VIA ELECTRONIC FILING

August 22, 2016

Hon. Gregory O. Block
Clerk of the Court
U.S. Court of Appeals for Veterans Claims
625 Indiana Avenue, N.W., Suite 900
Washington, DC 20004

Re:*Clifford H. Cox v. Robert A. McDonald, Secretary of Veterans Affairs*, No. 14-2779

Dear Mr. Block:

Pursuant to U.S. Vet. App. R. 30(b), Appellant Clifford H. Cox hereby advises the Court of additional pertinent and significant authority relevant to the above-referenced case.

The first additional authority is *Lefevre v. Secretary, Dep't of Veterans Affairs*, 66 F.3d 1191 (Fed. Cir. 1995). Pursuant to Rule 30(b), a copy of the decision is attached to this letter. This additional authority is relevant to this case because it addresses whether VA's choice as to whether to extend a legal presumption to an additional class of veterans constitutes a substantive rule. This is most relevant to page 12 of Appellant's initial brief and page 11 of his reply brief.

The other additional authorities are Board of Veterans' Appeals decisions in which the Board applied 38 U.S.C. § 1117 and 38 C.F.R. § 3.317 to veterans who served in Afghanistan. These Board decisions are relevant to Appellant's argument in Section III of his initial brief and Section II of his reply brief that the Secretary's interpretation of "Southwest Asia" as not including Afghanistan as expressed in the revised version of VA Training Letter 10-01 is arbitrary and capricious. Pursuant to Rule 30(b), copies of these decisions are attached to this letter. They may also be found at the following URLs:

www.va.gov/vetapp13/Files1/1301299.txt

www.va.gov/vetapp11/Files2/1119443.txt

www.va.gov/vetapp12/Files2/1211176.txt

www.va.gov/vetapp10/Files6/1042785.txt

www.va.gov/vetapp11/Files5/1140864.txt

www.va.gov/vetapp14/Files1/1410729.txt

www.va.gov/vetapp11/Files2/1113680.txt

www.va.gov/vetapp11/Files3/1127377.txt

www.va.gov/vetapp11/Files5/1145020.txt

www.va.gov/vetapp12/Files5/1231445.txt

www.va.gov/vetapp15/Files5/1545642.txt

www.va.gov/vetapp15/Files2/1512386.txt

www.va.gov/vetapp09/Files2/0917309.txt.

Respectfully submitted,

/s/ Katy S. Clemens
Katy S. Clemens

APPENDIX

LeFevre v. Secretary, Dep't of Veteran's Affairs

United States Court of Appeals for the Federal Circuit

September 15, 1995, Decided

94-7050

Reporter
66 F.3d 1191; 1995 U.S. App. LEXIS 26065

JENNIE R. ***LEFEVRE***, SALLY M. HILL, FREDERICK L. RADA AND MARY CHRISTINA VELDMAN, Petitioners, v. SECRETARY, DEPARTMENT OF VETERANS AFFAIRS, Respondent.

Subsequent History: [1]** Rehearing Denied October 13, 1995, Reported at: *1995 U.S. App. LEXIS 29853*. Certiorari Denied May 13, 1996, Reported at: *1996 U.S. LEXIS 3042*.

Prior History: Appealed From: Department of Veterans Affairs.

Disposition: AFFIRMED.

Core Terms

exposure, herbicide, studies, diseases, cancer, veterans, credible evidence, prostate cancer, nasal, scientific, biologic, liver, scientific evidence, task force, commodities, statistically significant, increased risk, statistical, outweighs, dioxin, recommendations, plausibility, summarized, carriers, animals, epidemiological, determinations, nasopharyngeal, occupational, capricious

Case Summary

Procedural Posture
Petitioner claimants appealed a ruling made by respondent Secretary of the Department of Veterans Affairs (VA), who refused to create a certain presumption regarding eligibility for benefits under the Agent Orange Act of 1991, *38 U.S.C.S. § 1116*.

Overview
Claimants sought disability and survivor benefits under *38 U.S.C.S. § 1116*, and requested that the VA create a presumption that three cancers were associated with exposure to herbicides in Vietnam. The scientific evidence provided to the VA showed that prostate cancer had limited evidence of being associated with Agent Orange, and that liver and nose cancer had insufficient evidence to show any association. The VA refused to create the presumptions and claimants sought review. The court found that it had jurisdiction to review the VA's determination under *38 U.S.C.S. § 502* because the determination constituted a rule that affected substantive rights. The court then affirmed, holding that the VA was not arbitrary or capricious in its determination because it relied on the medical and scientific evidence presented to it by the National Academy of Sciences, pursuant to statute, and created presumptions only for those diseases that appeared to have cause-and-effect relationships.

Outcome
The court affirmed the decision of the VA not to create presumptions regarding prostate, liver, and nose cancer.

LexisNexis® Headnotes

Evidence > Admissibility > Scientific Evidence > General Overview

Military & Veterans Law > Veterans > Claim Procedures

Torts > ... > Liability > Federal Tort Claims Act > General Overview

HN1 Within 60 days of receiving a National Academy of Sciences report, the Secretary of Veterans Affairs is to determine whether a positive association exists between the exposure of humans to an herbicide agent, and the occurrence of a disease in humans. *38 U.S.C.S. § 1116(b)(1)*. There is such a positive association if the credible evidence for the association is equal to or outweighs the credible evidence against the association. *38 U.S.C.S. § 1116(b)(3)*. If the Secretary determines, on the basis of sound medical and scientific evidence, that such positive association exists, he is required to establish a presumption of service connection for the disease. *38 U.S.C.S. § 1116(b)(1)*.

Administrative Law > Agency Rulemaking > Formal Rulemaking

Administrative Law > ... > Freedom of Information > Methods of Disclosure > Publication

Administrative Law > Judicial Review > General Overview

Administrative Law > Judicial Review > Reviewability > Jurisdiction & Venue

Military & Veterans Law > Veterans > Department of Veterans Affairs

Public Health & Welfare Law > ... > Disabled & Elderly Persons > Agency Actions & Procedures > Appeals & Reviews

HN2 Title *38 U.S.C.S. § 502* provides that an action of the Secretary of Veterans Affairs to which *5 U.S.C.S. §§ 552(a)(1)* or *553* (or both) refers, other than an action relating to the adoption or revision of the schedule of ratings for disabilities under *38 U.S.C.S. § 355*, is subject to judicial review. Such review shall be in accordance with the Administrative Procedure Act and may be sought only in the United States Court of Appeals for the Federal Circuit.

Administrative Law > Agency Rulemaking > Formal Rulemaking

Administrative Law > Judicial Review > Reviewability > Jurisdiction & Venue

HN3 A rule is substantive when it effects a change in existing law or policy which affects individual rights and obligations.

Administrative Law > Judicial Review > Reviewability > Jurisdiction & Venue

HN4 Judicial review of executive action will not be cut off unless there is persuasive reason to believe that such was the purpose of Congress.

Administrative Law > Judicial Review > Reviewability > General Overview

Administrative Law > Judicial Review > Reviewability > Jurisdiction & Venue

Immigration Law > Asylum, Refugees & Related Relief > Refugee Status > Administrative Proceedings

HN5 There is a well-settled presumption that agency actions are reviewable.

Administrative Law > Judicial Review > Standards of Review > Abuse of Discretion

Administrative Law > Judicial Review > Standards of Review > Arbitrary & Capricious Standard of Review

Environmental Law > Administrative Proceedings & Litigation > Judicial Review

Evidence > Admissibility > Scientific Evidence > General Overview

Military & Veterans Law > Veterans > Claim Procedures

Torts > ... > Liability > Federal Tort Claims Act > General Overview

HN6 Under the Administrative Procedure Act, a court reviews a Secretary's decision to determine whether it was arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law. *5 U.S.C.S. § 706(2)(A)*. This is a highly deferential standard of review. Under the unusual statutory scheme of the Agent Orange Act of 1991, *38 U.S.C.S. § 1116*, with the function of reviewing and evaluating the scientific evidence given to a non-governmental, independent scientific entity, an extremely strong showing of error is required before the court may properly reverse the Secretary of Veteran Affairs' determination.

Administrative Law > Judicial Review > Standards of Review > Clearly Erroneous Standard of Review

Military & Veterans Law > Veterans > Department of Veterans Affairs

Torts > ... > Liability > Federal Tort Claims Act > General Overview

HN7 The court's role is not to substitute its judgment for that of the Secretary of Veterans Affairs. Instead, it considers whether the Secretary has examined the relevant facts and articulated an adequate explanation for his action including a rational connection between the facts found and the choice made, and whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment.

Administrative Law > Agency Rulemaking > Formal Rulemaking

Administrative Law > Judicial Review > Standards of Review > General Overview

Evidence > Relevance > Relevant Evidence

HN8 In evaluating evidence, the critical question is its quality, not its quantity. Just as numerical superiority of witnesses alone could not necessarily entitle the plaintiff to relief, so numerical superiority of scientific studies does not require the trier of fact to accept them.

Governments > Legislation > Interpretation

HN9 Where 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.

Administrative Law > Judicial Review > Standards of Review > Arbitrary & Capricious Standard of Review

HN10 A court will not reverse an executive decision simply because there are uncertainties, analytical imperfections, or even mistakes in the pieces of the picture petitioners have chosen to bring to its attention, but only when there is such an absence of overall rational support as to warrant the description arbitrary and capricious.

Counsel: Frank W. Hunger, Assistant Attorney General, Department of Justice, Washington, D.C. Henry A. Azar, Jr., Attorney, Department of Justice, Civil Division, Washington, D.C., argued for respondent. With him on the brief was Theodore C. Hirt. Of counsel was David J. Barrans, Staff Attorney and Richard J, Hipolit, General Counsel, Department of Veterans Affairs, Washington, D.C.

Gershon M. Ratner, Attorney, National Veterans Legal Services Project, argued for petitioners.

Judges: Before RICH, Circuit Judge, FRIEDMAN, Senior Circuit Judge, and MICHEL, Circuit Judge.

Opinion by: FRIEDMAN

Opinion

[*1192] FRIEDMAN, *Senior Circuit Judge*.

The issue on the merits is the validity of the determination of the Secretary of Veterans Affairs, pursuant to the Agent Orange Act of 1991, *38 U.S.C. § 1116 (Supp. V. 1993)* (the 1991 Act), not to create a presumption that

prostate cancer, liver cancer, and nose cancer are connected to exposure to herbicides in Vietnam, which would be applied in determining eligibility for disability and survivor's benefits. The Secretary contends that under the 1991 Act we do not have jurisdiction to review his determination. **[**2]** We **[*1193]** hold that we have jurisdiction, and affirm his determination.

I.

A. In 1984, Congress recognized that it would be virtually impossible to determine on a case-by-case basis whether exposure to herbicides in Vietnam caused a disease in a particular veteran. 130 Cong. Rec. 13,159 (remarks of Senator Simpson). It therefore decided to require the Secretary to create or reject a presumption-of-service connection for particular diseases, based upon the statistical probability of such connection, as reflected in scientific studies of the relationship between those diseases and exposure to herbicides and the incidence of those diseases in persons and animals subject to herbicide exposure. *Id.* at 13,157-59; *See* Veterans' Dioxin and Radiation Exposure Compensation Act of 1984, Pub. L. No. 98-542, 98 Stat. 2725 (1984 Act).

By 1991 Congress had concluded that the Secretary's administration of the 1984 Act had created doubt about the way the Act was being applied. A Senate Committee report on the 1991 Act stated:

> A number of reviews of the scientific literature on the effects of exposure to dioxin have been carried out under contract with VA and published by VA pursuant to **[**3]** the mandate in [the 1984 Act]. . . . General acceptance of these reviews has been impaired because of concern that VA may have exerted influence on their content. Although the Committee does not share such a concern, it nevertheless recognizes that the perception of a possibility of some taint does exist and cannot be dismissed out of hand. Other than these reviews, the Committee is unaware of any other unified analysis of the results obtained from studies on the effects of dioxin exposure or of any up-to-date analysis.

S. Rep. No. 101-82, 101st Cong., 1st Sess. 41 (1989).

Congress therefore enacted the 1991 Act to provide

> a review, by an entity completely independent of VA, that will yield unified compilation and analysis of the results from the various scientific studies.
>
> In order to accomplish this result, the Committee bill would provide for an independent contract scientific organization the National Academy of Sciences unless NAS is unwilling to undertake this effort to undertake a comprehensive review and evaluation of all of the scientific evidence, literature, and studies including the Selected Cancers (SC) Study being carried out by CDC pertaining **[**4]** to the adverse health effects in humans or other animals of exposure to dioxin and other substances in herbicides used in Vietnam.

Id. at 42.

The 1991 Act directed the Secretary to seek to enter into an agreement with the National Academy of Science (the Academy or NAS), an independent non-profit, non-governmental scientific organization, under which the Academy would "review and summarize the scientific evidence and assess the strength thereof, concerning the association between exposure to an herbicide used in support of military operations in Vietnam," and "each disease suspected to be associated with such exposure." *38 U.S.C. § 1116*, Note, § 3(c). The agreement was to require the Academy to transmit to the Secretary written reports over ten years, the first within 18 months and the remaining ones at least every two years. *Id.*, Note § 3(g)(i).

Under the 1991 Act the Academy is directed, "for each disease reviewed," to

> determine (to the extent that available scientific data permit meaningful determinations)
>
> (A) whether a statistical association with herbicide exposure exists, taking into account the strength of the scientific evidence **[**5]** and the appropriateness of the statistical and epidemiological methods used to detect the association;

(B) the increased risk of the disease among those exposed to herbicides during service in the Republic of Vietnam during the Vietnam era; and

(C) whether there exists a plausible biological mechanism or other evidence of a **[*1194]** causal relationship between herbicide exposure and the disease.

(2) the Academy shall include in its reports under subsection (g) a full discussion of the scientific evidence and reasoning that led to its conclusions under this subsection.

Id., Note § 3(d).

HN1 Within 60 days of receiving the Academy's report, the Secretary is to determine whether a "positive association existed between (A) the exposure of humans to an herbicide agent, and (B) the occurrence of a disease in humans . . . ." *38 U.S.C. § 1116(b)(1)*. There is such a positive association "if the credible evidence for the association is equal to or outweighs the credible evidence against the association." *38 U.S.C. § 1116(b)(3)*. If the Secretary determines, "on the basis of sound medical and scientific evidence," that such positive association exists, **[**6]** he is required to establish a presumption of service connection for the disease. *38 U.S.C. § 1116(b)(1)*.

In making his determinations, the Secretary is required to "take into account" the Academy's report and "all other sound medical and scientific information and analysis available to the Secretary." *38 U.S.C. § 1116(b)(2)*. "In evaluating any study for the purpose of making such determinations, the Secretary shall take into consideration whether the results are statistically significant, are capable of replication, and withstand peer review." *Id.*

B. Pursuant to its agreement with the Secretary, the Academy conducted an extensive investigation in which it "reviewed and summarized the strength of the scientific evidence concerning the association between herbicide exposure during Vietnam service and each disease or condition suspected to be associated with such exposure." The result was a 764 page Report, which exhaustively reviewed the scientific evidence regarding the association between exposure to herbicides and various diseases. The Academy made no new studies, but reviewed existing evidence including various epidemiological studies and studies of biologic plausibility. **[**7]** The latter is biological evidence, usually from animal testing, that a particular agent is associated with a particular disease. The Report was based on the Academy's review of more than 6000 abstracts of scientific or medical articles, approximately 230 of which were given detailed analysis.

The Academy summarized the extent of the evidence of association between herbicide exposure and 31 specific health problems by placing each disease in one of four categories. The first category, diseases for which the scientific evidence constituted "Sufficient Evidence of an Association" "Between Specific Health Problems and Exposure to Herbicides," contained five diseases, none of which is at issue in this case. The second category was:

Limited/Suggestive Evidence of an Association:

Evidence is suggestive of an association between herbicides and the outcome but is limited because chance, bias, and confounding could not be ruled out with confidence. For example, at least one high-quality study shows a positive association, but the results of other studies are inconsistent.

The Report placed three types of cancer in this category, one of which, prostate cancer, is at **[**8]** issue here.

The third category was:

Inadequate/Insufficient Evidence to Determine Whether an Association Exists: The available studies are insufficient quality, consistency, or statistical power to permit a conclusion regarding the presence or absence of an association. For example, studies fail to control for confounding, have inadequate exposure assessment, or fail to address latency.

The Report placed 20 diseases in this category. Two of them--hepatobiliary (liver) and nasal/nasopharyngeal (nose) cancer--are at issue here.

The fourth category, "Limited/Suggested Evidence of No Association," contains 4 types of cancer. None of these is here involved.

The Report noted that the Academy "was charged with reviewing the scientific evidence, rather than making recommendations regarding DVA policy, and [placement of the **[*1195]** diseases in categories] is not intended to imply or suggest any policy decisions, which must rest with the Secretary."

The Report also considered separately whether exposure to herbicides increased risk for Vietnam veterans for each of the diseases. It concluded that "it is not possible for the Academy to quantify the degree of risk likely to have been **[**9]** experienced by Vietnam veterans because of their exposure to herbicides in Vietnam," "given the large uncertainties that remain about the magnitude of potential risk from exposure to herbicides in the occupational, environmental, and veterans studies that have been reviewed, inadequate control for important confounders in these studies, and the lack of information needed to extrapolate from the level of exposure in the studies reviewed to that of individual Vietnam veterans . . . ." Id.

In assessing the evidence of biologic plausibility, the Report noted: "Several studies . . . have been performed in laboratory animals. In general they have produced negative results, although some were not performed using rigorous criteria for the study of cancer in animals, and some produced equivocal results that could be interpreted as either positive or negative. . . . There is as yet no convincing evidence of, or mechanistic basis for, the carcinogenicity of any of the herbicides used in Vietnam." The Report also addressed the chemical compound known as TCDD or dioxin, which was a contaminant "found in varying levels in different batches of Agents Orange, Pink, Purple, and Green." The Academy **[**10]** reported that there was extensive evidence that dioxin caused cancer in laboratory animals.

C. Upon receipt of the Academy's Report, the Secretary announced that he would recognize as service connected the five diseases the Report had placed in the first category ("Sufficient Evidence of an Association"). The Department appointed a task force, "an internal, high-level panel" of experts, "to carefully analyze the report from a medical/scientific perspective and to solicit comments from representatives of veterans service organizations and other interested parties."

In a detailed report to the Secretary, the task force "attempted to translate the Academy's evaluation of the scientific literature and other available information into terms compatible with the legal mandate of P.L. 102-4, i.e. whether the credible evidence for an association between exposure to herbicides and any specific disease was equal to or outweighed the credible evidence against an association. This is not a simple task. The Task Force also tried to evaluate additional evidence presented by the veterans service organizations and a recently published follow-up on the Seveso incident published in Epidemiology **[**11]** ." The task force concluded that the Academy "had done a thorough review and evaluation of the available scientific and medical information regarding health effects of the exposure to Agent Orange and other herbicides used during the Vietnam conflict. There were no obvious gaps in the information sources cited," and "the approach taken by the NAS Committee was reasonable and scientifically sound and the organization of the report was understandable."

The task force made recommendations based on the Academy's conclusions. It endorsed the Secretary's decision that the five diseases that the Academy placed in its first category ("Sufficient Evidence of an Association") "also meet the standard for a positive finding under the statute, i.e., the credible evidence for an association is equal to or outweighs the credible evidence against an association." The task force spent substantial time on the three types of cancer that the Academy placed in the second category ("Limited Suggestive Evidence of an Association"). The task force concluded that two of those cancers (respiratory cancers and multiple myeloma) met the statutory standard and recommended the establishment of a presumption **[**12]** of service connection for them. It concluded, however, that prostate cancer did not meet the statutory standard and recommended not establishing a presumption of service connection for it. The task force concluded that none of the diseases that the Academy placed in the third category ("Inadequate/Insufficient Evidence of an Association"), which included liver and nose cancer, met the statutory standard, and recommended **[*1196]** not to establish a presumption of service connection for them.

The Secretary adopted the task force's recommendations, and published a detailed explanation of his decision in the Federal Register. *59 Fed. Reg. 341-46 (1994)*. He explained his reasons for denying a presumption of service connection for most of the diseases, including the three here at issue. The Secretary discussed the scientific reports, both pro and con, upon which he based his decision. The Secretary requested that the Academy "focus particularly on the evidence regarding prostate cancer and peripheral neuropathy in its next review."

D. The four petitioners are a Vietnam veteran who has prostate cancer and three widows of Vietnam veterans who died of liver or nose cancer. They allege that the veterans' **[**13]** exposure to herbicides in Vietnam caused the cancers. The veteran has a claim for disability compensation pending before the Department of Veterans Affairs. The three widows have pending their claims for dependency and indemnity compensation. The petition for review asserts that the Secretary's denial of a presumption for the three types of cancer "will cause the VA imminently to deny their claims for compensation."

The petition for review challenges the Secretary's determination "insofar as it determines *not* to allow veterans presumptive service connection, based on herbicide exposure in Vietnam, for prostate cancer, hepatobiliary cancers and nasal/nasopharyngeal cancer" (emphasis in original). The petitioners' brief asserts that the Secretary's denial of a "positive association" between those three types of cancers and exposure to herbicides in Vietnam was arbitrary, capricious and contrary to law.

II.

The jurisdiction of this court directly to review acts of the Secretary is set forth in ***HN2*** *38 U.S.C. § 502 (Supp. V. 1993)*:

> An action of the Secretary to which *section 552(a)(1)* or *553* of title 5 (or both) refers, other than an action relating to the adoption or revision **[**14]** of the schedule of ratings for disabilities under *section 355* of title 38, is subject to judicial review. Such review shall be in accordance with [the Administrative Procedure Act] and may be sought only in the United States Court of Appeals for the Federal Circuit.

Section 552(a)(1) requires each agency to publish in the Federal Register, among other things, "substantive rules of general applicability . . . and statements of general policy or interpretations of general applicability . . . ." *Section 553*, captioned "Rule making," specifies the procedure for rulemaking.

Thus, we may directly review rules promulgated by the Department of Veteran's Affairs, including substantive rules of general applicability, statements of general policy and interpretations of general applicability because these are all actions "to which *section 552(a)(1)* refers . . . ."

Section 551(4) of title 5 defines a rule as

> the whole or part of an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of an agency.

As our predecessor court **[**15]** explained: "rule making is legislative in nature, is primarily concerned with policy considerations for the future rather than the evaluation of past conduct, and looks not to the evidentiary facts but to policy-making conclusions to be drawn from the facts." *American Express Co. v. United States, 60 C.C.P.A. 86, 472 F.2d 1050 (C.C.P.A. 1973)* (citations omitted).

These definitions cover the Secretary's determination not to establish a presumption-of-service connection with respect to prostate, liver, and nose cancer and the veteran's exposure to herbicides in Vietnam, and therefore we have jurisdiction to review it. The determination was a rule because it was a "statement of general . . . applicability and future effect designed to implement . . . or prescribe . . . law or policy . . . ." It prescribed the basis on which the Department would adjudicate every claim seeking disability or survivor benefits for specified diseases allegedly caused by exposure to herbicides in Vietnam. It reflects the result of a process that was "legislative in nature, [was] primarily **[*1197]** concerned with policy considerations for the future . . . , and looked . . . to policy-making conclusions to be drawn from the facts." **[**16]** Congress delegated to the Secretary the authority to determine

whether or not to create a presumption of service connection between certain diseases and military service in Vietnam, and that determination would control the decisions in all subsequent cases involving the issue.

The Secretary contends that his determination is not a substantive rule because it will not have binding effect, since a claimant may establish service connection for any disease or injury by showing that it was incurred in service. Not only is this position unrealistic, but it is inconsistent with the reasons that led Congress in the 1984 Act to adopt the procedure of the Secretary creating presumptions of service connection for various diseases associated with herbicide exposure. Congress did so because it recognized that ordinarily it would be impossible for an individual veteran to establish that his disease resulted from exposure to herbicides in Vietnam.

Relying on the statement in *Animal Legal Defense Fund v. Quigg, 932 F.2d 920, 927 (Fed. Cir. 1991)* that ***HN3*** "a rule is substantive when it effects a change in existing law or policy which affects individual rights and obligations," the Secretary contends **[**17]** that his determination was merely an announcement "that there would be *no* change in the existing law and policy regarding service connection for those diseases" (emphasis in original). The policy decision that the 1991 Act required the Secretary to make was whether or not, under the Act's standards, to establish a presumption of service connection for various diseases. The Secretary's determination not to establish a presumption for a particular disease was just as much a change in policy as his determination to establish a presumption for another disease. Until the Secretary had acted, there was no existing law regarding presumptions for the Department to follow. The Secretary changed existing law by establishing or refusing to establish a presumption.

The Supreme Court dealt with a similar issue in *Frozen Food Express v. United States, 351 U.S. 40, 100 L. Ed. 910, 76 S. Ct. 569 (1956)*. That case involved the exception in § 203(b)(6) of the Interstate Commerce Act, 49 Stat. 543 (1935), from the requirement that motor carriers have certificates of public convenience and necessity, to carry "agricultural commodities."

"After an investigation instituted on its own motion [which included an evidentiary **[**18]** public hearing], the Commission issued an order that specified commodities are not 'agricultural' within the meaning of § 203(b)(6)." *Id. at 41*. The order incorporated findings from an accompanying report that "listed those commodities that the Commission [found] exempted under § 203(b)(6) and those that are not." *Id. at 42*. The order did not, however, direct carriers hauling the commodities declared non-exempt to comply with the certificate requirement. *Id. at 45* (Harlan, J., dissenting).

Frozen Food Express, a motor carrier that was transporting commodities that the Commission had ruled were not "agricultural commodities" (and therefore required a certificate), filed suit before a three-judge district court challenging the Commission's ruling. The district court "dismissed the action, saying that the 'order' of the Commission was not subject to judicial review," *id. at 43*, because "the 'order' was no more than a report of an investigation . . . 'which does not command the carrier to do, or to refrain from doing anything.'" *Id.* (quoting *United States v. L.A.R. Co., 273 U.S. 299, 47 S. Ct. 413, 71 L. Ed. 651 (1927)*).

The Supreme Court reversed, holding that the Commission's action **[**19]** was reviewable. It stated:

> The determination by the Commission that a commodity is not an exempt agricultural product has an immediate and practical impact on carriers who are transporting the commodities, and on shippers as well. The "order" of the Commission warns every carrier, who does not have authority from the Commission to transport those commodities, that it does so at the risk of incurring criminal penalties. § 222(a). **[*1198]** Where unauthorized operations occur, the Commission may proceed administratively and issue a cease and desist order. § 204(c). The determination made by the Commission is not therefore abstract, theoretical, or academic. The "order" of the Commission which classifies commodities as exempt or nonexempt is, indeed, the basis for carriers in ordering and arranging their affairs. The "order" of the Commission is in substance a "declaratory" one, see 60 Stat. 240, *5 U.S.C. § 1004(d)*, which touches vital interests of carriers and shippers alike and sets the standard for shaping the manner in which an important segment of the trucking business will be done.

Id. at 43-44 (citations omitted).

That reasoning covers the present case. The Secretary's **[**20]** determination not to establish a presumption of service connection for prostate, liver and nose cancers "has an immediate and practical impact" on Vietnam veterans and their survivors who claim benefits on the ground that the veterans' cancers resulted from exposure to herbicides, was not "abstract, theoretical, or academic," "touches vital interests of" veterans and their survivors, and "sets the standard for shaping the manner in which an important segment" of the Department's activities "will be done."

HN4 "Judicial review of executive action 'will not be cut off unless there is persuasive reason to believe that such was the purpose of Congress.'" *De Martinez v. Lamagno, 132 L. Ed. 2d 375, 115 S. Ct. 2227, 2231 (1995)* (citation omitted). Not only is there no showing that Congress so intended, but the few references to the subject in the legislative history of the 1991 Act support reviewability. During the debate on the 1991 Act, Senator Daschle stated that

> the Secretary's determination that a particular disease does not warrant a presumption of service connection would be subject to judicial review. For example, the Secretary's published determination that a presumption of service connection **[**21]** is not warranted for a particular disease clearly seems to be a "statement of general policy . . . subject to judicial review under the Veterans Judicial Review Act."

137 Cong. Rec. S1271 (daily ed. January 30, 1991). Senator DeConcini, the floor manager, agreed "that such a determination would be reviewable." *Id. Accord* 137 Cong. Rec. H731 (daily ed. Jan. 29, 1991) (statement of Rep. Evans). Moreover, in the 1984 Act, which first required the Secretary to determine whether a presumption was warranted, one of the bill's primary sponsors stated:

> The Administrator's compliance with the required process, as well as any regulations issued by the Administrator would be subject to judicial review.
>
> I cannot overstate the importance of judicial review. . . It is only just that . . . Vietnam veterans have their day in court.

130 Cong. Rec. 13,155 (remarks of Senator Specter).

HN5 There is a well-settled presumption that agency actions are reviewable. *See McNary v. Haitian Refugee Ctr., Inc., 498 U.S. 479, 496, 112 L. Ed. 2d 1005, 111 S. Ct. 888 (1991)*; *Wheeler v. United States, 11 F.3d 156, 159 (Fed. Cir. 1993)*. Nothing the Secretary relies on refutes that presumption. The Secretary's **[**22]** determination is reviewable.

III.

A. The 1991 Act created an unusual administrative scheme by which the Secretary is to determine whether there is a service connection between particular diseases and herbicide exposure in Vietnam. Unlike the typical responsibility assigned to a government agency, the Secretary was directed to enter into an agreement with the Academy, a private non-government scientific agency, for the latter to summarize and assess the scientific evidence dealing with the issue and report its findings to him. The major work involved thus was assigned to a non-government entity; the Academy was given 18 months to submit its report, but the Secretary was to render his decision within 60 days of receiving the report.

Following the receipt of the Academy's report, and obviously giving it great weight, the Secretary was to determine, for each of the diseases involved, whether there was a **[*1199]** "positive association" between exposure of people to a herbicide agent and the existence of the disease. The standard for determining whether a positive association exists is whether the "credible evidence" for the association equals or outweighs the credible evidence against it. If **[**23]** the Secretary finds a credible association for a particular disease, he must establish a presumption of service connection for it.

The statutory scheme contemplates that the Academy's findings on these medical and scientific issues reflected in the Report would be the key element in the Secretary's decision. Congress necessarily intended that the Secretary, although not bound by the Academy's findings, would place great reliance on them.

HN6 Under the Administrative Procedure Act, we review the Secretary's decision to determine whether it was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law . . . ." *5 U.S.C. § 706(2)(A)*. This is a "highly deferential" standard of review. *Ethyl Corp. v. EPA, 176 U.S. App. D.C. 373, 541 F.2d 1, 34* (D.C. Cir.), *cert. denied sub. nom.*, *426 U.S. 941 (1976)*. Under the unusual statutory scheme here involved, with the function of reviewing and evaluating the scientific evidence given to a non-governmental, independent scientific entity, an extremely strong showing of error would be required before we properly could reverse the Secretary's determination.

B. The petitioners make a sweeping attack on the evidentiary basis for the Secretary's **[**24]** findings and determinations. Although the argument is framed mainly in terms of the Secretary's alleged failure to consider the evidence in the Academy Report that indicated a positive association between the three cancers involved and herbicide exposure, it really asserts that the Secretary erred because he did not give sufficient weight to that evidence. In essence the petitioners urge us to reweigh the evidence and come to a different conclusion than the Secretary reached.

HN7 Our role, however, "is not to substitute our judgment for that of the" Secretary. *Motor Vehicle Mfrs. Ass'n. v. State Farm Mutual Auto Ins. Co., 463 U.S. 29, 43, 77 L. Ed. 2d 443, 103 S. Ct. 2856 (1983)*. Instead, we consider whether the Secretary has "examined the relevant facts and articulated an adequate explanation for [his] action including a rational connection between the facts found and the choice made. . . . [and] whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment." *Id.* As we show in Part IV, the Secretary's decision refusing to establish a presumption of service connection for the three cancers must stand.

The Secretary did not uncritically accept **[**25]** or merely rubber-stamp the Academy's factual findings. Instead, he carefully reviewed the evidentiary bases for them, recognizing the strengths and weaknesses of the underlying scientific studies that the Academy discussed. As the Academy had urged, he did not view the report's categorization of the diseases according to the strength of statistical association "as recommendations regarding DVA policy." Instead of merely applying the presumption to whole categories, the DVA task force, and then the Secretary, examined each disease to determine if it met the statutory standard. "The task force spent a great deal of time focusing on" the diseases in the Academy's second category, Limited/Suggestive Evidence of an Association, and determined that two of those diseases, respiratory cancers and multiple myeloma met the standard, whereas prostate cancer did not. The Secretary followed this recommendation, thus demonstrating independent judgment by recognizing that the Academy's factual conclusions did not equate to the ultimate decision entrusted to him.

The petitioners rely to a considerable extent upon two declarations by experts in biostatistics and toxicology (Drs. Levin and Legator), **[**26]** which they filed with their opening brief. Those declarations, however, were not part of the record on which the Secretary based his decision, and are not part of the record before this court. Indeed, this court denied the petitioners' motion to supplement the administrative record with those declarations. We therefore do not consider them.

[*1200] C. A major ground of the petitioners' challenge to the Secretary's evaluation of the evidence is that the Secretary improperly failed to recognize that the number of scientific studies showing a positive association between herbicide exposure and each of the three cancers was greater than the number showing no association or a negative association. According to the petitioners, the numerical superiority of this evidence required the Secretary to treat it as credible evidence of an association. They point out that the statutory evidentiary standard the Secretary is to apply in making his findings on whether a positive association exists is whether "credible evidence" for an association equals or outweighs the credible evidence against it. The statute does not define "credible evidence."

HN8 In evaluating evidence, however, the critical question is **[**27]** its quality, not its quantity. Just as "numerical superiority of witnesses alone could not necessarily entitle the plaintiff to relief," *Banks Construction Company v. United States, 176 Ct. Cl. 1302, 364 F.2d 357, 362 (Ct. Cl. 1966)*, so numerical superiority of scientific studies does not require the trier of fact to accept them.

The Department task force that reviewed the Academy Report anticipated and explained the reasons for rejecting the numerically-superior documents:

> it is likely that there will be controversy surrounding any conclusion about which evidence is credible and which evidence is less so or not credible. This is clearly demonstrated by the statements of Mark Venuti of the National Veterans Legal Services Project which have been endorsed by the Vietnam Veterans of America. Many readers of the NAS report will consider all positive evidence equally "credible" despite the confidence limits of the studies or the statistical significance of the findings. There will be a tendency to look at the charts prepared by the NAS and count up those studies which could be interpreted as positive and balancing them against cited studies showing no association or a negative association. **[**28]** This was not the purpose of those charts and the NAS staff and representatives of the Committee responsible for the report findings refused to interpret their findings that way either in the report or in face-to-face meetings with VA staff or at Congressional hearings.

The Secretary explained why he rejected the petitioners' approach:

> Simply comparing the number of studies which report a negative relative risk for a particular condition is not a valid method for determining whether the weight of evidence overall supports a finding that there is or is not a positive association between herbicide exposure and the subsequent development of the particular condition. Because of difference in statistical significance, confidence levels, control for confounding factors, etc., some studies are clearly more credible than others, and the Secretary has given them more weight in evaluating the overall credibility of the evidence concerning specific diseases.

59 F.R. 342.

There is no basis for assuming that, by using the term "credible evidence" in the 1991 Act, Congress intended to preclude the Secretary from applying the traditional principle that the critical issue in **[**29]** evaluating evidence is its quality, not its quantity. The Secretary cannot be faulted for refusing to follow the more numerous studies that support the petitioners' contentions.

D. The petitioners challenge the Secretary's refusal to establish a presumption of service connection for liver and nose cancer because he did not discuss the biologic plausibility of an association between those diseases and herbicide exposure. The 1991 Act provides that "for each disease reviewed, the Academy shall determine . . . whether there exists a plausible biological mechanism or the evidence of a causal relationship between herbicide exposure and the disease." *38 U.S.C. § 1116*, note d. Although the Act did not require the Secretary to address this factor, it required him to consider the Academy report, which he admittedly did. The petitioners contend that by implication the Act required him also to discuss biologic plausibility.

The fact that the 1991 Act expressly required the Academy to consider biologic **[*1201]** plausibility but did not impose a similar requirement on the Secretary is a strong indication that the latter was not required to do so. *Russello v. United States, 464 U.S. 16, 23, 78 L. Ed. 2d 17, 104 S. Ct. 296 (1983)* **[**30]** (***HN9*** "'Where 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'" (citation omitted)). This is particularly so because the Act specified in detail exactly what were the precise duties of the Academy and the Secretary, and provided specific standards for each of them to follow. If Congress had intended the Secretary specifically to consider biologic plausibility, it is a reasonable assumption that it would have told him to do so as it did for the Academy.

The Academy Report discussed biologic plausibility, but concluded that "there is as yet no convincing evidence of, or mechanistic basis for, the carcinogenicity of any of the herbicides used in Vietnam." The Report also addressed the carcinogenicity of dioxin, a contaminant "found in varying levels in different batches of Agents Orange, Pink, Purple, and Green," and reported extensive evidence that dioxin caused cancer in laboratory animals. Although the carcinogenicity of an herbicide contaminant could be viewed as credible evidence of a positive association, **[**31]** the Secretary could reasonably conclude otherwise. This is especially so because Congress directed that the Academy was specifically to address "whether there exists a plausible biological mechanism or other evidence of a causal relationship between herbicide exposure and the disease," and the presence of dioxin in an herbicide does not compel the conclusion that there was such a relationship caused by exposure to the herbicide.
IV.

We turn to the Secretary's refusal to establish a presumption of service connection for the three cancers involved.

1. The Secretary stated the following with regard to prostate cancer:

> The NAS report assigns prostate cancer to a category labeled limited/suggestive evidence of an association, which it defined as meaning there is evidence suggestive of an association between herbicide exposure and a particular health outcome, but that evidence is limited because chance, bias, and confounding could not be ruled out with confidence. Prostate cancer is a very common male genitourinary cancer which shows marked increased prevalence with age. There are statistically significant occupational studies which show no association between prostate cancer **[**32]** and herbicide exposure (e.g., Fingerhut . . .; Manz . . . ; Saracci . . . .). Some occupational studies have shown a slight elevated risk for prostate cancer among farm and forestry workers (e.g. Burmeister . . . ; Alavanja . . .); however, only one study concerning a small sub-set of farmers (Morrison . . .) associated the increased risk of prostate cancer among farmers specifically with herbicide exposure. The Morrison study is so recent that it is too early to determine whether its results will be replicated by other research. Accordingly, the Secretary has found that the credible evidence against an association between prostate cancer and herbicide exposure outweighs the credible evidence for such an association, and he has determined that a positive association does not exist.

