UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

Vet. App. No. 19-2805

ANTHONY HUERTA,

Appellant,

v.

ROBERT L. WILKIE,
Secretary of Veterans Affairs,

Appellee.

REPLY BRIEF FOR THE APPELLANT

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SUMMARY OF ARGUMENT

Despite the Secretary's contention that this case merely warrants a remand purportedly to develop additional evidence concerning the active status of Appellant's osteomyelitis of the pelvis, the appeal in reality presents the Court with a regulatory interpretation issue of first impression concerning 38 C.F.R. § 4.71a, Diagnostic Code (DC) 5000. In that regard, Appellant argues that the plain language of DC 5000 provides an independent basis for a disability rating of 100 percent for osteomyelitis of the pelvis. The Secretary disagrees, arguing contrary to several well-established canons of statutory and regulatory construction, that the proper interpretation of DC 5000 requires the Court to insert language otherwise absent from the regulation imposing the additional requirement of evidence of an active infection for osteomyelitis of the pelvis to warrant a rating of 100 percent. The proper application of DC 5000 to Appellant's osteomyelitis of the pelvis, without the impermissible requirement of an active infection, requires reversal of the Board of Veterans' Appeals (Board) decision, because the only permissible view of the evidence entitles Appellant to an evaluation of 100 percent from February 1, 1992 to June 3, 1994, and from July 6, 1995.

Contrary to the Secretary's argument, the record in this case presents no conflict about whether Appellant's osteomyelitis condition is active. The Secretary has conceded that the VA examiner medical opinions in 2016 and 2017, upon which the Board relied, are deficient. That concession leaves the

medical opinions of Appellant's private physician rendered in 2016 and 2017 as the only plausible competent evidence and medical opinions of record regarding Appellant's osteomyelitis. Those private medical opinions definitively support Appellant's claim that his osteomyelitis of the pelvis is chronic, intractable, and an ongoing process with an onset date of 1986. That being the case, the Board's decision must be reversed and remanded only for the prompt assignment of an appropriate rating.

ARGUMENT

I. The Plain Language of DC 5000 Provides an Independent Basis for a Disability Rating of 100 Percent for Osteomyelitis of the Pelvis Without Any Requirement for Evidence of an Active Infection

In his opening brief, Appellant explained that the text of DC 5000 establishes that his osteomyelitis of the pelvis independently entitles him to a disability rating of 100 percent, without any additional requirement for evidence of an active infection or otherwise a long history of intractability and debility or other continuous constitutional symptoms. Appellant's Brief (App. Br.) at 10-16.

The Secretary disagrees, arguing that "the text and structure of DC 5000 make clear that osteomyelitis 'acute, subacute, or chronic' is rated, in part, on its active or inactive status, and given the graduated structure of DC 5000, a 100% rating requires evidence of *active* osteomyelitis." (Emphasis in original). Secretary's Brief (Sec. Br.) at 16. Although conceding that "the word 'active' does not appear in the 100% criterion," Sec. Br. at 18, the Secretary argues that

the Court nonetheless should construe the criterion as if the word “active” were present thereby limiting its application to osteomyelitis of the pelvis with “active infection processes only.” *Id.* The Secretary cites as support for his argument the “graduated structure” of DC 5000 and the fact that the 10 percent rating refers to the lack of an active infection and the 20, 40 and 60 percent criteria require active infections or infection processes, as do two of the “independent alternatives enumerated” in the 100% criterion, which use “terms such as ‘long history’ and ‘other continuous.’” Sec. Br. at 17-18.

The Secretary’s textual argument is flawed. It is an impermissible attempt to rewrite the 100 percent evaluation criterion of DC 5000 to establish an “active infection process” requirement for osteomyelitis of the pelvis not present in the regulation and is an effort that runs afoul of several well-settled canons of statutory or regulatory interpretation. At the outset, the Secretary’s argument is predicated on the extraordinary position that the Court must craft and insert language into the regulation’s 100 percent evaluation criterion, language the Secretary admits is currently absent from the regulation’s text, in order properly to construe it as requiring an active infection process for osteomyelitis of the pelvis. But, it is a basic principle of statutory construction that courts “ordinarily resist[ ] reading words into a statute that do not appear on its face.” *See Novartis AG v. Ezra Ventures LLC*, 909 F.3d 1367, 1372 (Fed. Cir. 2018) (quoting *Bates v. United States*, 522 U.S. 23, 29 (1997)).

