremities. In providing the requested opinion, the examiner should consider all relevant evidence of record, including both medical and lay evidence, citing to specific evidence where appropriate. The examiner should specifically discuss the Veteran's statements concerning his symptoms of numbness in his hands and his functional difficulties due to his Parkinson's disease.

The examiner is advised that the Veteran is competent to report symptoms, treatment, and injuries observable to a layperson. *Jandreau v. Nicholson*, 492 F.3d 1372, 1377 (Fed. Cir. 2007). The examiner is also reminded that the absence of documented treatment in service or thereafter is not fatal to a service connection claim, and the absence of evidence in the service treatment records is an insufficient basis, by itself, for a negative opinion. *See Ledford v. Derwinski*, 3 Vet. App. 87, 89 (1992). Thus, the examiner is to consider the totality of the record, and not just the absence of clinical treatment, in weighing the Veteran's statements asserting symptomatology.

The examiner must provide a comprehensive rationale for all opinions expressed. If the examiner cannot provide the requested opinion without resorting to speculation, it must be so stated, and the examiner must provide the reasons why an opinion would require speculation. The examiner must indicate whether there was any further need for information or testing necessary to make a determination. The examiner must indicate whether an opinion could not be rendered due to

limitations of knowledge in the medical community at large and not those of the particular examiner.

4. After any newly obtained evidence has been associated with the claims file, schedule the Veteran for an examination with an appropriately qualified examiner to determine the nature and etiology of any currently diagnosed respiratory condition. The entire claims file, including a copy of this remand, must be made available to the examiner and the examination report must reflect that such review was completed.

The examiner is asked to provide an opinion as to whether it is at least as likely as not (i.e., a 50 percent or greater probability) that any currently diagnosed respiratory condition, to include COPD, is related to the Veteran's military service, to include as being due to herbicide agent exposure and/or asbestos exposure. The examiner should specifically discuss his treatment records indicating abnormalities of his lungs.

The examiner is advised that the Veteran is competent to report symptoms, treatment, and injuries observable to a layperson. *Jandreau v. Nicholson*, 492 F.3d 1372, 1377 (Fed. Cir. 2007). The examiner is also reminded that the absence of documented treatment in service or thereafter is not fatal to a service connection claim, and the absence of evidence in the service treatment records is an insufficient basis, by itself, for a negative opinion. *See Ledford v. Derwinski*, 3 Vet. App. 87, 89 (1992). Thus, the examiner is to consider the totality of the record, and not just the absence of clinical treatment, in weighing the Veteran's statements asserting symptomatology.

The examiner must provide a comprehensive rationale for all opinions expressed and discuss relevant evidence where appropriate. If the examiner cannot provide the requested opinion without resorting to speculation, it must be so stated, and the examiner must provide the reasons why an opinion would require speculation. The examiner must indicate whether there was any further need for information or testing necessary to make a determination. The examiner must indicate whether an opinion could not be rendered due to limitations of knowledge in the medical community at large and not those of the particular examiner.

5. After any newly obtained evidence has been associated with the claims file, schedule the Veteran for an examination with an appropriately qualified examiner to determine the nature and etiology of any currently sleep disorder. The entire claims file, including a copy of this remand, must be made available to the examiner and the examination report must reflect that such review was completed.

The examiner is asked to provide an opinion as to whether it is at least as likely as not (i.e., a 50 percent or greater probability) that any currently diagnosed sleep disorder is related to the Veteran's military service, to include as being due to herbicide agent exposure and/or asbestos exposure and/or caused or aggravated by his peripheral neuropathy or Parkinson's disease. The examiner should specifically discuss the private treatment record indicating that his peripheral neuropathy may be interfering with his sleep.

The examiner is advised that the Veteran is competent to report symptoms, treatment, and injuries observable to a

layperson. *Jandreau v. Nicholson*, 492 F.3d 1372, 1377 (Fed. Cir. 2007). The examiner is also reminded that the absence of documented treatment in service or thereafter is not fatal to a service connection claim, and the absence of evidence in the service treatment records is an insufficient basis, by itself, for a negative opinion. *See Ledford v. Derwinski*, 3 Vet. App. 87, 89 (1992). Thus, the examiner is to consider the totality of the record, and not just the absence of clinical treatment, in weighing the Veteran's statements asserting symptomatology.