59 F.R. 242 (1994).

The Secretary's decision accurately analyzes and summarizes the Academy's findings and is reasonable in light of that analysis. In placing prostate cancer in the "limited/suggestive evidence of an association" category, the Academy pointed out:

> Most of the agricultural studies indicate some elevation in risk of prostate cancer. One large well-done study in farmers showed **[**33]** an increased risk, and subanalyses in this study indicate that the increased risk is specifically associated with herbicide exposure. The three major production worker studies . . . all show a small, but not statistically significant elevation in risk. . . . It should be noted, however, that most of the associations are relatively weak (< 1.5).

[*1202] The petitioners point out, and the Secretary concedes, that he erred in citing the Fingerhut, Manz, and Saracci studies as supporting the statement that "there are statistically significant occupational studies which show no association between prostate cancer and herbicide exposure." Instead, the three studies actually show a positive association, but are not statistically significant. The quoted portion of the statement, however, is not inaccurate. It would have been accurately supported if the Secretary had cited to the Ronco and Wicklund studies, which were statistically significant and showed a negative association and none at all, respectively.

HN10 We will "not reverse simply because there are uncertainties, analytical imperfections, or even mistakes in the pieces of the picture petitioners have chosen to bring to [our] attention **[**34]** . . . but only when there is such an absence of overall rational support as to warrant the description arbitrary and capricious." *Center for Auto Safety v. Peck, 243 U.S. App. D.C. 117, 751 F.2d 1336, 1370 (D.C. Cir. 1985)* (citation omitted). In this case, the Secretary's miscitation of the three studies does not so undermine the Secretary's rationale as to render it arbitrary and capricious.

The petitioners also contend that the Secretary erred in characterizing the Morrison study as a small subset. The Academy Report shows that the Secretary's statement is accurate. His statement referred to a subset of the study that covered only 20 cases of exposure to herbicides. The Secretary reasonably could have concluded that because the entire study covered 1,138 cases of exposure, this was but a small segment of the study.

The petitioners further object to the Secretary's statement that it is "too early to determine whether [Morrison's] results will be replicated by other research." They contend that this statement indicates that the Secretary misconstrued his statutory mandate to consider whether the studies are capable of replication. The Secretary's statement merely reflects the Morrison study's warning **[**35]** that the results "should be considered tentative because of the relatively low increases in risk and because an association has not been noted previously." The Secretary reasonably recognized that future research on the issue might undermine or contradict the conclusions of the Morrison study. Indeed, a further Academy report on prostate cancer was due in July 1995.

The petitioners make various arguments concerning the relative merits of the studies the Academy considered. As noted, however, it is not our function to reweigh the evidence. The Secretary's decision is reasonable based on the Academy's factual determinations, particularly its finding that almost all studies, certainly all statistically significant ones, show a weak positive association at best.

B. The Secretary stated with regard to hepatobiliary (liver) cancers

> The NAS report assigns . . . hepatobiliary cancers . . . to a category labeled inadequate/insufficient evidence to determine whether an association exists, which is defined as meaning that the available studies are insufficient quality, consistency, or statistical power to permit a conclusion regarding the presence or absence of an association with **[**36]** herbicide exposure.

. . .

> Hepatobiliary cancers are cancers of the liver and bile duct. There are a variety of risk factors that should be considered by a credible study, including hepatitis B and C, alcohol abuse, cirrhosis, exposure to . . . PCB, and smoking. The relevant studies are few and have not adequately controlled for these risk factors. A Swedish case control study (Hardell . . . 1984 . . .) showed a relationship between herbicide exposure and the subsequent development of hepatobiliary cancer; however, other studies of similar size (Ronco . . . 1992 . . .; Wiklund . . . 1983 . . .) indicated no relationship. A large occupational study (Fingerhut et al, 1991) and a study of farmers in Denmark and Italy (Ronco 1992) found no relationship. Accordingly, the Secretary has found that the credible evidence against an association between hepatobiliary cancer and herbicide exposure outweighs the credible evidence for **[*1203]** such an association, and he has determined that a positive association does not exist.

59 F.R. 343 (1994).

The Academy Report summarized the various studies as follows:

> There are relatively few occupational, environmental, or veterans studies **[**37]** of liver cancer (Table 8-6), and most of these are small in size and have not controlled for life-style-related risk factors. One of the largest studies (Hardell et al., 1984) indicates an increased risk for liver cancer and exposure to herbicides, but another study of Swedish agricultural workers (Wiklund, 1983) estimates a relative risk that is significantly less than 1.0 [i.e. a protective association]. The estimated relative risks from other studies are both positive and negative. As a whole, given the methodological difficulties associated with most of the few existing studies, the evidence regarding liver cancer is not convincing with regard to either an association with herbicides/TCDD or the lack of an association.

The petitioners contend that the Secretary erred in stating that there were few studies. This statement, however, reflects the Academy's statement based on the 18 studies that it examined. The petitioners cite no other studies that they contend the Secretary also should have considered.

According to the petitioners, the Secretary erred in failing to consider that nine studies are in favor of association, that eight are against it and that one finds no association. **[**38]** Instead, the Secretary relied on the studies with comparably sized samples, all of which were among the largest. Of the four he discussed, three do not show a positive association. Moreover, none of the 18 studies are statistically significant. Given this evidence, the Secretary reasonably concluded that the credible evidence against an association outweighed the credible evidence for one.

C. The Secretary stated with regard to nasal/nasopharyngeal cancer:

> The NAS report assigns . . . nasal/nasopharyngeal cancer to a category labeled inadequate/insufficient evidence to determine whether an association exists, which is defined as meaning that the available studies are insufficient quality, consistency, or statistical power to permit a conclusion regarding the presence or absence of an association with herbicide exposure.

. . .

> NAS noted an association between nasal cancers and occupational exposure to nickel and to chromates. Exposure to wood dust is also a risk factor for nasal cancers; smoking and exposure to formaldehyde may increase the risk associated with wood dust. There is also evidence that leather workers have an increased risk for nasal cancers and that **[**39]** there is an association between chronic nasal diseases and consumption of salt preserved foods. Most studies (e.g. Wiklund, 1983; Ronco et al. 1992) showed inconclusive results, and often did not control for confounding variables. Two other epidemiological studies based on the same three cases (Saracci et al., 1991. Coggon D., Pannett B., Winter P.D., Achedson E.D., Bonsall J., 1986. Mortality of workers exposed to 2 methyl-4-chlorophenoxyacetic acid. Scandinavian Journal of Work, Environment, and Health 12:448-454) and one case-control study (Hardell L., Johansson B. Axelson O., 1982. Epidemiological study of nasal and nasopharyngeal cancer and their relation to phenoxy acid or chlorophenol exposure. American Journal of Industrial Medicine 3 247-257) showed increased risk associated with herbicide exposure. however, that risk was not statistically significant, which diminishes the importance of these studies. Accordingly, the Secretary has found that the credible evidence against an association between nasal/nasopharyngeal cancers and herbicide exposure outweighs the credible evidence for such an association, and he has determined that a positive association does not exist.

[40]** *59 F.R. 346 (1994)*.

The Secretary's discussion again echoed the Academy's Report, which discussed numerous factors and exposures to things other than herbicides that have been associated with an increased risk of nasal cancer. It summarized the epidemiological results much as the Secretary did, noting that the Saracci **[*1204]** and Coggon studies were based on the same three cases and that the Hardell study "found [a positive association] for those exposed to phenoxy acids, based on eight exposed cases." It noted that a Center for Disease Control study of Vietnam veterans found no "significant associations for Vietnam service," and that "other studies showed inconclusive results." It summarized the epidemiologic evidence as "inadequate or insufficient . . . to determine whether an association exists between exposure to herbicides and nasal/nasopharyngeal cancer."

Aside from the biologic plausibility and numerical arguments previously discussed, the petitioners contend that the Secretary made two key errors with regard to nasal cancers. They contend that the Secretary (as did the Academy) mistakenly stated that the Sarraci and Coggon studies were based on the same three cases. Even if this **[**41]** statement was wrong, however, it did not render the Secretary's decision arbitrary or capricious. Neither he nor the Academy attached any significance to the supposedly-shared samples, but only noted the fact. It does not appear to have influenced the Secretary's conclusion. Instead, he focused on the inconclusive nature of the studies discussed, citing their lack of significance.

The petitioners also contend that the Secretary's decision was arbitrary and capricious because it did not discuss a subset of the Hardell study that showed a positive association between chlorophenol exposure and nasal cancer. The Secretary's decision discusses the Hardell study in terms of what it shows regarding "the risk associated with herbicide exposure." This shows that he was aware of the Hardell study, but considered only the part dealing with

herbicide exposure. Other than the inclusion of the subset in a table in the Academy's report, the petitioners offer no convincing reason why the chlorophenol subset was a relevant factor that the Secretary should have deemed credible evidence of a relationship between herbicide exposure and nasal cancer. They have thus failed to demonstrate that this was **[**42]** relevant evidence, and thus the Secretary's alleged failure to consider it would not be arbitrary and capricious. *Citizens to Preserve Overton Park v. Volpe, 401 U.S. 402, 416, 28 L. Ed. 2d 136, 91 S. Ct. 814 (1971)*.

AFFIRMED.

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On appeal from the
Department of Veterans Affairs Regional Office in Winston-Salem, North Carolina

THE ISSUES

1. Entitlement to an initial compensable evaluation for a residual scar of a left thumb laceration.

2. Entitlement to an initial compensable evaluation for tinea unguium of the bilateral toenails.

3. Entitlement to service connection for bilateral hearing loss.

4. Entitlement to service connection for anemia.

5. Entitlement to service connection for mixed personality disorder (claimed as post-traumatic stress disorder (PTSD)).

6. Entitlement to service connection for bilateral compound hyperopic astigmatism and anisometropic amblyopia (claimed as an eye condition).

7. Entitlement to service connection for left shoulder pain.

8. Entitlement to service connection for left ankle pain.

9. Entitlement to service connection for bilateral knee pain.

10. Entitlement to service connection for lower and thoracic back pain.

11. Entitlement to service connection for chronic upper respiratory infections.

12. Entitlement to service connection for left upper quadrant pain.

REPRESENTATION

Appellant represented by: Veterans of Foreign Wars of the United States

ATTORNEY FOR THE BOARD

K. L. Wallin, Counsel

INTRODUCTION

The Veteran served on active duty from October 2000 to September 2005.

These matters come before the Board of Veterans' Appeals (BVA or Board) on appeal from a November 2005 rating decision of the Department of Veterans Affairs (VA) Regional Office (RO) in Winston-Salem, North Carolina.

The Board notes that the November 2005 decision also denied entitlement to service connection for hemorrhoids and headaches, and the Veteran appealed these determinations. Thereafter, in an August 2006 rating decision, service connection was awarded for headaches and hemorrhoids. As the

benefits sought have been granted, the claims are no longer in appellate status.
The claims of entitlement to service connection for left shoulder, left ankle, bilateral knee, back, and left upper quadrant pain, as well as the claim for chronic upper respiratory infections, are addressed in the REMAND portion of the decision below and are REMANDED to the RO via the Appeals Management Center (AMC), in Washington, DC.

FINDINGS OF FACT

1. The Veteran has been apprised of what evidence would substantiate the claims for benefits, and the allocation of responsibility for obtaining such evidence, and all relevant medical and lay evidence obtainable and necessary to render a decision in these matters has been received.

2. The service connected residual scar of a left thumb laceration does not show symptomatology consistent with limitation of motion of the thumb with a gap of one to two inches between the thumb pad and the fingers, a superficial unstable scar, a painful scar on examination, a scar that is deep or causes limited motion in an area or areas exceeding 6 square inches, or a scar that is superficial and that does not cause limited motion in an area or areas of 144 square inches.

3. The service connected tinea unguium of the bilateral toenails does not show symptomatology consistent with dermatitis or eczema covering at least five percent, but less than 20 percent of the entire body, or at least five percent, but less than 20 percent of exposed areas affected, or intermittent systemic therapy such as corticosteroids or other immunosuppressive drugs required for a total duration of less than six weeks during a 12-month period.

4. Bilateral hearing loss disability is not shown in service and the Veteran does not currently have a diagnosis of bilateral hearing loss disability pursuant to the applicable regulation.

5. Anemia existed prior to the Veteran's period of active duty service and did not undergo an increase in severity of disability during that period. The competent medical evidence of record does not contain any currently diagnosed anemia.

6. The Veteran has been diagnosed with a mixed personality disorder, which is not a disease or injury within the applicable legislation and thus, service connection is precluded.

7. The Veteran has been diagnosed with a refractive error of the eyes (bilateral compound hyperopic astigmatism and anisometropic amblyopia), which is not a disease or injury within the applicable legislation and thus, service connection is precluded.

CONCLUSIONS OF LAW

1. The criteria for an initial compensable evaluation for a residual scar of a left thumb laceration have not been met for any period. 38 U.S.C.A. §§ 1155, 5107 (West 2002); 38 C.F.R. §§ 3.102, 3.159, 4.1-4.14, 4.71a, Diagnostic Codes 5224, 5228, 4.118, Diagnostic Codes 7801-7805 (2008).

2. The criteria for an initial compensable evaluation for tinea unguium of the bilateral toenails have not been met for any period. 38 U.S.C.A. §§ 1155, 5107 (West 2002); 38 C.F.R. §§ 3.102, 3.159, 4.1-4.14, 4.118, Diagnostic Codes 7801-7805 (2008).

3. The criteria for the establishment of service connection for bilateral hearing loss have not been met. 38 U.S.C.A. §§

1101, 1110 (West 2002); 38 C.F.R. §§ 3.102, 3.303, 3.385 (2008).

4. The criteria for the establishment of service connection for anemia have not been met. 38 U.S.C.A. §§ 1101, 1110 (West 2002); 38 C.F.R. §§ 3.102, 3.303, 3.306 (2008).

5. The criteria for the establishment of service connection for a mixed personality disorder have not been met. 38 U.S.C.A. §§ 1101, 1110 (West 2002); 38 C.F.R. §§ 3.102, 3.303 (2008).

6. The criteria for the establishment of service connection for bilateral compound hyperopic astigmatism and anisometropic amblyopia have not been met. 38 U.S.C.A. §§ 1101, 1110 (West 2002); 38 C.F.R. §§ 3.102, 3.303 (2008).

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

Duties To Notify And Assist

The Veterans Claims Assistance Act of 2000 (VCAA), codified in part at 38 U.S.C.A. §§ 5103, 5103A, and implemented at 38 C.F.R. § 3.159, amended VA's duties to notify and assist a claimant in developing the information and evidence necessary to substantiate a claim.

Under 38 U.S.C.A. § 5103, VA must notify the claimant of any information or evidence not of record that is necessary to substantiate the claim, as well as what parts of that information or evidence VA will seek to provide, and what parts VA expects the claimant to provide. 38 C.F.R. § 3.159(b) (2008).

VA must provide such notice to a claimant prior to an initial unfavorable decision on a claim for VA benefits by the agency of original jurisdiction (AOJ), even if the adjudication occurred prior to the enactment of the VCAA. See Pelegrini v. Principi, 18 Vet. App. 112, 119-120 (2004). Furthermore, the VCAA requirements of 38 U.S.C.A. § 5103(a) and 38 C.F.R. § 3.159(b) apply to all elements of a claim for service connection, so that VA must specifically provide notice that a disability rating and an effective date will be assigned if service connection is awarded. Dingess/Hartman v. Nicholson, 19 Vet. App. 473 (2006); aff'd sub nom. Hartman v. Nicholson, 483 F.3d 1311 (2007).

As to the left thumb scar residuals and bilateral toenails tinea ungum claims, these claims arise from the Veteran's disagreement with the initial rating assigned after the grant of service connection. The courts have held, and VA's General Counsel has agreed, that where an underlying claim for service connection has been granted and there is disagreement as to "downstream" questions, the claim has been substantiated and there is no need to provide additional VCAA notice or prejudice from absent VCAA notice. Hartman v. Nicholson, 483 F.3d 1311 (Fed. Cir. 2007); Dunlap v. Nicholson, 21 Vet. App. 112 (2007); VAOPGCPREC 8-2003 (2003).

The United States Court of Appeals for Veterans Claims (Court) has elaborated that filing a notice of disagreement begins the appellate process, and any remaining concerns regarding evidence necessary to establish a more favorable decision with respect to downstream elements (such as an effective date) are appropriately addressed under the notice provisions of 38 U.S.C.A. §§ 5104 and 7105 (West 2002). Goodwin v. Peake, 22 Vet. App. 128 (2008). Where a claim has been substantiated after the enactment of the VCAA, the appellant bears the burden of demonstrating any prejudice from defective VCAA notice with respect to the downstream elements. Id. There has been no allegation of such error in this case.

As to the service connection claims, VA complied with its notification responsibilities in an attachment to the June 2005 claims form, which was sent to the Veteran as part of the Benefits Delivery at Discharge (BDD) Program. This attachment notified the Veteran of the evidence needed to substantiate a service connection claim. The attachment also notified the Veteran of VA's responsibilities in obtaining information to assist the Veteran in completing her claims, and identified the Veteran's duties in obtaining information and evidence to substantiate her claims.

In March 2006, the Veteran was provided with notice of the type of evidence necessary to establish a disability rating or effective date for the pertinent claimed disabilities under consideration, pursuant to the recent holding in the Dingess decision.

VA has a duty to assist the Veteran in the development of the claim. This duty includes assisting the Veteran in the procurement of service treatment records and pertinent medical records and providing an examination when necessary. 38 U.S.C.A. § 5103A; 38 C.F.R. § 3.159. In this case, VA has made reasonable efforts to obtain relevant records adequately identified by the Veteran. The claims file includes the Veteran's service treatment records, post-service VA treatment records, and reports of VA examination.

The Board notes the Veteran's representative has argued that the July 2005 VA examination was inadequate to measure the severity of the Veteran's left thumb disability as left hand strength was not measured; however, the Board finds that the examination is adequate for rating purposes. VA's duty to assist a Veteran includes providing a thorough and contemporaneous examination when the record does not adequately reveal the current state of the Veteran's disability. Hart v. Mansfield, 21 Vet. App. 505, 508 (2007). As discussed below, the July 2005 VA examiner took a complete medical history from the Veteran and performed a physical examination, to include range of motion studies, strength testing (which was normal), and visual inspection. Radiographic studies were also performed. As the July 2005 VA examination report as well as the other evidence of record adequately reveals the current state of the Veteran's disability, a remand for a new examination is not required.

The Board finds that the VCAA provisions have been considered and complied with. The Veteran was notified and aware of the evidence needed to substantiate these claims. There is no indication that there is additional evidence to obtain or additional notice that should be provided. There is no indication that there is any prejudice to the Veteran by the order of the events in this case. See Pelegrini v. Principi, 18 Vet. App. 112 (2004); Bernard v. Brown, 4 Vet. App. 384 (1993). The Veteran's claims were last readjudicated in an August 2007 supplemental statement of the case. Any error in the sequence of events or content of the notice is not shown to have affected the essential fairness of the adjudication or to have caused injury to the Veteran. See Mayfield v. Nicholson, 499 F.3d 1317 (Fed. Cir. 2007); see also ATD Corp. v. Lydall, Inc., 159 F.3d 534, 549 (Fed. Cir. 1998).

For the reasons set forth above, the Board finds that VA has complied with the VCAA's notification and assistance requirements. The claims herein decided are thus ready to be considered on the merits.

Analysis

The Board has reviewed all the evidence in the Veteran's claims file. Although the Board has an obligation to provide adequate reasons and bases supporting this decision, there is no requirement that the evidence submitted by the appellant or obtained on her behalf be discussed in detail. Rather, the Board's analysis below will focus specifically on what

evidence is needed to substantiate each claim and what the evidence in the claims file shows, or fails to show, with respect to each claim. See Gonzales v. West, 218 F.3d 1378, 1380-81 (Fed. Cir. 2000) and Timberlake v. Gober, 14 Vet. App. 122, 128-30 (2000).

I. Claims for Higher Initial Ratings

Criteria for Rating Disabilities

Disability ratings are determined by applying the criteria set forth in the VA Schedule for Rating Disabilities (Rating Schedule) and are intended to represent the average impairment of earning capacity resulting from disability. 38 U.S.C.A. § 1155; 38 C.F.R. § 4.1. Disabilities must be reviewed in relation to their history. 38 C.F.R. § 4.1.

VA should interpret reports of examination in light of the whole recorded history, reconciling the various reports into a consistent picture so that the current rating may accurately reflect the elements of disability. 38 C.F.R. § 4.2. Any reasonable doubt regarding the degree of disability should be resolved in favor of the claimant. 38 C.F.R. § 4.3. Where there is a question as to which of two evaluations apply, the higher of the two should be assigned where the disability picture more nearly approximates the criteria for the next higher rating. 38 C.F.R. § 4.7. When considering functional impairment caused by a service-connected disorder, evaluations should be based on an assessment of the lack of usefulness, and adjudicators should consider the effects of the disabilities upon the person's ordinary activity. 38 C.F.R. § 4.10. See also Schafrath v. Derwinski, 1 Vet. App. 589 (1991).

In order to evaluate the level of disability and any changes in condition, it is necessary to consider the complete medical history of a Veteran's disability. Schafrath, 1 Vet. App. at 594. In general, the degree of impairment resulting from a disability is a factual determination and generally the Board's primary focus in such cases is upon the current severity of the disability. Francisco v. Brown, 7 Vet. App. 55, 57-58 (1994); Solomon v. Brown, 6 Vet. App. 396, 402 (1994). However, in Fenderson v. West, 12 Vet. App. 119 (1999), it was held that the rule from Francisco does not apply where the appellant has expressed dissatisfaction with the assignment of an initial rating following an initial award of service connection for that disability. Rather, at the time of an initial rating, separate ratings can be assigned for separate periods of time based on the facts found - a practice known as "staged" ratings.

Ratings shall be based as far as practicable, upon the average impairments of earning capacity with the additional proviso that the Secretary shall from time to time readjust this schedule of ratings in accordance with experience. To accord justice, therefore, to the exceptional case where the schedular evaluations are found to be inadequate, the Under Secretary for Benefits or the Director, Compensation and Pension Service, upon field station submission, is authorized to approve on the basis of the criteria set forth in this paragraph an extra-schedular evaluation commensurate with the average earning capacity impairment due exclusively to the service-connected disability or disabilities. The governing norm in these exceptional cases is: A finding that the case presents such an exceptional or unusual disability picture with such related factors as marked interference with employment or frequent periods of hospitalization as to render impractical the application of the regular schedular standards. 38 C.F.R. § 3.321(b)(1).

A. Left Thumb

The Veteran contends that her service-connected residual scar of a left thumb laceration warrants an initial compensable

rating due to difficulty with grip and grasp. Service connection for residuals of a left thumb injury to include a scar, non-dominant, was awarded in a November 2005 rating decision. The RO assigned a noncompensable disability rating effective September 2005.

The Veteran is appealing the original assignment of the noncompensable rating. As such, the severity of the disability at issue shall be considered from the initial assignment of the disability rating to the present time. See Fenderson, 12 Vet. App. at 126.

The Veteran's left thumb scar has been rated as noncompensable under 38 C.F.R. § 4.118, Diagnostic Code 7805, which instructs to rate the scar on limitation of function of the affected part. A 10 percent rating is warranted for ankylosis of the thumb or limitation of motion of the thumb with a gap of one to two inches (2.5 to 5.1 cm.) between the thumb pad and the fingers, with the thumb attempting to oppose the fingers. 38 C.F.R. § 4.71a, Diagnostic Codes 5224, 5228.

Having carefully considered the Veteran's contentions in light of the evidence of record and the applicable law, the Board finds that the evidence discussed below reflects that the Veteran's residual scar of a left thumb laceration has for the entire period of initial rating more closely approximated the criteria for the current noncompensable rating. 38 C.F.R. § 4.7.

The service treatment records show the Veteran lacerated her left thumb with a knife in February 2005. She received 5 sutures. On the July 2005 VA pre-discharge examination, the Veteran reported pain and difficulty gripping and grasping as a result of the injury. She denied time lost from work. The examiner noted that the Veteran was right hand dominant. She stated that she was able to fasten buttons, tie shoelaces, pick up paper, and tear paper without difficulty. The Veteran was able to approximate the proximal transverse crease of the palm. Her left hand strength was within normal limits.

Range of motion was as follows: radial abduction 70 degrees; palmar abduction 70 degrees; metacarpal phalangeal joint (MP) flexion 60 degrees; and interphalangeal joint (IP) flexion 60 degrees. Opposition of the thumb was within normal limits. There was no evidence of ankylosis of the thumb or any other digit. X-ray findings of the left hand were normal. The examiner found no functional impairment from the scar of the left thumb. The scar measured 0.5 cm. by 0.2 cm. There was no tenderness, disfigurement, ulceration, adherence, instability, tissue loss, keloid formation, hypopigmentation, hyperpigmentation, or abnormal texture. The examiner found that the only residuals of the left thumb injury were subjective complaints of pain and the objective scar.

VA outpatient treatment records dated between 2005 and 2007 were negative for complaints or treatment of the left thumb scar. A February 2007 neurological examination was similarly negative.

In addition, the Board notes that there are other rating criteria for the skin; however, a higher rating is not warranted under these code sections as there has been no objective evidence of a superficial unstable scar, a painful scar on examination, a scar that is deep or causes limited motion in an area or areas exceeding 6 square inches, or a scar that is superficial and that does not cause limited motion in an area or areas of 144 square inches. 38 C.F.R. § 4.118, Diagnostic Codes 7801-7804.

In sum, it appears that the Veteran's residual scar of the left thumb most nearly approximate the criteria for a noncompensable rating. A compensable rating, to include "staged" ratings, is not warranted for any period of the initial rating because the evidence does not show

symptomatology consistent with, or that more nearly approximates, limitation of motion of the thumb with a gap of one to two inches between the thumb pad and the fingers, a superficial unstable scar, a painful scar on examination, a scar that is deep or causes limited motion in an area or areas exceeding 6 square inches, or a scar that is superficial and that does not cause limited motion in an area or areas of 144 square inches. 38 C.F.R. § 4.71a, Diagnostic Codes 5224, 5228, 4.118, Diagnostic Codes 7801-7804; See Fenderson, 12 Vet. App. at 126.

Finally, the Board considered the doctrine of reasonable doubt, however, as the preponderance of the evidence is against the Veteran's claim, the doctrine is not for application. 38 U.S.C.A. § 5107(b); 38 C.F.R. §§ 4.3, 4.7.

B. Toenails

The Veteran contends that her service-connected tinea unguium of the bilateral toenails warrants an initial compensable rating due to symptoms to include exudation, itching, crusting, and shedding of the bilateral toenails. Service connection for tinea unguium of the bilateral toenails was awarded in a November 2005 rating decision. The RO assigned a noncompensable disability rating effective September 2005.

The Veteran is appealing the original assignment of the noncompensable rating. As such, the severity of the disability at issue shall be considered from the initial assignment of the disability rating to the present time. See Fenderson, 12 Vet. App. at 126.

The Veteran's toenails have been rated as noncompensable under 38 C.F.R. § 4.118, Diagnostic Code 7813, which provides that tinea unguium is to be rated as scars (Diagnostic Codes 7801-7805) or dermatitis (Diagnostic Code 7806) depending upon the predominant disability.

The predominant disability is more consistent with dermatitis or eczema. Under diagnostic code 7806, dermatitis or eczema covering less than five percent of the entire body, or less than five percent of exposed areas affected, and no more than topical therapy required during the past 12-month period. 38 C.F.R. § 4.118. A 10 percent is warranted for dermatitis or eczema covering at least five percent, but less than 20 percent of the entire body, or at least five percent, but less than 20 percent of exposed areas affected, or intermittent systemic therapy such as corticosteroids or other immunosuppressive drugs required for a total duration of less than six weeks during the past 12-month period. Id.

At the outset, the Board notes that a higher rating is not warranted under Diagnostic Codes 7801-7804 as there has been no objective evidence of a superficial unstable scar, a painful scar on examination, a scar that is deep or causes limited motion in an area or areas exceeding 6 square inches, or a scar that is superficial and that does not cause limited motion in an area or areas of 144 square inches. 38 C.F.R. § 4.118.

Having carefully considered the Veteran's contentions in light of the evidence of record and the applicable law, the Board finds that the Veteran's tinea unguium of the bilateral toenails has for the entire period of the initial rating more closely approximated the criteria for the current noncompensable rating. 38 C.F.R. § 4.7. In this regard, service treatment records show the Veteran was treated for toenail fungus. Upon VA examination in July 2005, prior to her discharge from active military service, the Veteran reported exudation, itching, shedding, and crusting of the toenails. She indicated that these symptoms occurred constantly. The Veteran denied any treatment within the past 12 months for the condition. There was no functional impairment resulting from the tinea unguium. The Veteran denied any time lost from work.

Physical examination showed only crusting of the toenails. There was no ulceration, exfoliation, tissue loss, induration, inflexibility, hypopigmentation, hyperpigmentation, abnormal texture or limitation of motion. The skin lesion was not in an exposed area. The skin lesion covered an area relative to less than one percent of the whole body. Tinea unguium was not associated with a systemic disease and did not manifest in connection with a nervous condition. Examination of the feet did not show any signs of abnormal weight bearing. Gait was within normal limits and the Veteran did not require an assistive device for ambulation.

VA outpatient treatment records dated between 2005 and 2007 were negative for complaints or treatment of the toenails.

In sum, it appears that the Veteran's tinea unguium of the bilateral toenails most nearly approximate the criteria for a noncompensable rating. A compensable rating, to include "staged" ratings, is not warranted for any period of the initial rating because the evidence does not show symptomatology consistent with, or that more nearly approximates, dermatitis or eczema covering at least five percent, but less than 20 percent of the entire body, or at least five percent, but less than 20 percent of exposed areas affected, or intermittent systemic therapy such as corticosteroids or other immunosuppressive drugs required for a total duration of less than six weeks during the past 12-month period. 38 C.F.R. § 4.118, Diagnostic Code 7806, 7813; See Fenderson, 12 Vet. App. at 126.

Finally, the Board considered the doctrine of reasonable doubt, however, as the preponderance of the evidence is against the Veteran's claim, the doctrine is not for application. 38 U.S.C.A. § 5107(b); 38 C.F.R. §§ 4.3, .7.

C. Extraschedular Rating Considerations

Pursuant to § 3.321(b)(1), the Under Secretary for Benefits or the Director, Compensation and Pension Service, is authorized to approve an extraschedular evaluation if the case "presents such an exceptional or unusual disability picture with such related factors as marked interference with employment or frequent periods of hospitalization as to render impractical the application of the regular schedular standards." The question of an extraschedular rating is a component of a claim for an increased rating. See Bagwell v. Brown, 9 Vet. App. 337, 339 (1996). Although the Board may not assign an extraschedular rating in the first instance, it must specifically adjudicate whether to refer a case for extraschedular evaluation when the issue either is raised by the claimant or is reasonably raised by the evidence of record. Barringer v. Peake, 22 Vet. App. 242 (2008).

If the evidence raises the question of entitlement to an extraschedular rating, the threshold factor for extraschedular consideration is a finding that the evidence before VA presents such an exceptional disability picture that the available schedular evaluations for that service-connected disability are inadequate. Therefore, initially, there must be a comparison between the level of severity and symptomatology of the claimant's service-connected disability with the established criteria found in the rating schedule for that disability. Thun v. Peake, 22 Vet. App. 111 (2008).

Under the approach prescribed by VA, if the criteria reasonably describe the claimant's disability level and symptomatology, then the claimant's disability picture is contemplated by the rating schedule, the assigned schedular evaluation is, therefore, adequate, and no referral is required. In the second step of the inquiry, however, if the schedular evaluation does not contemplate the claimant's level of disability and symptomatology and is found inadequate, the RO or Board must determine whether the claimant's exceptional disability picture exhibits other related factors such as those provided by the regulation as

"governing norms." 38 C.F.R. 3.321(b)(1) (related factors include "marked interference with employment" and "frequent periods of hospitalization"). When the rating schedule is inadequate to evaluate a claimant's disability picture and that picture has related factors such as marked interference with employment or frequent periods of hospitalization, then the case must be referred to the Under Secretary for Benefits or the Director of the Compensation and Pension Service for completion of the third step-a determination of whether, to accord justice, the claimant's disability picture requires the assignment of an extraschedular rating. Id.

The discussion above reflects that the symptoms of the Veteran's left thumb laceration scar and bilateral toenails tinea unguium are contemplated by the applicable rating criteria. Thus, consideration of whether the Veteran's disability picture exhibits other related factors such as those provided by the regulations as "governing norms" is not required. In any event, the Veteran indicated that she has not lost any time from work due to the service-connected disabilities, there is no evidence revealing frequent periods of hospitalization, and there is no indication that the Veteran's symptoms have otherwise rendered impractical the application of the regular schedular standards. Therefore, referral for consideration of an extraschedular evaluation for either of the service-connected disabilities addressed herein is not warranted. 38 C.F.R. § 3.321(b)(1).

II. Service Connection

Criteria

Service connection may be established for a disability resulting from disease or injury incurred in or aggravated by service. 38 U.S.C.A. § 1110; 38 C.F.R. § 3.303. Evidence of continuity of symptomatology from the time of service until the present is required where the chronicity of a condition manifested during service either has not been established or might reasonably be questioned. 38 C.F.R. § 3.303(b). Regulations also provide that service connection may be granted for any disease diagnosed after discharge, when all the evidence, including that pertinent to service, establishes that the disability was incurred in service. 38 C.F.R. § 3.303(d).

Moreover, where a Veteran served continuously for ninety (90) days or more during a period of war, or during peacetime service after December 31, 1946, and sensorineural hearing loss becomes manifest to a degree of at least 10 percent within one year from date of termination of such service, such disease shall be presumed to have been incurred in service, even though there is no evidence of such disease during the period of service. This presumption is rebuttable by affirmative evidence to the contrary. 38 U.S.C.A. §§ 1101, 1112, 1113, 1137 (West 2002); 38 C.F.R. §§ 3.307, 3.309.

Generally, in order to prevail on the issue of service connection there must be medical evidence of a current disability; medical evidence, or in certain circumstances, lay evidence of in- service occurrence or aggravation of a disease or injury; and medical evidence of a nexus between an in-service injury or disease and the current disability. See Hickson v. West, 12 Vet. App. 247, 253 (1999); see also Pond v. West, 12 Vet App. 341, 346 (1999).

A. Bilateral Hearing Loss

The Veteran contends that she is entitled to service connection for bilateral hearing loss. She has set forth no specific incident as to service incurrence, but did inform the VA examiner that she had "significant" noise exposure

during military service.

Having carefully considered the Veteran's claim in light of the record and the applicable law, the Board finds that the preponderance of the evidence is against the Veteran's claim and the appeal as to this issue will be denied.

The Board finds that it does not appear from the record that the Veteran has a diagnosed hearing loss disability. Pursuant to 38 C.F.R. § 3.385, impaired hearing will be considered to be a disability when the auditory threshold in any of the frequencies 500, 1000, 2000, 3000, 4000 Hertz is 40 decibels or greater, or when at least three of the frequencies 500, 1000, 2000, 3000, 4000 Hertz are 26 decibels or greater, or when speech recognition scores using the Maryland CNC Test are less than 94 percent.

Service treatment records do show the Veteran had some routine noise exposure and here was some evidence of diminished hearing. For example, as noted by the Veteran's representative in the March 2009 informal hearing presentation, a July 2001 VA audiogram showed pure tone thresholds of between 15 and 30 decibels at the relevant frequencies. However, neither this nor any other audiograms showed the auditory threshold in any of the frequencies to be 40 or more decibels, the auditory thresholds of three of the frequencies to be 26 decibels or greater, or speech recognition scores less than 94 percent. Thus, there is no evidence of a hearing loss disability in service.

However, the absence of in- service evidence of hearing loss is not fatal to a claim for that disability. See Ledford v. Derwinski, 3 Vet. App. 87, 89 (1992). Evidence of a current hearing loss disability (i.e., one meeting the requirements of 38 C.F.R. § 3.385) and a medically sound basis for attributing such disability to service may serve as a basis for a grant of service connection for hearing loss. See Hensley v. Brown, 5 Vet. App. 155, 159 (1993).

The Veteran's claim in this case must be denied because the evidence reflects that she does not have a current hearing loss disability. See Brammer v. Derwinski, 3 Vet. App. 223, 225 (1992); see also McClain v. Nicholson, 21 Vet. App. 319, 321 (2007) (the requirement of the existence of a current disability is satisfied when a Veteran has a disability at the time he files his claim for service connection or during the pendency of that claim, even if the disability resolves prior to adjudication of the claim). Id. at 321.

The July 2005 report of VA examination on file notes that the Veteran has problems with difficulty understanding conversational speech, but they do not show that these problems with hearing are so severe as to cause a hearing loss disability as defined by 38 C.F.R. § 3.385. Pure tone thresholds, in decibels, were as follows:

HERTZ

500
1000
2000
3000
4000
RIGHT
10
10
5
5
5
LEFT
10

5
10
5
5

Speech audiometry revealed speech recognition ability of 100 percent bilaterally. The diagnosis was no measurable hearing loss, according to VA standards, in either ear.

Thus, in the absence of a current hearing loss disability, an essential element of the claim has not been established.

Though the Veteran contends that she currently has bilateral hearing loss that is related to her military service, there is no medical evidence on file supporting the Veteran's assertions and her statements do not constitute competent evidence of a medical diagnosis or nexus opinion. Espiritu v. Derwinski, 2 Vet. App. 492, 494-95 (1992).

In sum, the evidence is not in relative equipoise. The file contains no record of hearing loss during service or hearing loss for VA compensation purposes thereafter. The record does not contain any medical evidence diagnosing hearing loss disability for VA compensation purposes, nor does it contain medical evidence linking either condition to service. Thus, the preponderance of the evidence is against the claim and the appeal must therefore be denied. 38 U.S.C.A. § 5107(b); Ortiz v. Principi, 274 F.3d 1361, 1364 (Fed. Cir. 2001); Gilbert v. Derwinski, 1 Vet. App. 49, 55-57 (1990).

B. Anemia

The Veteran essentially contends that she is entitled to service connection for anemia. She has not set forth any specific incident as to service incurrence or arguments as to why her pre-existing anemia was aggravated during her active military service.

Considering the evidence of record, summarized in pertinent part below, and in light of the applicable laws and regulations, the Veteran's claim must be denied. In this regard, every Veteran shall be taken to have been in sound condition when examined, accepted, and enrolled for service, except as to defects, infirmities, or disorders noted at the time of the examination, acceptance, and enrollment, or where clear and unmistakable evidence demonstrates that the injury or disease existed before acceptance and enrollment and was not aggravated by such service. 38 U.S.C.A. § 1111.