Nor does the Secretary's "graduated structure" argument fare any better. The fact that DC 5000 uses the word "active" in the 10 and 20 percent evaluation criteria and otherwise references active infection processes in the 40 and 60 percent criteria demonstrates that the Secretary knows how to craft a regulation that expressly requires an active infection process and he would have done so in the 100 percent criterion for osteomyelitis of the pelvis if that was what he had intended. Instead, the Secretary opted to include no language requiring an active infection process for a 100 percent rating for osteomyelitis of the pelvis and that omission should be regarded as intentional and given effect. *Tropf v. Nicholson*, 20 Vet.App. 317, 321 n.1 (2006) ("Numerous authorities state that when a statute or regulation omits a term in one place that is used in other places, that omission should be regarded as intentional and given effect."); *Heino v. Shinseki*, 683 F.3d 1372, 1379 (Fed. Cir. 2012) ("It is well settled that '[w]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion.' " (quoting *Russello v. United States*, 464 U.S. 16, 23 (1983)).[1]

Similarly, there is no merit to the Secretary's argument that the express requirement for an active infection process in two of the independent

[1] The canons of construction apply equally to regulations and statutes. *See Tatum v. Shinseki,* 24 Vet.App. 139, 142-43 (2010) (citing *Smith v. Brown*, 35 F.3d 1516, 1523 (Fed. Cir. 1994)).

osteomyelitis alternatives in the 100 percent evaluation criterion of DC 5000 mandates a similar result for osteomyelitis of the pelvis where the text contains no such requirement. The Secretary has conceded that "DC 5000 provides independent alternatives to establish a 100% rating, including osteomyelitis of the pelvis." Sec. Br. at 16. The first four independent alternatives in the 100 percent criterion of DC 5000 reflect specific manifestations of the disease without reference to any active infection process requirement: osteomyelitis of the pelvis; osteomyelitis of the vertebrae; osteomyelitis extending into major joints; or osteomyelitis with multiple localization. The final alternative includes a general diagnosis of osteomyelitis with what the Secretary characterizes to be a requirement for an active infection process, including a long history of intractability and debility, anemia, amyloid liver changes, or other continuous constitutional symptoms. *See* Sec. Br. at 16.

By listing osteomyelitis of the pelvis (as well as the three other specific manifestations) as alternative evaluation criteria from the criteria requiring active infection processes, the 100 percent rating for DC 5000 expressly differentiates between osteomyelitis requiring an active infection process and specific manifestations of osteomyelitis, such as that in the pelvis, that require no such active infection process. *See Tedesco v. Wilkie*, 31 Vet.App. 360, 365 (2019)(DC 5055 expressly differentiates between limitation of motion and pain because it lists the two as alternative evaluation criteria) (citing *McDowell v. Shinseki*, 23 Vet.App. 207, 220 (2009) (regulation's use of the disjunctive "or"

signified “alternative components”), *aff’d*, 396 F. App’x 691 (Fed. Cir. 2010)). Thus, contrary to the Secretary’s argument, it is clear from the use of differentiated independent alternatives in the 100 percent evaluation criterion of DC 5000 that the Secretary knew how to insert language expressly requiring an active infection process and would have utilized such language for osteomyelitis of the pelvis if that was what he had intended. Instead, osteomyelitis of the pelvis reflects no language requiring an active infection process and “there is no reason here to assume that different phrases in a single regulation actually mean the same thing in operation.” *Tedesco* at 365.

The Secretary’s interpretation of DC 5000 also runs afoul of another canon of statutory construction, because it violates the well-settled principle that a regulation must be construed to give effect, if possible, to every clause and word of the regulation and should avoid rendering any of the regulatory text meaningless or as mere surplusage. *See Sharp v. United States*, 580 F.3d 1234, 1238 (Fed. Cir. 2009). By asserting that a 100 percent rating for osteomyelitis of the pelvis requires an active infection process, the Secretary assigns no meaning or significance to the four specific osteomyelitis conditions identified by the evaluation criterion – osteomyelitis of the pelvis, vertebrae, major joints or with multiple localizations.