The examiner must provide a comprehensive rationale for all opinions expressed and discuss relevant evidence where appropriate. If the examiner cannot provide the requested opinion without resorting to speculation, it must be so stated, and the examiner must provide the reasons why an opinion would require speculation. The examiner must indicate whether there was any further need for information or testing necessary to make a determination. The examiner must indicate whether an opinion could not be rendered due to limitations of knowledge in the medical community at large and not those of the particular examiner.

6. After any newly obtained evidence has been associated with the claims file, schedule the Veteran for an examination with an appropriately qualified examiner to determine the nature and etiology of any currently diagnosed right shoulder disability. The entire claims file, including a copy of this remand, must be made available to the examiner and the examination report must reflect that such review was completed.

The examiner is asked to provide an opinion as to whether it is at least as likely as not (i.e., a 50 percent or

greater probability) that any currently diagnosed right shoulder disability is related to the Veteran's military service, to include as being due to or aggravated by a service-connected disability (including as due to or aggravated by a fall caused by his Parkinson's disease and/or right knee disabilities). The examiner should specifically discuss the treatment record indicating that the Veteran injured his shoulder after falling.

The examiner is advised that the Veteran is competent to report symptoms, treatment, and injuries observable to a layperson. *Jandreau v. Nicholson*, 492 F.3d 1372, 1377 (Fed. Cir. 2007). The examiner is also reminded that the absence of documented treatment in service or thereafter is not fatal to a service connection claim, and the absence of evidence in the service treatment records is an insufficient basis, by itself, for a negative opinion. *See Ledford v. Derwinski*, 3 Vet. App. 87, 89 (1992). Thus, the examiner is to consider the totality of the record, and not just the absence of clinical treatment, in weighing the Veteran's statements asserting symptomatology.

The examiner must provide a comprehensive rationale for all opinions expressed and discuss relevant evidence where appropriate. If the examiner cannot provide the requested opinion without resorting to speculation, it must be so stated, and the examiner must provide the reasons why an opinion would require speculation. The examiner must indicate whether there was any further need for information or testing necessary to make a determination. The examiner must indicate whether an opinion could not be rendered due to limitations of knowledge in the medical community at large and not those of the particular examiner.

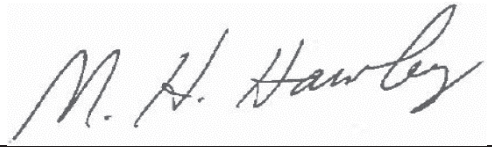
7. After any newly obtained evidence has been associated with the claims file, schedule the Veteran for an examination with an appropriately qualified examiner to determine the nature and etiology of any currently diagnosed prostate condition. The entire claims file, including a copy of this remand, must be made available to the examiner and the examination report must reflect that such review was completed.

The examiner is asked to provide an opinion as to whether it is at least as likely as not (i.e., a 50 percent or greater probability) that any currently diagnosed prostate condition is related to the Veteran's military service, to include as being due to herbicide agent exposure. The examiner should specifically discuss the treatment records showing elevated PSA levels and records indicating that his prostate was enlarged.

The examiner is advised that the Veteran is competent to report symptoms, treatment, and injuries observable to a layperson. *Jandreau v. Nicholson*, 492 F.3d 1372, 1377 (Fed. Cir. 2007). The examiner is also reminded that the absence of documented treatment in service or thereafter is not fatal to a service connection claim, and the absence of evidence in the service treatment records is an insufficient basis, by itself, for a negative opinion. *See Ledford v. Derwinski*, 3 Vet. App. 87, 89 (1992). Thus, the examiner is to consider the totality of the record, and not just the absence of clinical treatment, in weighing the Veteran's statements asserting symptomatology.

The examiner must provide a comprehensive rationale for all opinions expressed and discuss relevant evidence where appropriate. If the examiner cannot provide the requested opinion without resorting to speculation, it

must be so stated, and the examiner must provide the reasons why an opinion would require speculation. The examiner must indicate whether there was any further need for information or testing necessary to make a determination. The examiner must indicate whether an opinion could not be rendered due to limitations of knowledge in the medical community at large and not those of the particular examiner.



M. H. HAWLEY
Veterans Law Judge
Board of Veterans' Appeals

Attorney for the Board S. Ferguson, Associate 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).