To rebut the presumption of sound condition under section 1111 of the statute for disorders not noted on the entrance or enlistment examination, VA must show by clear and unmistakable evidence both that the disease or injury existed prior to service and that the disease or injury was not aggravated by service. VAOPGCPREC 3-2003 (July 16, 2003).

Clear and unmistakable evidence is a more formidable evidentiary burden than the preponderance of the evidence standard. See Vanerson v. West, 12 Vet. App. 254, 258 (1999) (noting that "clear and convincing" burden of proof, while a higher standard than a preponderance of the evidence, is a lower burden to satisfy than clear and unmistakable evidence). It is an "onerous" evidentiary standard, requiring that the no-aggravation result be "undebatable". Cotant v. West, 17 Vet. App. 116, 131 (2003) (citing Laposky v. Brown, 4 Vet. App. 331, 334 (1993) (citing Akins v. Derwinski, 1 Vet. App. 228, 232 (1991)) and Vanerson, 12 Vet. App. at 258, 261; Id. at 263 (Nebeker, C.J., concurring in part and dissenting in part).

Concerning clear and unmistakable evidence that the disease or injury was not aggravated by service, the second step necessary to rebut the presumption of soundness, a lack of aggravation may be shown by establishing that there was no increase in disability during service or that any increase in disability was due to the natural progress of the preexisting

condition. Wagner v. Principi, 370 F.3d 1089, 1096 (Fed. Cir. 2004); 38 U.S.C.A. § 1153.

Where a preexisting disease or injury is noted on the entrance examination, section 1153 of the statute provides that "[a] preexisting injury or disease will be considered to have been aggravated by active military, naval, or air service, where there is an increase in disability during such service, unless there is a specific finding that the increase in disability is due to the natural progress of the disease." 38 U.S.C.A. § 1153; 38 C.F.R. § 3.306(a).

For Veterans who served during a period of war or after December 31, 1946, clear and unmistakable evidence is required to rebut the presumption of aggravation where the pre-service disability underwent an increase in severity during service, and clear and unmistakable evidence includes medical facts and principles which may be considered to determine whether the increase is due to the natural progress of the condition. 38 C.F.R. § 3.306(b).

Temporary or intermittent flare-ups of symptoms of a preexisting condition, alone, do not constitute sufficient evidence for a non-combat Veteran to show increased disability for the purposes of determinations of service connection based on aggravation under section 1153 unless the underlying condition worsened. Davis v. Principi, 276 F. 3d 1341, 1346-47 (Fed. Cir. 2002); Hunt v. Derwinski, 1 Vet. App. 292, 297 (1991).

In addition, under section 3.310(a) of VA regulations, service connection may be established on a secondary basis for a disability, which is proximately due to, or the result of service-connected disease or injury. 38 C.F.R. § 3.310(a). Establishing service connection on a secondary basis requires evidence sufficient to show (1) that a current disability exists and (2) that the current disability was either (a) proximately caused by or (b) proximately aggravated by a service-connected disability. Allen v. Brown, 7 Vet. App. 439, 448 (1995) (en banc).

In this matter, the Veteran's service treatment records show that anemia was found upon enlistment examination in January 1999. The examiner noted that hemoglobin was low. The examiner also noted that the Veteran had been anemic since September 1998. Thus, it appears that the disability for which the Veteran is claiming service connection was "noted" at entry, and the presumption of sound condition did not attach.

Testing in April 2000 showed a hemoglobin level of 11. In July 200, hemoglobin was still low normal. A waiver was recommended. The Veteran was found qualified for service.

The Veteran did not receive any treatment on active duty for anemia. Upon VA examination in July 2005, prior to her discharge, the Veteran denied any treatment for anemia. Laboratory testing showed the Veteran's hemoglobin level was 11.7. The examiner found this to be nonsignificant. The examiner concluded there was no pathology to render a diagnosis of anemia.

It is clear from the evidence delineated above, that anemia existed prior to the Veteran's military service. In the case of aggravation, the pre-existing disease or injury will be considered to have been aggravated where there is an increase in disability during service, unless there is a specific finding that the increase is due to the natural progress of the disease. See 38 U.S.C.A. § 1153; 38 C.F.R. §§ 3.304, 3.306(a).

There has been no showing that the anemia underwent an increase in disability during service. Wagner, 370 F.3d at 1096; 38 U.S.C.A. § 1153. Significantly, while the Veteran claims to have suffered from chronic anemia since 2001 productive of light-headedness, headaches, fatigability,

weakness and shortness of breathe, she has submitted no evidence in support of her claim.
Beyond the initial notation of anemia in January 1999, there was no treatment during the Veteran's active military service for anemia. Similarly, there was no evidence of post-service treatment for anemia.

Aggravation may not be conceded where the disability underwent no increase in severity during service on the basis of all the evidence of record pertaining to the manifestations of the disability prior to, during and subsequent to service.
38 C.F.R. § 3.306(b). It is clear from the evidence that anemia both existed prior to service and was not aggravated by his active military service. VAOPGCPREC 3-2003 (July 16, 2003).

In addition, as noted above, Congress specifically limits entitlement for service-connected disease or injury to cases where inservice incidents have resulted in a disability. See 38 U.S.C.A. § 1110. In the absence of proof of present disability there can be no valid claim. Brammer v. Derwinski, 3 Vet. App. at 225. Here, there is no current diagnosis of anemia. Without a diagnosed disability, service connection cannot be granted.

The evidence is not in relative equipoise. Thus, the preponderance of the evidence is against the claim, and the appeal must therefore be denied. 38 U.S.C.A. § 5107(b); Ortiz, 274 F.3d at 1364; Gilbert, 1 Vet. App. at 55-57.

C. Personality Disorder

The Veteran contends that she is entitled to service connection for her mixed personality disorder. When the Veteran originally filed her claim, she indicated that she had PTSD as a result of her Gulf War service.

Having carefully considered the Veteran's claim in light of the record and the applicable law, the Board finds that the preponderance of the evidence is against the Veteran's claim and the appeal as to this issue will be denied.

At the outset, the Board notes that in order for a claim for service connection for PTSD to be successful, there must be: (1) medical evidence diagnosing the condition in accordance with 38 C.F.R. § 4.125(a); (2) a link, established by medical evidence, between the current symptoms and an in-service stressor; and
(3) credible supporting evidence that the claimed in-service stressor occurred.
38 C.F.R. § 3.304(f).

In the instant case, the August 2005 VA examiner found that the Veteran did not meet the criteria for a diagnosis of PTSD because there was no stressor or trauma. As such, compensation may not be awarded on this basis. Id.

The Veteran has however been diagnosed with a personality disorder for which service connection is precluded. While VA outpatient treatment records dated in March 2007 note the Veteran was mildly depressed because she wasn't working, a formal diagnosis was not rendered. The only diagnosed mental health disorder is the mixed personality disorder and pursuant to 38 C.F.R. § 3.303 (c), personality disorders are not disease or injuries within the applicable legislation.

D. Compound Hyperopic Astigmatism and Anisometropic Amblyopia

The Veteran contends that she is entitled to service connection for her "eye condition." She has not set forth any specific incident as to service incurrence.

Having carefully considered the Veteran's claim in light of

the record and the applicable law, the Board finds that the preponderance of the evidence is against the Veteran's claim and the appeal as to this issue will be denied.

In the instant case, service treatment records simply show the Veteran had a refractive error in the left eye. Records dated in October 2000 indicate the Veteran had early keratoconus; however, there were no further notations in service or any current findings thereof.

Upon VA examination in August 2005, prior to her discharge from service, the examiner noted the Veteran's reported that her ocular history was remarkable for strabismus in the left eye and color blindness, which was refuted as shown below. Ophthalmic examination showed the Veteran's uncorrected distance visual acuity was 20/25 in the right eye and 20/50 in the left eye. Her uncorrected near vision was 20/25 in the right eye and 20/50 in the left eye. The pupils were equal and reactive. The confrontation visual fields to finger counting were full bilaterally.

Goldmann visual field test was full and normal bilaterally. Extraocular muscles were full. There was no double vision. Intraocular pressure was 11 bilaterally. The angles were open and not occludible. The external examination was within normal limits. The conjuctiva was clear. There was some endothelial changes present in the left eye. Iris, anterior chamber, and lens were clear, as was the vitreous bilaterally. The macula was clear. There were no retinal breaks or detachments. Color vision test was normal. There was no strabismus noted on examination. The Veteran was diagnosed with compound hyperopic astigmatism greater in the left eye than the right. She was also diagnosed with anisometropic amblyopia secondary to the difference in hyperopia and astigmatism between the eyes. The examiner found the Veteran's complaints to be refractive in nature. She was given a prescription for new glasses.

VA outpatient treatment records dated between 2005 and 2007 were negative for treatment referable to the eyes.

The Veteran has a refractive error for which service connection is precluded. Pursuant to 38 C.F.R. § 3.303 (c) refractive errors of the eye are not diseases or injuries within the applicable legislation.

ORDER

Entitlement to an initial compensable evaluation for a residual scar of a left thumb laceration is denied.

Entitlement to an initial compensable evaluation for tinea unguium of the bilateral toenails is denied.

Entitlement to service connection for bilateral hearing loss is denied.

Entitlement to service connection for anemia is denied.

Entitlement to service connection for mixed personality disorder (claimed as PTSD) is denied.

Entitlement to service connection for bilateral compound hyperopic astigmatism and anisometropic amblyopia (claimed as an eye condition) is denied.

REMAND

The Veteran has also filed claims of entitlement to service connection for left shoulder, left ankle, bilateral knee, back, and left upper quadrant pain, as well as chronic upper respiratory infections. A determination has been made that additional evidentiary development is necessary. Accordingly, further appellate consideration will be deferred

and this case remanded for action as described below.

The Board's review of the evidentiary record discloses that while the Veteran has been afforded examinations by VA to properly ascertain the nature and extent of severity of the disabilities at issue, she has recently argued that she is entitled to service connection for the symptoms noted above on a presumptive basis, as a Persian Gulf Veteran who exhibits objective indications of "a qualifying chronic disability" that became manifest during active military, naval or air service in the Southwest Asia theater of operations during the Persian Gulf War, or to a degree of 10 percent or more not later than not later than December 31, 2011. 38 C.F.R. § 3.317(a)(1).

The Veteran's DD-214 shows she served in Afghanistan from October 2002 to March 2003 and in Iraq from March 2004 to September 2004. As such, she is considered a Persian Gulf War Veteran. 38 C.F.R. § 3.317(d).

Service treatment records contain treatment for upper respiratory infections, as well as bilateral knee, left shoulder, left upper quadrant, and back pain. There was no pathology found to diagnosis left shoulder, left ankle, bilateral knee, back, or left upper quadrant disorders. The July 2005 VA examination simply noted left shoulder, left ankle, bilateral knee, back, and left upper quadrant pain. Chronic upper respiratory infections were not found upon examination.

VA outpatient treatment records dated between 2005 and 2007 show the Veteran continued to complain of joint and abdominal pain. There was some indication that the Veteran may have patellofemoral syndrome of the knees and/or irritable bowel syndrome. No definitive diagnoses have been attached to the claimed disorders, they remain undiagnosed.

Since the Veteran recently articulated this theory of entitlement in the March 2009 Informal Hearing Presentation, the claims have not been developed and/or adjudicated by the RO on this basis. Moreover, separate theories in support of a claim for a particular disability are to be adjudicated as a single claim. See Robinson v. Mansfield, 21 Vet. App. 545, 550-51 (2008), citing Bingham v. Principi, 421 F.3d. 1346, 1349 (Fed. Cir. 2005). A remand is therefore necessary to address this theory of entitlement with regard to these claims and to afford the Veteran additional VA examinations to ascertain the etiology of disabilities at issue claimed to be due to her active service in the Persian Gulf.

Finally, ongoing VA medical records dated subsequent to August 2007 pertinent to the issues should also be obtained. 38 U.S.C.A. § 5103A(c) (West 2002); see also Bell v. Derwinski, 2 Vet. App. 611 (1992) (VA medical records are in constructive possession of the agency, and must be obtained if the material could be determinative of the claim).

Accordingly, the case is REMANDED for the following action:

1. The RO should obtain any outstanding VA and/or private treatment records not on file pertaining to the issues subject to this REMAND. All requests for records and their responses should be clearly delineated in the claims folder.

2. The RO should arrange for a VA medical examination of the Veteran by appropriate medical examiners familiar with Persian Gulf War diseases for the purpose of ascertaining whether the Veteran's left shoulder, left ankle, bilateral knee, lower and thoracic back, and left upper quadrant pain, as well as chronic upper respiratory infections, represent an objective indication of

chronic disability resulting from an undiagnosed illness related to the Veteran's Persian Gulf War service, or a medically unexplained chronic multisymptom illness, which is defined by a cluster of signs or symptoms.

The claims file and a separate copy of this remand must be made available to and reviewed by the examiner or examiners prior and pursuant to conduction and completion of the examinations. The examiner or examiners must annotate the examination reports that the claims file was in fact made available for review in conjunction with the examinations. Any further indicated special studies must be conducted.
The examiner must address the following medical issues:

As to the Veteran's left shoulder, left ankle, bilateral knee, lower and thoracic back, and left upper quadrant pain, as well as chronic upper respiratory infections, do any of these symptoms represent an objective indication of chronic disability resulting from an undiagnosed illness related to the Veteran's Persian Gulf War service, or a medically unexplained chronic multisymptom illness, which is defined by a cluster of signs or symptoms.

Any opinions expressed by the examiner or examiners must be accompanied by a complete rationale.

3. The Veteran must be given adequate notice of the date and place of any requested examination. A copy of all notifications, including the address where the notice was sent must be associated with the claims folder. The Veteran is to be advised that failure to report for a scheduled VA examination without good cause shown may have adverse effects on her claims.

4. After the development requested above has been completed to the extent possible, the AMC/RO should again review the record and readjudicate the claims under all appropriate statutory and regulatory provisions and legal theories. If any benefit sought on appeal remains denied, the Veteran and her representative, if any, should be furnished a supplemental statement of the case. The Veteran should be afforded an appropriate time period for response before the claims file is returned to the Board for further appellate consideration.

The purpose of this remand is to assist the Veteran with the development of her claims. The Veteran has the right to submit additional evidence and argument on the matters the Board has remanded. Kutscherousky v. West, 12 Vet. App. 369 (1999).

No action is required of the Veteran until further notice. However, the Board takes this opportunity to advise the Veteran that the conduct of the efforts as directed in this remand, as well as any other development deemed necessary, is needed for a comprehensive and correct adjudication of her

claims. Her cooperation in VA's efforts to develop her claims, including reporting for any scheduled VA examinations, is both critical and appreciated.

These claims must be afforded expeditious treatment. The law requires that all claims that are remanded by the Board of Veterans' Appeals or by the United States Court of Appeals for Veterans Claims for additional development or other appropriate action must be handled in an expeditious manner. See 38 U.S.C.A. §§ 5109B, 7112 (West Supp. 2008).

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J. HAGER
Veterans Law Judge, Board of Veterans' Appeals

Department of Veterans Affairs

Citation Nr: 1545642
Decision Date: 10/27/15 Archive Date: 11/02/15

DOCKET NO. 09-31 999) DATE
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On appeal from the
Department of Veterans Affairs Regional Office in Montgomery, Alabama

THE ISSUE

Entitlement to service connection for a disability manifested by left knee pain, to include as due to an undiagnosed illness.

REPRESENTATION

Appellant represented by: Disabled American Veterans

ATTORNEY FOR THE BOARD

M. Thomas, Associate Counsel

INTRODUCTION

The Veteran served on active duty from April 1985 to March 1988 and from January 2005 to April 2006, including service in Afghanistan from March 2005 to March 2006.

The Board previously denied the appeal for service connection for a bilateral knee disorder in October 2000. The Veteran did not appeal. In January 2007, he filed an application to reopen the claim for entitlement to service connection for a bilateral knee disorder. In December 2012, the Board reopened and remanded the claim for further development. In June 2013, the RO granted service connection for the right knee, constituting a full grant of the benefit as to the right knee. Therefore, the only remaining issue on appeal is entitlement to service connection for the left knee.

FINDINGS OF FACT

1. The Veteran served in the Southwest Asia theater of operations during the Persian Gulf War.

2. The Veteran left knee pain has manifested to a compensable degree and has not been attributed to a known clinical diagnosis.

CONCLUSION OF LAW

A disability manifested by left knee pain was incurred in service. 38 U.S.C.A. §§ 1110, 1117, 5103(a), 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.102, 3.303, 3.317 (2015).

REASONS AND BASES FOR FINDINGS AND CONCLUSION

Under the relevant laws and regulations, service connection may be granted for a disability resulting from disease or injury incurred in or aggravated by active service. 38 U.S.C.A. §§ 1110, 1131; 38 C.F.R. § 3.303(a). Service connection will be granted if the evidence demonstrates that a current disability resulted from an injury or disease incurred in or aggravated by active military service. 38 U.S.C.A. § 1110; 38 C.F.R. § 3.303(a).

Establishing service connection generally requires competent evidence of three things: (1) a current disability; (2) in-service incurrence or aggravation of a disease or injury; and (3) a causal relationship, i.e., a nexus, between the current disability and an in-service precipitating disease, injury, or event. Fagan v. Shinseki, 573 F.3d 1282, 1287 (Fed. Cir. 2009); 38 C.F.R. § 3.303(a). Consistent with this framework, service connection is warranted for a disease first diagnosed after discharge when all of the evidence, including that pertinent to service, establishes that the disease was incurred in service. 38 C.F.R. § 3.303(d).

Service connection may be granted to a Persian Gulf veteran who exhibits objective indications of chronic disability resulting from an undiagnosed illness. 38 U.S.C.A. § 1117(a); 38 C.F.R. § 3.317(a). A Persian Gulf veteran is one who served in the Southwest Asia theater of operations during the Persian Gulf War. 38 U.S.C.A. § 1117(f); 38 C.F.R. § 3.317(e). The symptoms must be manifest to a degree of 10 percent or more during the presumptive periods prescribed by the Secretary or by December 31, 2016. By history, physical examination and

laboratory tests, the disability cannot be attributed to any known clinical diagnosis.

Objective indications of chronic disability include both 'signs' in the medical sense of objective evidence perceptible to an examining physician, and other, non-medical indicators that are capable of independent verification. Disabilities that have existed for 6 months or more and disabilities that exhibit intermittent episodes of improvement and worsening over a 6-month period will be considered chronic. 38 U.S.C.A. § 1117; 38 C.F.R. § 3.317. The signs and symptoms which may be manifestations of undiagnosed illness include joint pain. 38 U.S.C.A. §§ 1117(g)(5); 38 C.F.R. § 3.317(b)(5).

The Veteran served in the Southwest Asia theater of operations between March 2005 and March 2006, during the Persian Gulf War. Therefore, he is a Persian Gul veteran as defined by the regulations. Next, he has experienced left knee pain since that time which is accurately characterized as an undiagnosed illness as it has not been attributed to a known clinical diagnosis.

His VA medical treatment records consistently refer to his having left knee pain, but the only diagnosis is for arthralgia, which "is defined as pain in a joint." Lichtenfels v. Derwinski, 1 Vet. App. 484, 488 (1991). All of the left knee X-rays show no abnormality. While he complained of knee pain during his first period of active duty in the 1980s, it appears that this pain resolved and is unrelated to the pain he reports since his service in Afghanistan. Therefore, left knee pain constitutes an undiagnosed illness that is most similar to, but is not a diagnosis of, arthritis.

Next, the regulations provide that, when rating disabilities based on limitation of motion, the intent of the Rating Schedule is to "recognize painful motion with joint or periarticular pathology as productive of disability," as well as to recognize that "actually painful" joints, due to healed injury, are entitled to at least the minimum compensable rating for the joint. 38 C.F.R. § 4.59.

Similarly, disability of the musculoskeletal system is primarily the inability, due to damage or infection in parts of the system, to perform the normal working movements of the body with normal excursion, strength, speed, coordination and endurance. Functional loss may be due to the absence or deformity of structures or other pathology, or it may be due to pain, supported by adequate pathology and evidenced by the visible behavior in undertaking the motion. 38 C.F.R. § 4.40.

As the Board has contemplated undiagnosed left knee pain as analogous to arthritis, Diagnostic Code (DC) 5010 instructs that arthritis to be rated under DC 5003, which, in turn, provides a minimum 10 percent rating on the basis of painful arthritis and noncompensable limitation of motion caused by pain. See 38 C.F.R. § 4.71a. Limitation of motion may be used to rate disabilities of the joints of the knees and the provisions of 38 C.F.R. § 4.59 have a bearing even with respect to joint disorders that do not involve arthritis. See Burton v. Shinseki, 25 Vet. App. 1 (2011) (38 C.F.R. § 4.59 provides for a minimum 10 percent rating for painful, unstable, or malaligned joints that involve residuals of injuries in non-arthritis contexts).

The medical treatment records include several objective indications of compensable chronic disability. The VA medical treatment records repeatedly report complaints of left knee pain, dating back to 2005. In a January 2013 VA examination, the examiner reported that the Veteran's left knee flexion ended at 130 degrees, while the normal endpoint is 140 degrees. These objective indications of chronic left knee disability have existed for six months or more.

In sum, the undiagnosed chronic disability of the left knee discussed above is analogous to arthritis. Under 38 C.F.R. § 4.59, the symptoms of pain and limitation of motion is deemed to have manifested to a degree of 10 percent or more, the minimum compensable rating for the joint, not later than December 31, 2016. Therefore, the disability manifested by left knee pain resulted from an undiagnosed illness and service connection is warranted.

As the benefits sought have been granted in full, discussion of the Veterans Claims Assistance Act of 2000 is unnecessary.

ORDER

Service connection for a disability manifested by left knee pain is granted.

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L. HOWELL
Veterans Law Judge, Board of Veterans' Appeals

Department of Veterans Affairs

Citation Nr: 1301299
Decision Date: 01/14/13 Archive Date: 01/23/13

DOCKET NO. 06-12 828) DATE
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On appeal from the
Department of Veterans Affairs Regional Office in San Juan, the Commonwealth of Puerto Rico

THE ISSUES

1. Entitlement to service connection for depressive disorder, not otherwise specified (NOS).

2. Entitlement to service connection for an acquired psychiatric disability other than depressive disorder, including, but not limited to posttraumatic stress disorder (PTSD), generalized anxiety disorder, and major depressive disorder.

3. Entitlement to service connection for a chronic headaches disability.

4. Entitlement to a higher initial disability rating for the service-connected lumbar paravertebral myositis and muscle spasm with early degenerative changes from L3 to S1 (lumbar spine disability) rated as 30 percent disabling from December 21, 2003 and rated as 40 percent disabling from April 4, 2005.

5. Entitlement to an effective date prior to March 18, 2004 for the grant of service connection for hypertension.

6. Entitlement to an initial compensable disability rating for the service-connected right knee patellar tendonitis, status post anterior cruciate ligament (ACL) repair.

7. Entitlement to service connection for an ear disorder, other than tinnitus.

8. Entitlement to service connection for a disability of the cervical spine.

9. Entitlement to service connection for joint pain, muscular pain, loss of memory, dizziness, rash, fatigue and shortness of breath, to include as part of an undiagnosed illness pursuant to 38 C.F.R. § 3.317.

10. Entitlement to a total disability rating for compensation purposes based on individual unemployability due to service-connected disabilities (TDIU).

REPRESENTATION

Appellant represented by: Keith Snyder, Attorney

ATTORNEY FOR THE BOARD

L.B. Cryan, Counsel

INTRODUCTION

The Veteran served on active duty from September 1999 to December 2003.

This case is before the Board of Veterans' Appeals (Board) on appeal from rating decisions issued in, May 2004, February 2005 and August 2005 by the San Juan, Puerto Rico Regional Office (RO) of the Department of Veterans Affairs (VA) .

The case has a complicated procedural history. The Veteran filed his initial claim of service connection in January 2004, just one month after his discharge from active duty. In a May 2004 rating decision, the RO granted service connection for lumbar paravertebral myositis and muscle spasm with early degenerative changes from L3 to S1 (low back disability) and assigned an initial 30 percent rating, effective from December 21, 2003, the day following the Veteran's last day of active service. The RO also granted service connection for hypertension and assigned an initial disability rating of 10 percent, effective from March 18, 2004. In addition, the RO granted service connection for right knee patellar tendonitis (right knee disability) and assigned a noncompensable rating, effective from December 21, 2003. Finally, the RO denied claims of service connection for an ear condition, headaches of the migraine type and an acquired psychiatric disorder variously diagnosed. Notice of the May 2004 rating decision was sent to the Veteran in May 2004.

In a June 2004 notice of disagreement (NOD), the Veteran specifically indicated disagreement with the following:

1. Ear Condition (Tinnitus)
2. Migraine Headaches

3. Depressive Disorder, Anxiety, Stress, Nightmares
4. Lower Back Condition
5. Hypertension - Effective Date Should Be the Date of My Claim

Notably, this was the first time that the Veteran had specifically mentioned tinnitus, and the RO therefore treated that as a new claim of service connection for tinnitus, separate and apart from the issue of service connection for an ear condition. In a separate statement, also received in June 2004, the Veteran filed the following new claims of service connection: (1) neuropathy on both arms; (2) skin condition; (3) stomach condition. Possible irritated bowel condition; (4) chronic joint pain (all); and (5) upper cervical condition.

In a December 2004 rating decision, the RO granted service connection for carpal tunnel syndrome (CTS) of the right and left hands and assigned separate 10 percent disability ratings for each hand, effective from December 21, 2003. Additionally, the RO granted service connection for duodenal ulcer and assigned an initial 10 percent disability rating effective from December 21, 2003. Decisions on entitlement to service connection for a cervical condition and a left knee condition were deferred. Finally, claims of service connection for headaches (as a result of exposure to ionizing radiation), folliculitis, and, right and left elbow olecranon bursitis were denied. The Veteran did not submit a timely NOD with respect to any issue decided in the December 2004 rating decision.

Then, on January 12, 2005, the RO issued a statement of the case (SOC) addressing the 5 issues appealed in the Veteran's June 2004 NOD, as noted above. The following week, the RO received correspondence from the Veteran indicating a request to reopen the, "case of my right knee condition that was awarded a 0% service connected." The Veteran noted that there was new evidence, specifically an MRI report of the right knee which he requested to have reviewed in conjunction with a claim for increase. The Veteran specifically indicated in this correspondence that he disagreed with the decision made on the case of his right knee condition. This correspondence was received at the RO on January 19, 2005, within one year of the date on which the May 2004 notice of the May 2004 rating decision was issued. Because the Veteran specifically (and timely) disagreed with the initial noncompensable disability rating assigned for the service-connected right knee disability, and submitted new evidence to support his claim, the RO should have construed the January 2005 correspondence as a timely NOD to the May 2004 rating decision with respect to the initial noncompensable rating assigned for the right knee disability. 38 C.F.R. § 3.156(b).

On January 21, 2005, the RO received correspondence from the Veteran in response to the January 2005 SOC. In this correspondence, the Veteran specifically indicated that he was replying to "your letter dated 1-12-05" (the SOC) and that he wanted his statement to be considered as a NOD. Because the Veteran was disagreeing with the SOC, and this disagreement was timely, it can only be construed as a substantive appeal to the Board. Although the Veteran did not submit his substantive appeal on a VA Form 9, he made clear in his statement dated January 18, 2005 and received at the RO on January 21, 2005, that he disagreed with the SOC of January 12, 2005. In his statement, he noted that he had been seeking treatment for all of his diagnosed and claimed conditions since discharge from service, which he pointed out was within the first post-service year. Because the Veteran clearly intended to appeal these issues, the RO accepted the correspondence in lieu of a VA Form 9. In Percy v. Shinseki, 23 Vet. App. 37 (2009, the United States Court of Appeals for Veterans Claims (Court) distinguished the issues of a timely notice of disagreement (NOD) versus a timely Substantive Appeal and held that a timely Substantive Appeal was not a jurisdictional requirement for the Board's consideration of a veteran's claim. In Percy, the Court specifically found that, because the RO had never addressed the issue of timeliness in the SOC, and because the veteran was not informed that there was a timeliness issue until his claim was before the Board, that the RO had essentially waived any objections it might have offered to the timeliness, and had implicitly accepted his appeal. Here, the RO never notified the Veteran that he did not timely appeal the issues addressed in the January 2005 SOC. Instead, the RO merely considered the Veteran's statements as claims for reconsideration. The RO later issued an SSOC in April 2008 informing the Veteran that those issues were on appeal. With respect to the lumbar spine disability, it is considered on appeal from the May 2004 rating decision, because a higher initial rating of 40 percent was assigned within one year, thus demonstrating that new and material evidence was received within one year of the May 2004 rating decision. See 38 C.F.R. § 3.156(b) (2012).

Meanwhile, the January 2005 statement also raised new claims of service connection for PTSD and a claim of service connection for an undiagnosed illness manifested by symptoms of fatigue, muscle pain, shortness of breath, joint pain, rash, dizziness, memory loss and headaches. In addition, the Veteran indicated an inability to work as a result of his service-connected disabilities. Thus, a claim for a TDIU was raised.

In a February 2005 rating decision, the RO granted service connection for tinnitus and assigned a maximum allowed 10 percent rating, effective from December 21, 2003, the first day following discharge from service. The RO also denied claims of service connection for a left knee disability (even though the Veteran never claimed service connection for a left knee disability) and a cervical condition. Notice of that determination was sent to the Veteran on February 24, 2005.

In April 2005 correspondence, the Veteran once again referred to the claims for an increased rating for the service-connected back condition; PTSD and major depression; headaches, cervical condition, an earlier effective date for hypertension, and entitlement to a TDIU. This is also within one year of the May 2004 rating decision and also constitutes a substantive appeal.

In an August 2005 rating decision, the RO increased the 30 percent disability rating to 40 percent for the low back disability, effective from April 4, 2005. Although the Veteran has always maintained that the effective date for the grant of service connection for hypertension should be earlier than March 18, 2004, the RO did not address this claim; instead, the RO confirmed and continued the initial 10 percent rating assigned for the service connected hypertension, an issue which has never been claimed by the Veteran. The RO also confirmed and continued a noncompensable rating for the service connected right knee disability, and confirmed and continued a 10 percent

rating for the service-connected duodenal ulcer. In addition, the RO denied claims of service connection for PTSD and ear condition, as well as joint pain, loss of memory, dizziness, rash, fatigue, shortness of breath and entitlement to a TDIU. Finally, the RO confirmed and continued the prior denials of service connection for depressive disorder with anxiety features, headaches of the migraine type and a cervical condition, although the RO does not specifically indicate that these claims were previously denied claims. With regard to the claim of service connection for a cervical condition, the RO noted in the February 2005 rating decision that the STRs were negative for findings or a diagnosis of a cervical condition; however, on reconsideration in August 2005, the RO indicated that the STRs revealed one instance of a complaint of cervical pain, although no diagnosis was provided at that time. The RO nonetheless denied the claim in the August 2005 rating decision because no diagnosis of a cervical condition was provided in VA spine examinations of April 2004 or July 2005.

In August 2005 correspondence, the Veteran disagreed with all of the denied issues in the August 2005 rating decision. In March 2006, the RO issued an SOC addressing all issues listed on the Cover Page of this decision, except the issue of entitlement to an initial compensable disability rating for the service-connected right knee patellar tendonitis, status post anterior cruciate ligament (ACL) repair. The Veteran's VA Form 9, substantive appeal to the Board, as to the issues addressed in the March 2006 SOC, was received at the RO in April 2006. Supplemental Statements of the Case were issued to the Veteran in April 2008 and January 2009. The Veteran's claim of service connection for a cervical condition was reconsidered in August 2005, following the receipt of an April 2005 notice of disagreement, and that denial was perfected on appeal. As such, the issue is one of service connection and not whether new and material evidence has been received to reopen a finally disallowed claim.

With regard to the claim(s) of service connection for depressive disorder, not otherwise specified, and an acquired psychiatric disorder other than depressive disorder, not otherwise specified, to include PTSD, generalized anxiety disorder, and major depressive disorder, the United States Court of Appeals for Veterans Claims (Court) has held that the scope of a mental health disability claim includes any mental disability that may reasonably be encompassed by the claimant's description of the claim, reported symptoms, and the other information of record. See Clemons v. Shinseki, 23 Vet. App. 1 (2009). Therefore, the issue was recharacterized as shown on the first page of this decision.

The issues on appeal have been recharacterized and/or reorganized as reflected on the cover page of this document for purposes of clarity and to provide better organization in an attempt to more specifically reflect the Veteran's intentions.

The issues of entitlement to a higher initial disability rating for the service-connected lumbar paravertebral myositis and muscle spasm with early degenerative changes from L3 to S1 (lumbar spine disability) rated as 30 percent disabling from December 21, 2003 and rated as 40 percent disabling from April 5, 2005; entitlement to an effective date prior to March 18, 2004 for the grant of service connection for hypertension; entitlement to service connection for an acquired psychiatric disability other than depressive disorder, including, but not limited to PTSD, generalized anxiety disorder, and major depressive disorder; entitlement to an initial compensable disability rating for the service-connected right knee patellar tendonitis, status post anterior cruciate ligament (ACL) repair; entitlement to service connection for an ear disorder, other than tinnitus; entitlement to service connection for a disability of the cervical spine; entitlement to service connection for joint pain, muscular pain, loss of memory, dizziness, rash, fatigue and shortness of breath, to include as part of an undiagnosed multi-symptom illness pursuant to 38 C.F.R. § 3.317; and entitlement to a total disability rating for compensation purposes based on individual unemployability due to service-connected disabilities (TDIU) are addressed in the REMAND portion of the decision below and are REMANDED to the Department of Veterans Affairs Regional Office.

FINDINGS OF FACT

1. The medical and lay evidence of record is credible, and it establishes that the Veteran, as likely as not, developed depressive disorder, NOS, during service.

2. The medical and lay evidence of record is credible, and it establishes that chronic recurring headaches of the migraine type were first shown during service and have continued since that time.

CONCLUSIONS OF LAW

1. Resolving all doubt in the Veteran's favor, depressive disorder, NOS, was incurred in service. 38 U.S.C.A. §§ 1101, 5107 (West 2002); 38 C.F.R. §§ 3.303, 3.304 (2012).

Resolving all doubt in the Veteran's favor, a headache disability was incurred in service. 38 U.S.C.A. §§ 1110, 7104 (West 2002); 38 C.F.R. §§ 3.303 (2012).

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

The grant of service connection for a disability manifested by headaches of the migraine type, and depressive disorder, NOS, constitutes a complete grant of the benefits sought on appeal with respect to those issue. As such, any defect with regard to VA's duty to notify and assist the Veteran with the development of his claim with respect to these grants of service connection is harmless error, and no further discussion of VA's duty to notify and assist is necessary.

The Veteran seeks service connection for an acquired psychiatric disorder and chronic headaches. Historically, the Veteran served on active duty from September 1999 to December 2003. He asserts that he developed a psychiatric disorder and chronic headaches during service and has experienced symptoms ever since.

The Veteran has sought service connection for an acquired psychiatric disorder and a headache disorder since his separation from service in December 2003. His initial claim of service connection for a psychiatric disorder in January 2004 was denied because the RO indicated that the Veteran's service treatment records (STRs) failed to show a diagnosis or treatment for any acquired psychiatric disorder. The claim of service connection for headaches was initially denied because the RO determined that the Veteran did not have an in-service diagnosis of migraine, and therefore service connection on a direct basis was not warranted. Furthermore, the RO found that service connection on a presumptive basis was not warranted because although the diagnosis of migraine-type headaches was made within the first post-service year, the severity of the disability was not shown to be at least 10 percent disabling. Thus, service connection was not warranted pursuant to 38 C.F.R. § § 3.307, 3.309.

In general, service connection may be granted for disability resulting from disease or injury incurred in or aggravated by service. 38 U.S.C.A. § 1110; 38 C.F.R. § 3.303(a). Service connection may also be granted for any disease diagnosed after discharge when all the evidence, including that pertinent to service, establishes that the disease was incurred in service. 38 C.F.R. § 3.303(d).

Where there is a chronic disease shown as such in service or within the presumptive period under § 3.307 so as to permit a finding of service connection, subsequent manifestations of the same chronic disease at any later date, however, remote, are service connected, unless clearly attributable to intercurrent causes. 38 C.F.R. § 3.303(b). This rule does not mean that any manifestations in service will permit service connection. To show chronic disease in service there is required a combination of manifestations sufficient to identify the disease entity, and sufficient observation to establish chronicity at the time as distinguished from merely isolated findings or a diagnosis including the word "chronic". When the disease entity is established, there is no requirement of evidentiary showing of continuity. When the fact of chronicity in service is not adequately supported, then a showing of continuity after discharge is required to support the claim. 38 C.F.R. § 3.303(b).

Continuous service for 90 days or more during a period of war, or peace time service after December 31, 1946, and post-service development of a presumptive disease such as migraine headaches to a degree of 10 percent within one year from the date of termination of such service, establishes a rebuttable presumption that the disease was incurred in service. 38 U.S.C.A. §§ 1101, 1112, 1113; 1137; 38 C.F.R. §§ 3.307, 3.309.

The credibility and weight of all the evidence, including the medical evidence, should be assessed to determine its probative value, and the evidence found to be persuasive or unpersuasive should be accounted for, and reasons should be provided for rejecting any evidence favorable to the claimant. See Masors v. Derwinski, 2 Vet. App. 181 (1992). Equal weight is not accorded to each piece of evidence contained in the record; every item of evidence does not have the same probative value.

In determining whether service connection is warranted for a disability, VA is responsible for determining whether the evidence supports the claim or is in relative equipoise, with the veteran prevailing in either event, or whether a preponderance of the evidence is against the claim, in which case the claim is denied. Gilbert v. Derwinski, 1 Vet. App. 49 (1990).

Lay assertions may serve to support a claim for service connection by establishing the occurrence of observable events or the presence of disability or symptoms of disability subject to lay observation. 38 U.S.C.A. § 1153(a) (West 2002); 38 C.F.R. § 3.303(a) (2009); Jandreau v. Nicholson, 492 F.3d 1372 (Fed. Cir. 2007); see also Buchanan v. Nicholson, 451 F. 3d 1331, 1336 (Fed. Cir. 2006) (addressing lay evidence as potentially competent to support presence of disability even where not corroborated by contemporaneous medical evidence). The United States Court of Appeals for the Federal Circuit (Federal Circuit) has clarified that lay evidence can be competent and sufficient to establish a diagnosis or etiology when (1) a lay person is competent to identify a medical condition; (2) the lay person is reporting a contemporaneous medical diagnosis, or (3) lay testimony describing symptoms at the time supports a later diagnosis by a medical professional. Davidson v. Shinseki, 581 F.3d 1313 (Fed. Cir. 2009).