Under the Secretary’s construction of DC 5000, striking from the regulation the phrase “Of the pelvis, vertebrae, or extending into major joints, or with multiple localization” would not change the evaluation criteria for a 100 percent

rating, because the Secretary interprets the evaluation criteria as if they read: "Osteomyelitis, acute, subacute, or chronic … [with an active infection process] or long history of intractability and debility, anemia, amyloid liver changes, or other continuous constitutional symptoms." For the Secretary, the specific manifestations of osteomyelitis identified in the regulation are of no consequence, because he asserts generally that any manifestation of osteomyelitis, whether in the pelvis, vertebrae or elsewhere requires an active infection process to warrant a rating of 100 percent. By ignoring and rendering superfluous the regulation's express reference to the four specific manifestations of osteomyelitis, the Secretary's interpretation is plainly wrong. *See Corley v. United States*, 556 U.S. 303, 314 (2009) ("'[a] statute should be construed so that effect is given to all its provisions, so that no part will be inoperative or superfluous, void or insignificant ....'" (quoting *Hibbs v. Winn*, 542 U.S. 88, 101 (2004) (alterations in Corley)).

Reversal of the Board's decision is required, because with the proper application of DC 5000 to Appellant's osteomyelitis of the pelvis absent the erroneous requirement of an active infection, the only permissible view of the evidence entitles him to an evaluation of 100 percent from February 1, 1992 to June 3, 1994, and from July 6, 1995. *See Gutierrez v. Principi*, 19 Vet.App. 1, 10 (2004).

II. The Record in this Case Presents No Conflict About Whether Appellant's Osteomyelitis of the Pelvis is Active

Contrary to the Secretary's argument, Sec. Br. at 11, the record in this case presents no conflict about whether Appellant's osteomyelitis condition is active. Once one disregards the VA examiner medical opinions in 2016 and 2017, which the Secretary acknowledges are deficient, the medical opinions of Appellant's private physician, Dr. William Beauchamp, rendered in 2016 and 2017 are the only plausible competent evidence and medical opinion of record regarding Appellant's osteomyelitis. Dr. Beauchamp's medical opinions definitively support Appellant's claim that his osteomyelitis of the pelvis is chronic, intractable, and an ongoing process with an onset date of 1986. R. at 1482 (1482-1491). Accordingly, the Board's decision must be reversed and remanded only for the prompt assignment of an appropriate rating. *See Traut v. Brown*, 6 Vet.App. 495, 500 (1994).

The Secretary describes Dr. Beauchamp's medical opinion provided in August 2016, in which he "diagnosed chronic, recurrent osteomyelitis that is refractory to surgical treatment, that will require lifelong antibiotic treatment, and that resulted in five or more recurrent infections of osteomyelitis following the initial infection." Sec. Br. at 5. The Secretary notes that Dr. Beauchamp documented multiple "current symptoms of pain, swelling, tenderness, warmth, malaise, and muscle atrophy" as well as five recurring infections between 1989 and 1994. *Id.; see also* App. Br. at 5-6 (describing in detail Dr. Beauchamp's

2016 medical opinion). In addition, the Secretary notes that Dr. Beauchamp's medical opinion in 2017 describes Appellant's osteomyelitis as "consisting of a 'long history of intractability and debility' and constitutional symptoms of pain, tenderness, decreased [range] of motion, and instability." Sec. Br. at 7. The Secretary explains that Dr. Beauchamp opined that Appellant's "osteomyelitis of the pelvis was likely secondary to his surgery in 1985 and an incidental bacteremia that led to the subsequent infection(s)" and a 2016 MRI showed retained metal fragments at the site of the 1985 surgery. *Id.; see also* App. Br. at 7-8 (describing in detail Dr. Beauchamp's 2017 medical opinion).

The Board denied Appellant's entitlement to a higher rating for osteomyelitis of the pelvis, affording greater probative value to the VA medical opinions in 2016 and 2017 than to Dr. Beauchamp's opinions and finding that Appellant's osteomyelitis was no longer active, having largely been resolved since 1992. Sec. Br. at 8. However, the Secretary now concedes that the Board's decision was erroneous because the two VA medical opinions upon which it relied were flawed. Sec. Br. at 11-13. Consequently, such faulty VA medical opinions must be disregarded as competent medical evidence of record.