Psychiatric disorder

The STRs show that the Veteran reported psychiatric symptoms on his post-deployment health assessment forms in July 2003 after his return from Iraq. He specifically indicated that, although he was not directly involved in combat, he reported, by checking a box corresponding to "a lot" that he felt little interest or pleasure in doing things and felt down, depressed, or hopeless. The Veteran also reported that over the previous month, he had feelings of being on guard, watchful or being easily startled by an event. He also indicated that recent experiences made him feel numb or detached from others, activities and surroundings. The Veteran also indicated that he had thoughts or concerns that he may have serious conflicts with his spouse, family members or friends and/or that he might verbally lose control with someone.

Shortly after discharge from service, a VA outpatient psychiatric treatment record from January 2004 reveals that the Veteran presented with a persistent depressed mood, irritability, insomnia, nightmares with war content, anxiety, death wishes and alcohol abuse for the prior month. The Veteran reported to the examiner that he had never before abused alcohol but he had been unable to control his intake over the previous month even though he knew it was hurtful to himself and his family. On examination, the Veteran's mood was depressed. The diagnostic impression was depression, not otherwise specified (NOS). The Veteran was prescribed medication for depression and anxiety. At a follow-up appointment one month later, the Veteran reported some improvement in his mood, although it was inconsistent. The Veteran stopped taking seroquel due to sedation. The diagnostic impression remained depressive disorder, NOS, and PTSD was to be ruled out.

On what appears to be a Gulf War registry examination dated in March 2004, the Veteran reported depression, strange dreams and other psychiatric symptomatology. The examiner noted a diagnosis of PTSD (2003).

At a VA psychiatric examination in April 2004, the Veteran reported nightmares of situations where he finds himself in the same place in the desert, dressed in uniform. Although the Veteran did not serve in direct combat, he reportedly witnessed casualties and was reportedly heavily impacted by the living conditions of the people in Afghanistan. The Veteran reported anxiety and insomnia, irritability and a lack of desire to socialize. The Veteran also reports that he becomes verbally aggressive with his wife. On examination, the Veteran's mood was anxious, depressed, and somewhat tense. Affect was constricted. Attention, concentration and memory were only fair. The diagnosis was depressive disorder, NOS, with anxiety features.

A March 2005 private medical report from Dr. J.L.M., MD, indicates that the Veteran has a diagnosis of major depressive disorder, recurrent severe with psychotic features due to severe general medical conditions; and, a diagnosis of PTSD. The examiner also indicated that bipolar mixed type needed to be ruled out. In complete contrast to the VA medical records, the private report indicates that the Veteran's prognosis is "very poor poor" and that the Veteran is not able to handle his funds.

A July 2005 VA "Gulf War Guidelines" examination also notes diagnoses of PTSD and anxiety disorder. A July 2005 VA psychiatric examination notes a review of the claims file, and in particular, the private treatment record of March 2005 noted above. The VA examiner specifically noted that the diagnosis of PTSD was not based on any identified stressors. Based on a mental status examination of the Veteran, the examiner concluded that the Veteran did not meet the DSM-IV criteria for a diagnosis of PTSD; however, he did diagnose depressive disorder, NOS.

VA in-patient treatment records show that the Veteran was admitted as an in-patient to a VA facility due to mental health instability. A March 2006 discharge summary notes that the Veteran was admitted for approximately two weeks with an admission diagnosis of major depressive disorder recurrent with psychotic features; PTSD in acute exacerbation.

In sum, the evidence of record reveals a clear and unquestionable diagnosis of depressive disorder, NOS, immediately after service separation and thereafter. In a VA medical record of February 2004 the Veteran's report of frequent nightmares and intrusive thoughts since returning from deployment was noted. He also had a sad mood, poor sleep, short temper, and often irritable. The clinician diagnosed depressive disorder, NOS. Although other psychiatric diagnoses have been suggested or diagnosed by one or more examiners, a depressive disorder has been consistently diagnosed by medical professionals since discharge from service. The Veteran reported symptoms of an acquired psychiatric disorder during service, and this is documented in the STRS. The evidence further reflects continuity of symptoms since discharge from service, beginning in January 2004, the month following discharge from service.

In sum, the Veteran has a diagnosis of depressive disorder, NOS, which was diagnosed shortly after discharge from service. Given the Veteran's credible statements regarding the onset of his psychiatric symptoms in service, as well as the STR evidence showing reports of post-deployment symptomatology in service, and the continuity of the post-service medical evidence of record, beginning in January 2004, almost immediately following his December 2003 service separation, continuity of depressive disorder, NOS, symptoms since service is shown in this case. The Veteran is competent to report what happened to him, and in particular, when he began to have depressive symptoms, and there is no reason to doubt the Veteran's credibility in this regard. Moreover, continuity of symptoms is shown by the objective evidence of record in this case. The Veteran reported that he had depression and nervousness when he was discharged from service, and has attempted to establish service connection for the disability ever since. Based on the foregoing, it is at least as likely as not that the Veteran's depressive disorder, NOS, had its onset during service.

In sum, the Veteran has medical evidence of a depressive disorder, NOS; he has provided competent and credible statements regarding in-service onset of symptoms and various VA examiner have noted the Veteran's in-service onset of symptoms and continuity ever since service. Furthermore, the claims file shows continuity of symptoms of major depressive disorder since discharge from service. Thus, the criteria for entitlement to service connection for major depressive disorder are met in this case. The Veteran is therefore entitled to the benefit of the doubt. See 38 U.S.C.A. § 5107(b); 38 C.F.R. § 3.102. Accordingly service connection for depressive disorder, NOS, is warranted.

Headaches

With regard to the claim of service connection for headaches, the STRs also show, on the same 2003 post-deployment form, that the Veteran reported that he experienced headaches while deployed in the Middle East.

A VA examination in April 2004 noted the Veteran's reports of the onset of headaches while in Afghanistan. He reportedly never went to sick call for the headaches. He took Panadol or Motrin with benefit within one hour. The Veteran described the headaches as right-sided, with a pressure combined with a pulsatile throbbing sensation with the pain rated a 7 out of 10 on the pain intensity scale. The headaches are accompanied by photo and sonophobia. The headaches were more frequent while on active duty, but he still reported about two per week currently. The examiner noted that the Veteran's medical chart revealed that the Veteran's current treatment involved multiple medications prescribed by his primary care physician. The diagnosis was chronic recurring headaches of the migraine-type, non prostrating, as described.

After reviewing the evidence, the criteria for a headache disability are also met. The Veteran reported headaches on his post-deployment health assessment and a VA examiner in April 2004, only 4 months after discharge from

service provided a diagnosis of migraine-type headaches. Although the severity of the headaches may not have risen to a compensable degree at that time, which would have warranted service connection on a presumptive basis, the evidence nonetheless establishes continuity of symptoms since service. As such, service connection on a direct basis is warranted. The Veteran is competent to report a symptom such as headache pain, and there is no reason to doubt his credibility in that regard. He reports that the headaches began in Afghanistan and continued thereafter and a medical professional has provided a diagnosis of chronic recurring headaches of the migraine-type. Evidence of headaches is shown on the STRs, and a chronic headache disability is diagnosed only 4 months post service. These findings, along with the Veteran's credible statements regarding his symptoms during service, and thereafter, during the VA examination of April 2004 provides the requisite evidence to grant this claim.

Given the evidence of in-service onset of headaches, and, continuity of symptoms since service, all doubt is resolved in favor of the Veteran and the criteria are met for establishing service connection for headaches. The Veteran is therefore entitled to the benefit of the doubt. See 38 U.S.C.A. § 5107(b); 38 C.F.R. § 3.102. Accordingly service connection for headaches is warranted.

(CONTINUED ON NEXT PAGE)

ORDER

Service connection for depressive disorder, NOS, is granted.

Service connection for migraine-type headaches is granted.

REMAND

In addition to having a diagnosis of depressive disorder, NOS, the Veteran's psychiatric disorder has been variously diagnosed as PTSD, a generalized anxiety disorder, adjustment disorder and major depressive disorder. As noted in the Introduction, the Court held that the scope of a mental health disability claim includes any mental disability that may reasonably be encompassed by the claimant's description of the claim, reported symptoms, and the other information of record. See Clemons v. Shinseki, 23 Vet. App. 1 (2009). Therefore, the Board must consider whether during the pendency of his claim, the Veteran suffers from psychiatric disabilities other than the service-connected depressive disorder, NOS, that are related to active service and determine whether any other service-connected disabilities may have different symptoms from those attributed to the service-connected major depressive disorder. Although VA's anti-pyramiding regulation precludes the evaluation of the same disability under various diagnoses, the Board must still determine whether the Veteran in fact has separately diagnosed disabilities. See Amberman v. Shinseki, 570 F.3d 1377, 1381 (2009) (stating that the veteran's "bipolar affective disorder and PTSD could have different symptoms and it could therefore be improper in some circumstances for the VA to treat these separately diagnosed conditions as producing only the same disability"). It was noted that for rating purposes, the question is whether the defined diagnoses have overlapping symptomatology. Id. This is both factual and medical determination that may change over time. See Amberman. (noting the Board's acknowledgment that the veteran's bipolar affective disorder and PTSD may be assigned separate ratings "if the record ever subsequently contains competent evidence which distinguishes manifestations" of one disorder from the other).

In light of the foregoing, the RO must determine whether the Veteran has PTSD, generalized anxiety disorder, major depressive disorder, adjustment disorder, and/or any other acquired psychiatric disorder. In this regard, the RO must schedule the Veteran for a VA examination to determine from what, if any, psychiatric disabilities the Veteran suffers, other than the consistently diagnosed depressive disorder, NOS, for which the Veteran has established service-connection.

With regard to the Veteran's claim of service connection for PTSD, service connection for PTSD, as opposed to other acquired psychiatric disorders, requires that three elements must be present according to VA regulations:

(1) medical evidence diagnosing the condition in accordance with 38 C.F.R. § 4.125(a); (2) credible supporting evidence that the claimed in-service stressor actually occurred; and (3) a link, established by medical evidence, between the current symptoms and the claimed in-service stressor. 38 C.F.R. § 3.304(f) (2011). See Cohen v. Brown, 10 Vet. App. 128, 138 (1997).

The diagnosis of a mental disorder must conform to the Diagnostic and Statistical Manual of Mental Disorders (4th ed. 1994) (DSM-IV), and be supported by the findings of a medical examiner. See 38 C.F.R. § 4.125 (a) (2011).

In adjudicating a claim for service connection for PTSD, VA is required to evaluate the supporting evidence in light of the places, types, and circumstances of service, as evidenced by service records, the official history of each organization in which the veteran served, the veteran's military records, and all pertinent medical and lay evidence. 38 U.S.C.A. § 1154(a) (West 2002); 38 C.F.R. §§ 3.303(a), 3.304 (2011).

The evidence necessary to establish the occurrence of a recognizable stressor during service to support a diagnosis of PTSD will vary depending upon whether the veteran engaged in "combat with the enemy." If the evidence establishes that the veteran engaged in combat with the enemy and the claimed stressor is related to that combat, in the absence of clear and convincing evidence to the contrary, (and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the appellant's service), the veteran's lay testimony alone may establish the occurrence of the claimed in-service stressor. See 38 C.F.R. § 3.304(d) (2011);

see also 38 U.S.C.A. § 1154(b) (West 2002); VAOPGCPREC 12-99.

VA General Counsel has held that "[t]he ordinary meaning of the phrase 'engaged in combat with the enemy,' as used in 38 U.S.C.A. § 1154(b), requires that a veteran have participated in events constituting an actual fight or encounter with a military foe or hostile unit or instrumentality." The determination whether evidence establishes that a veteran engaged in combat with the enemy is resolved on a case-by-case basis with evaluation of all pertinent evidence and assessment of the credibility, probative value, and relative weight of the evidence. VAOGCPREC 12-99; 65 Fed. Reg. 6,256-58 (Feb. 8, 2000).

Effective July 13, 2010, VA amended 38 C.F.R. § 3.304(f). The amended version of 38 C.F.R. § 3.304(f)(3) eliminated the need for stressor corroboration in circumstances in which the veteran's claimed in-service stressor is related to "fear of hostile military or terrorist activity." Specifically, the amended version of 38 C.F.R. § 3.304(f)(3) states:

If a stressor claimed by a veteran is related to the veteran's fear of hostile military or terrorist activity and a VA psychiatrist or psychologist, or a psychiatrist or psychologist with whom VA has contracted, confirms that the claimed stressor is adequate to support a diagnosis of [PTSD] and the veteran's symptoms are related to the claimed stressor, in the absence of clear and convincing evidence to the contrary, and provided the claimed stressor is consistent with the places, types, and circumstances of the veteran's service, the veteran's lay testimony alone may establish the occurrence of the claimed in-service stressor.

For purposes of this paragraph, "fear of hostile military or terrorist activity" means that a veteran experienced, witnessed, or was confronted with an event or circumstance that involved actual or threatened death or serious injury, or a threat to the physical integrity of the veteran or others, such as from an actual or potential improvised explosive device; vehicle-imbedded explosive device; incoming artillery, rocket, or mortar fire; grenade; small arms fire, including suspected sniper fire; or attack upon friendly military aircraft, and the veteran's response to the event or circumstance involved a psychological or psycho-physiological state of fear, helplessness, or horror.

See 75 Fed. Reg. 39,843-39,852 (July 13, 2010), codified at 38 C.F.R. § 3.304(f)(3) (2011).

It appears from the record that the Veteran's claimed stressors have not been corroborated, and that there may not be enough evidence to corroborated them. However, given the recent regulation change, and the fact that the Veteran's service included service in the war zone in Iraq and Afghanistan, the VA psychiatric examiner should obtain a history of the Veteran's deployment, and determine or opine as to whether the Veteran's stressor(s) are related to his fear of hostile military or terrorist activity; and, if so, whether the Veteran's symptoms meet the criteria for a DSM IV diagnosis of PTSD based on the Veteran's service.

In addition, the Board notes that the Veteran's private physician, Dr. Lopez, diagnosed major depressive disorder due to severe general medical conditions including disorders that are not currently service-connected. As a result the issue of secondary service connection is raised and VA should notify the Veteran how he can substantiate his claim on that basis.

The issues of entitlement to a higher initial disability rating for the service-connected lumbar paravertebral myositis and muscle spasm with early degenerative changes from L3 to S1 (lumbar spine disability) rated as 30 percent disabling from December 21, 2003 and rated as 40 percent disabling from April 5, 2005 must be remanded to afford the Veteran adequate due process of law. The RO increased the disability rating for the low back disability from 30 percent to 40 percent, effective from April 5, 2005, the date on which the RO perceived the Veteran to have filed a claim for an increased rating. However, as noted in the Introduction section above, the Board construes the April 2005 document as a substantive appeal with regard to the issue of entitlement to a higher initial rating for the service-connected lumbar spine disability. In light of this finding, the RO must readjudicate the claim for increase based on a finding that the Veteran's appeal is timely as to the issue of entitlement to an initial disability rating in excess of 30 percent for the service-connected lumbar spine disability. In other words, the RO must consider whether a disability rating in excess of 30 percent is warranted during the entire time period since the grant of service connection (and whether a rating in excess of 40 percent is warranted since April 5, 2005). Moreover, since the last VA examination of record was conducted in 2005, nearly 7 years ago, a contemporaneous VA examination of the spine is necessary to assess the current nature, extent and severity of the service-connected low back disability.

With regard to the issue of entitlement to an effective date prior to March 18, 2004 for the grant of service connection for hypertension, the RO did not include this issue in any supplemental statements of the case (SSOC's) because it considered the issue unappealed. More specifically, as noted in the Introduction section above, the RO addressed the issue in a January 2005 SOC, but the RO never addressed the issue again because, as with the other issues listed on that SOC, the RO did not consider the Veteran to have timely appealed those issues. However, the Board has determined that the Veteran clearly intended to appeal the issues on the January 2005 and the RO should have considered the Veteran's numerous statements received within the appeal period as timely substantive appeals in lieu of a VA Form 9. As such, the issue of entitlement to an effective date prior to March 18, 2004 for the grant of service connection for hypertension is on appeal and the RO must now notify the Veteran of this fact and allow the Veteran an appropriate amount of time to submit evidence in support of his claim.

With regard to the claim of entitlement to service connection for an ear disorder, other than tinnitus, there is some question as to what exactly the Veteran is claiming at this point. In his June 2004 NOD, the Veteran specifically indicated that the "ear condition" that he was claiming was tinnitus. The RO treated this as a new claim of service connection for tinnitus and subsequently granted service connection for tinnitus. The Veteran did not subsequently disagree with the initial 10 percent disability rating assigned for the service-connected tinnitus, and the Veteran has not subsequently expressed any desire or submitted any correspondence or evidence

clarifying what, if any, "ear condition" other than tinnitus, he is intended to service connect. Thus, although the Veteran has perfected a claim of service connection for "an ear condition" it is unclear as to what disability, if any, the Veteran is claiming at this point as service connection for tinnitus has been granted. On remand, the Veteran should be asked to clarify what ear condition, if any, to include hearing loss and/or some specific ear disease, (other than tinnitus) for which he is claiming service connection. Then, if warranted, the Veteran should be afforded an appropriate examination to determine whether such ear condition exists and to obtain a nexus opinion.

With regard to the claim of service connection for a cervical spine disorder, the claim was last denied because the evidence of record at that time did not show a current diagnosis of a neck disability. The RO found that the spine examinations of April 2004 and July 2005 specifically did not show complaints of a cervical condition. However, it is critical to note that these examinations were specifically limited to the lumbar spine; therefore, it is not surprising that the Veteran's neck complaints were not mentioned on those reports. Moreover, the more recent VA outpatient treatment records dated in January 2008 show a diagnosis of cervicalgia. Although the Veteran's one-time in-service notation of neck pain was associated with a viral gastroenteritis, the Veteran is nonetheless competent to state that he suffers from neck pain that began during service. In light of the foregoing, he should be afforded a VA examination to determine what current neck disability exists, and whether any current neck disability had its onset during service or is otherwise related thereto.

With regard to the claims of service connection for joint pain, muscular pain, loss of memory, dizziness, rash, fatigue and shortness of breath, the Veteran asserts that he has joint pain, muscular pain, loss of memory, dizziness, rash, fatigue and shortness of breath, to include as part of an undiagnosed multi-symptom illness pursuant to 38 C.F.R. § 3.317. He asserts that service connection is warranted pursuant to 38 C.F.R. § 3.317 based on service in the Southwest Asia Theater of Operations during the Persian Gulf War.

Because the Veteran served in the Southwest Asia Theater of operations during the Persian Gulf War, service connection may also be established under 38 C.F.R. § 3.317. Under that section, service connection may be warranted for a Persian Gulf veteran who exhibits objective indications of a qualifying chronic disability that became manifest during active military, naval or air service in the Southwest Asia theater of operations during the Persian Gulf War, or to a degree of 10 percent or more not later than not later than December 31, 2016. 38 C.F.R. § 3.317(a)(1). (Effective December 29, 2011, VA revised § 3.317(a)(1)(i) to extend the period during which disabilities associated with undiagnosed illnesses and medically unexplained chronic multisymptom illnesses must become manifest in order for a veteran to be eligible for compensation. The period was extended from December 31, 2011 to December 31, 2016. See 76 Fed. Reg. 81,834 (Dec. 29, 2011) (interim final rule extending statutory period).

For purposes of 38 C.F.R. § 3.317, there are three types of qualifying chronic disabilities: (1) an undiagnosed illness; (2) a medically unexplained chronic multi symptom illness; and (3) a diagnosed illness that the Secretary determines in regulations prescribed under 38 U.S.C. 1117(d) warrants a presumption of service-connection.

An undiagnosed illness is defined as a condition that by history, physical examination and laboratory tests cannot be attributed to a known clinical diagnosis. In the case of claims based on undiagnosed illness under 38 U.S.C.A. § 1117 ; 38 C.F.R. § 3.117 , unlike those for "direct service connection," there is no requirement that there be competent evidence of a nexus between the claimed illness and service. Gutierrez v. Principi, 19 Vet. App. 1, 8-9 (2004). Further, lay persons are competent to report objective signs of illness. Id.

A medically unexplained chronic multi symptom illnesses is one defined by a cluster of signs or symptoms, and specifically includes chronic fatigue syndrome, fibromyalgia, and irritable bowel syndrome, as well as any other illness that the Secretary determines meets the criteria in paragraph (a)(2)(ii) of this section for a medically unexplained chronic multi symptom illness.

A "medically unexplained chronic multi symptom illness" means a diagnosed illness without conclusive pathophysiology or etiology that is characterized by overlapping symptoms and signs and has features such as fatigue, pain, disability out of proportion to physical findings, and inconsistent demonstration of laboratory abnormalities. Chronic multi symptom illnesses of partially understood etiology and pathophysiology will not be considered medically unexplained. 38 C.F.R. § 3.317(a)(2)(ii).

"Objective indications of chronic disability" include both "signs," in the medical sense of objective evidence perceptible to an examining physician, and other, non-medical indicators that are capable of independent verification. 38 C.F.R. § 3.317(a)(3). Signs or symptoms that may be manifestations of undiagnosed illness or medically unexplained chronic multi symptom illness include, but are not limited to, the following: (1) fatigue; (2) signs or symptoms involving skin; (3) headache; (4) muscle pain; (5) joint pain; (6) neurologic signs or symptoms; (7) neuropsychological signs or symptoms; (8) signs or symptoms involving the respiratory system (upper or lower); (9) sleep disturbances; (10) gastrointestinal signs or symptoms; (11) cardiovascular signs or symptoms; (12) abnormal weight loss; and (13) menstrual disorders. 38 C.F.R. § 3.317(b).

For purposes of section 3.317, disabilities that have existed for six months or more and disabilities that exhibit intermittent episodes of improvement and worsening over a six-month period will be considered chronic. The six-month period of chronicity will be measured from the earliest date on which the pertinent evidence establishes that the signs or symptoms of the disability first became manifest. 38 C.F.R. § 3.317(a)(4).

According to the Veteran's DD Form 214, he did serve in Southwest Asia, in both Afghanistan and Iraq. His STRs show that on an April 2003 post-deployment health assessment, the Veteran reported symptoms of fatigue, weakness, malaise, and headaches, generalized body aches, joint pain, skin rash, difficulty remembering, difficulty breathing and dizziness during his deployment. The Veteran also noted that he was not seen in sick call at all during that deployment, despite his complaints.

At a July 2005 VA Gulf War Guidelines examination, the Veteran was diagnosed with various objectively identifiable disabilities including hypertension; a right ACL tear, post operative repair; degenerative disc disease of the lumbar spine; other unspecified degenerative joint disease (arthritis); muscular spasm due to low back pain; and gastroesophageal reflux disease. However, the examiner also noted "generalized arthralgias and myalgias" but provided no opinion as to etiology. In addition, the examiner did not address the Veteran's reports of fatigue, dizziness, shortness of breath, skin rash or claimed memory impairment, particularly in the context of whether the Veteran might have an undiagnosed illness manifested by a cluster of symptoms such as the ones he reports.

In light of the Veteran's complaints in the STRs, as well as the reports of symptoms since service, as well as his reports of neck pain, he should be afforded a VA examination to determine whether he suffers from an undiagnosed illness manifested by the reported symptoms. If no undiagnosed illness is found, then the examiner should opine as to whether the Veteran has objective findings of the claimed symptoms and if so, whether there is any relationship between a current disability and service.

With regard to the claim of entitlement to an initial compensable disability rating for the service-connected right knee patellar tendonitis, status post anterior cruciate ligament (ACL) repair, the RO issued a rating decision granting service connection for this disability in May 2004. In January 2005, the Veteran submitted a notice of disagreement (NOD) with respect to the initial noncompensable disability rating assigned following the grant of service connection for the right knee disability.

The RO has not yet issued a Statement of the Case as to the issue of entitlement to an initial compensable rating for the service-connected right knee patellar tendonitis status post ACL repair. As such, the RO is now required to send the Veteran a statement of the case as to this issues in accordance with 38 U.S.C.A. § 7105 (West 2002) and 38 C.F.R. §§ 19.29, 19.30 (2012). In this regard, the United States Court of Appeals for Veterans Claims (Court) has held that where a Notice of Disagreement has been submitted, the veteran is entitled to a Statement of the Case. The failure to issue a Statement of the Case is a procedural defect requiring a remand. Manlincon v. West 12 Vet. App. 238 (1999); Godfrey v. Brown, 7 Vet. App. 398 (1995).

In addition, VA treatment records dated from January 2008 should be obtained. See Bell v. Derwinski, 2 Vet. App. 611 (1992) (VA has constructive notice of VA generated documents that could reasonably be expected to be part of the record). In addition, it appears that records dating from December 2004 to April 2006 may not all have been obtained.

The Board notes that the Veteran is in receipt of Social Security Administration (SSA) disability benefits. It does not appear, however, that the RO attempted to obtain the records upon which SSA relied in reaching its decision. The Court of Appeals for Veterans Claims has held that VA's duty to assist encompasses obtaining medical records that supported an SSA award of disability benefits as they may contain information relevant to VA claims. Murincsak v. Derwinski, 2 Vet. App. 363, 369-70 (1992); see also 38 U.S.C.A. § 5103A(c)(3) (West 2002); 38 C.F.R. § 3.159(c)(2) (2011); Diorio v. Nicholson, 20 Vet. App. 193, 199-200 (2006); Quartuccio v. Principi, 16 Vet. App. 183, 187 (2002). Those records should be requested, and associated with the Veteran's claims file.

Finally, the Veteran maintains that he is unable to work due to his service-connected disabilities. The law provides that TDIU may be granted upon a showing that the Veteran is unable to secure or follow a substantially gainful occupation due solely to impairment resulting from his or her service-connected disabilities. See 38 U.S.C.A. § 1155; 38 C.F.R. §§ 3.340, 3.341, 4.16. Consideration may be given to a Veteran's level of education, special training, and previous work experience in arriving at a conclusion, but not to his or her age or the impairment caused by nonservice-connected disabilities. See 38 C.F.R. §§ 3.341, 4.16, 4.19.

In this regard, TDIU may be assigned when the disabled person is, in the judgment of the rating agency, unable to secure or follow a substantially gainful occupation as a result of service-connected disabilities. 38 C.F.R. § 4.16(a). If there is only one such disability, it must be rated at 60 percent or more; if there are two or more disabilities, at least one disability must be rated at 40 percent or more, with sufficient additional disability to bring the combined rating to 70 percent or more. Id.

If, however, a Veteran fails to meet the applicable percentage standards enunciated in 38 C.F.R. § 4.16(a), rating boards should refer to the Director, Compensation and Pension Service for extra-schedular consideration all cases where the Veteran is unable to secure or follow a substantially gainful occupation by reason of service- connected disability. 38 C.F.R. § 4.16(b). See also Fanning v. Brown, 4 Vet. App. 225 (1993). The Veteran's service-connected disabilities, employment history, educational and vocational attainment, and all other factors having a bearing on the issue must be addressed. 38 C.F.R. § 4.16(b).

With regard to the claim for a TDIU, this issue is inextricably intertwined with the above described increased rating and service connection issues. Thus, the Veteran's TDIU claim must be deferred pending the outcome of his other claim(s). See Holland v. Brown, 6 Vet. App. 443 (1994).

Accordingly, the case is REMANDED for the following action:

1. Given the complicated procedural history in this case, send the Veteran an updated Duty-to-Assist letter to the Veteran addressing all of the Veteran's claims on appeal as indicated by this Decision/Remand. Ensure that the letter complies with 38 C.F.R. § 3.159 and that the Veteran is informed as to how he can substantiate his claim for service connection for a psychiatric disorder as secondary to service-connected disabilities.

In the letter, inform the Veteran that his claim for an effective date prior to March 18, 2004 for the grant of service connection for hypertension is on appeal, and provide him with adequate notice of what is necessary to substantiate this claim.

Clarify whether the Veteran's grant of service connection for tinnitus satisfies his claim of service connection for an ear condition, and if not, request that he provide a specific ear disability or symptoms of an ear disability for which he is claiming service connection, including, but not limited to, hearing loss. If the Veteran identifies a specific ear disability, or symptoms of an ear disability, then conduct any development deemed appropriate, including, but not limited to a VA examination.

2. Obtain and associate with the claims file the following VA medical records pertaining to the Veteran:

a. VA medical records dating from December 2004 to April 2006; and

b. VA medical records dating from January 2008.

3. Request, directly from the SSA, complete copies of any determination on a claim for disability benefits from that agency as well as the records, including medical records, considered in adjudicating the claim. All attempts to fulfill this development should be documented in the claims file.

All attempts to fulfill this development should be documented in the claims file. If after continued efforts to obtain the records it is concluded that it is reasonably certain they do not exist or further efforts to obtain them would be futile, the RO must notify the Veteran and (a) identify the specific records the RO is unable to obtain; (b) briefly explain the efforts that the RO made to obtain those records; (c) describe any further action to be taken by the RO with respect to the claim; and (d) inform the Veteran that he is ultimately responsible for providing the evidence. The Veteran must then be given an opportunity to respond.

4. Request that the Veteran identify any non-VA records relevant to his claims. With appropriate authorization from the Veteran, obtain and associate with the claims file all pertinent private treatment records identified by the Veteran that have not already been obtained.

If, after making reasonable efforts to obtain named records the RO is unable to secure same, the RO must notify the Veteran and (a) identify the specific records the RO is unable to obtain; (b) briefly explain the efforts that the RO made to obtain those records; (c) describe any further action to be taken by the RO with respect to the claim; and (d) inform the Veteran that he is ultimately responsible for providing the evidence. The Veteran must then be given an opportunity to respond.

5. Schedule the Veteran for a VA examination by an appropriate physician to examine the Veteran's cervical spine and lumbar spine. The claims file must be made available to, and reviewed by, the examiner, and the examination report must reflect that the claims file was reviewed.

a. The examiner is specifically requested to identify any current disabilities of the cervical spine. Then, the examiner is requested to opine as to whether any such disability, at least as likely as not (50 percent probability or greater), had its onset during service or within the first post-service year; and/or whether any such disability is at least as likely as not related to any disease or injury in service. Importantly, the examiner's opinion should consider the Veteran's STRs which show complaints of joint pain. Additionally, the examiner should consider the Veteran's statements as to his injuries sustained during service and his description of symptoms during service and thereafter.

b. With regard to the service-connected lumbar spine disability, the examiner should determine the nature, extent, and severity of the service-connected lumbar spine disability since his service separation. All indicated tests, including X-ray, magnetic resonance imaging (MRI) if indicated, and range of motion studies, must be conducted. The claims file must be made available to and reviewed by the examiner in conjunction with the examination.

The examiner should indicate if the Veteran's low back disability is productive of incapacitating episodes as described in the rating schedule, and if so, determine the frequency of any incapacitating episodes in terms of the rating schedule.

The examiner should provide an opinion as to the extent that pain limits the functional ability of the back in terms of additional functional limitation due to pain. The examiner should describe the extent the lumbar spine disability exhibits weakened movement, excess fatigability, incoordination, and/or ankylosis. These determinations should be expressed in terms of the degree of additional range of motion loss. The examiner should also portray the degree of additional range of motion loss due to pain on use or during flare-ups.

The examiner should also determine whether the Veteran's service-connected low back disability is productive of any associated neurologic abnormalities, including in the lower extremities and bowel or bladder impairment and, if so, the level of severity.

6. Schedule the Veteran for the appropriate VA examination(s) to determine if the Veteran has an undiagnosed illness manifested by his reported symptoms of joint pain, muscular pain, loss of memory, dizziness, rash, fatigue and shortness of breath. In so doing, the examiner must first address each of the Veteran's reported symptoms and determine whether there are any objective signs and/or symptoms of the existence of such reported symptoms; and, if so, then opine as to whether any such symptoms can be attributed to a known clinical diagnosis.

After addressing each symptom separately, the examiner should opine as to whether any diagnosed disability, at least as likely as not (a 50 percent or greater likelihood) had its onset during service, or is otherwise related to any disease or injury in service.

For symptoms without a known diagnosis, the examiner should address whether the Veteran's reported undiagnosed symptoms represent an undiagnosed illness or a medically unexplained chronic multisymptom illness, such as chronic fatigue syndrome and/or fibromyalgia, for example. The claims file must be made available to, and reviewed by, the examiner, and the examination report must reflect that the claims file was reviewed.

Importantly, the examiner's opinion should consider the Veteran's STRs which show post-deployment complaints of the above noted symptoms. Additionally, the examiner should consider the Veteran's credible and competent statements as to his symptoms during service and his description of symptoms and any treatment by healthcare providers thereafter.

7. Schedule the Veteran for a VA psychiatric examination to determine the current nature and likely etiology of any acquired psychiatric disorder, other than depressive disorder, NOS, to include, but not limited to PTSD, generalized anxiety disorder, major depressive disorder and adjustment disorder. The claims folder must be made available to and reviewed by the examiner in conjunction with the requested study.

The examiner in this regard should elicit from the Veteran and record a full clinical history referable to acquired psychiatric disorders, including the PTSD. The examiner must thoroughly review the Veteran's claims file, to include a copy of this remand, and any additional pertinent evidence added to the record. The examiner should first identify what current psychiatric disorder(s) exist and reconcile the disorder(s) found with the psychiatric diagnoses of record. If the symptoms of one psychiatric disorder are overlapping with any other psychiatric disorder, the examiner should so state, in as much detail as possible.

The examiner should opine as to whether the Veteran's acquired psychiatric disorder(s), diagnosed as adjustment disorder, major depressive disorder, and generalized anxiety disorder began in or are related to active service. See VA treatment records dated in April 2004 and August 2007 as well as the March 2005 report of Dr. Lopez. Please provide a complete explanation for the opinion.

The examiner should also address whether it is at least as likely as not (a probability of 50 percent or greater) that adjustment disorder, major depressive disorder, and generalized anxiety disorder, are due to service-connected disabilities. See the March 2005 report of Dr. Lopez. Please provide a complete explanation for the opinion.

If not, are adjustment disorder, major depressive disorder, and generalized anxiety disorder at least as likely as not aggravated (i.e., worsened in severity) beyond the natural progress by service-connected disabilities. Please provide a complete explanation for the opinion.

Psychological testing deemed warranted should be conducted with a view toward determining whether the Veteran in fact meets the criteria for a diagnosis of PTSD. The VA or VA-contracted psychiatrist or psychologist must identify the specific stressor(s)underlying any PTSD diagnosis and comment upon the link between the current symptomatology and the Veteran's stressor(s). In the report, the examiner must address whether it is at least as likely as not (a probability of 50 percent or greater) that any diagnosed PTSD is related to his fear of hostile military or terrorist activity. If not, is it at least as likely as not (a probability of 50 percent or greater) that any diagnosed PTSD is related to a specific stressor identified by the Veteran. Please provide a complete explanation for the opinion.

8. Provide the Veteran with a Statement of the Case as to the issues of entitlement to an initial compensable disability rating for the service-connected right knee patellar tendonitis, status post anterior cruciate ligament (ACL) tear, in accordance with 38 U.S.C.A. § 7105 (West 2002) and 38 C.F.R. §§ 19.29, 19.30 (2012). If the Veteran perfects his appeal by submitting a timely and adequate substantive appeal, then the RO should return the claim to the Board for the purpose of appellate disposition.

9. After conducting any further development deemed necessary and ensuring that all examinations are complete, readjudicate the issues on appeal. If any benefit sought remains denied, the Veteran and his representative should be furnished a supplemental statement of the case in accordance with 38 C.F.R. § 19.31(b)(1), to include the issue of entitlement to an effective date prior to March 18, 2004, for the grant of service connection for hypertension, and be given an opportunity to respond. The case should then be returned to the Board for appellate review, if indicated.

The appellant has the right to submit additional evidence and argument on the matter or matters the Board has remanded. Kutscherousky v. West, 12 Vet. App. 369 (1999).

This claim must be afforded expeditious treatment. The law requires that all claims that are remanded by the Board of Veterans' Appeals or by the United States Court of Appeals for Veterans Claims for additional development or other appropriate

action must be handled in an expeditious manner. See 38 U.S.C.A. §§ 5109B, 7112 (West Supp. 2012).

_____

S. S. TOTH
Veterans Law Judge, Board of Veterans' Appeals

Department of Veterans Affairs

Citation Nr: 1119443
Decision Date: 05/19/11 Archive Date: 05/27/11

DOCKET NO. 06-18 054) DATE
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On appeal from the
Department of Veterans Affairs Regional Office in Waco, Texas

THE ISSUES

1. Entitlement to service connection for a left hand disability, including due to undiagnosed illness.

2. Entitlement to service connection for a right hand disability, including due to undiagnosed illness.

3. Entitlement to service connection for a low back disability, including due to undiagnosed illness.

REPRESENTATION

Appellant represented by: Disabled American Veterans

ATTORNEY FOR THE BOARD

Tiffany Sykes, Associate Counsel
INTRODUCTION

The Veteran served on active duty from June 1999 to August 2004.

This case comes before the Board of Veterans' Appeals (Board) on appeal from an October 2004 rating decision of the Winston-Salem, North Carolina, Department of Veterans Affairs (VA) Regional Office (RO). During the pendency of the appeal, the Veteran moved to Waco, Texas, and his claims file was transferred to the RO in Waco.

There initially were five claims on appeal of entitlement to service connection for a right hand disability, left hand disability, right knee disability, left knee disability and low back disability. In May 2009, the Board remanded these claims to the RO via the Appeals Management Center (AMC) for additional development and consideration. The Board also referred a claim of clear and unmistakable error (CUE) in the October 7, 2004, rating decision that denied service connection for hearing loss to the RO. That claim has since been granted in a July 2010 rating decision and is no longer on appeal because the Veteran has not appealed either the initial rating or effective date. See Grantham v. Brown, 114 F.3d 1156 (Fed. Cir. 1997) (indicating he must separately appeal these "downstream" issues).

In a November 2010 rating decision, the RO also granted the Veteran's claims of service connection for right and left knee disabilities and assigned initial disability ratings of 10 percent, effective August 3, 2004. However, these claims are also no longer on appeal because the Veteran has not appealed either the initial ratings or effective dates. Id.

The case is now, once more, before the Board for appellate review.

FINDINGS OF FACT

1. The Veteran served in the Southwest Asia Theater of operations during the Persian Gulf War in Afghanistan from August 2002 to February 2003 and in Iraq from September 2003 to March 2004.

2. The Veteran's service treatment records note complaints of bilateral hand and low back pain beginning in service. He has continued to complain of pain in his hands and low back since his separation from service, as confirmed by the July 2004, October 2009, and October 2010 VA compensation examinations.

CONCLUSION OF LAW

Resolving all reasonable doubt in his favor, it is just as likely as not that the Veteran's bilateral hand and low back pain is at least partially a manifestation of undiagnosed illness or qualifying chronic disability to warrant presuming they were incurred in service. 38 U.S.C.A. §§ 1101, 1110, 1112, 1113, 1116, 1117, 1131, 1137, 5107 (West 2002 & Supp. 2010); 38 C.F.R. §§ 3.102, 3.303, 3.307, 3.309, 3.317 (2010).

REASONS AND BASES FOR FINDINGS AND CONCLUSION

I. The Duties to Notify and Assist

As provided by the Veterans Claims Assistance Act (VCAA), VA has duties to notify and assist claimants in substantiating claims for VA benefits. 38 U.S.C.A. §§ 5100, 5102, 5103, 5103A, 5107, 5126 (West 2002 & Supp. 2010); 38 C.F.R. §§ 3.102, 3.156(a), 3.159 and 3.326(a) (2010). Here, though, the Board need not discuss whether there has been VCAA compliance because the claims are being granted, regardless. See, e.g., 38 C.F.R. § 20.1102 (2010) (harmless error).

II. Entitlement to Service Connection for Right and Left Hand Disabilities and a Low Back Disability, Including as Due to Undiagnosed Illnesses

The Veteran contends that he suffers from bilateral hand and low back pain as a result of his military service.

Service connection may be established for disability resulting from personal injury suffered or disease contracted in line of duty, or for aggravation of a pre-existing injury suffered or disease contracted in line of duty. 38 U.S.C.A. §§ 1110, 1131; 38 C.F.R. § 3.303. The law also provides that service connection may be granted for any disease diagnosed after discharge when all the evidence, including that pertinent to service, establishes that the disease was incurred in service. 38 C.F.R. § 3.303(d).

Generally, to establish "direct" service connection, there must be (1) medical evidence of a current disability, (2) medical evidence, or in certain circumstances lay testimony, of in-service incurrence or aggravation of an injury or disease, and (3) medical evidence of a nexus between the current disability and the in-service disease or injury. See Gutierrez v. Principi, 19 Vet. App. 1, 5 (2004); Hickson v. West, 12 Vet. App. 247, 253 (1999).

Because the Veteran served in the Southwest Asia Theater of operations during the Persian Gulf War, service connection may also be established under 38 C.F.R. § 3.317. Under that section, service connection may be warranted for a Persian Gulf Veteran who exhibits objective indications of a qualifying chronic disability that became manifest during active military, naval or air service in the Southwest Asia Theater of operations during the Persian Gulf War, or to a degree of 10 percent or more not later than December 31, 2011. 38 C.F.R. § 3.317(a)(1).

For purposes of 38 C.F.R. § 3.317, there are three types of qualifying chronic disabilities: (1) an undiagnosed illness; (2) a medically unexplained chronic multi symptom illness; and (3) a diagnosed illness that the Secretary determines in regulations prescribed under 38 U.S.C.A 1117(d) warrants a presumption of service connection.

An undiagnosed illness is defined as a condition that by history, physical examination, and laboratory tests cannot be attributed to a known clinical diagnosis. In the case of claims based on undiagnosed illness under 38 U.S.C.A. § 1117; 38 C.F.R. § 3.117, unlike those for "direct service connection," there is no requirement that there be competent evidence of a nexus between the claimed illness and service. Gutierrez v. Principi, 19 Vet. App. at 8-9. Further, lay persons are competent to report objective signs of illness. Id. To determine whether the undiagnosed illness is manifested to a degree of 10 percent or more the condition must be rated by analogy to a disease or injury in which the functions affected, anatomical location, or symptomatology are similar. See 38 C.F.R. § 3.317(a)(5); see also Stankevich v. Nicholson, 19 Vet. App. 470 (2006).

A medically unexplained chronic multi symptom illness is one defined by a cluster of signs or symptoms and specifically includes chronic fatigue syndrome, fibromyalgia, and irritable bowel syndrome, as well as any other illness that the Secretary determines meets the criteria in paragraph (a)(2)(ii) of this section for a medically unexplained chronic multi symptom illness.

A medically unexplained chronic multi symptom illness also means a diagnosed illness without conclusive pathophysiology or etiology that is characterized by overlapping symptoms and signs and has features such as fatigue, pain, disability out of proportion to physical findings, and inconsistent demonstration of laboratory abnormalities. Chronic multisymptom illnesses of partially understood etiology and pathophysiology will not be considered medically unexplained. 38 C.F.R. § 3.317(a)(2)(ii).

Effective September 29, 2010, for purposes of 38 C.F.R. § 3.317, presumptive service connection is warranted for Brucellosis; Campylobacter jejuni; Coxiella burnetii (Q fever); Malaria; Mycobacterium tuberculosis; Nontyphoid Salmonella; Shigella; Visceral leishmaniasis; and West Nile virus. 75 Fed. Reg. 59,968, 59,971 (September 29, 2010) (to be codified at 38 C.F.R. § 3.117(c)(2)).

Objective indications of chronic disability include both "signs," in the medical sense of objective evidence perceptible to an examining physician, and other, non-medical indicators that are capable of independent verification. 38 C.F.R. § 3.317(a)(3). Signs or symptoms that may be manifestations of undiagnosed illness or medically unexplained chronic multi symptom illness include, but are not limited to, the following: (1) fatigue; (2) signs or symptoms involving skin; (3) headache; (4) muscle pain; (5) joint pain; (6) neurologic signs or symptoms; (7) neuropsychological signs or symptoms; (8) signs or symptoms involving the respiratory system (upper or lower); (9) sleep disturbances; (10) gastrointestinal signs or symptoms; (11) cardiovascular signs or symptoms; (12) abnormal weight loss; and (13) menstrual disorders. 38 C.F.R. § 3.317(b).

For purposes of section 3.317, disabilities that have existed for six months or more and disabilities that exhibit intermittent episodes of improvement and worsening over a six-month period will be considered chronic. The six-month period of chronicity will be measured from the earliest date on which the pertinent evidence establishes that the signs or symptoms of the disability first became manifest. 38 C.F.R. § 3.317(a)(4).

Compensation shall not be paid under 38 C.F.R. § 3.317 if there is affirmative evidence that an undiagnosed illness was not incurred during active military, naval, or air service in the Southwest Asia Theater of operations

during the Persian Gulf War; or there is affirmative evidence that an undiagnosed illness was caused by a supervening condition or event that occurred between the Veteran's most recent departure from active duty in the Southwest Asia Theater of operations during the Persian Gulf War and the onset of the illness; or there is affirmative evidence that the illness is the result of the Veteran's own willful misconduct or the abuse of alcohol or drugs. 38 C.F.R. § 3.317(c).

After the evidence has been assembled, it is the Board's responsibility to evaluate the entire record. 38 U.S.C.A. § 7104(a) (West 2002). When there is an approximate balance of evidence regarding the merits of an issue material to the determination of the matter, the benefit of the doubt in resolving each such issue shall be given to the claimant. 38 U.S.C.A. § 5107; 38 C.F.R. § 3.102 (reasonable doubt to be resolved in Veteran's favor). In Gilbert v. Derwinski, 1 Vet. App. 49, 53 (1990), the Court stated that "a Veteran need only demonstrate that there is an 'approximate balance of positive and negative evidence' in order to prevail." To deny a claim on its merits, the preponderance of the evidence must be against the claim. See Alemany v. Brown, 9 Vet. App. 518, 519 (1996), citing Gilbert, 1 Vet. App. at 54.

As an initial matter, the Veteran's DD-Form 214 reflects that he served in the Persian Gulf theater for the purposes of 38 U.S.C.A. § 1117 from August 2002 to February 2003 and again from September 2003 to March 2004.

As to direct service connection, service connection for these disorders cannot be granted. The Board observes that service connection for symptoms such as pain without an identified underlying disability is precluded. See Sanchez-Benitez v. West, 13 Vet. App. 282 (1999) aff'd in part, vacated, and remanded in part on other grounds, 259 F.3d 1356 (Fed. Cir. 2001) (a symptom, without a diagnosed or identifiable underlying malady or condition, does not in and of itself constitute a disability for which service connection may be granted).

Regardless, after review of the record, the probative and persuasive evidence of record reflects that the Veteran's claimed disabilities of bilateral hand and low back pain are the result of his service in Southwest Asia during the Persian Gulf conflict.

Specifically, the evidence reflects that the complaints of bilateral hand and low back pain are not attributable to any diagnosable disorders. The Board notes that the Veteran's service treatment records show complaints of bilateral hand pain beginning in May 2003 and June 2003, following his first period of deployment in Afghanistan, and continuing since that time. Further, the Veteran's low back pain began in January 2002 and May 2002, prior to either deployment, but the Veteran specifically contends that the back pain increased in severity and has continued since his military service ended in August 2004. Moreover, there is no indication the Veteran sustained an injury which may have caused these disorders.

The Veteran underwent a VA examination in July 2004, prior to his separation from service. During this examination, the Veteran did not identify any specific traumatic event to account for the complaints of pain in his hands and low back. Upon physical examination of his hands, the examiner determined they were both normal, without heat, redness, or tenderness. Range of motion was also noted as being within normal limits, and the Veteran had a firm grip. Concerning the low back, the examiner noted the curvature of the lumbosacral spine was maintained, and the back muscles were not in spasm. Further, range of motion was within normal limits, and there was no evidence of muscle atrophy or radiating pain on movement. Consequently, the examiner determined there was "no pathology identified on physical examination to render a diagnosis" for either the Veteran's complaints of pain in his hands or low back. Moreover, x-ray findings for the right and left hands and the low back failed to show any abnormalities.

In October 2009, the Veteran underwent a second VA compensation examination. Upon physical examination of his hands, the examiner noted no symptoms of arthritis. The Veteran could make full grips with both hands, and no fractures or dislocations were found per x-ray findings. The examiner diagnosed idiopathic bilateral hand pain. A medical nexus opinion was not provided.

The October 2009 VA compensation examination of the Veteran's low back also failed to show spasms, ankylosis, incapacitating episodes, pain on motion, or abnormal spinal curvature. Specifically, the Veteran's range of motion was within normal limits, and there was no indication of pain following repetitive motion. Further, x-ray findings showed a normal lumbosacral spine. The VA examiner diagnosed the Veteran with mechanical low back pain but also failed to render a medical opinion as to the etiology of this pain.

The only VA treatment record in the claims file is dated from November 2009, at which time the Veteran continued to complain of bilateral hand pain. However, there was no resultant diagnosis to account for this complaint, much less a medical opinion concerning the etiology of his disorder.

In October 2010, the Veteran again underwent VA compensation examinations specifically to obtain medical nexus opinions concerning his complaints of pain in his hands and low back. The VA examiner specifically opined that the Veteran's bilateral hand and low back conditions were less likely as not caused by or a result of service. The examiner based the medical nexus opinions on the fact that both the July 2004 and October 2009 VA examiners failed to find a specific pathology sufficient to render a diagnosis. However, there is no indication the VA examiner considered the application of 38 C.F.R. § 3.317 when addressing the Veteran's claims.

As such, the Veteran's bilateral hand and low back pain have not been attributed to known causes, and therefore, service connection for these disorders due to undiagnosed illness must be granted on this basis. 38 C.F.R. § 3.317.

ORDER

The claim of service connection for a right hand disability is granted.

The claim of service connection for a left hand disability is granted.

The claim of service connection for a low back disability is granted.

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JENNIFER HWA
Acting Veterans Law Judge, Board of Veterans' Appeals

Department of Veterans Affairs

Citation Nr: 1211176
Decision Date: 03/28/12 Archive Date: 04/05/12

DOCKET NO. 09-27 503) DATE
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On appeal from the
Department of Veterans Affairs Regional Office in San Juan, the Commonwealth of Puerto Rico

THE ISSUES

1. Entitlement to service connection for allergic rhinitis.

2. Entitlement to service connection for macular degeneration, refractive error, incipient senile cataracts, and crowded optic nerve.

3. Entitlement to service connection for headaches.

4. Entitlement to service connection for fatigue.

5. Entitlement to service connection for joint pain.

6. Entitlement to service connection for sleep disturbance.

7. Entitlement to an increased initial rating for a cervical spine disability, rated 10 percent prior to November 10, 2009, and 20 percent since November 10, 2009.

8. Entitlement to an increased initial rating for a lumbar spine disability, rated 10 percent prior to November 10, 2009, and 20 percent since November 10, 2009.

9. Entitlement to a compensable rating for a right elbow disability prior to November 10, 2009, and a rating in excess of 10 percent since November 10, 2009.

10. Entitlement to a compensable rating for trigger finger of the right third finger.

ATTORNEY FOR THE BOARD

A. Cryan, Counsel

INTRODUCTION

The Veteran served on active duty from January 1968, to May 1968, from April 1991 to July 1991, from February 2003 to July 2004, and from February 2006 to October 2007.

This matter comes before the Board of Veterans' Appeals (Board) on appeal from June 2008 and November 2008 rating decisions by the Department of Veterans Affairs (VA) Regional Office (RO) in San Juan, Puerto Rico.

The appeal is REMANDED to the RO via the Appeals Management Center in Washington, D.C.

REMAND

A review of the claims file shows that a remand is necessary before a decision on the merits of the claims can be reached.

As an initial matter, the Board notes that it does not appear that all of the Veteran's service medical records have been associated with the claims file. Records dated as early as 1996 were associated with the claims file. However, the Veteran had periods of service in 1968 and 1991 and no records dated during those time periods are of record. The Veteran's most recent service separation from shows 21 years of inactive duty. It does not appear that any records for the Veteran's periods of inactive duty have been associated with the claims file. The Appeals Management Center should attempt to obtain any records dated during those periods of active service and any period of inactive duty.

The Veteran was last afforded VA examinations to assess his increased ratings claims in November 2009. Although the Veteran has not alleged that the symptomatology of his disabilities has increased in severity, he has indicated that the currently assigned ratings do not accurately compensate the severity of his disabilities, and the examinations are over two years old. Because the November 2009 examinations are somewhat stale, the Board finds that more current examinations are needed in this case.

With regard to the issue of entitlement to rhinitis, the Veteran's service medical records include examinations in April 2001 and March 2002 which do not include any findings related to rhinitis. The Veteran reported asthma on

an April 2001 report of medical history form prepared in conjunction with the April 2001 examination.

VA outpatient treatment reports show that the Veteran was seen for a report of rhinitis in February 2005. He reported that he had previously undergone a surgical procedure to remove nasal polyps.

Service medical records for the Veteran's last period of service reflect complaints and treatment for allergies and nasal congestion which required the use of medications. Allergic rhinitis was listed as part of the Veteran's medical history on an entry dated in July 2007.

A Veteran is presumed sound on entry into service except for conditions noted on examination at the time of entry into service, or shown by clear and unmistakable evidence to have pre-existed service. 38 U.S.C.A. § 1132 (West 2002); 38 C.F.R. § 3.303(c) (2011). Only those conditions recorded in examination reports can be considered as noted and a history of preservice existence of conditions recorded at the time of examination does not constitute a notation of a condition. 38 C.F.R. § 3.304(b) (2011). Determination of the existence of a pre-existing condition may be supported by contemporaneous evidence, or recorded history in the record, which provides a sufficient factual predicate to support a medical opinion or a later medical opinion based upon statements made by the Veteran about the pre-service history of his condition. Miller v. West, 11 Vet. App. 345 (1998); Harris v. West, 203 F.3d. 1347 (Fed. Cir. 2000).

To rebut the presumption of sound condition for conditions not noted at entrance into service, VA must show by clear and unmistakable evidence both that the disease or injury existed prior to service and that the disease or injury was not aggravated by service. VAOPGCPREC 3-03 (July 16, 2003), 70 Fed. Reg. 23027 (May 4, 2005). A lack of aggravation may be shown by establishing that there was no increase in disability during service or that any increase in disability was due to the natural progress of the preexisting condition. Wagner v. Principi, 370 F.3d 1089 (Fed. Cir. 2004); 38 U.S.C.A. § 1153 (West 2002).

In order to properly assess the Veteran's claim for service connection for rhinitis, he should be scheduled for a VA examination which includes an opinion as to the etiology of the claimed rhinitis.

With regard to the issue of entitlement to service connection for macular degeneration, refractive error, incipient senile cataracts, and crowded optic nerve, the Veteran's service medical records dated in June 2007 show a diagnosis of macular degeneration of both eyes, optic nerve hypoplasia of the right eye, and presbyopia. Refractive error was also listed as one of the Veteran's problems in a July 2007 entry.

The Veteran was afforded a VA examination in March 2008 at which time the examiner diagnosed the Veteran with refractive error, bilateral incipient senile cataracts, and small optic nerves with crowded optic nerve in the right eye. The examiner opined that the Veteran's loss of vision was caused by or as a result of his refractive error and that the right eye crowded optic nerve was not related to his military service and was likely an anatomic variation. The examiner noted that cluster headaches should not be ruled out. With regard to the Veteran's symptoms (described as right eye stabbing pain and light flashes), the examiner was unable to resolve that issue without resort to mere speculation. No determination was made with regard to whether macular degeneration was an appropriate diagnosis. Because it is not clear whether macular degeneration is an appropriate diagnosis and because the examiner failed to offer an opinion as to the etiology of the diagnosed cataracts, another examination with etiology opinion should be obtained.

With regard to the issues of headaches, fatigue, joint pain, and sleep disturbance, the Veteran has claimed those disabilities are due to anthrax vaccines. Additionally, the Veteran has indicated that fatigue, joint pain, and sleep disturbance are a cluster of symptoms of fibromyalgia.

The Veteran had service in Afghanistan during the time period from June 2006 to May 2007. Thus, his claims for service connection must also be considered as possibly due to undiagnosed illnesses or as fibromyalgia. 38 U.S.C.A. § 1117 (West 2002); 38 C.F.R. § 3.317 (2011). Compensation is warranted for a Persian Gulf Veteran who exhibits objective indications of a qualifying chronic disability that became manifest during service on active duty in the Armed Forces in the Southwest Asia theater of operations, or to a degree of 10 percent during the presumptive period prescribed by the Secretary. The term "qualifying chronic disability" includes an undiagnosed illness, or a medically unexplained chronic multi-symptom illness (such as chronic fatigue syndrome, fibromyalgia, and irritable bowel syndrome) that is defined by a cluster of signs or symptoms. 38 C.F.R. § 3.317(a)(2) (2011). Objective indications of a qualifying chronic disability include both signs, in a medical sense of objective evidence perceptible to an examining physician, and other, non-medical indicators that are capable of independent verification. 38 C.F.R. § 3.317(a)(3) (2011).

An undiagnosed illness is defined as a condition that, by history, physical examination and laboratory tests cannot be attributed to a known clinical diagnosis. 38 C.F.R. § 3.317(a)(1)(ii) (2011). Signs or symptoms that may be manifestations of undiagnosed illness or medically unexplained chronic multi-symptom illness include, but are not limited to, the following: (1) fatigue; (2) signs or symptoms involving skin; (3) headache; (4) muscle pain; (5) joint pain; (6) neurologic signs or symptoms; (7) neuropsychological signs or symptoms; (8) signs or symptoms involving the respiratory system (upper or lower); (9) sleep disturbances; (10) gastrointestinal signs or symptoms; (11) cardiovascular signs or symptoms; (12) abnormal weight loss; and (13) menstrual disorders. 38 C.F.R. § 3.317(b) (2011).

Although the Veteran was afforded several examinations, the Veteran was not specifically examined for the purpose of ascertaining the nature and etiology of the claimed disorders. Moreover, because the Veteran has confirmed service in the Southwest Asia theater of operations from 2006 to 2007, has reported symptomatology which may be a signs or symptoms of an undiagnosed illness, and the issue of service connection for an undiagnosed illness has not been adjudicated by the RO, the Board finds that an examination should be scheduled to determine whether the Veteran has an undiagnosed illness manifested by headaches, fatigue, joint pain, and sleep disturbance, whether

any disorders are a medically unexplained chronic multi-symptom illness such as fibromyalgia, or whether they are otherwise related to service, including vaccinations for anthrax.

Associated with the claims file are VA outpatient treatment reports dated from February to May 2005. Because there may be outstanding VA medical records that contain information pertinent to the Veteran's claims, an attempt to obtain such records should be made. 38 C.F.R. § 3.159(c)(2) (2011); Bell v. Derwinski, 2 Vet. App. 611 (1992).

Accordingly, the case is REMANDED for the following action:

1. Contact the National Personnel Records Center (NPRC) or any other appropriate agencies to obtain the Veteran's service medical records for periods of active service in 1968 and 1991 and all periods of inactive service. Any available records should be associated with the claims file. Any negative responses should be associated with the claims file.

2. Obtain any VA outpatient treatment reports dated since May 2005. If the Veteran identifies any other relevant medical records, those records should be obtained. Any negative responses should be associated with the claims file.

3. Schedule the Veteran for the appropriate VA examinations to assess his service-connected cervical and lumbar spine disorders, right elbow epicondylitis and trigger finger of the right third finger. The examiner must review the claims file and must note that review in the report. Any and all indicated evaluations, studies, and tests deemed necessary by the examiner should be accomplished and any results must be included in the examination report. Range of motion studies must be conducted and all functional losses should be identified, such as pain on use, weakness, incoordination, fatigability, or excess motion. The spine examination should include a neurological examination. A complete rationale for any opinions expressed must be provided.

4. Schedule the Veteran for a VA examination to assess his claimed rhinitis. The examiner must review the claims file and must note that review in the report. The report of examination should include a complete rationale for all opinions expressed. Any necessary tests should be obtained. The examiner should provide an opinion as to whether it is at least as likely as not (50 percent or greater probability) that rhinitis is related to the Veteran's active service, including treatment for nasal congestion and allergies in service. The examiner should also specifically state whether there is clear and unmistakable evidence that rhinitis existed prior to service and, if so, whether rhinitis was aggravated beyond the natural progression of the disorder by the Veteran's active service.

5. Schedule the Veteran for a VA examination to determine the etiology of any current eye disability. The examiner should review the claims file and should note that review in the examination report. The report of examination should include a complete rationale for all opinions expressed. Specifically the examiner should provide the following information:

a) Diagnose all current eye disabilities.

b) Is it at least as likely as not (50 percent or more probability) that any current eye disability is related to the Veteran's service, or to his inservice treatment for macular degeneration, optic nerve hypoplasia of the right eye, or presbyopia?

c) For each eye disability diagnosed, please state whether that disability is refractive error or a congenital or developmental defect.

d) For each eye disability found to be refractive error or a congenital or development defect, state whether that disability was increased in severity beyond the natural progress of the disorder during the Veteran's service.

6. Schedule the Veteran for a VA examination to determine the nature and etiology of the claimed headaches, fatigue, joint pain, and sleep disturbance. The examiner must review the claims file and must note that review in the report. All indicated tests should be conducted, and the reports of any such studies should be incorporated into the examination report to be associated with the claims file. For any disorder found on examination, the examiner should opine as to whether it is at least as likely as not (probability of 50 percent or greater) that the disability had its onset as a result of military service or is otherwise related to active duty including vaccinations for anthrax. The examiner should set forth the medical reasons for accepting or rejecting the Veteran's lay statements regarding the manifestations of the claimed disorders and provide a complete rationale for all opinions expressed. The examiner should further indicate whether any symptomatology represents an objective indication of chronic disability resulting from an undiagnosed illness related to the Veteran's service in the Southwest Asia theater of operations, or a medically unexplained chronic multisymptom illness such as fibromyalgia. For the claimed headaches, fatigue, joint pain, and sleep disturbance, the examiner should specifically state for each disorder whether the disorder can be attributed to a known clinical diagnosis.

7. Then, readjudicate the claims. If action remains adverse to the Veteran, issue a supplemental statement of the case and allow the appropriate time for response. Then, return the case to the Board.

The appellant has the right to submit additional evidence and argument on the matter or matters the Board has remanded. Kutscherousky v. West, 12 Vet. App. 369 (1999).

This claim must be afforded expeditious treatment. The law requires that all claims that are remanded by the Board or the United States Court of Appeals for Veterans Claims for additional development or other appropriate action must be handled in an expeditious manner. 38 U.S.C.A. §§ 5109B, 7112 (West Supp. 2011).

_____
HARVEY P. ROBERTS
Veterans Law Judge, Board of Veterans' Appeals

Under 38 U.S.C.A. § 7252 (West 2002), only a decision of the Board of Veterans' Appeals is appealable to the United States Court of Appeals for Veterans Claims. This remand is in the nature of a preliminary order and does not constitute a decision of the Board on the merits of your appeal. 38 C.F.R. § 20.1100(b) (2011).

Citation Nr: 1042785
Decision Date: 11/15/10 Archive Date: 11/24/10

DOCKET NO. 09-01 771) DATE
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On appeal from the
Department of Veterans Affairs Regional Office in St. Petersburg, Florida

THE ISSUES

1. Entitlement to service connection for bilateral hearing loss.

2. Entitlement to service connection for brain trauma, also claimed as traumatic brain injury (TBI).

3. Entitlement to service connection for a low back disorder.

4. Entitlement to service connection for a disorder of the cervical spine.

5. Entitlement to service connection for migraine headaches.

6. Entitlement to service connection for a psychiatric disorder, to include posttraumatic stress disorder (PTSD).

REPRESENTATION

Appellant represented by: Disabled American Veterans

WITNESS AT HEARING ON APPEAL

Appellant

ATTORNEY FOR THE BOARD

Jeanne Schlegel, Counsel

INTRODUCTION

The Veteran served on active duty from June 2004 to October 2004, and from March 2005 to August 2006.

This matter comes before the Board of Veterans' Appeals (Board) from May and October 2008 (PTSD) rating decisions of the Department of Veterans Affairs (VA) Regional Office (RO) in St. Petersburg, Florida.

The Veteran provided testimony at a travel Board hearing held before the undersigned Veterans Law Judge (VLJ) in July 2010. A transcript of that hearing is of record. During the hearing, the parties agreed to hold the record open for 60 days to allow for the submission of additional evidence. Additional evidence was received during this time period which was accompanied by a waiver.

At the July 2010 hearing, the Veteran elected to withdraw from appellate consideration service connection claims for bilateral hearing loss and brain trauma/TBI. Accordingly, those claims will be formally dismissed herein.

The Board also notes that a service connection claim for tinnitus was appealed following the denial of the claim in a May 2008 rating action. While the appeal was pending, the claim was granted by virtue of a May 2009 rating decision. Accordingly, that claim is no longer in appellate status before the Board.

In July 2008, the Veteran originally filed a claim of entitlement to service connection for PTSD, as well as claiming service

connection for an additional psychiatric disorder identified as anxiety. Accordingly, the Board has recharacterized the issue on appeal to be more expansive, as indicated on the title page. See Clemons v. Shinseki, 23 Vet. App. 1, 4-5 (2009), (the scope of a claim pursued by a claimant includes any diagnosis that may reasonably be encompassed by the claimant's description of the claim, reported symptoms, and the other information of record).

The service connection claims for a disorder of the cervical spine, headaches and a psychiatric disorder to include PTSD are addressed in the REMAND portion of the decision below and are REMANDED to the RO via the Appeals Management Center (AMC), in Washington, DC.

FINDINGS OF FACT

1. In July 2010, prior to promulgation of a decision in the appeal, the Veteran withdrew his appeal as to the claims of entitlement to service connection for bilateral hearing loss and brain trauma/TBI.

2. A currently manifested low back disorder, diagnosed as degenerative disk disease at L5-S1, has been etiologically linked by competent medical evidence and credible lay evidence to the Veteran's period of active service.

CONCLUSIONS OF LAW

1. The criteria for withdrawal of a substantive appeal by the Veteran pertaining to the claim of entitlement to service connection for bilateral hearing loss, have been met. 38 U.S.C.A. § 7105(b)(2), (d)(5) (West 2002); 38 C.F.R. §§ 20.202, 20.204 (2010).

2. The criteria for withdrawal of a substantive appeal by the Veteran pertaining to the claim of entitlement to service connection for brain trauma, also claimed as TBI, have been met. 38 U.S.C.A. § 7105(b)(2), (d)(5) (West 2002); 38 C.F.R. §§ 20.202, 20.204 (2010).

3. Resolving all reasonable doubt in the Veteran's favor, the criteria for service connection for a low back disorder are met. 38 U.S.C.A. § 1110 (West 2002); 38 C.F.R. §§ 3.102, 3.159, 3.303 (2010).

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

Under 38 U.S.C.A. § 7105, the Board may dismiss any appeal which fails to allege specific error of fact or law in the determination being appealed. A substantive appeal may be withdrawn in writing at any time before the Board promulgates a decision. 38 C.F.R. § 20.202. Withdrawal may be made by the appellant or by his or her authorized representative. 38 C.F.R. § 20.204.

At the July 2010 travel Board hearing, the Veteran and his representative expressed their intention to withdraw the appeals relating to service connection claims for bilateral hearing loss and brain trauma/TBI. The hearing transcript documents this action as well as the Veteran's understanding and affirmation to withdraw those issues from appellate consideration. Therefore, no allegations of errors of fact or law, therefore, remain for appellate consideration with respect to these two claims. Accordingly, the Board does not have jurisdiction to review the appeal with respect to the two aforementioned claims and they are dismissed.

Duty to Notify and Assist

Initially, the Board observes that the Veteran's service treatment records (STRs) are unavailable in this case. Even prior to the enactment of the Veterans Claims Assistance Act of 2000, the United States Court of Appeals for Veterans Claims

(Court) had held that in cases where the Veteran's STRs were unavailable/incomplete, through no fault of the veteran, there was a "heightened duty" to assist the veteran in the development of the case. See generally McCormick v. Gober, 14 Vet. App. 39, 45-49 (2000); O'Hare v. Derwinski, 1 Vet. App. 365, 367 (1991). In this case, a formal finding of unavailability of the Veteran's complete STRs was made in May 2008 and the record reflects that the Veteran is aware of this fact.

The Veterans Claims Assistance Act of 2000 (VCAA), 38 U.S.C.A. §§ 5100, 5102-5103A, 5106, 5107, 5126 (West 2002 & Supp. 2009), 38 C.F.R. §§ 3.102, 3.156(a), 3.159 and 3.326(a) (2010), requires VA to assist a claimant at the time that he or she files a claim for benefits. As part of this assistance, VA is required to notify claimants of what they must do to substantiate their claims. 38 U.S.C.A. § 5103(a); 38 C.F.R. § 3.159(b)(1).

Specifically, VA must inform the claimant of any information and evidence not of record (1) that is necessary to substantiate the claim; (2) that the claimant is to provide; and (3) that VA will attempt to obtain. See Beverly v. Nicholson, 19 Vet. App. 394, 403 (2005) (outlining VCAA notice requirements)

Further, in Dingess v. Nicholson, the United States Court of Appeals for Veterans Claims (Court) held that, upon receipt of an application for a service-connection claim, VA is required to review the evidence presented with the claim and to provide the Veteran with notice of what evidence not previously provided will help substantiate the claim. 19 Vet. App. 473 (2006); see also 38 U.S.C.A. § 5103(a); 38 C.F.R. § 3.159(b).

A VCAA notice letter was sent to the Veteran in November 2007, which addressed the service connection claim for a low back disorder. This letter appears to have satisfied the requirements of the VCAA. The Board also notes that the November 2007 letter provided the Veteran with notice as required by the United States Court of Appeals for Veterans Claims in Dingess v. Nicholson, 19 Vet. App. 473 (2006).

The Board need not, however, discuss in further detail the sufficiency of the letter or VA's development of the claim in light of the fact that the Board is granting the service connection claim for a low back disorder. Any potential error on the part of VA in complying with the provisions of the VCAA has essentially been rendered moot by the Board's grant of the benefits sought on appeal.

Factual Background

The Veteran filed a service connection claim for a low back disorder in October 2007.

The file contains a copy of a medical history prescreening report dated in December 2003, reflecting that the Veteran denied having a history of recurrent back pain or back surgery, and that clinical evaluation of the spine was normal. Also on file is a post-deployment health assessment report dated in July 2006, which indicates that the Veteran's MOS was as a truck driver and reflects that he denied having back pain during deployment.

The file includes two lay statements provided in November 2007, apparently from family members, indicating that the Veteran had been in contact with them during his period of service and had complained of back soreness which he believed was due to unloading trucks and lifting supplies. A third lay statement was received from a military comrade of the Veteran's who served in Afghanistan with him, which indicated that the Veteran was tasked with lifting and carrying boxes of heavy ammunition. The statement indicated that during deployment, the Veteran had told the author of the statement (Sgt. M. A.) that he was having problems with back pain and cramping, with frequent complaints of back pain throughout the deployment.

A VA record dated in October 2007 documents the Veteran's complaints of low back pain and reflects that scoliosis was shown on examination.

A physical profile report of August 2009 reveals that the Veteran was on a permanent profile due to a back condition and PTSD, for which he was being followed by VA.

The Veteran presented testimony at a travel Board hearing held in July 2010. He indicated that he sustained a back injury during service during a particular mission in Afghanistan which involved lifting Air Force pallets onto a truck. The Veteran indicated that he reported the injury and sought treatment at that time; however it was noted at the hearing that the Veteran STRs could not be located. He further indicated that he had sought treatment for low back problems since service from a private source, Dr. G.

At and following the hearing, additional evidence was presented for the record which was accompanied by a waiver. This evidence includes a VA MRI report of the lumbar spine dated in August 2008 which reveals degenerative disc disease (DDD) at L5-S1 with disc desiccation and Schmorl's node defect. Also presented was a private medical statement of Dr. G. dated in March 2009, indicating that the Veteran had been a patient of his since September 2008, due to back pain which the Veteran had developed during military service while driving trucks and lifting heavy objects. Dr. G. noted that an MRI of the lumbar spine had revealed DDD at L5-S1 and observed that there seemed to be some narrowing of the neural foramen at L5-S1 with annular disk bulge. The doctor indicated that the Veteran was taking Oxycodone daily, due to symptoms of pain and tenderness, and advised that he should avoid lifting over 10 pounds. D.G's prognosis revealed that the Veteran had a chronic illness with the possibility that he might develop more degenerative changes in the spine.

Analysis

The Veteran maintains that service connection is warranted for a low back disorder. On the formal claim form (VA Form 21-526), he indicated that he served in Afghanistan from July 2005 to July 2006, performing duties as a truck driver for 5-ton vehicles. He stated that he sustained lumbar strain from lifting crates of heavy ammunition to the truck bed, which was 5 feet high.

When, through no fault of a veteran, records under the control of the Government are unavailable, VA's duty then requires that VA advise the veteran of his right to support his claim by submitting alternate sources of evidence, including service medical personnel statements, or lay evidence, such as "buddy" affidavits or statements. Dixon v. Derwinski, 3 Vet. App. 261, 263 (1992). Washington v. Nicholson, 19 Vet. App. 362 (2005); Cromer v. Nicholson, 19 Vet. App. 215 (2005). The Veteran was notified in correspondence dated in May 2008 that his STRS could not be located and a formal finding to this effect was also issued for the file in May 2008.

In a case such as this where it appears that Veteran's STRs are unavailable, the Board's obligation to explain its findings and conclusions, and to consider carefully the benefit-of-the-doubt rule, is heightened. See O'Hare v. Derwinski, 1 Vet. App. 365, 367 (1991); Pruitt v. Derwinski, 2 Vet. App. 83, 85 (1992). The Board must point out; however, the O'Hare precedent does not raise a presumption that the missing medical records would, if they still existed, necessarily support the Veteran's claim.

It is VA's defined and consistently applied policy to administer the law under a broad interpretation, consistent, however, with the facts shown in every case. When, after careful consideration of all procurable and assembled data, a reasonable doubt arises regarding service origin, the degree of disability, or any other point, such doubt will be resolved in favor of the claimant. By reasonable doubt it is meant that an approximate balance of positive and negative evidence exists which does not satisfactorily prove or disprove the claim. It is a substantial doubt and one within the range of probability as distinguished from pure speculation or remote possibility. See 38 U.S.C.A. § 5107(b) (West 2002); 38 C.F.R. § 3.102 (2010).

Case law does not establish a heightened "benefit of the doubt," only a heightened duty of the Board to consider the applicability of the benefit of the doubt, to assist the claimant in developing the claim, and to explain its decision when the veteran's medical records have been destroyed. See Ussery v. Brown, 8 Vet. App. 64 (1995). Similarly, the case law does not lower the legal standard for proving a claim for service connection, but rather increases the Board's obligation to evaluate and discuss in its decision all of the evidence that may be favorable to the appellant. Russo v. Brown, 9 Vet. App. 46 (1996).

Service connection may be granted if the evidence demonstrates that a current disability resulted from an injury or disease incurred or aggravated in active military service. 38 U.S.C.A. § 1110; 38 C.F.R. § 3.303(a). If there is no showing of a resulting chronic condition during service, then a showing of continuity of symptomatology after service is required to support a finding of chronicity. 38 C.F.R. § 3.303(b). Service connection may also be granted for any injury or disease diagnosed after discharge, when all the evidence, including that pertinent to service, establishes that the disease or injury was incurred in service. 38 C.F.R. § 3.303(d). Moreover, where a veteran served continuously for ninety (90) days or more during a period of war, or during peacetime service after December 31, 1946, and arthritis becomes manifest to a degree of 10 percent within one year from date of termination of such service, such disease shall be presumed to have been incurred in service, even though there is no evidence of such disease during the period of service. 38 C.F.R. § 3.307(a)(1).

Generally, in order to establish service connection, there must be (1) evidence of a current disability; (2) medical, or in certain circumstances, lay evidence of in-service incurrence or aggravation of a disease or injury; and (3) evidence of a nexus between the claimed in-service disease or injury and the current disability. See Hickson v. West, 12 Vet. App. 247, 253 (1999).

In this case, element (1) evidence of the currently claimed low back disability, is clearly established by findings of DDD at L5-S1, made upon MRI studies of August 2008.

With respect to element (2), evidence of service incurrence, as previously noted there are essentially no STRs on file. However, the Veteran has provided credible testimony to the effect that while serving in Afghanistan, he sustained a back injury for which he sought treatment. A veteran is competent to testify as to a condition within his knowledge and personal observation. See Barr v. Nicholson, 21 Vet. App. 303 (2007). His testimony is corroborated by 3 lay statements attesting to the personal knowledge of (military comrade), and reports from the Veteran made during service (to family members), relating to his having back problems during service. Lay assertions may serve to support a claim for service connection by supporting the occurrence of lay-observable events or the presence of disability or symptoms of disability subject to lay observation. 38 U.S.C.A. § 1153(a); 38 C.F.R. § 3.303(a); Jandreau v. Nicholson, 492 F.3d 1372 (Fed. Cir. 2007); see Buchanan v. Nicholson, 451 F. 3d 1331, 1336 (Fed. Cir. 2006) (addressing lay evidence as potentially competent to support presence of disability even where not corroborated by contemporaneous medical evidence).