First, the Secretary admits that "the March 2017 VA medical opinion did not address the August 2016 diagnostic report [an MRI showing punctate metallic foreign body in the left hip posterior superficial soft tissues with associated metallic artifact (R. at 1491)] when it opined '[t]here have been no signs of osteomyelitis since 1992.'" Sec. Br. at 12. This failure of the March 2017 VA

medical opinion to address the 2016 MRI results and Dr. Beauchamp's reliance on them rendered it inadequate and of no probative value. An adequate medical report must rest on correct facts and reasoned medical judgment so as inform the Board on a medical question and facilitate the Board's consideration and weighing of the report against any contrary reports. *See Acevedo v. Shinseki*, 25 Vet.App. 286, 293 (2012). The March 2017 VA medical opinion's failure to discuss or assess the significance of the 2016 MRI results demonstrated that it neither was based upon consideration of Appellant's prior medical history and examinations nor did it describe the disability in sufficient detail to ensure that it was a fully informed one. *See D'Aries v. Peake*, 22 Vet.App. 97, 104 (2008).

Second, the Secretary admits that "the August 2016 VA examination does not appear to consider evidence of a December 1991 infection that was resolved with additional treatment in early 1992" when concluding that Appellant's "current osteomyelitis condition was resolved with no additional episodes or recurring osteomyelitis infections since the initial infection in 1985." Sec. Br. at 12. A medical opinion, like that proffered by the VA in 2016, which is based on an inaccurate factual premise, has no value and it is error to afford it any probative value. *See Reonal v. Brown*, 5 Vet.App. 458, 460 (1993).

Despite the Secretary's concession that the VA medical opinions were inadequate, he nonetheless seeks to support his claim that a remand is warranted by criticizing Dr. Beauchamp's medical opinions purportedly "because the August 2016 and June 2017 private opinions also leave relevant medical

questions unanswered" and thus "alone are insufficient to assign an increased rating." Sec. Br. at 15. The Secretary opines that because Dr. Beauchamp's opinions identify only five recurrent infections with the last in 1994, there is inadequate support for the conclusion that Appellant's osteomyelitis was chronic. Sec. Br. at 14. The Secretary also opines that Dr. Beauchamp's medical opinions do not adequately address the state of the infection site or identify any current treatment. Sec. Br. at 14-15. The Court should disregard the Secretary's criticisms of Dr. Beauchamp's private medical opinions, because they are premised on the Secretary's interpretation of the medical evidence of record, which amounts to nothing more than an impermissible *post hoc* rationalization by appellate counsel. *See Lyles v. Shinseki,* 2012 WL 6200488 *5 (Vet.App. Dec. 13, 2012) (citing *Doty v. United States,* 53 F.3d 1244, 1251 (Fed. Cir .1995) (Courts may not accept appellate counsel's *post hoc* rationalizations for agency action. It is well established that an agency's action must be upheld, if at all, on the basis articulated by the agency itself.)).

Moreover, the record amply demonstrates that Dr. Beauchamp conducted an in-person examination of Appellant in 2016, leading to and supporting his medical opinion that Appellant's osteomyelitis of the pelvis was chronic, intractable, and an ongoing process with an onset date of 1986. R. at 1482 (1482-1491). Dr. Beauchamp reviewed Appellant's medical history as reflected in the detailed chronology and history in his Osteomyelitis DBQ. R. at 1486-1487 (1482-1491). In addition, Dr. Beauchamp performed a physical examination of

Appellant to include range of motion measurements, close examination of his scars, hips, buttocks and extremities, and scrutiny of Appellant's current symptoms and condition. R. at 1488 (1482-1491); 754 (742-757). Dr. Beauchamp's examination found Appellant presented with multiple symptoms of intractability, debility or continuous constitutional conditions relating to his osteomyelitis including at the site of the infection: (1) decreased range of motion of the thoracolumbar spine and left hip; (2) constant deep pain in the lower back and left hip with flare ups; (3) occasional swelling or edema at the iliac bone graft site; (4) malaise with easy fatigue and debility; (5) visibly significant muscle atrophy at the iliac bone graft site and sites of multiple incisional and drainage procedures on the mid-left gluteus maximus; and, (6) muscle weakness and atrophy of the left gluteus maximus and gluteus medius due to chronic infection and surgical intervention. R. at 1488 (1482-1491). Dr. Beauchamp further articulated the current condition of Appellant's osteomyelitis by explaining that Appellant's function loss is reflected in his various restrictions, including: (1) limited ability to pay attention to detailed operations or staying on task for more than 20 to 30 minutes at one time; (2) an inability to walk, stand, or sit for more than one hour without changing position or stretching; (3) limited to lifting/carrying more than 10 pounds generally and 20 pounds rarely; and (4) occasional use of a cane. R. at 1484; 1488 (1482-1491).