While clinical evidence does not reflect that the Veteran's back problems materialized during the first post-service year; the earliest documentation of back complaints is shown in a VA medical record of October 2007, just following the Veteran's first post-service year. Significantly, a private medical statement of May 2009 documents the Veteran's complaints of back pain in and since military service, essentially linking such complaints to the post-service findings of DDD at L5-S1.

The file contains credible and consistent clinical documentation and lay evidence of the Veteran's in-service back injury and of continuity and chronicity of low back problems in and since service. Significantly, the Veteran's complaints of low back symptomatology are well documented in clinical records dated from

2007 forward and current manifestations have essentially been linked to service by the Veteran's private doctor.

In essence, all of the elements as discussed in the Hickson case have been established. The Board could remand this case for medical opinion that provides a more detailed discussion regarding the relationship between service and the currently manifested symptomatology and diagnoses relating to the low back. However, given the proximity of the time frame, lay and documented clinical evidence of chronicity and continuity of low back symptomatology in and since service, and the absence of STRs in this case, the Board concludes that the evidence is at least in equipoise as to the matter of to whether the a currently manifested low back disorder is etiologically linked to service. Accordingly, a remand is not necessary here. Cf. Mariano v. Principi, 17 Vet. App. 305, 312 (2003) (noting that, because it is not permissible for VA to undertake additional development to obtain evidence against an appellant's case, VA must provide an adequate statement of reasons or bases for its decision to pursue such development where such development could be reasonably construed as obtaining additional evidence for that purpose.)

Resolving any doubt in favor of the Veteran, the Board concludes that service connection for a low back disorder is warranted. Accordingly, the claim is granted.

ORDER

The appeal concerning the issue of entitlement to service connection for bilateral hearing loss is dismissed.

The appeal concerning the issue of entitlement to service connection for brain trauma, also claimed as TBI, is dismissed.

Entitlement to service connection for a low back disorder is granted, subject to the law and regulations governing the award of monetary benefits.

REMAND

Additional development is required with respect to the service connection claims for a disorder of the cervical spine, headaches, and for a psychiatric disorder to include PTSD.

Initially, the Board points out that VA examinations have not yet been furnished with respect to any of the aforementioned claimed conditions, but are warranted in this case, for reasons which will be discussed herein and in light of the fact that the service treatment records (STRs) in this case are unavailable. In cases where the STRs are unavailable or incomplete through no fault of the Veteran, there is a heightened obligation to assist the Veteran in the development of his case. O'Hare v. Derwinski, 1 Vet. App. 365 (1991).

The Board notes that fulfillment of VA's duty to assist a claimant includes providing a medical examination or obtaining a medical opinion where it is deemed necessary to make a decision on the claim. 38 U.S.C.A. § 5103A (West 2002); 38 C.F.R. § 3.159(c)(4) (2009). In a claim for service connection, medical evidence that suggests a nexus but is too equivocal or lacking in specificity to support a decision on the merits still triggers the duty to assist if it indicates that the Veteran's condition may be associated with service. McLendon v. Nicholson, 20 Vet. App. 79 (2006) (recognizing that 38 C.F.R. § 3.159(c)(4) presents a low threshold for the requirement that evidence indicates that the claimed disability/death may be associated with in-service injuries for purposes of a VA examination).

With respect to the service connection claim for a disorder of the cervical spine, the Veteran maintains that this condition was caused by the use of Kevlar helmets jolting in a 5-ton truck riding over unpaved roads in Afghanistan, in conjunction with his MOS as a truck driver. A VA medical record dated in March 2009 reflects that muscle spasms of the neck were noted. A private

medical statement of Dr. G. indicates that the Veteran had cervicalgia with pain, but it is not clear that this finding relates to the neck and cervical spine. As such, it is not clear at this point whether the Veteran has a current neck disability, and whether if so, such is etiologically related to service. As such, additional development of this claim, to include providing a VA examination, is warranted.

With respect to the Veteran's claimed headaches, in hearing testimony provided in 2010, he indicated that he began experiencing headaches upon returning from Southwest Asia and has continued to have problems since that time. Complaints of headaches are shown in VA records dated in 2009, assessed as atypical head pains and possible ice pick headaches.

Because the veteran served in the Southwest Asia Theater of operations during the Persian Gulf War period, service connection may also be established under 38 C.F.R. § 3.317. Under that section, service connection may be warranted for (1) a Persian Gulf veteran who (2) exhibits objective indications of chronic disability resulting from an illness or combination of illnesses manifested by one or more signs or symptoms such as those listed in paragraph (b) of 38 C.F.R. § 3.317; which (3) became manifest either during active military, naval or air service in the Southwest Asia theater of operations during the Persian Gulf War, or to a degree of 10 percent or more not later than December 31, 2011; and (4) that such symptomatology by history, physical examination, and laboratory tests cannot be attributed to any known clinical diagnosis. See 71 Fed. Reg. 75669, 75672 (Dec. 18, 2006); 38 C.F.R. § 3.317(a)(1); see also see Neumann v. West, 14 Vet. App. 12, 22 (2000), vacated on other grounds, 14 Vet. App. 304 (2001) (per curiam order). Signs or symptoms that may be manifestations of undiagnosed illness or medically unexplained chronic multisymptom illness include, headaches. 38 C.F.R. § 3.317(b). As such, a VA examination addressing the theories of entitlement raised by the evidence pertaining to this claim is warranted.

With respect to the Veteran's claim for a psychiatric disorder to include PTSD, VA records reflect that anxiety disorder was diagnosed in August 2008. As such, clarification is required to ascertain whether the Veteran currently has a diagnosed psychiatric disorder other than PTSD which is etiologically related to service, warranting additional development.

There is no current diagnosis of PTSD on file; however, a physical profile form dated in September 2009 references PTSD for which the Veteran was being followed by VA. Establishing service connection for PTSD requires that there be (1) medical evidence diagnosing the condition in accordance with 38 C.F.R. § 4.125(a); (2) a link, established by medical evidence, between current symptoms and an in-service stressor; (3) and credible supporting evidence that the claimed in-service stressor actually occurred. 38 C.F.R. § 3.304(f) (2010); see also Cohen v. Brown, 10 Vet. App. 128, 138 (1997). The diagnosis of a mental disorder must conform to the Diagnostic and Statistical Manual of Mental Disorders (4th ed. 1994) (DSM-IV) and be supported by the findings of a medical examiner. See 38 C.F.R. § 4.125(a) (2010).

In adjudicating a service connection claim for PTSD, VA is required to evaluate the supporting evidence in light of the places, types, and circumstances of service, as evidenced by service records, the official history of each organization in which the Veteran served, the Veteran's military records, and all pertinent medical and lay evidence. 38 U.S.C.A. § 1154(a); 38 C.F.R. §§ 3.303(a), 3.304.

Effective July 13, 2010, VA amended 38 C.F.R. § 3.304(f) by liberalizing, in certain circumstances, the evidentiary standards for establishing the occurrence of an in-service stressor for non-combat veterans. See 75 Fed. Reg. 39,843-39,852 (effective July 13, 2010). These revised regulations apply in cases like the Veteran's, which were appealed to the Board prior to July 13, 2010, but not decided by the Board as of that date. 75 Fed. Reg. 41092 (July 15, 2010) (to be codified at 38 C.F.R. § 3.304(f)).

The revised regulations pertaining to PTSD no longer require the verification of an in-service stressor if the Veteran was in a location involving "fear of hostile military or terrorist activity." Such a location can be evidenced by awards such as the Iraq Campaign Medal or the Vietnam Service Medal. Lay testimony alone can be used to establish the occurrence of an in-service stressor in these situations. The new regulatory provision requires that: (1) A VA psychiatrist or psychologist, or contract equivalent, must confirm that the claimed stressor is adequate to support a diagnosis of PTSD; (2) the claimed stressor is consistent with the places, types, and circumstances of the Veteran's service; and (3) the Veteran's symptoms are related to the claimed stressor. Id.

Specifically, the amended version of 38 C.F.R. § 3.304(f)(3) states:

If a stressor claimed by a veteran is related to the veteran's fear of hostile military or terrorist activity and a VA psychiatrist or psychologist, or a psychiatrist or psychologist with whom VA has contracted, confirms that the claimed stressor is adequate to support a diagnosis of [PTSD] and the veteran's symptoms are related to the claimed stressor, in the absence of clear and convincing evidence to the contrary, and provided the claimed stressor is consistent with the places, types, and circumstances of the veteran's service, the veteran's lay testimony alone may establish the occurrence of the claimed in-service stressor.

For purposes of this paragraph, "fear of hostile military or terrorist activity" means that a veteran experienced, witnessed, or was confronted with an event or circumstance that involved actual or threatened death or serious injury, or a threat to the physical integrity of the veteran or others, such as from an actual or potential improvised explosive device; vehicle-imbedded explosive device; incoming artillery, rocket, or mortar fire; grenade; small arms fire, including suspected sniper fire; or attack upon friendly military aircraft, and the veteran's response to the event or circumstance involved a psychological or psycho-physiological state of fear, helplessness, or horror.

Previously, VA was required to undertake extensive development to determine whether a non-combat veteran actually experienced the claimed in-service stressor and lay testimony, by itself, was not sufficient to establish the occurrence of the alleged stressor; instead, credible supporting evidence of a corroborated in-service stressor was required. Dizoglio v. Brown, 9 Vet. App. 163, 166 (1996).

At this point, there is no PTSD diagnosis of record, it has not been established that the Veteran engaged in combat with the enemy and his reported in-service stressors have not been corroborated. However, in light of the amendment to VA regulations discussed above, the Board finds that a remand is necessary to afford the Veteran a VA examination with a VA psychiatrist or psychologist or a psychiatrist or psychologist with whom VA has contracted in order to give him an opportunity to substantiate his claim.

The AMC/RO shall arrange for the Veteran to undergo the development requested herein. In addition, the Veteran will be given an opportunity to provide any additional information or evidence relating this claim on Remand.

Accordingly, the case is REMANDED for the following action:

1. The Veteran should be afforded an opportunity to submit or identify any additional evidence relevant to his service connection claims for a disorder of the cervical spine, headaches, and for a psychiatric disorder to include PTSD. Based on his response, the RO must attempt to procure copies of all records which have not previously been obtained from identified treatment sources. In addition, all VA psychiatric records, as well as outpatient records dated from April 2009 forward should be obtained for the record.

2. The RO/AMC shall arrange for the Veteran to undergo an appropriate VA examination so as to ascertain the underlying cause, time of onset, and etiology of his claimed disorder of the cervical spine (not claimed as a manifestation of undiagnosed illness). The claims file, to include a complete copy of this remand, shall be made available to the examiner in conjunction with conducting the examination of the Veteran. The examiner shall annotate the report to reflect that review of the claims file was undertaken. A discussion of the Veteran's lay history and symptomatology as well as the documented pertinent medical history should also be included. All appropriate tests or studies should be accomplished, and all clinical findings should be reported in detail. The examiner's report shall also address the following matters:

A The examiner shall clearly identify (by diagnosis) whether the Veteran currently has a disability or disabilities of the cervical spine.

B. If the Veteran has a currently manifested disorder of the cervical spine, the examiner should render an opinion as to whether it is at least as likely as not (a 50 percent or more probability) that the disability found on examination is of service etiology; i.e. was incurred in or is etiologically related to (to include by virtue of continuity and chronicity of symptomatology in and since service) the Veteran's periods of active service extending from June 2004 to October 2004, and/or from March 2005 to August 2006.

C. A report of the examination shall be prepared and associated with the Veteran's VA claims folder. The examiner shall explain any opinion provided, to include supporting references to evidence in the file, as appropriate.

The medical basis for all opinions expressed shall be discussed for the record. It would be helpful if the examiner, in expressing his or her opinion, would use the language "likely," "unlikely" or "at least as likely as not." The term "at least as likely as not" does not mean "within the realm of medical possibility." Rather, it means that the weight of medical evidence both for and against a conclusion is so evenly divided that it is as medically sound to find in favor of causation as it is to find against causation.

3. The RO/AMC shall arrange for the Veteran to undergo an appropriate VA examination so as to ascertain the underlying cause, time of onset, and etiology of his claimed headaches. The claims file, to include a complete copy of this remand, shall be made available to the examiner in conjunction with conducting the examination of the Veteran. The examiner shall annotate the report to reflect that review of the claims file was undertaken. A discussion of the Veteran's lay history and symptomatology as well as the documented pertinent medical history shall also be included. All appropriate tests or studies shall be accomplished, and all clinical findings should be reported in detail. The examiner's report shall also address the following matters:

A. The examiner shall clearly identify (by diagnosis) whether the Veteran currently has a disability or disabilities which is/are manifested at least in part by headaches.

B. If the Veteran has any currently diagnosed headache-related disability, the examiner shall render an opinion as to whether it is at least as likely as not (a 50 percent or more probability) that the disability found on examination is of service etiology; i.e. was incurred in or is etiologically related to (to include by virtue of continuity and chronicity of symptomatology in and since service) the Veteran's periods of active service extending from June 2004 to October 2004, and/or from March 2005 to August 2006.

In considering the etiology, the examiner is asked to consider and discuss whether the headaches might at least as likely as not be a manifestations of undiagnosed illness associated with the Veteran's service in Southwest Asia.

C. A report of the examination shall be prepared and associated with the Veteran's claims folder. The examiner shall explain any opinion provided, to include supporting references to evidence in the file, as appropriate.

The medical basis for all opinions expressed should be discussed for the record. It would be helpful if the examiner, in expressing his or her opinion, would use the language "likely," "unlikely" or "at least as likely as not." The term "at least as likely as not" does not mean "within the realm of medical possibility." Rather, it means that the weight of medical evidence both for and against a conclusion is so evenly divided that it is as medically sound to find in favor of causation as it is to find against causation.

4. Schedule the Veteran for VA examination by a psychiatrist or psychologist in conjunction with the pending service connection claim for a psychiatric disorder to include PTSD. All studies deemed appropriate in the medical opinion of the examiner shall be performed, and all findings should be set forth in detail. The claims file and a copy of this remand shall be made

available to the examiner, who shall review the entire claims folder in conjunction with this examination. This fact shall be so indicated in the examination report. The rationale for any opinion expressed shall be included in the examination report. If the examiner determines that it is not feasible to respond to any of the inquiries below, the examiner shall explain why it is not feasible to respond.

The examiner shall elicit from the Veteran a narrative of his history of relevant symptoms during and since service; and any stressors (stressful events) he attributes as a cause of PTSD.

With respect to the PTSD claim, the examiner shall initially determine whether the criteria for a diagnosis of PTSD in accordance with the Diagnostic and Statistical Manual of Mental Disorders (4th ed. 1994) (DSM-IV) have been met. See 38 C.F.R. § 4.125(a). If so, the VA examiner is asked to render an opinion as to whether it is at least as likely as not (fifty percent or greater) that: 1) the Veteran experienced, witnessed, or was confronted by an event or circumstance that involved actual or threatened death or serious injury, or a threat to the physical integrity of the Veteran or others, and the Veteran's response to that event or circumstance involved a psychological or psycho-physiological state of fear, helplessness, or horror; 2) that the claimed stressor is adequate to support a diagnosis of PTSD; and 3) that the Veteran's symptoms are related to the claimed stressor.

The examiner shall also identify and diagnose any currently manifested psychiatric disorder (other than PTSD) and describe the manifestations of each diagnosed disorder. For each such diagnosed psychiatric disorder, the examiner is asked to address whether it is at least as likely as not (a 50 percent, or greater, likelihood), that the disorder was incurred during or first manifested during either of the Veteran's periods of active service extending from June 2004 to October 2004, and/or from March 2005 to August 2006, or during the first-post service year. The examiner shall address the more general question of whether it is at least as likely as not that any currently manifested psychiatric disorder (other than PTSD) is etiologically related to the Veteran's period of active service.

The medical basis for all opinions expressed should be discussed for the record. It would be helpful if the examiner, in expressing his or her opinion, would use the language "likely," "unlikely" or "at least as likely as not." The term "at least as likely as not" does not mean "within the realm of medical possibility." Rather, it means that the weight of medical evidence both for and against a conclusion is so evenly divided that it is as medically sound to find in favor of causation as it is to find against causation.

5. It is at the discretion of the RO to undertake any additional action necessary to substantiate the Veteran's reported

stressors, should a diagnosis of PTSD be made.

(The Board notes that this development may not be necessary in light of the potential applicability of the new PTSD regulations to this claim, should these provisions permit a basis for granting the claim.)

6. After the requested development has been completed, the examination reports should be reviewed to ensure that they are in complete compliance with the directives of this remand. If any report is deficient in any manner, it should be returned to the examiner.

7. Then readjudicate the Veteran's claims on appeal, with application of all appropriate laws and regulations and consideration of any additional information obtained. If any decision with respect to these claims remains adverse to the Veteran, he and his representative should be furnished a supplemental statement of the case and afforded a reasonable period of time within which to respond thereto. The supplemental statement of the case must contain notice of all relevant actions taken on the claim for benefits, to include a summary of the evidence and applicable law and regulations pertinent to the issues currently on appeal.

The appellant has the right to submit additional evidence and argument on the matter or matters the Board has remanded. Kutscherousky v. West, 12 Vet. App. 369 (1999).

This claim must be afforded expeditious treatment. The law requires that all claims that are remanded by the Board of Veterans' Appeals or by the United States Court of Appeals for Veterans Claims for additional development or other appropriate action must be handled in an expeditious manner. See 38 U.S.C.A. §§ 5109B, 7112 (West Supp. 2009).

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JONATHAN B. KRAMER
Veterans Law Judge, Board of Veterans' Appeals

Department of Veterans Affairs

Citation Nr: 1140864
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On appeal from the
Department of Veterans Affairs Regional Office in Waco, Texas

THE ISSUES

1. Entitlement to service connection for a low back disorder.

2. Entitlement to service connection for a foot disorder.

3. Entitlement to service connection for bilateral hearing loss.

4. Entitlement to service connection for tinnitus.

5. Entitlement to service connection for a stomach disability, to include irritable bowel syndrome (IBS).

6. Entitlement to service connection for sleep apnea.

REPRESENTATION

Appellant represented by: Texas Veterans Commission

WITNESSES AT HEARING ON APPEAL

Appellant and his wife

ATTORNEY FOR THE BOARD

J. W. Loeb

INTRODUCTION

The issues of service connection for a urinary tract infection and for a prostate disorder have been raised by the record, but have not been adjudicated by the Agency of Original Jurisdiction (AOJ). Therefore, the Board does not have jurisdiction over them, and they are referred to the AOJ for appropriate action.

The Veteran served on active duty from May 1978 to May 1982 and from July 2005 to May 2006; he also had service in the Reserves. He has been awarded the Combat Action Ribbon and the Afghanistan Campaign Medal with Globe and Anchor.

This case comes before the Board of Veterans' Appeals (Board) on appeal of rating decisions of the Department of Veterans Affairs (VA) Regional Office in Waco, Texas (RO).

Based on the Board's actions below, and the fact that the Veteran's contentions involving a stomach disorder and IBS are essentially the same, the Board has consolidated the claims for service connection for a stomach disorder and for IBS into one issue. See Clemons v. Shinseki, 23 Vet. App. 1 (2009) ((holding that a claim is not limited to the diagnosis identified by the Veteran, but for a disability that may reasonably be encompassed by several factors including: (1) the claimant's description of the claim; (2) the symptoms the claimant describes; and (3) the information that the claimant submits or that VA obtains in support of the claim.)).
The Veteran testified at a personal hearing before the undersigned Veterans Law Judge sitting at the RO in April 2011, and a transcript of the hearing is of record. At this hearing, the Veteran withdrew the issues of entitlement to service connection for diabetes mellitus and for an initial compensable evaluation for service-connected erectile dysfunction. Consequently, these issues are no longer part of the Veteran's appeal.

The issues of service connection for a low back disability and a hearing loss in the left ear are REMANDED to the RO via the Appeals Management Center (AMC), in Washington, DC. VA will notify the Veteran if further action is required.

FINDINGS OF FACT

1. All known and available service medical records have been obtained; the Veteran has been advised under the facts and circumstances of this case as to the evidence which would substantiate his claims for service connection for a foot disorder, tinnitus, a stomach disability, hearing loss in the right ear, and sleep apnea; and he has otherwise been assisted in the development of his claims.

2. The Veteran served in combat and was exposed to acoustic trauma in service.

3. With resolution of the benefit of the doubt accorded to the Veteran, the Veteran's bilateral plantar fasciitis is causally related to service.

4. With resolution of the benefit of the doubt accorded to the Veteran, the Veteran's tinnitus is causally related to service.

5. The Veteran has IBS that is causally related to service.

6. The Veteran's statements that he currently has hearing loss in the right ear and sleep apnea due to service injury are not competent.

7. The evidence on file does not show a hearing loss in the right ear under the VA definition of hearing loss.

8. The June 2009 VA examiner's opinion that the Veteran's sleep apnea is not due to service is competent, credible and probative evidence.

CONCLUSIONS OF LAW

1. The criteria for the establishment of service connection for bilateral plantar fasciitis are approximated. 38 U.S.C.A. §§ 1154, 5103A, 5107, 7104 (West 2002); 38 C.F.R. §§ 3.102, 3.159, 3.303, 3.304 (2011).

2. The criteria for the establishment of service connection for tinnitus are approximated. 38 U.S.C.A. §§ 1154, 5103A, 5107, 7104 (West 2002); 38 C.F.R. §§ 3.102, 3.159, 3.303, 3.304 (2011).

3. The criteria for the establishment of service connection for IBS have been met. 38 U.S.C.A. §§ 1117, 1154, 5103A, 5107, 7104 (West 2002); 38 C.F.R. §§ 3.102, 3.159, 3.304, 3.310, 3.317 (2011).

4. Hearing loss in the right ear was not incurred in or aggravated by active duty; nor may sensorineural hearing loss be presumed to have been incurred therein. 38 U.S.C.A. 38 U.S.C.A. §§ 101, 1101, 1110, 1112, 1113, 1131, 1137, 1154, 5103, 5103A, 5107 (West 2002); 38 C.F.R. §§ 3.1, 3.102, 3.159, 3.303, 3.304, 3.307, 3.309, 3.385 (2011).

5. The criteria for service connection for sleep apnea are not met. 38 U.S.C.A. §§ 1110, 1131, 1154, 5103, 5103A, 5107 (West 2002); 38 C.F.R. §§ 3.102, 3.159, 3.303, 3.304 (2011).

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

In this decision, the Board will discuss the relevant law which it is required to apply. This includes statutes published in Title 38, United States Code ("38 U.S.C.A."); regulations published in the Title 38 of the Code of Federal Regulations ("38 C.F.R.") and the precedential rulings of the Court of Appeals for the Federal Circuit (as noted by citations to "Fed. Cir.) and the Court of Appeals for Veterans Claims (as noted by citations to "Vet. App.").

The Board is bound by statute to set forth specifically the issue under appellate consideration and its decision must also include separately stated findings of fact and conclusions of law on all material issues of fact and law presented on the record, and the reasons or bases for those findings and conclusions. 38 U.S.C.A. § 7104(d); see also 38 C.F.R. § 19.7 (implementing the cited statute); see also Vargas-Gonzalez v. West, 12 Vet. App. 321, 328 (1999); Gilbert v. Derwinski, 1 Vet. App. 49, 56-57 (1990) (the Board's statement of reasons and bases for its findings and conclusions on all material facts and law presented on the record must be sufficient to enable the claimant to understand the precise basis for the Board's decision, as well as to facilitate review of the decision by courts of competent appellate jurisdiction). The Board must also consider and discuss all applicable statutory and regulatory law, as well as the controlling decisions of the appellate courts).

Duty to Assist and Notify

The Board has considered the Veterans Claims Assistance Act of 2000 (VCAA). See 38 U.S.C.A. §§ 5100, 5102, 5103, 5103A, 5106, 5107, 5126 (West 2002 and Supp. 2010). The regulations implementing VCAA have been enacted. See 38 C.F.R. §§ 3.102, 3.156(a), 3.159, 3.326(a) (2011).

VA has a duty to notify the claimant of any information and evidence needed to substantiate and complete a claim. 38 U.S.C.A. §§ 5102, 5103. See also Quartuccio v. Principi, 16 Vet. App. 183 (2002).

After having carefully reviewed the record on appeal, the Board has concluded that the notice requirements of VCAA have been satisfied with respect to the issues decided.

The notice and assistance provisions of VCAA should be provided to a claimant prior to any adjudication of the claim. Pelegrini v. Principi, 18 Vet. App. 112 (2004). The RO sent the Veteran a letter in September 2007, prior to adjudication, that informed him of the requirements to establish entitlement to service connection.

In accordance with the requirements of VCAA, the letter informed the Veteran what evidence and information he was responsible for obtaining and the evidence that was considered VA's responsibility to obtain. Additional private evidence was subsequently added to the claims files after the letter was issued.

In compliance with the duty to notify the Veteran of what information would substantiate his claim, the Veteran was informed in the September 2007 letter on disability ratings and effective dates. See Dingess/Hartman v. Nicholson, 19 Vet. App. 473 (2006).

VA has a duty to assist the claimant in obtaining evidence necessary to substantiate a claim. VCAA also requires VA to provide a medical examination when such an examination is necessary to make a decision on the claim. 38 U.S.C.A. § 5103A(d); 38 C.F.R. § 3.159. An examination of the Veteran's hearing was conducted in December 2007, and a sleep evaluation was conducted in June 2009.

The Board concludes that all available evidence has been obtained and that there is sufficient medical evidence on file on which to decide the issues below. The Veteran has been given ample opportunity to present evidence and argument in support of his claims, including at his April 2011 hearing. All general due process considerations have been complied with by VA, and the Veteran has had a meaningful opportunity to participate in the development of the claim. Mayfield v. Nicholson, 19 Vet. App. 103 (2005), rev'd on other grounds, 444 F.3d 1328 (Fed. Cir. 2006); 38 C.F.R. § 3.103 (2007).

The Board has reviewed the record in regard to whether the Veteran was afforded his due process rights in the development of evidence through testimony. At the April 2011 hearing, the Veteran was afforded an extensive opportunity to present testimony, evidence, and argument. The transcript reveals an appropriate colloquy between the Veteran and the Veterans Law Judge, in accordance with Stuckey v. West, 13 Vet. App. 163 (1999) and Constantino v. West, 12 Vet. App. 517 (1999) (relative to the duty of hearing officers to suggest the submission of favorable evidence).

Analyses of the Claims

The Veteran seeks service connection for a foot disorder, tinnitus, a stomach disability, hearing loss in the right ear, and sleep apnea. Having carefully considered the Veteran's contentions on her low back in light of the evidence of record and the applicable law, the Board finds that the weight of such evidence is in approximate balance and the claims for service connection for bilateral plantar fasciitis and tinnitus will be granted on this basis. 38 U.S.C.A.§ 5107(b) (West 2002); Alemany v. Brown, 9 Vet. App. 518 (1996); Brown v. Brown, 5 Vet. App. 413 (1993) (under the "benefit-of-the-doubt" rule, where there exists "an approximate balance of positive and negative evidence regarding the merits of an issue material to the determination of the matter," the claimant shall prevail upon the issue).

Service connection for IBS will also be granted as a presumptive disorder under 38 C.F.R. § 3.317.

Because no hearing loss in the right ear is shown and because the nexus opinion on file is against the claim for service connection for sleep apnea, the preponderance of the evidence is against the claims and the appeal will be denied.

Service connection may be granted for disability or injury incurred in or aggravated by active military service. 38 U.S.C.A. § 1110; 38 C.F.R. § 3.303(a). Service connection may also be granted for disability shown after service, when all of the evidence, including that pertinent to service, shows that it was incurred in service. 38 C.F.R. § 3.303(d); Cosman v. Principi, 3 Vet. App. 303, 305 (1992).

In the case of sensorineural hearing loss in the frequencies of 500 to 4000 hertz, service connection may be granted if the disorder is manifested to a compensable degree within one year following separation from service. 38 U.S.C.A. §§ 1101, 1112, 1113; 38 C.F.R. §§ 3.307, 3.309.

In order to establish service connection for the claimed disorder, there must be (1) medical evidence of a current disability; (2) medical, or in certain circumstances, lay evidence of in-service incurrence or aggravation of a disease or injury; and (3) medical evidence of a nexus between the claimed in-service disease or injury and the current disability. See Hickson v. West, 12 Vet. App. 247, 253 (1999).

In the case of any veteran who has engaged in combat with the enemy in active service during a period of war, satisfactory lay or other evidence that an injury or disease was incurred or aggravated in combat will be accepted as sufficient proof of service connection if the evidence is consistent with the circumstances, condition or hardships of such service, even though there is no official record of such incurrence or aggravation. Every reasonable doubt shall be resolved in favor of the Veteran. 38 U.S.C.A. § 1154(b) (West 2002); 38 C.F.R. § 3.304(d).

However, 38 U.S.C.A. § 1154(b) can be used only to provide a factual basis upon which a determination could be made that a particular disease or injury was incurred or aggravated in service, not to link the claimed disorder etiologically to the current disorder. See Libertine v. Brown, 9 Vet. App. 521, 522-23 (1996). Section 1154(b) does not establish service connection for a combat veteran; it aids him by relaxing the adjudicative evidentiary requirements for determining what happened in service. A veteran must still generally establish his claim by competent medical evidence tending to show a current disability and a nexus between that disability and those service events. See Gregory v. Brown, 8 Vet. App. 563, 567 (1996).

Under the provisions of specific legislation enacted to assist Veterans of the Persian Gulf War, service

connection may be established for a qualifying chronic disability which became manifest either during active service in the Southwest Asia theater of operations during the Persian Gulf War or to a degree of 10 percent or more not later than December 31, 2011. 38 U.S.C.A. § 1117; 38 C.F.R. § 3.317(a)(1)(i). The term "qualifying chronic disability" means a chronic disability resulting from an undiagnosed illness; a medically unexplained chronic multisymptom illness (such as chronic fatigue syndrome, fibromyalgia, and irritable bowel syndrome) that is defined as a cluster of signs or symptoms; or, any diagnosed illness that VA determines in regulations warrants a presumption of service-connected. 38 U.S.C.A. § 1117(a)(2).

Signs or symptoms that may be a manifestation of an undiagnosed illness or a chronic multisymptom illness include: (1) fatigue, (2) unexplained rashes or other dermatological signs or symptoms, (3) headache, (4) muscle pain, (5) joint pain, (6) neurological signs and symptoms, (7) neuropsychological signs or symptoms, (8) signs or symptoms involving the upper or lower respiratory system, (9) sleep disturbances, (10) gastrointestinal signs or symptoms, (11) cardiovascular signs or symptoms, (12) abnormal weight loss, and (13) menstrual disorders. 38 U.S.C.A. § 1117(g).

The term "Persian Gulf Veteran" means a Veteran who served on active military, naval, or air service in the Southwest Asia theater of operations during the Persian Gulf War. 38 C.F.R. § 3.317(d)(1). The Southwest Asia theater of operations includes Iraq, Kuwait, Saudi Arabia, the neutral zone between Iraq and Saudi Arabia, Bahrain, Qatar, the United Arab Emirates, Oman, the Gulf of Aden, the Gulf of Oman, the Persian Gulf, the Arabian Sea, the Red Sea, and the airspace above these locations. 38 C.F.R. § 3.317(d)(2).

As is noted above, the Board is required to follow applicable statutes and regulations in its decisions. Applicable regulations provide that impaired hearing will be considered to be a disability when the auditory threshold in any of the frequencies 500, 1000, 2000, 3000, and 4000 hertz, in ISO units, is 40 decibels or greater; or when the auditory thresholds for at least three of these frequencies are 26 decibels or greater; or when speech recognition scores using the Maryland CNC Test are less than 94 percent. 38 C.F.R. § 3.385.

The Board must determine the value of all evidence submitted, including lay and medical evidence. Buchanan v. Nicholson, 451 F.3d 1331 (Fed. Cir. 2006). The evaluation of evidence generally involves a 3-step inquiry. First, the Board must determine whether the evidence comes from a "competent" source. The Board must then determine if the evidence is credible, or worthy of belief. Barr v. Nicholson, 21 Vet. App. 303, 308 (2007) (observing that once evidence is determined to be competent, the Board must determine whether such evidence is also credible). The third step of this inquiry requires the Board to weigh the probative value of the proffered evidence in light of the entirety of the record.

Competent lay evidence means any evidence not requiring that the proponent have specialized education, training, or experience. Lay evidence is competent if it is provided by a person who has knowledge of facts or circumstances and conveys matters that can be observed and described by a lay person. 38 C.F.R. § 3.159. Lay evidence may be competent and sufficient to establish a diagnosis of a condition when:
(1) a layperson is competent to identify the medical condition (i.e., when the layperson will be competent to identify the condition where the condition is simple, for example a broken leg, and sometimes not, for example, a form of cancer);

(2) the layperson is reporting a contemporaneous medical diagnosis, or;

(3) lay testimony describing symptoms at the time supports a later diagnosis by a medical professional.

Jandreau v. Nicholson, 492 F. 3d 1372 (Fed. Cir. 2007); see also Davidson v. Shinseki, 581 F.3d 1313 (Fed. Cir. 2009) (where widow seeking service connection for cause of death of her husband, the Veteran, the Court holding that medical opinion not required to prove nexus between service connected mental disorder and drowning which caused Veteran's death).

In ascertaining the competency of lay evidence, the Courts have generally held that a layperson is not capable of opining on matters requiring medical knowledge. Routen v. Brown, 10 Vet. App. 183 (1997). In certain instances, however, lay evidence has been found to be competent with regard to a disease with "unique and readily identifiable features" that is "capable of lay observation." See, e.g., Barr v. Nicholson, 21 Vet. App. 303 (2007) (concerning varicose veins); see also Jandreau v. Nicholson, 492 F. 3d 1372 (Fed. Cir. 2007) (a dislocated shoulder); Charles v. Principi, 16 Vet. App. 370 (2002) (tinnitus); Falzone v. Brown, 8 Vet. App. 398 (1995) (flatfeet). Laypersons have also been found to not be competent to provide evidence in more complex medical situations. See Woehlaert v. Nicholson, 21 Vet. App. 456 (2007) (concerning rheumatic fever).

Competent medical evidence is evidence provided by a person who is qualified through education, training, or experience to offer medical diagnoses, statements, or opinions. Competent medical evidence may also include statements conveying sound medical principles found in medical treatises. It also includes statements contained in authoritative writings, such as medical and scientific articles and research reports or analyses. 38 C.F.R. § 3.159(a)(1).

After determining the competency and credibility of evidence, the Board must then weigh its probative value. In this function, the Board may properly consider internal inconsistency, facial plausibility, and consistency with other evidence submitted on behalf of the claimant. Caluza v. Brown, 7 Vet. App. 498, 511-512 (1995), aff'd, 78 F.3d 604 (Fed. Cir. 1996) (per curiam) (table); see Madden v. Brown, 125 F.3d 1447 (Fed Cir. 1997) (holding that the Board has the "authority to discount the weight and probative value of evidence in light of its inherent characteristics in its relationship to other items of evidence").

Foot Disorder

The Veteran's service treatment reports do not reveal any complaints of findings of a foot disorder during his initial period of service.

He was diagnosed with bilateral plantar fasciitis in November 1998, which is prior to his second period of active duty.

In a July 2003 Naval Reserve medical examination, the physician stated that the plantar fasciitis diagnosed in 1998 had resolved. However, the Veteran was again diagnosed with bilateral plantar fasciitis in October 2006, which is within five months after release from his second period of service. Plantar fasciitis was subsequently diagnosed in June, July, and December 2007.

As there is medical evidence that the bilateral plantar fasciitis noted before the Veteran's second period of service had resolved, and bilateral plantar fasciitis was reported beginning within five months of separation from the Veteran's second period of service, approximate continuity is demonstrated, the evidence is in equipoise and the Board finds the Veteran had plantar fasciitis as a result of his second period of service.

By extending the benefit of the doubt to the Veteran, as required by law, the Board finds that service connection for plantar fasciitis is warranted. See 38 U.S.C.A.
§ 5107(b); 38 C.F.R. § 3.102; Alemany v. Brown, 9 Vet. App. 518, 519 (1996). Consequently, service connection for bilateral plantar fasciitis is warranted.

Tinnitus

The Veteran's DD Form 214 reveals that the Veteran served during the Global War on Terrorism and was awarded the Combat Action Ribbon. His service treatment records do not reveal any complaints of ringing in the ears.

According to a September 2007 statement from the Veteran, he was subjected to rocket attacks in service.

According to an October 2007 statement from B.W. Holland, M.D., the Veteran had hearing loss and tinnitus due to service.

A VA examiner who conducted a VA audiological evaluation in December 2007 concluded that the Veteran's hearing loss in the left ear and tinnitus were not due to service.

According to statements from Dr. Holland dated in March and July 2008, the Veteran's tinnitus was due to acoustic trauma in service.

The Veteran's wife noted in a June 2008 statement that the Veteran had hearing loss and tinnitus since returning from his second period of service.

According to an August 2008 statement from L. Kirk, D.O., the Veteran was being treated for hearing loss and tinnitus, most likely due to a blast injury.

The Veteran testified at his travel board hearing in April 2011 that he was exposed to acoustic trauma in service from rocket attacks.

There is evidence both for and against the claim for service connection for tinnitus. Because the Veteran has claimed exposure to rocket attacks, and because he has been awarded the Combat Action Ribbon, the presumption of 38 U.S.C.A. § 1154 is applicable in this case. The Veteran is competent to testify that he experienced ringing in his ears in service and had experienced ringing in his ears since service. See Charles v. Principi, 16 Vet. App. 370, 373-74 (2002).

Consequently, the evidence is, at least, in relative equipoise and the claim will be granted. By extending the benefit of the doubt to the Veteran, the Board finds that service connection for tinnitus is warranted. See 38 U.S.C.A. § 5107(b); 38 C.F.R. § 3.102; Alemany v. Brown, 9 Vet. App. 518, 519 (1996).

IBS

The medical evidence on file reveals gastrointestinal complaints beginning in November 2006, soon after separation from the Veteran's second period of active duty. IBS and gastroesophageal reflux disease were diagnosed on VA evaluation in December 2007, for which the Veteran was prescribed medications.