Dr. Beauchamp's medical opinion offered in a letter dated June 19, 2017, described the etiology of Appellant's various infections and chronic osteomyelitis of the pelvis as likely secondary to his surgery in 1985, expressly noting that Appellant "was found on a 2016 MRI to have retained metal fragments at the site of 1985 surgery." R. at 617 (614-618). Dr. Beauchamp concluded his letter with a medical opinion that Appellant continues to suffer from chronic osteomyelitis of the pelvis, with a long history of intractability and debility and constitutional symptoms, specifically referring to his current condition and the site of his infections:

> Today, Mr. Huerta continues to have Osteomyelitis of the Pelvis with a long history of intractability and debility. He has constitutional symptoms including pain and point tenderness, decreased range of motion of the lumbar spine and left hip, and instability that impact his activities of daily living. Osteomyelitis is a severe, persistent, and often incapacitating infection. It is often recurring because it is difficult to treat definitively.

R. at 617-618 (614-618).

The record reflects additional evidence regarding the chronic nature of Appellant's osteomyelitis. A VA Form 10-2911 Nursing Plan dated June 19, 1989, reflects Appellant's diagnosis with "Draining Sinus + Iliac Crest (Chronic Osteo)." R. at 1741. VA Treatment Records dated March 1, 2017 (R. at 316 (314-318)) and March 20, 2018 (R. at 98 (97-101)) reflect that Appellant's medical history includes chronic osteomyelitis. A VA C&P Examination Report dated December 7, 2017, reflects "chronic osteomyelitis" as a medical diagnosis

relevant to the understanding or management of Appellant's care. R. at 113 (112-116). In addition, in a Statement of the Case dated October 30, 2017, the VA Regional Office (RO) concluded that Appellant's osteomyelitis of the pelvis "should be considered chronic" because, although resolved and not active since 1992, "regulations [38 C.F.R. § 4.43] note that once recurring supurative [sic] osteomyelitis is identified, this condition should be considered as a continuously disabling process …" R. at 445 (430-453).

The Secretary argues that the RO's conclusion that Appellant's osteomyelitis was chronic should be discounted, because the Board "may disregard apparent favorable findings made by the agency of original jurisdiction," citing *McBurney v. Shinseki*, 23 Vet.App. 136, 139 (2009), *aff'd per curiam,* 407 Fed. App'x 480 (Fed. Cir. 2011). The Secretary's reliance on *McBurney* is misplaced, because the Board neither overturned nor reconsidered the RO's determination that Appellant's osteomyelitis was chronic. The Board's decision to leave intact the RO's osteomyelitis ratings appealed by Appellant was based on the finding that the condition had not been active since 1992; the Board took no issue with nor did it overturn or disagree with in any way the RO's determination that the condition was chronic but presently inactive: "While the Board concedes that the Veteran's osteomyelitis infection indeed first manifested in the Veteran's left pelvis region, DC 5000 explicitly contemplates diagnosis criteria for 'acute, subacute, or chronic' osteomyelitis based upon its active or inactive status

…" and …"the most probative evidence of record suggests that the Veteran's osteomyelitis has been resolved without further residuals conclusively attributable to osteomyelitis since 1992." R. at 18 (5-20). Moreover, the RO's determination, affirmed by the Board, that Appellant's chronic osteomyelitis of the pelvis is rated at 20 percent from 1992 to 1994 and from 1995 to 1997, and thereafter at 10 percent (R. at 914-918 (910-939): R. at 19 (5-20)) resulted in the award of benefits and the payment of disability compensation, making *McBurney* inapposite. *See Murphy v. Shinseki,* 26 Vet.App. 510, 514-515 (2014) (*McBurney* inapplicable to cases where the RO finding of fact or law results in the award and payment of VA benefits).

CONCLUSION

For the foregoing reasons, Appellant requests that the Board's decision be reversed and vacated, with a remand only for the prompt assignment of an appropriate rating.

Respectfully submitted,

Date: December 6, 2019

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