For the purposes of establishing service connection under 38 C.F.R. § 3.317, IBS is one of the multisymptom illnesses considered a qualifying chronic disability if manifested either during active service in the Southwest Asia theater of operations during the Persian Gulf War or to a degree of 10 percent or more not later than December 31, 2011 38 C.F.R. § 3.317(a)(2)(i)(B)(3). The Veteran had service in Afghanistan as part of the Global War on Terror. IBS was diagnosed on VA evaluation in December 2007. Consequently, service connection for IBS is warranted and the claim will be granted.

Hearing Loss in the Right Ear and Sleep Apnea

The Veteran's service treatment records reveal that he complained on a February 1980 medical history report of hearing loss. On audiological evaluation in April 1982, the Veteran's hearing was within the VA definition of normal in both ears, with decibel thresholds at the relevant frequencies of 20 or lower in each ear. A hearing loss was found in the left ear at 3000 hertz beginning in July 1996.

Private treatment reports for October 2007 diagnose hearing loss and tinnitus due to service.

According to a September 2007 statement from F.A.W. in support of the Veteran's claim, the Veteran was subjected to rocket attacks in service. A September 2007 statement from R.E.G., who lived with the Veteran at the WACO VA for six weeks, is to the effect that the Veteran snored very loudly.

VA audiological evaluation in December 2007 showed hearing loss in the left ear and hearing within the VA definition of normal in the right ear. The examiner concluded that the Veteran's hearing loss was not due to service noise exposure.

According to March and July 2008 statements from B.W. Holland, M.D., the Veteran had hearing loss and tinnitus due to a blast injury incurred during service in Afghanistan. No audiological findings were provided.

A statement from the Veteran's wife, received by VA in June 2008, reveals that the Veteran has had hearing loss and tinnitus since returning from service in 2006.

According to an August 2008 letter from L. Kirk, D.O., the Veteran was being treated for hearing loss and tinnitus, most likely due to a blast injury incurred in service. No audiological findings were provided.

The diagnosis on a VA sleep study in November 2008 was obstructive sleep apnea.

February and March 2009 statements from the Veteran's wife and friends discuss his sleep problems and relate current diagnoses.

A VA evaluation was conducted in June 2009. After review of the claims files and examination of the Veteran, the diagnosis was sleep apnea diagnosed at the Waco VA by a sleep study. However, as to the etiology, the examiner noted that there was no evidence of sleep apnea during service; that the Veteran said that he could not sleep in Afghanistan because of recurrent mortar attacks, and that the Veteran also said that he could not sleep in service because of nightmares.

The Veteran testified at his hearing in April 2011 that he was exposed to acoustic trauma in service, including rocket attacks, and that he has had sleep apnea since service. The Veteran's wife also testified in support of the claims.

There is no evidence in service of either hearing loss in the right ear or sleep apnea. Although the Veteran is competent to report his hearing and sleep problems, he is clearly not competent to report that he has a current hearing loss in the right ear or sleep apnea which was caused during or as a result of active service. Laypersons are not competent to provide evidence in certain medical situations. Woehlaert v. Nicholson, 21 Vet. App. 456 (2007).

Instead, competent medical evidence is required. Such evidence is that provided by a person who is qualified through education, training, or experience to offer medical diagnoses, statements, or opinions. Competent medical evidence may also include statements conveying sound medical principles found in medical treatises. It also includes statements contained in authoritative writings, such as medical and scientific articles and research reports or analyses. 38 C.F.R. § 3.159(a)(1).

Generally, the degree of probative value which may be attributed to a medical opinion issued by a VA or private treatment provider is weighed by such factors as its thoroughness and degree of detail, and whether there was review of the Veteran's claims file. Prejean v. West, 13 Vet. App. 444 (2000). Also significant is whether the examining medical provider had a sufficiently clear and well-reasoned rationale, as well as a basis in objective supporting clinical data. Bloom v. West, 12 Vet. App. 185 (1999); Hernandez-Toyens v. West, 11 Vet. App. 379 (1998). See also Claiborne v. Nicholson, 19 Vet. App. 181 (2005) (rejecting medical opinions that did not indicate whether the physicians actually examined the Veteran, did not provide the extent of any examination, and did not provide any supporting clinical data). The Court has held that a bare conclusion, even one reached by a health care professional, is not probative without a factual predicate in the record. Miller v. West, 11 Vet. App. 345 (1998).

In order for a medical opinion to be probative, the medical examiner must have correct information regarding the relevant facts of the case. Nieves-Rodriguez v. Peake, 22 Vet. App. 295 (2008), Guerrieri v. Brown, 4 Vet. App. 467 (1993) (observing that the evaluation of medical evidence involves inquiry into, inter alia, the medical expert's personal examination of the patient, the physician's knowledge and skill in analyzing the data, and the medical conclusion that the physician reaches); see Shipwash v. Brown, 8 Vet.App. 218 (1995); Flash v. Brown, 8 Vet.App. 332 (1995) (regarding the duty of VA to provide medical examinations conducted by medical professionals with full access to and review of the Veteran's claims folder); but see D'Aries v. Peake, 22 Vet. App. 97, 106 (2008) (holding that it is not necessary for a VA medical examiner to specify review of the claims folder where it is clear from the report that the examiner has done so and is familiar with the claimant's extensive medical history).

The Veteran served in combat. However, as noted above, although Section 1154(b) lowers the evidentiary burden for a combat veteran in establishing the presence of a disease or injury in service, it does not negate the need for medical evidence of a current disability and medical evidence of a nexus between a current disability and active

service. See Libertine v. Brown, 9 Vet. App. 521, 524 (1996); Caluza v. Brown, 7 Vet. App. 498, 507 (1995), aff'd per curiam, 78 F.3d 604 (Fed. Cir. 1996); Collette v. Brown, 82 F.3d 389 (Fed. Cir. 1996).

In this case, there is no clinical evidence on file of a hearing loss in the right ear under the VA definition of hearing loss noted above. With respect to the claim for sleep apnea, the only nexus opinion on file, which is based on a review of the claims files and examination of the Veteran and contains a supporting rationale, is against the claim. Although the examiner did not specifically conclude in June 2009 that the Veteran's current sleep apnea is not causally related to service, the finding of an absence of evidence of sleep apnea in service and the notations in June 2009 of why the Veteran said that he could not sleep in service, which are unrelated to sleep apnea, lead to the inescapable conclusion that this opinion is against the claim. Consequently, remanding this issue for additional clarification is unnecessary.

The Board has considered the April 2011 testimony and the lay statements in support of the Veteran's claims. There is no medical evidence of hearing loss in the right ear and lay persons are not competent to provide an opinion on the etiology of a disability such as sleep apnea. The weight of the medical evidence on file is against the sleep apnea claim.

Finally, in reaching this decision, the Board has considered the doctrine of reasonable doubt; however, as the preponderance of the evidence is against the service connected claims for hearing loss in the right ear and for sleep apnea, the doctrine is not for application. Gilbert v. Derwinski, 1 Vet. App. 49 (1990).

ORDER

Service connection for bilateral plantar fasciitis is granted.

Service connection for tinnitus is granted.

Service connection for IBS is granted.

Service connection for hearing loss in the right ear is denied.

Service connection for sleep apnea is denied.

REMAND

With respect to the issues of entitlement to service connection for hearing loss in the left ear, although the December 2007 opinion is against the claim because it was concluded that the Veteran's hearing loss started between his first and second periods of service, this opinion does not address whether this preexisting hearing loss was aggravated by the Veteran's second period of service.

Although the Veteran had low back problems in service, with lumbar strain diagnosed in September 1979, there is no nexus medical opinion on file on whether the Veteran currently has a low back due to service.

Based on the above, the Board finds that additional development is warranted prior to Board adjudication of the issues of service connection for hearing loss in the left ear and a low back disability.
VA has the authority to schedule a compensation and pension examination when such is deemed to be necessary, and the Veteran has an obligation to report for that examination.

Pursuant to 38 C.F.R. § 3.327(a) (2011), an examination will be requested whenever VA determines, as in this case, that there is a need to verify the nature and etiology of a disability. See also 38 C.F.R. § 3.159 (2011).

Consequently, the case is REMANDED to the AMC/RO for the following actions:

1. The AMC/RO must ascertain if the Veteran has received any VA, non-VA, or other medical treatment for hearing loss in the left ear and a low back disability that is not evidenced by the current record. The Veteran will be provided with the necessary authorizations for the release of any treatment records not currently on file. The AMC/RO will then attempt to obtain these records and associate them with the claims folder. If VA is unsuccessful in obtaining any medical records identified by the Veteran, it must inform the Veteran of this and provide him an opportunity to submit copies of the outstanding medical records.

2. After the above has been completed, the AMC/RO must arrange for review of the claims files by the examiner who evaluated the Veteran in December 2007, if available, to determine whether the Veteran's preexisting hearing loss in the left ear was aggravated by his second period of service. If this reviewer is unavailable, this opinion will be obtained from another appropriate health care provider. The claims folder should be made available and reviewed by the health care provider prior to the evaluation. The following considerations will govern the evaluation:
a. The claims folder and a copy of this remand will be made available to the examiner for review in conjunction with the opinion, and the examiner must specifically acknowledge receipt and review of these materials in any report generated.

b. After reviewing the claims files, the reviewer must provide an opinion on whether the Veteran's preexisting hearing loss in the left ear was measurably aggravated beyond normal progression by service noise exposure.

c. Although the reviewer must review the claims folder, the reviewer's attention is drawn to the following:

(1) Hearing in the Veteran's left ear was within the VA definition of normal on separation audiological examination from his initial period of service in April 1982, when pure tone thresholds from 500 to 4000 hertz were 20 decibels or lower.

(2) Audiological examinations in July 1996 and June 1998, which were between his periods of active duty, reveal defective hearing in the left ear, with a pure tone threshold of 45 decibels at 4000 hertz; and a July 2003 audiological examination shows a 45 decibel threshold a 3000 and 4000 hertz in the left ear.

(3) An April 2007 audiological examination shows pure tone thresholds in the left ear of 45 decibels at 2000 hertz and 50 decibels at 3000 and 4000 hertz.

(4) The December 2007 audiological examination shows pure tone thresholds in the left ear of 40 decibels at 2000 and 4000 hertz and 45 decibels at 3000 4000 hertz.

d. In all conclusions, the reviewer must identify and explain the medical basis or bases, with identification of the evidence of record. If the examiner is unable to make a determination without resorting to mere speculation, he/she should so state.

e. If the reviewer responds to the above inquiry that he/she cannot so opine without resort to speculation, the AMC/RO will attempt to clarify whether there is evidence that must be obtained in order to render the opinion non-speculative and to obtain such evidence.

Any necessary tests or studies must be conducted, and all clinical findings will be reported in detail. The report prepared must be typed.

3. The AMC/RO must arrange for examination of the Veteran by an appropriate health care provider to determine the nature and etiology of any current low back disability. The claims folder should be made available and reviewed by the health care provider prior to the evaluation. The following considerations will govern the evaluation:

a. The claims folder and a copy of this remand will be made available to the examiner for review in conjunction with the opinion, and the examiner must specifically acknowledge receipt and review of these materials in any report generated.

b. After reviewing the claims files and examining the Veteran, the examiner must provide an opinion on whether the Veteran currently has a low back disability that was caused or aggravated beyond normal progression by service.

c. In all conclusions, the examiner must identify and explain the medical basis or bases, with identification of the evidence of record. If the examiner is unable to make a determination without resorting to mere speculation, he/she should so state.

d. If the reviewer responds to the above inquiry that he/she cannot so opine without resort to speculation, the AMC/RO will attempt to clarify whether there is evidence that must be obtained in order to render the opinion non-speculative and to obtain such evidence.

Any necessary tests or studies must be conducted, and all clinical findings will be reported in detail. The report prepared must be typed.

4. The AMC/RO will notify the Veteran that it is his responsibility to report for the above examination and to cooperate in the development of the claims. The consequences for failure to report for a VA examination without good cause may include denial of a claim. 38 C.F.R. §§ 3.158, 3.655 (2011). In the event that the Veteran does not report for the aforementioned examination, documentation needs to be obtained which shows that notice scheduling the examination was sent to the last known address. It should also be indicated whether any notice that was sent was returned as undeliverable.

5. Thereafter, the AMC/RO will review the claims files and ensure that the foregoing development actions have been conducted and completed in full. If any development is incomplete, appropriate corrective action is to be implemented. See 38 C.F.R. § 4.2 (If the findings on an examination report does not contain sufficient detail, it is incumbent upon the rating board to return the report as inadequate for evaluation purposes).

6. After the above has been completed, the AMC/RO must readjudicate the claims of service connection for hearing loss in the left ear and for a low back disorder, with consideration of all of the evidence of record. If either of the benefits sought on appeal remains denied, the Veteran and his representative will be furnished a supplemental statement of the case with reasons and bases for the decision. The Veteran and his representative will be then given an appropriate opportunity to respond thereto.

The Veteran has the right to submit additional evidence and argument on the matters the Board has remanded. Kutscherousky v. West, 12 Vet. App. 369 (1999).

By this remand, the Board intimates no opinion as to the final disposition of the unresolved issue. The RO and the Veteran are advised that the Board is obligated by law to ensure that the RO complies with its directives, as well as those of the appellate courts. It has been held that compliance by the Board or the RO is neither optional nor discretionary. Where the remand orders of the Board or the Courts are not complied with, the Board errs as a matter of law when it fails to ensure compliance. Stegall v. West, 11 Vet. App. 268, 271 (1998).

This claim must be afforded expeditious treatment. The law requires that all claims that are remanded by the Board or by the United States Court of Appeals for Veterans Claims for additional development or other appropriate action must be handled in an expeditious manner. See 38 U.S.C.A. §§ 5109B, 7112 (West Supp. 2010).

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Vito A. Clementi
Veterans Law Judge, Board of Veterans' Appeals

Department of Veterans Affairs

Citation Nr: 1410729
Decision Date: 03/14/14 Archive Date: 03/20/14

DOCKET NO. 09-07 791) DATE
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On appeal from the
Department of Veterans Affairs Regional Office in Phoenix, Arizona

THE ISSUES

1. Entitlement to service connection for a skin disorder.

2. Entitlement to service connection for hemorrhoids.

REPRESENTATION

Veteran represented by: The American Legion

ATTORNEY FOR THE BOARD

A. Ozger, Associate Counsel

INTRODUCTION

The Veteran served on active duty from November 1999 to October 2007.

This matter comes to the Board of Veterans' Appeals (Board) on appeal from a March 2008 rating decision issued by the Department of Veterans Affairs (VA) Regional Office (RO) in Oakland, California. Jurisdiction of the Veteran's claims file is currently with the RO in Phoenix, Arizona.

The Board notes that the Veteran also perfect an appeal as to the issue of entitlement to service connection for allergic rhinitis; however, in an April 2013 rating decision, service connection for such disability was granted. Therefore, this issue is no longer before the Board.

The Board observes that, in addition to the paper claims file, the Veteran also has electronic Virtual VA and Veteran Benefits Management System (VBMS) paperless claims files. A review of the documents in Virtual VA reveals that, with the exception of additional VA treatment records associated in March 2013, which were considered by the agency of original jurisdiction (AOJ) in the April 2013 supplemental statement of the case, and a February 2014 Written Brief Presentation submitted by the Veteran's representative, they are either duplicative of the evidence in the paper claims file or are irrelevant to the issues on appeal. Further, the Veteran's VBMS file does not contain any documents at this time.

The issue of entitlement to service connection for hemorrhoids is addressed in the REMAND portion of the decision below and is REMANDED to the RO via the Appeals Management Center (AMC), in Washington, D.C.

FINDING OF FACT

1. The Veteran had active service in the Southwest Asia Theater of operations during the Persian Gulf War.

2. The Veteran's skin disorder has been attributed to known clinical diagnoses.

3. A skin disorder, diagnosed as porokeratoses, tinea versicolor, and a rash, is not shown to be causally or etiologically related to any disease, injury, or incident during service.

CONCLUSION OF LAW

The criteria for service connection for a skin disorder have not been met. 38 U.S.C.A. §§ 1110, 1117, 5107 (West 2002); 38 C.F.R. §§ 3.102, 3.303, 3.317 (2013).

REASONS AND BASES FOR FINDINGS AND CONCLUSION

I. VA's Duties to Notify and Assist

The Veterans Claims Assistance Act of 2000 (VCAA) and implementing regulations impose obligations on VA to provide claimants with notice and assistance. 38 U.S.C.A. §§ 5102, 5103, 5103A, 5107; 38 C.F.R §§ 3.102, 3.156(a), 3.159,

3.326(a). Proper VCAA notice must inform the claimant of any information and evidence not of record (1) that is necessary to substantiate the claim; (2) that VA will seek to provide; and (3) that the claimant is expected to provide. 38 U.S.C.A. § 5103(a); 38 C.F.R. § 3.159(b)(1).

In Dingess/Hartman v. Nicholson, 19 Vet. App. 473 (2006), the United States Court of Appeals for Veterans Claims (Court) held that the VCAA notice requirements of 38 U.S.C.A. § 5103(a) and 38 C.F.R. § 3.159(b) apply to all five elements of a service connection claim. Those five elements include: 1) Veteran status; 2) existence of a disability; 3) a connection between the Veteran's service and the disability; 4) degree of disability; and 5) effective date of the disability.

In Pelegrini v. Principi, 18 Vet. App. 112 (2004), the Court held that VCAA notice, as required by 38 U.S.C.A. § 5103(a), must be provided to a claimant before the initial unfavorable AOJ decision on the claim for VA benefits.

In the instant case, the Board finds that VA has satisfied its duty to notify under the VCAA. Specifically, a November 2007 letter, sent prior to the initial unfavorable decision issued in March 2008, advised the Veteran of the evidence and information necessary to substantiate his service connection claim as well as his and VA's respective responsibilities in obtaining such evidence and information. Additionally, such letter advised him of the information and evidence necessary to establish a disability rating and an effective date in accordance with Dingess/Hartman, supra.

Relevant to the duty to assist, the Veteran's service treatment records (STRs) as well as post-service VA and private treatment records have been obtained and considered. The Veteran has not identified any additional, outstanding records that have not been requested or obtained.

In determining whether the duty to assist requires that a VA medical examination be provided or medical opinion obtained with respect to a Veteran's claim for benefits, there are four factors for consideration. These four factors are: (1) whether there is competent evidence of a current disability or persistent or recurrent symptoms of a disability; (2) whether there is evidence establishing that an event, injury, or disease occurred in service, or evidence establishing certain diseases manifesting during an applicable presumption period; (3) whether there is an indication that the disability or symptoms may be associated with the Veteran's service or with another service-connected disability; and (4) whether there otherwise is sufficient competent medical evidence of record to make a decision on the claim. 38 U.S.C. § 5103A(d); 38 C.F.R. § 3.159(c)(4). With respect to the third factor above, the Court has stated that this element establishes a low threshold and requires only that the evidence "indicates" that there "may" be a nexus between the current disability or symptoms and the Veteran's service. McLendon v. Nicholson, 20 Vet. App. 79 (2006).

The Board notes that the Veteran has not been provided with a VA medical examination and/or opinion regarding his claim for service connection for a skin disorder; however, the Board finds that such is not necessary in the instant case. Specifically, as will be discussed below, the Veteran's STRs are negative for any complaints, treatment, or findings referable to a skin disorder or rash. Moreover, while he served in Southwest Asia, his skin disorder has been attributed to known clinical diagnoses. Additionally, as will be explained further herein, the Board finds that the Veteran's claim that his skin disorder first manifested in service and continued to the present time to be not credible. Finally, the Veteran's VA treatment provider has indicated that his skin disorder is not a result of his exposure to oils and chemicals during service; rather, it is sun-induced or genetically caused. The Court has held that VA is not required to provide a medical examination when there is not credible evidence of an event, injury, or disease in service. See Bardwell v. Shinseki, 24 Vet. App. 36 (2010). Additionally, a mere conclusory generalized lay statement that service event or illness caused the claimant's current condition is insufficient to require the Secretary to provide an examination. See Waters v. Shinseki, 601 F.3d 1274, 1278 (2010). Therefore, the Board finds that a VA examination and/or opinion is not necessary to decide the claim.

Thus, the Board finds that VA has fully satisfied the duty to assist. In the circumstances of this case, additional efforts to assist or notify the Veteran in accordance with the VCAA would serve no useful purpose. See Soyini v. Derwinski, 1 Vet. App. 540, 546 (1991) (strict adherence to requirements of the law does not dictate an unquestioning, blind adherence in the face of overwhelming evidence in support of the result in a particular case; such adherence would result in unnecessarily imposing additional burdens on VA with no benefit flowing to the appellant); Sabonis v. Brown, 6 Vet. App. 426, 430 (1994) (remands which would only result in unnecessarily imposing additional burdens on VA with no benefit flowing to the appellant are to be avoided). VA has satisfied its duty to inform and assist the Veteran at every stage in this case, at least insofar as any errors committed were not harmful to the essential fairness of the proceeding. Therefore, he will not be prejudiced as a result of the Board proceeding to the merits of his claim.

II. Analysis

Service connection may be granted for a disability resulting from disease or injury incurred in or aggravated by service. 38 U.S.C.A. § 1110; 38 C.F.R. § 3.303(a). Service connection may also be granted for any disease diagnosed after discharge, when all of the evidence, including that pertinent to service, establishes that the disease was incurred in service. 38 C.F.R. § 3.303(d).

Direct service connection may not be granted without evidence of a current disability; in-service incurrence or aggravation of a disease or injury; and a nexus between the claimed in-service disease or injury and the present disease or injury.
38 U.S.C.A. § 1112; 38 C.F.R. § 3.304. See also Caluza v. Brown, 7 Vet. App. 498, 506 (1995) aff'd, 78 F.3d 604 (Fed. Cir. 1996) [(table)].

Where a Veteran served for at least 90 days during a period of war or after December 31, 1946, and manifests certain chronic diseases to a degree of 10 percent within one year from the date of termination of such service, such disease shall be presumed to have been incurred or aggravated in service, even though there is no evidence of such disease during the period of service. 38 U.S.C.A. §§ 1101, 1112; 38 C.F.R. §§ 3.307, 3.309. In some cases, service connection may also be established under 38 C.F.R. § 3.303(b) by (a) evidence of (i) a chronic disease shown as such in service (or within an applicable presumptive period under 38 C.F.R. § 3.307) and (ii) subsequent manifestations of the same chronic disease, or (b) if the fact of chronicity in service in not adequately supported, by evidence of continuity of symptomatology. However, the Federal Circuit has held that the provisions of 38 C.F.R. § 3.303(b) relating to continuity of symptomatology can be applied only in cases involving those conditions explicitly recognized as chronic under 38 C.F.R. § 3.309(a). Walker v. Shinseki, 708 F.3d 1331 (Fed. Cir. 2013).

Service connection may also be established for a Persian Gulf Veteran who exhibits objective indications of "qualifying chronic disability," a chronic disability resulting from an undiagnosed illness, a medically unexplained chronic multisymptom illness (such as chronic fatigue syndrome, fibromyalgia, and irritable bowel syndrome) that is defined by a cluster of signs or symptoms, or any diagnosed illness that the Secretary determines, through December 31, 2016, warrants a presumption of service connection. 38 U.S.C.A. § 1117.

An "undiagnosed illness" is one that by history, physical examination, and laboratory tests cannot be attributed to any known clinical diagnosis. 38 C.F.R.
§ 3.317(a)(1)(ii). A "qualifying chronic disability" is defined, in part, as an undiagnosed illness. 38 C.F.R. § 3.317(a)(2)(i)(A). Signs or symptoms involving the skin may be a manifestation of an undiagnosed illness or a chronic multisymptom illness. 38 C.F.R. § 3.317(b)(2).

When there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter, the Secretary shall give the benefit of the doubt to the claimant. 38 U.S.C.A. § 5107; 38 C.F.R. § 3.102; see also Gilbert v. Derwinski, 1 Vet. App. 49, 53 (1990).

The Veteran claims that his skin disorder had its onset during service and has continued to the present time. Specifically, he contends that such affects his upper body, to include his forearms, and such itches, scabs, and bleeds. Therefore, he alleges that service connection for such disorder is warranted.

The Board initially notes that the Veteran had active service in the Southwest Asia Theater of operations during the Persian Gulf War as his service records reflect service in Afghanistan. However, the Veteran's skin disorder has been diagnosed as porokeratoses, tinea versicolor, and a rash. Therefore, as such has been attributed to a known clinical diagnosis, the Veteran is not entitled to service connection based on an undiagnosed illness. Likewise, as his skin disorder is not recognized as a chronic disease per VA regulations, he is not entitled to presumptive service connection for such disorder.

The Veteran's STRs are negative for any complaints, treatment, or findings referable to a skin disorder or rash. In this regard, the September 1999 entrance examination reflects that, upon clinical evaluation, the Veteran had a pilonidal cyst. In December 1999, he was seen for complaints referable to his pilonidal cyst and received treatment throughout service. The Board notes, however, that the Veteran has already been awarded service connection for scar/residuals of pilonidal cyst.

The remainder of the STRs reflect skin complaints referable to folliculitis, warts, and a sebaceous cyst; however, none show complaints, treatment, or diagnoses similar to the type of skin disorder for which the Veteran is currently claiming entitlement to service connection. Specifically, in March 2000, the Veteran was treated for folliculitis on the thighs and a wart on his right fifth toe. April 2000, June 2002 and August 2002 records reveal a wart on the right index finger. In March 2003, he had verrucous lesions in the right groin area. Warts was diagnosed. A December 2005 record reflects that the Veteran had a sebaceous cyst on his chest. Such records are otherwise negative for any findings referable to the skin. Moreover, a May 2007 examination conducted in preparation for the Veteran's separation from service showed no findings referable to his skin other than a pilonidal cyst.

Furthermore, at various times the Veteran reported his medical history during service, he consistently denied skin complaints. Specifically, in a March 2004 Report of Medical History, the Veteran denied a past and current medical history of skin diseases. In an August 2006 questionnaire obtained in connection with a smallpox vaccination, the Veteran denied have ever had eczema or atopic dermatitis, which was described as an itchy, red, scaly rash that lasts more than 2 weeks and often comes and goes. In a September 2007 Post-Deployment Health Assessment, the Veteran indicated that he did not, either currently or during his deployment, have skin diseases or rashes.

Post-service VA treatment records reflect that, in October 2007, the same month the Veteran separated from service, he reported no persistent skin rash. Likewise, a January 2008 VA general examination did not show complaints or diagnoses referable to a skin disorder other than a sebaceous cyst removed from his chest. The first documentation of a skin disorder is in May 2008 when the Veteran was noted to have macules with flaking on his arms and a rash was diagnosed. In November 2009, the Veteran complained of a skin rash with itchiness on both forearms and tinea versicolor was diagnosed. Finally, in February 2010, it was noted that the Veteran had small lesions that itched on the forearms and hands, and porokeratoses. At such time, the Veteran indicated that such had been present for five to seven years and he was concerned that such was related to oil and chemical exposure during service; however, his treating physician indicated that such were not due to his claimed exposure; rather, such were sun-induced or genetically caused.

In support of his claim, the Veteran has alleged that his current skin disorder started during service and is caused by his in-service exposure to chemicals and oils as a result of his duties as a crew chief of C-130's. Lay

witnesses are competent to provide testimony or statements relating to symptoms or facts of events that the lay witness observed and is within the realm of his or her personal knowledge, but not competent to establish that which would require specialized knowledge or training, such as medical expertise. Layno v. Brown, 6 Vet. App. 465, 469-70 (1994). As such, the Board finds that the Veteran is competent to report the nature and onset of his skin symptomatology as well as the nature of his duties during service. Additionally, lay evidence may also be competent to establish medical etiology or nexus. Davidson v. Shinseki, 581 F.3d 1313, 1316 (Fed. Cir. 2009). However, "VA must consider lay evidence but may give it whatever weight it concludes the evidence is entitled to" and a mere conclusory generalized lay statement that service event or illness caused the claimant's current condition is insufficient to require the Secretary to provide an examination. Waters, supra.

However, in the instant case, the Board finds that the question regarding the potential relationship between the Veteran's skin disorder and any instance of his service, to include exposure to chemicals and oils, is complex in nature. See Woehlaert v. Nicholson, 21 Vet. App. 456 (2007) (although the claimant is competent in certain situations to provide a diagnosis of a simple condition such as a broken leg or varicose veins, the claimant is not competent to provide evidence as to more complex medical questions); Jones v. Brown, 7 Vet. App. 134, 137 (1994) (where the determinative issue is one of medical causation, only those with specialized medical knowledge, training, or experience are competent to provide evidence on the issue). In this regard, the question of causation involves a medical subject concerning an internal physical process extending beyond an immediately observable cause-and-effect relationship. Specifically, the diagnosis and determination of etiology of a skin disorder requires the interpretation of results found on physical examination and knowledge of the dermatological system. As such, the question of etiology in this case may not be competently addressed by lay evidence, and the Board accords the Veteran's statements regarding the etiology of such disorder little probative value as he is not competent to opine on such a complex medical question.

The Board further finds that the Veteran's statements regarding the onset and continuity of symptomatology referable to his skin disorder to be not credible. In weighing credibility, VA may consider interest, bias, inconsistent statements, bad character, internal inconsistency, facial plausibility, self-interest, consistency with other evidence of record, malingering, desire for monetary gain, and demeanor of the witness. Caluza v. Brown, 7 Vet. App. 498 (1995). In the instant case, the Board finds the Veteran's statements regarding continuity of symptomatology to be not credible as they are inconsistent with the other evidence of record and were made under circumstances indicating bias or interest.

Specifically, the Veteran's service treatment records are negative for any complaints, treatment, or diagnoses similar to the type of skin disorder for which he is currently claiming entitlement to service connection. Moreover, on various reports of medical history, the Veteran denied skin diseases or rashes. Furthermore, in October 2007, the same month the Veteran separated from service, he reported no persistent skin rash. Rucker v. Brown, 10 Vet. App. 67, 73 (1997) (ascribing heightened credibility to statements made to clinicians for the purpose of treatment); See Williams v. Gov. of Virgin Islands, 271 F.Supp.2d 696, 702 (V.I.2003) (noting that statements made for the purpose of diagnosis or treatment "are regarded as inherently reliable because of the recognition that one seeking medical treatment is keenly aware of the necessity for being truthful in order to secure proper care"). Therefore, the Veteran's current statements, made in connection with his pending claim for VA benefits, that his skin disorder had its onset in service and has continued to the present time is inconsistent with the contemporaneous evidence, to include his own reports. As such, the Veteran's lay assertions of onset and continuity of skin symptomatology are less credible and persuasive in light of the other evidence of record, and are, in fact, outweighed by this evidence. Consequently, based on the foregoing evidence, the Board finds that the Veteran's statements regarding the onset and continuity of skin symptomatology to be not credible and are accorded no probative weight.

Therefore, the Board finds that a skin disorder is not shown to be causally or etiologically related to any disease, injury, or incident during service. In reaching this decision, the Board has considered the applicability of the benefit of the doubt doctrine. However, the preponderance of the evidence is against the Veteran's claim. As such, that doctrine is not applicable in the instant appeal, and his claim must be denied. 38 U.S.C.A. § 5107; 38 C.F.R. § 3.102; Gilbert, supra.

ORDER

Service connection for a skin disorder is denied.

REMAND

Although the Board regrets the additional delay, a remand is necessary to ensure that due process is followed and that there is a complete record upon which to decide the Veteran's claim for service connection for hemorrhoids so that he is afforded every possible consideration. 38 U.S.C.A. § 5103A; 38 C.F.R. § 3.159.

In this regard, the Board finds that a remand is necessary in order to afford the Veteran a VA examination so as to determine the current nature and etiology of his hemorrhoids. STRs reflect that, in October 2004, the Veteran complained of blood in his stool on and off for a couple of months. It was observed that he had blood in his stools once every couple of weeks. Following a physical examination, rectal bleed by history was diagnosed. Post-service records reflect that, at the January 2008 VA examination, a history of hemorrhoids was specifically not noted to be present. However, a VA treatment dated the same month reveals a prior medical history of hemorrhoids with intermittent spotting with blood and itching. Likewise, VA treatment records reveal diagnoses and treatment for hemorrhoids in May 2008, June 2008, and November 2009. Moreover, a January 2010 VA treatment record reveals mild active hemorrhoids on examination. In light of the notation of rectal bleeding during service and the Veteran's continued treatment for hemorrhoids after service, the Board finds that he should be afforded a

VA examination in order to determine the etiology of such disorder.

Additionally, while on remand, the Veteran should be requested to identify any VA or non-VA healthcare provider who treated him for his hemorrhoids. After obtaining any necessary authorization from the Veteran, the AOJ should attempt to obtain any outstanding treatment records for consideration in his appeal.

Accordingly, the case is REMANDED for the following action:

1. The Veteran should be requested to identify any VA or non-VA healthcare provider who treated him for his hemorrhoids. After obtaining any necessary authorization from the Veteran, the AOJ should attempt to obtain any outstanding treatment records. All reasonable attempts should be made to obtain such records. If any records cannot be obtained after reasonable efforts have been made, issue a formal determination that such records do not exist or that further efforts to obtain such records would be futile, which should be documented in the claims file. The Veteran must be notified of the attempts made and why further attempts would be futile, and allowed the opportunity to provide such records, as provided in 38 U.S.C.A. § 5103A(b)(2) and 38 C.F.R. § 3.159(e).

2. After all outstanding records have been associated with the claims file, the Veteran should be afforded an appropriate VA examination to determine the current nature and etiology of his hemorrhoids. The claims file, to include a copy of this Remand, must be made available to, and be reviewed by, the examiner. Any indicated evaluations, studies, and tests should be conducted.

The examiner should offer an opinion as to whether it is at least as likely as not that the Veteran's hemorrhoids began during service or is otherwise causally related to any incident of service, to include his October 2004 complaints of rectal bleeding.

In offering any opinion, the examiner must consider the full record, to include the Veteran's service treatment records and lay statements regarding onset and continuity of symptoms referable to hemorrhoids. The rationale for any opinion offered should be provided.

3. After completing the above, and any other development as may be indicated by any response received as a consequence of the actions taken in the preceding paragraphs, the Veteran's claim should be readjudicated based on the entirety of the evidence. If the claim remains denied, the Veteran and his representative should be issued a supplemental statement of the case. An appropriate period of time should be allowed for response.

Thereafter, the case should be returned to the Board for further appellate consideration, if otherwise in order. The Board intimates no opinion as to the outcome of this case. The Veteran need take no action until so informed. The purpose of this REMAND is to ensure compliance with due process considerations.

The Veteran has the right to submit additional evidence and argument on the matters the Board has remanded. Kutscherousky v. West, 12 Vet. App. 369 (1999).

This claim must be afforded expeditious treatment. The law requires that all claims that are remanded by the Board or by the United States Court of Appeals for Veterans Claims for additional development or other appropriate action must be handled in an expeditious manner. See 38 U.S.C.A. §§ 5109B, 7112 (West Supp. 2013).

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A. JAEGER
Veterans Law Judge, Board of Veterans' Appeals

Department of Veterans Affairs

Citation Nr: 1113680
Decision Date: 04/06/11 Archive Date: 04/15/11

DOCKET NO. 06-25 153A) DATE
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On appeal from the
Department of Veterans Affairs Regional Office in Montgomery, Alabama

THE ISSUE

Entitlement to service connection for a bilateral ankle disability, to include as a result of an undiagnosed illness.

REPRESENTATION

Appellant represented by: Disabled American Veterans

ATTORNEY FOR THE BOARD

J. C. Schingle, Associate Counsel

INTRODUCTION

The Veteran served on active duty from March 2000 to August 2004. This service included active duty in Afghanistan from October 2001 to May 2002 and from July 2003 to April 2004.

This matter comes before the Board of Veterans' Appeals (Board) on appeal from a November 2004 rating action of the Department of Veterans Affairs (VA) Regional Office (RO) in Buffalo, New York. Due to the location of the Veteran's residence, the jurisdiction of his appeal remains with the RO in Montgomery, Alabama.

In September 2009, the Board remanded the issue on appeal for additional development. The claim has since been returned to the Board for adjudication.

For the reasons set forth below, the appeal is once again REMANDED to the RO via the Appeals Management Center (AMC), in Washington, DC. VA will notify the Veteran if further action is required.

REMAND

Although further delay is regrettable, the Board finds that a remand necessary because the AMC has not substantially complied with the Board's prior September 2009 remand directives. In Stegall v. West, 11 Vet. App. 268, 271 (1998), the United States Court of Appeals for Veterans Claims (the Court) held that compliance with remand instructions is neither optional nor discretionary. The Court further held that the Board errs as a matter of law when it fails to ensure compliance with remand orders. Although VBA is required to comply with remand orders, it is substantial compliance, not absolute compliance that is required. See Dyment v. West, 13 Vet.App. 141, 146-47 (1999) (holding that there was no Stegall violation when the examiner made the ultimate determination required by the Board's remand, because such determination "more that substantially complied with the Board's remand order").
In September 2009, the Board remanded the issue on appeal to the RO, through the AMC, for further development. Specifically, the Board remanded the issue, in pertinent part, for a new VA examination to determine whether the Veteran had a diagnosed bilateral ankle disability related to service, or whether his ankle symptomotology resulted from an undiagnosed illness related to his Persian Gulf War Service. The Board remand instructed the VA examiner to conduct a thorough VA examination and to provide objective medical findings with opinions regarding etiology.

In April 2010, the Veteran was afforded a VA examination in which the examiner noted the Veteran's history of treatment for multiple ankle sprains in service and provided a diagnosis of chronic bilateral ankle sprain with mild functional limitations. He then opined that it was at least as likely as not that the ankle sprains occurred during active service. However, the Board notes that the examiner's opinion merely reiterated a fact previously established by the record (that the Veteran incurred multiple ankle sprains in service) and did not provide insight regarding the etiology of the Veteran's bilateral ankle disability.

In January 2011, the VA examiner provided a follow-up addendum in which he again noted the Veteran's history of bilateral ankle sprains and diagnosed multiple sprains of the bilateral ankles with no functional limitations. He stated that, although the Veteran was treated for ankle sprains in service, sprains resolve over a period of time, and that there were no objective findings of instability on current examination. He opined that the Veteran's subjective complaints were less likely as not caused by or the result of ankle sprains which occurred during active duty.

The Board finds the above April 2010 VA examination report and the January 2011 addendum do not contain the critical information required by the Board's September 2009 remand. In this regard, the reports provide conflicting information with regard to diagnosis, and it remains unclear whether the Veteran has a currently diagnosed bilateral ankle disability. As noted above, both reports acknowledge that the Veteran experienced ankle sprains in service. However, while the 2010 report noted current mild functional limitation, the 2011 report noted no objective findings of instability and implied that the Veteran's complaints were merely subjective in nature. Additionally, neither report provided adequate rationale for the medical opinion expressed. Moreover, neither report addressed the question of whether the Veteran's bilateral ankle symptoms could be attributed to an undiagnosed illness as the result of his service.

Therefore, because the examination report did not contain crucial information required by the Board's remand, the Board finds that Stegall requirements have not been met and that the claim must be remanded.

Accordingly, the case is REMANDED for the following action:

1. Schedule the Veteran for an appropriate VA examination to determine the nature, extent, and etiology of any bilateral ankle disorder that he may have. The examiner should be provided with the claims file for review in conjunction with this examination.

For any current ankle disorder diagnosed on examination, the examiner should clearly state the diagnosis and express an opinion as to whether it is at least as likely as not, i.e., a 50 percent probability or greater, that such disability had its clinical onset in service or is otherwise related to service.

If the Veteran's ankle symptomatology cannot be attributed to any known clinical diagnosis, the examiner should indicate whether such symptoms represent an objective indication of chronic disability resulting from an undiagnosed illness related to the Veteran's Persian Gulf War service, or a medically unexplained chronic multi-symptom illness.

All opinions are to be accompanied by a clear rationale consistent with the evidence of record.
2. Then, readjudicate the claim for service connection for a bilateral ankle disability, including as a result of an undiagnosed illness. If this benefit is not granted, the Veteran and his representative should be furnished a supplemental statement of the case and be afforded an opportunity to respond. The case should then be returned to the Board for appellate review.

No action is required of the Veteran until he is notified by the RO; however, the Veteran is advised that failure to report for any scheduled examination may result in the denial of his claim. 38 C.F.R. § 3.655 (2010). The Veteran has the right to submit additional evidence and argument on the matter that the Board has remanded. Kutscherousky v. West, 12 Vet. App. 369 (1999).

This claim must be afforded expeditious treatment. The law requires that all claims that are remanded by the Board or by the Court for additional development or other appropriate action must be handled in an expeditious manner. See 38 U.S.C.A. §§ 5109B, 7112 (West Supp. 2010).

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THERESA M. CATINO
Acting Veterans Law Judge, Board of Veterans' Appeals

Under 38 U.S.C.A. § 7252 (West 2002), only a decision of the Board is appealable to the Court. This remand is in the nature of a preliminary order and does not constitute a decision of the Board on the merits of your appeal. 38 C.F.R. § 20.1100(b) (2010).

Citation Nr: 1127377
Decision Date: 07/22/11 Archive Date: 07/29/11

DOCKET NO. 08-04 468) DATE
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On appeal from the
Department of Veterans Affairs Regional Office in Pittsburgh, Pennsylvania

THE ISSUES

1. Entitlement to service connection for a psychiatric disorder, to include posttraumatic stress disorder (PTSD).

2. Entitlement to service connection for hearing loss.

3. Entitlement to service connection for tinnitus.

REPRESENTATION

Appellant represented by: Disabled American Veterans

ATTORNEY FOR THE BOARD

S. Finn, Associate Counsel

INTRODUCTION

The Veteran served on active duty from May 2001 to August 2005, during the Gulf War Era.

These matters come before the Board of Veterans' Appeals (Board) on appeal from a June 2007 rating decision of the RO.

Although the Veteran initially requested a hearing, the Veteran withdrew his request in a July 2009 lay statement.

Of preliminary importance, the Board is cognizant of the recent decision of the U.S. Court of Appeals for Veterans Claims (Court), in Clemons v. Shinseki, 23 Vet. App. 1 (2009).

In Clemons, the Court found that the Board erred in not considering the scope of the Veteran's claim of service connection for PTSD as including any mental disability that may reasonably be encompassed by the claimant's description of the claim, reported symptoms, and the other information of record.

In light of Clemons, and based on the medical evidence of record, the Board has recharacterized the Veteran's claim as one of service connection for a psychiatric disorder, to include PTSD.

The issues of service connection for a psychiatric disorder and tinnitus are addressed in the REMAND portion of the decision below and are REMANDED to the RO via the Appeals Management Center (AMC), in Washington, DC.

FINDING OF FACT

The Veteran currently is not shown to have a hearing disability in either ear for which VA compensation is payable under the law.

CONCLUSION OF LAW

The claim of service connection for bilateral hearing loss must be denied by operation of law. 38 U.S.C.A. §§ 1110, 1112, 1113, 1131, 5103, 5103A, 5107 (West 2002 & Supp. 2010); 38 C.F.R. §§ 3.159, 3.303, 3.307, 3.309 (2010).

REASONS AND BASES FOR FINDING AND CONCLUSION

I. Duties to Notify and Assist

The VCAA, codified at 38 U.S.C.A. §§ 5100, 5102, 5103, 5103A, 5106, 5107, and 5126, was signed into law on November 9, 2000. Implementing regulations were created, codified at 38 C.F.R. §§ 3.102, 3.156(a), 3.159, and 3.326.

VCAA notice consistent with 38 U.S.C.A. § 5103(a) and 38 C.F.R. § 3.159(b) must: (1) inform the claimant about the information and evidence not of record that is necessary to substantiate the claim; (2) inform the claimant about

the information and evidence that VA will seek to provide; and (3) inform the claimant about the information and evidence that the claimant is expected to provide. The Board notes that a "fourth element" of the notice requirement, requesting the claimant to provide any evidence in the claimant's possession that pertains to the claim, was recently removed from the language of 38 C.F.R. § 3.159(b)(1). See 73 Fed. Reg. 23,353-356 (April 30, 2008).

Prior to the initial adjudication of the Veteran's claim for hearing loss in the June 2007 rating decision, he was provided notice of the VCAA in January 2007. The VCAA letter indicated the types of information and evidence necessary to substantiate the claim, and the division of responsibility between the Veteran and VA for obtaining that evidence, including the information needed to obtain lay evidence and both private and VA medical treatment records. The Veteran also received notice pertaining to the downstream disability rating and effective date elements of his claim, and was furnished a Statement of the Case in January 2008. Dingess v. Nicholson, 19 Vet. App. 473 (2006); see also Mayfield v. Nicholson, 444 F.3d 1328 (Fed. Cir. 2006).

The Board acknowledges that the Veteran has not been afforded a VA examination in conjunction with his claim for hearing loss. A medical examination or medical nexus opinion is necessary if the information and evidence of record does not contain sufficient competent medical evidence to decide the claim, but (a) contains competent lay or medical evidence of a current diagnosed disability or persistent or recurrent symptoms of disability; (b) establishes that the veteran suffered an event, injury, or disease in service; and (c) indicates that the claimed disability or symptoms may be associated with the established event, injury, or disease in service or with another service-connected disability. See 38 C.F.R. § 3.159(c)(4).

Upon review, the Board has concluded that a remand for examination of the Veteran and/or a medical nexus opinion is not warranted in this case, because the information and evidence of record does not reflect a diagnosis of a current disability.

All relevant evidence necessary for an equitable resolution of the issue on appeal has been identified and obtained, to the extent possible. The evidence of record includes service treatment records, service personnel records, VA outpatient treatment reports, and statements from the Veteran and his representative. The Veteran has not indicated that he has any further evidence to submit to VA, or which VA needs to obtain. There is no indication that there exists any additional evidence that has a bearing on this case that has not been obtained. The Veteran and his representative have been accorded ample opportunity to present evidence and argument in support of his appeal. All pertinent due process requirements have been met. See 38 C.F.R. § 3.103.

II. Service Connection for Hearing Loss

The Veteran asserts that he is experiencing bilateral hearing loss that is due to noise exposure from helicopter engines, weapons cache explosions, rocket-attacks, close quarters gun fire, flashbacks, and other combat related hazards while in Afghanistan.

The Veteran's DD Form 214 reflects a primary specialty of a unit supply specialist.

Service connection may be granted for a disability resulting from disease or injury incurred in or aggravated by service. 38 U.S.C.A. §§ 1110, 1131; 38 C.F.R. § 3.303(a).

For the showing of chronic disease in service, there is required a combination of manifestations sufficient to identify the disease entity and sufficient observation to establish chronicity at the time. If chronicity in service is not established, a showing of continuity of symptoms after discharge is required to support the claim. 38 C.F.R. § 3.303(b).

Service connection may also be granted for any disease diagnosed after discharge when all of the evidence establishes that the disease was incurred in service. 38 C.F.R. § 3.303(d).

VA regulations provide that compensation will be paid to a Persian Gulf veteran who exhibits objective indications of a qualifying chronic disability if that disability (a) became manifest either during active service in the Southwest Asia Theater of Operations during the Persian Gulf War, or to a degree of 10 percent or more not later than December 31, 2011, and (b) by history, physical examination, and laboratory tests cannot be attributed to any known clinical diagnosis. 38 C.F.R. § 3.317.

For VA purposes, a qualifying chronic disability presently means a chronic disability resulting from any of the following (or any combination of the following): (A) An undiagnosed illness; or (B) The following medically unexplained chronic multi-symptom illnesses that are defined by a cluster of signs or symptoms (Chronic fatigue syndrome, Fibromyalgia, or Irritable bowel syndrome).

The term medically unexplained chronic multi-symptom illness means a diagnosed illness without conclusive pathophysiology or etiology, that is characterized by overlapping symptoms and signs and has features such as fatigue, pain, disability out of proportion to physical findings, and inconsistent demonstration of laboratory abnormalities.

Chronic multi-symptom illnesses of partially understood etiology and pathophysiology will not be considered medically unexplained. "Objective indications of chronic disability" include both "signs," in the medical sense of objective evidence perceptible to an examining physician, and other, non-medical indicators that are capable of independent verification. Disabilities that have existed for 6 months or more and disabilities that exhibit intermittent episodes of improvement and worsening over a 6-month period will be considered chronic. The 6-month period of chronicity will be measured from the earliest date on which the pertinent evidence establishes that the

signs or symptoms of the disability first became manifest. Id.

Signs or symptoms which may be manifestations of undiagnosed illness or medically unexplained chronic multi-symptom illness include, but are not limited to: (1) Fatigue, (2) Unexplained rashes or other dermatological signs or symptoms, (3) Headache, (4) Muscle pain, (5) Joint pain, (6) Neurological signs and symptoms, (7) Neuropsychological signs or symptoms, (8) Signs or symptoms involving the upper or lower respiratory system, (9) Sleep disturbances, (10) Gastrointestinal signs or symptoms, (11) Cardiovascular signs or symptoms, (12) Abnormal weight loss, and (13) Menstrual disorders. 38 C.F.R. § 3.317(b).

Compensation shall not be paid under this section if there is affirmative evidence that an undiagnosed illness was not incurred during active service in the Southwest Asia Theater of Operations during the Persian Gulf War, if there is affirmative evidence that an undiagnosed illness was caused by a supervening condition or event that occurred between the veteran's most recent departure from active duty in the Southwest Asia Theater of Operations during the Persian Gulf War and the onset of the illness, or if there is affirmative evidence that the illness is the result of the Veteran's own willful misconduct or the abuse of alcohol or drugs. 38 C.F.R. § 3.317(c).

The United States Court of Appeals for the Federal Circuit (Federal Circuit) has held that when a claimed disorder is not included as a presumptive disorder direct service connection may nevertheless be established by evidence demonstrating that the disease was in fact "incurred" during the service. See Combee v. Brown, 34 F.3d 1039 (Fed. Cir. 1994).

The applicable regulations provide that impaired hearing shall be considered a disability when the auditory thresholds in any of the frequencies of 500, 1000, 2000, 3000, and 4000 Hz are 40 decibels or greater; the thresholds for at least three of these frequencies are 26 decibels or greater; or when speech recognition scores are 94 percent or less. 38 C.F.R. § 3.385.

The record before the Board contains service treatment records (STRs) and post-service medical records. Dela Cruz v. Principi, 15 Vet. App. 143, 148-49 (2001) (a discussion of all evidence by the Board is not required when the Board has supported its decision with thorough reasons and bases regarding the relevant evidence).

A careful review of the STRs shows no complaints or finding referable to hearing loss. The Veteran denied hearing loss in an April 2001 Report of Medical History. April 2001 audiometric studies presented findings that were not consistent with a hearing disability for VA compensation purposes. (See also May 2001 Audiometric Findings). The May 2005 separation report of medical assessment shows no complaint of hearing loss.

Moreover, the post-service treatment records reflect no diagnosis or treatment of hearing loss.

A March 2008 comprehensive audiometric examination reported hearing and word recognition within normal limits.

A diagnosed identifiable underlying malady or condition is needed to constitute a disability for which service connection can be granted. Sanchez-Benitez v. Principi, 259 F.3d 1356 (Fed. Cir. 2001).

In the absence of a confirmed diagnosis consistent with disability, meaning medical evidence showing the Veteran has the alleged condition, service connection must be denied.

The case law is well settled on this point. In order for a claimant to be granted service connection for a claimed disability, there must be evidence of a current disability. See Wamhoff v. Brown, 8 Vet. App. 517, 521 (1996); Brammer v. Derwinski, 3 Vet. App. 223, 225 (1992) (service connection is limited to cases wherein the service incident has resulted in a disability, and in the absence of proof of a present disability, there can be no valid claim); see also Rabideau v. Derwinski, 2 Vet. App. 141, 144 (1992) (service connection claim must be accompanied by evidence establishing the claimant currently has the claimed disability).

Here, the medical evidence shows that the Veteran does not have a hearing loss disability meeting the criteria of 38 C.F.R. § 3.385 for which VA compensation benefits may be paid. As such, by law, the claim of service connection for bilateral hearing loss must be denied.

The Board is aware that lay statements may be sufficient to establish a medical diagnosis or nexus. See Davidson v. Shinseki, 581 F.3d 1313, 1316 (Fed. Cir. 2009).

In ascertaining the competency and probative value of lay evidence, recent decisions of the United States Court of Appeals for Veterans Claims (Court) have underscored the importance of determining whether a layperson is competent to identify the medical condition in question.

As a general matter, a layperson is not capable of opining on matters requiring medical knowledge. See 38 C.F.R. § 3.159(a)(2). In certain instances, however, lay evidence has been found to be competent with regard to a disease with "unique and readily identifiable features" that is "capable of lay observation." See Barr v. Nicholson, 21 Vet. App. 303, 308-09 (2007) (concerning varicose veins); see also Jandreau v. Nicholson, 492 F.3d 1372, 1376-77 (Fed. Cir. 2007) (a dislocated shoulder); Charles v. Principi, 16 Vet. App. 370, 374 (2002) (tinnitus); Falzone v. Brown, 8 Vet. App. 398, 405 (1995) (flatfoot).

That notwithstanding, a Veteran is not competent to provide an opinion as to more complex medical questions involving medical diagnosis or etiology. See Woehlaert v. Nicholson, 21 Vet. App. 456, 462 (2007) (concerning rheumatic fever); see also Routen v. Brown, 10 Vet. App. 183, 186 (1997) ("a layperson is generally not capable of opining on matters requiring medical knowledge").

In the present case, the Veteran is not competent to diagnose the degree of hearing loss necessary to meet VA

thresholds for disability purposes; although he is competent to observe such continuous symptoms as to the inability to hear sounds. See Sanchez-Benitez v. West, 13 Vet. App. 282, 285 (1999).

However, the Veteran's current lay assertions are not found to be credible for the purpose of establishing a continuity of symptomatology referable to having hearing loss manifestations beginning in service as they are inconsistent with the medical evidence of record and earlier and more probative statements recorded at the time of his separation from service.

Without such evidence of a disability, no further action with regard to the matter of service connection is warranted at this time. Clemons v. Shinseki, 23 Vet. App. 1 (2009).

ORDER

Service connection for bilateral hearing loss must be denied as a matter of law.

REMAND

On July 13, 2010, VA published a final rule that amended its adjudication regulations governing service connection for PTSD by liberalizing, in certain circumstances, the evidentiary standard for establishing the required in-service stressor. 75 Fed. Reg. 39843 (July 13, 2010).

Specifically, the final rule amends, in part, 38 C.F.R. § 3.304(f) in that "[i]f a stressor claimed by a Veteran is related to the Veteran's fear of hostile military or terrorist activity and a VA psychiatrist or psychologist, or a psychiatrist or psychologist with whom VA has contracted, confirms that the claimed stressor is adequate to support a diagnosis of [PTSD] and that the Veteran's symptoms are related to the claimed stressor, in the absence of clear and convincing evidence to the contrary, and provided the claimed stressor is consistent with the places, types, and circumstances of the Veteran's service, the Veteran's lay testimony alone may establish the occurrence of the claimed in-service stressor." 38 C.F.R. § 3.304(f)(3).

For purposes of this paragraph, "fear of hostile military or terrorist activity" means that a Veteran experienced, witnessed, or was confronted with an event or circumstance that involved actual or threatened death or serious injury, or a threat to the physical integrity of the Veteran or others, such as from an actual or potential improvised explosive device; vehicle-imbedded explosive device; incoming artillery, rocket, or mortar fire; grenade; small arms fire, including suspected sniper fire; or attack upon friendly military aircraft, and the Veteran's response to the event or circumstance involved a psychological or psycho-physiological state of fear, helplessness, or horror.

Further, the Veteran was diagnosed with tinnitus in March 2008. The Board observes that the Court has determined that, for tinnitus, the Veteran is competent to present evidence of continuity of symptomatology and diagnosis. See Charles v. Principi, 16 Vet. App. 370, 374-75 (2002); see also Davidson v. Shinseki, supra.

Given the diagnosis of tinnitus, the Veteran's lay statements of nexus, the relaxation of stressor verification requirements primarily during wartime, the Veteran should be afforded a VA examination for tinnitus and a psychiatric disability, to include whether he has a confirmed diagnosis of PTSD and whether the VA examiner finds it is related to the identified stressors.

Prior to arranging for the Veteran to undergo further VA examination, the RO should obtain and associate with the claims folder all outstanding VA medical records and any pertinent private records.

The Board emphasizes that records generated by VA facilities that may have an impact on the adjudication of a claim are considered constructively in the possession of VA adjudicators during the consideration of a claim, regardless of whether those records are physically on file. See Dunn v. West, 11 Vet. App. 462, 466-67 (1998); Bell v. Derwinski, 2 Vet. App. 611, 613 (1992).

Accordingly, the case is REMANDED for the following action:
1. The RO should undertake any action that may be necessary to comply with notice requirements of 38 U.S.C.A. § 5013(a) and 38 C.F.R. § 3.159(b), including notice to the Veteran of what information and evidence, if any, are still needed to substantiate his claim for service connection for PTSD, with specific citation to the recent change to 38 C.F.R. § 3.304(f). See 75 Fed. Reg. 39843 (July 13, 2010).
2. After securing any necessary release forms, with full address information, the RO should obtain all outstanding records referable to treatment of the Veteran by VA and any other pertinent health care provider. All records and/or responses received should be associated with the claims folder. If any VA or private records sought are not obtained, notify the Veteran and his representative of the records that were not obtained, explain the efforts taken to obtain them, and describe further action to be taken.

3. Then, the Veteran should be afforded a VA psychiatric examination to determine the nature and etiology of any psychiatric disability, to include PTSD, found to be present. If the examiner diagnoses the Veteran as having PTSD, then the examiner should indicate the stressor(s) underlying the diagnosis.

The claims file, including a copy of this REMAND, should be made available to and reviewed by the examiner. All indicated tests and studies should be accomplished, and clinical findings should be reported in detail.

Based on a review of the claims file and the clinical findings on examination, the examiner is requested to offer

an opinion as to the following:

(a) Whether the Veteran has a current diagnosis of PTSD pursuant to the criteria of the DSM-IV?

(b) If so, what are the stressor(s) to which the Veteran's PTSD is related; and

(c) Whether it is at least as likely as not (whether there is a 50 percent chance or more) that PTSD is due to the Veteran's alleged in-service stressor(s).

(d) Whether it is at least as likely as not (whether there is a 50 percent chance or more) that a psychiatric disability other than PTSD is due to the Veteran's service.

In all conclusions, the examiner(s) must identify and explain the medical basis or bases, with identification of the evidence of record. See Dalton v. Nicholson, 21 Vet. App. 23 (holding that an examination was inadequate where the examiner did not comment on the Veteran's report of in-service injury but relied on the service medical records to provide a negative opinion).

The examiner(s) is to specifically address in his or her conclusion the issue contained in the purpose of the examination, as noted.

A complete rationale must be provided for all opinions rendered. If the examiner(s) finds that he/she must resort to speculation to render the requested opinion, he/she must state what reasons, with specificity, that this question is outside the scope for a medical professional conversant in VA practices.

4. The Veteran should be afforded a VA audiological examination, with the appropriate examiner, to determine the nature and etiology of his claimed tinnitus. The Veteran's claims file should be made available to the examiner prior to the examination, and the examiner is requested to review the entire claims file in conjunction with the examination.

All tests and studies deemed necessary by the examiner should be performed. Based on a review of the claims file and the clinical findings of the examination, the examiner is requested to offer an opinion as to whether it is at least as likely as not (e.g., a 50 percent or greater probability) that the tinnitus, if present, is etiologically related to the Veteran's period of active service.

In all conclusions, the examiner(s) must identify and explain the medical basis or bases, with identification of the evidence of record. See Dalton v. Nicholson, 21 Vet. App. 23 (holding that an examination was inadequate where the examiner did not comment on the Veteran's report of in-service injury but relied on the service medical records to provide a negative opinion). The examiner(s) is to specifically address in his or her conclusion the issue contained in the purpose of the examination, as noted.

A complete rationale must be provided for all opinions rendered. If the examiner(s) finds that he/she must resort to speculation to render the requested opinion, he/she must state what reasons, with specificity, that this question is outside the scope for a medical professional conversant in VA practices.

5. The Veteran is hereby advised that failure to report for any scheduled VA examination without good cause shown may result in the denial of his claims.

6. After completing the requested actions, and any additional notification and development deemed warranted, the RO should readjudicate the claim in light of all evidence of record. If any benefit sought on appeal is not granted to the Veteran's satisfaction, he and his representative should be furnished a supplemental statement of the case, and should be afforded an appropriate period of time within which to respond thereto.

The Veteran has the right to submit additional evidence and argument on the matter or matters the Board has remanded. Kutscherousky v. West, 12 Vet. App. 369 (1999).

This claim must be afforded expeditious treatment. The law requires that all claims that are remanded by the Board of Veterans' Appeals or by the United States Court of Appeals for Veterans Claims for additional development or other appropriate action must be handled in an expeditious manner. See 38 U.S.C.A. §§ 5109B, 7112 (West Supp. 2010).

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D. C. Spickler
Veterans Law Judge, Board of Veterans' Appeals

Department of Veterans Affairs

Citation Nr: 1145020
Decision Date: 12/09/11 Archive Date: 12/14/11

DOCKET NO. 08-13 039A) DATE
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On appeal from the
Department of Veterans Affairs Regional Office in St. Petersburg, Florida

THE ISSUES

1. Entitlement to service connection for an acquired psychiatric disorder, to include posttraumatic stress disorder (PTSD) and an anxiety disorder.

2. Entitlement to service connection for a neck disorder, claimed as cervical strain and neuropathy of the neck.

3. Entitlement to service connection for a bilateral disorder of the lower extremities, to include a peripheral disorder or knee disorder.

REPRESENTATION

Appellant represented by: Disabled American Veterans

ATTORNEY FOR THE BOARD

Timothy D. Rudy, Counsel

INTRODUCTION

The Veteran served on active duty from November 2001 to March 2006. He also served in the Southwest Asia theater of operations from February 2003 to February 2004, and from December 2004 to November 2005.

This matter comes before the Board of Veterans' Appeals (Board) on appeal from rating decisions issued in July 2007 and October 2007 by the Department of Veterans Affairs (VA) Regional Office (RO) in St. Petersburg, Florida.

Subsequent to the May 2008 Statement of the Case, the Veteran submitted additional evidence, including VA outpatient medical records. Most, if not all, of this material appears duplicative of evidence already found within the claims file. Nevertheless, in September 2011, the Veteran's representative submitted a written waiver of initial RO consideration of this material and the Board has accepted this additional material for inclusion in the record. See 38 C.F.R. § 20.1304(c) (2010).

After this appeal was filed, the United States Court of Appeals for Veterans Claims (Court) issued a decision in Clemons v. Shinseki, 23 Vet. App. 1 (2009). In Clemons, the Court held that, when a claimant identifies PTSD without more, it cannot be considered a claim limited only to that diagnosis, but rather must be considered a claim for any mental disability that may reasonably be encompassed by several factors including the claimant's description of the claim, the symptoms the claimant describes, and the information the claimant submits or that VA obtains in support of the claim. The Court found that such an appellant did not file a claim to receive benefits only for a particular diagnosis, but for the affliction (symptoms) his mental condition, whatever it is, causes him. Id.

In Clemons, the Veteran had filed a claim for service connection for PTSD. The evidence of record showed he had been diagnosed with other psychiatric disabilities, but VA considered only the claim of entitlement to service connection for PTSD without considering entitlement to service connection for any other diagnosed psychiatric disability. The Court determined this was error. In this case, medical evidence of record shows the Veteran has been treated for a generalized anxiety disorder. In his December 2006 claim, the Veteran requested service connection both for PTSD and for a mental disorder due to skin affliction. The Board observes that the RO subsequently adjudicated both claims independently. In his written submissions, the Veteran asserted his psychiatric symptoms were probably due to anxiety and not to PTSD. Accordingly, in line with Clemons, the Board has recharacterized these two claims on appeal as one for an acquired psychiatric disorder, as reflected on the cover page.

Also in this case, medical evidence of record shows the Veteran has complained of neck pain and bilateral knee pain. In his December 2006 claim, the Veteran originally requested service connection for neuropathy of the neck and a peripheral leg disorder. In his Notice of Disagreement, VA Form 9, Substantive Appeal, and an April 2008 signed statement, the Veteran asserted that his service representative might have misrepresented his conditions because he has a cervical strain rather than neuropathy of the neck and because he had difficulty with bilateral crepitus knees (or patella-femoral syndrome) and not with neuropathy of the lower extremities. Accordingly, in line with Clemons, the Board has recharacterized these various claims on appeal as reflected on the cover page.

FINDINGS OF FACT

1. The evidence of record shows that the Veteran's psychiatric disorder, diagnosed as a generalized anxiety disorder, is causally or etiologically related to active duty service.

2. The evidence of record does not show that the Veteran currently has a neck disability.

3. The evidence of record does not show that the Veteran currently has a bilateral disability of the lower extremities, to include either a peripheral nerve or neuropathy disorder or a knee disorder.

CONCLUSIONS OF LAW

1. The Veteran's psychiatric disorder, diagnosed as a generalized anxiety disorder, was incurred in or aggravated by active duty service. 38 U.S.C.A. §§ 1110, 1111, 1153, 5107 (West 2002 & Supp. 2010); 38 C.F.R. §§ 3.303, 3.304, 3.306 (2011).

2. The criteria for entitlement to service connection for a neck disorder, claimed as cervical strain and neuropathy of the neck, have not been met. 38 U.S.C.A. §§ 1110, 5107 (West 2002 & Supp. 2010); 38 C.F.R. §§ 3.102, 3.303 (2011).

3. The criteria for entitlement to service connection for a bilateral disorder of the lower extremities, to include a peripheral disorder or knee disorder, have not been met. 38 U.S.C.A. §§ 1110, 5107 (West 2002 & Supp. 2010); 38 C.F.R. §§ 3.102, 3.303 (2011).

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

VCAA

The provisions of the Veterans Claims Assistance Act of 2000 (VCAA), codified at 38 C.F.R. §§ 3.102, 3.156(a), 3.159, 3.326(a) and as interpreted by the Court, have been satisfied by information provided to the Veteran in letters from the RO dated in January 2007, March 2007, and October 2008. These letters notified the Veteran of VA's responsibilities in obtaining information to assist the Veteran in completing his claims, and identified the Veteran's duties in obtaining information and evidence to substantiate his claims. (See 38 C.F.R. §§ 3.102, 3.156(a), 3.159, 3.326(a); Quartuccio v. Principi, 16 Vet. App. 183 (2002); Pelegrini v. Principi, 18 Vet. App. 112 (2004). See also Mayfield v. Nicholson, 19 Vet. App. 103, 110 (2005), reversed on other grounds, 444 F.3d 1328 (Fed. Cir. 2006); Dingess/Hartman v. Nicholson, 20 Vet. App. 473 (2006); Mayfield v. Nicholson (Mayfield II), 20 Vet. App. 537 (2006)).

Recently, the Court in Dingess/Hartman found that the VCAA notice requirements applied to all elements of a claim. An additional notice as to disability ratings and effective dates was provided in the January 2007 and October 2008 correspondence.

In any event, the Veteran has neither alleged nor demonstrated any prejudice with regard to the content or timing of the notice. See Shinseki v. Sanders, 129 S. Ct. 1696 (2009) (reversing prior case law imposing a presumption of prejudice on any notice deficiency, and clarifying that the burden of showing that an error is harmful, or prejudicial, normally falls upon the party attacking the agency's determination). In view of the above, notice requirements pertinent to the issues on appeal have been met.

The Board also notes that service treatment records are missing from the claims file, are evidently unavailable from the National Personnel Records Center (NPRC), and are presumed lost. The RO has issued two memoranda, dated in April 2007 and September 2008, about its efforts to obtain the Veteran's service treatment records and associate them with the claims file. The RO was able to obtain several of the Veteran's pre-deployment and post-deployment health assessments related to his deployments to Southwest Asia as well as some pre-induction service personnel records. The Board is mindful that, in a case such as this, where service treatment records are unavailable, there is a heightened obligation to explain our findings and conclusions and to consider carefully the benefit-of-the-doubt rule. Cuevas v. Principi, 3 Vet. App. 542, 548 (1992); Pruitt v. Derwinski, 2 Vet. App. 83, 85 (1992); O'Hare v. Derwinski, 1 Vet. App. 365, 367 (1991). While it is unfortunate that the Veteran's service treatment records are unavailable, this appeal must be decided on the evidence of record and, where possible, the Board's analysis has been undertaken with this heightened obligation set forth in Cuevas and O'Hare in mind.

The Board also finds that the duty to assist has been fulfilled regarding these claims as VA medical records relevant to these matters have been requested or obtained and the Veteran has been provided with VA examinations. The available medical evidence is sufficient for an adequate determination of the issues on appeal. Therefore, the Board finds that there has been substantial compliance with all pertinent VA laws and regulations and to move forward with these claims would not cause any prejudice to the Veteran.

Service Connection - Laws and Regulations

Service connection may be granted for a disability resulting from personal injury suffered or disease contracted in line of duty or for aggravation of pre-existing injury suffered or disease contracted in line of duty. 38 U.S.C.A. § 1110 (West 2002); 38 C.F.R. § 3.303 (2011).

VA regulations provide that where a veteran served 90 days or more of continuous, active military service during a

period of war or after January 1, 1947, and certain chronic diseases, including a psychosis and arthritis, become manifest to a degree of 10 percent within one year from date of termination of service, such disease shall be presumed to have been incurred in service even though there is no evidence of such disease during the period of service. This presumption is rebuttable by affirmative evidence to the contrary. 38 U.S.C.A. §§ 1101, 1110, 1112, 1113 (West 2002); 38 C.F.R. §§ 3.307, 3.309 (2011).

In addition, service connection may be granted for any disease diagnosed after discharge, when all of the evidence, including that pertinent to service, establishes the disease was incurred in service. 38 C.F.R. § 3.303(d). For the showing of chronic disease in service, there are required a combination of manifestations sufficient to identify a disease entity, and sufficient observation to establish chronicity at the time, as distinguished from merely isolated findings or a diagnosis including the word chronic. Continuity of symptomatology is required only where the condition noted during service is not, in fact, shown to be chronic or when the diagnosis of chronicity may be legitimately questioned. When the fact of chronicity in service is not adequately supported, then a showing of continuity after discharge is required to support the claim. 38 C.F.R. § 3.303(b).

Generally, in order to prevail on the issue of service connection on the merits, there must be medical evidence of (1) a current disability; (2) medical, or in certain circumstances, lay evidence of in-service incurrence or aggravation of a disease or injury; and (3) medical evidence of a nexus between the claimed in-service disease or injury and the present disease or injury. Hickson v. West, 12 Vet. App. 247, 253 (1999). The Federal Circuit has held that a veteran seeking disability benefits must establish the existence of a disability and a connection between service and the disability. Boyer v. West, 210 F.3d 1351, 1353 (Fed. Cir. 2000).

Entitlement to service connection for PTSD also requires medical evidence diagnosing the condition in accordance with 38 C.F.R. § 4.125(a); a link, established by medical evidence, between current symptoms and an in-service stressor; and credible supporting evidence that the claimed in-service stressor occurred. 38 C.F.R. § 3.304(f) (2011).

The law provides that secondary service connection shall be awarded when a disability is "proximately due to or the result of a service-connected disease or injury." 38 C.F.R. § 3.310(a). See Libertine v. Brown, 9 Vet. App. 521, 522 (1996); Harder v. Brown, 5 Vet. App. 183, 187 (1993). Additional disability resulting from the aggravation of a non-service-connected condition by a service-connected condition is also compensable under 38 C.F.R. § 3.310(a). Allen v. Brown, 7 Vet. App. 439, 448 (en banc). Establishing service connection on a secondary basis therefore requires evidence sufficient to show (1) that a current disability exists and (2) that the current disability was either (a) caused by or (b) aggravated by a service connected disability.

A veteran is presumed in sound condition except for defects noted when examined and accepted for service. According to 38 C.F.R. § 3.304(b), the term "noted" denotes only such conditions that are recorded in examination reports. The existence of conditions prior to service reported by the veteran as medical history does not constitute a notation of such conditions, but will be considered together with all other material evidence in determining the question of when a disease or disability began. See 38 C.F.R. § 3.304(b)(1).

Clear and unmistakable evidence that the disability existed prior to service will rebut the presumption of soundness. 38 U.S.C.A. § 1111; VAOPGCPREC 3-2003. A pre-existing disease will be considered to have been aggravated by active service where there is an increase in disability during service, unless there is a specific finding that the increase in disability is due to the natural progression of the disease. 38 U.S.C.A. § 1153; 38 C.F.R. § 3.306.

The Veteran has the responsibility to establish an increase in severity. See Jensen v. Brown, 19 F.3d 1413, 1417 (Fed. Cir. 1994). Such increase must be shown through independent medical evidence. See Paulson v. Brown, 7 Vet. App. 466, 470-471 (1995); Crowe v. Brown, 7 Vet. App. 238, 246 (1994). Should such increase be established, aggravation is presumed to be the result of service, unless rebutted by clear and unmistakable evidence. 38 U.S.C.A. § 1111; Wagner v. Principi, 370 F.3d 1089 (Fed. Cir. 2004); see also VAOPGCPREC 3-03 (July 16, 2003); 38 U.S.C.A. § 1153; 38 C.F.R. § 3.306(b). A claimant is not required to show that the disease or injury increased in severity during service before VA's duty under the rebuttal standard attaches. Cotant v. Principi, 17 Vet. App. 116 (2003); see also VAOPGCPREC 3-03.

In cases where a veteran asserts service connection for injuries or disease incurred or aggravated in combat, 38 U.S.C.A. § 1154(b) and its implementing regulation, 38 C.F.R. § 3.304(d), are applicable. This statute and regulation ease the evidentiary burden of a combat veteran by permitting the use, under certain circumstances, of lay evidence.

Otherwise, when a condition may be diagnosed by its unique and readily identifiable features, the presence of the disorder is not a determination "medical in nature" and is capable of lay observation. In such cases, the Board is within its province to weigh that testimony and to make a credibility determination as to whether that evidence supports a finding of service incurrence and continuity of symptomatology sufficient to establish service connection. See Barr v. Nicholson, 21 Vet. App. 303 (2007).

Lay evidence can be competent and sufficient to establish a diagnosis of a condition when (1) a layperson is competent to identify the medical condition, (2) the layperson is reporting a contemporaneous medical diagnosis, or (3) lay testimony describing symptoms at the time supports a later diagnosis by a medical professional. Jandreau v. Nicholson, 492 F.3d 1372 (Fed. Cir. 2007).

The Board must assess the credibility and weight of all the evidence, including the medical evidence, to determine its probative value, accounting for evidence which it finds to be persuasive or unpersuasive, and providing reasons for rejecting any evidence favorable to the claimant. See Masors v. Derwinski, 2 Vet. App. 181 (1992);

Gilbert v. Derwinski, 1 Vet. App. 49 (1990). Equal weight is not accorded to each piece of evidence contained in the record; every item of evidence does not have the same probative value.

Psychiatric Disorder

The Veteran seeks service connection for an acquired psychiatric disorder, to include PTSD and an anxiety disorder. He contends that any psychiatric disorder is the result of his active duty service. In written statements associated with the claims file, the Veteran states that he had two tours in the Middle East (in Turkey, Kuwait and Iraq) driving heavy equipment. He said that stresses in combat zones, driving 12 and 15 hours a day in convoys, missing his family and friends at home after recently graduating from high school, and being in a strange part of the world for some reason caused severe anxiety, fragmented sleep, a low tolerance for frustration, a mood disorder, irritability, hypervigilance, an exaggerated startle response and other somatic-related symptoms, as well as self-isolation and difficulty sustaining substantive employment or a meaningful relationship.

Available service personnel records reveal that the Veteran was part of the U.S. Army incentive enlistment and delayed entry programs. According to an April 2001 document, the Veteran had received a psychiatric consultation in the past. According to information supplied in September 2001 in connection with the Veteran's request for a security clearance (which application is associated with his available service personnel records) and other records on file, he received psychological counseling while in high school from approximately June 1999 to July 1999 after a friend had committed suicide.

Service personnel records reveal that the Veteran served in Afghanistan in Operation Enduring Freedom from February 2003 to February 2004 and served in Iraq in Operation Iraqi Freedom from December 2004 to November 2005 as a motor transport operator. His DD Form 214 noted that the Veteran had served in imminent danger pay areas.

As noted above, most of the Veteran's service treatment records are unavailable and have not been associated with the claims file. However, according to his December 2005 post-deployment assessment, which is available, while the Veteran denied being engaged in direct combat where he discharged his weapon, he did feel that he was in great danger of being killed during his Iraq deployment.

According to a February 2007 VA history and physical, the Veteran had a past medical history of anxiety while driving and in sexual relationships. He was referred to the VA mental health clinic. He was also negative for a PTSD screen.

A subsequent February 2007 VA psychiatric evaluation noted that the Veteran had increasing anxiety and a low frustration tolerance since his time in war zones. The Veteran said that he thought his anxiety in crowds was related to his anxiety while serving as the lookout for roadside bombs in Iraq. He said that he had depression in the past, but it was more anxiety now. He also explained that when he was in the tenth grade a friend had committed suicide and he saw a physician who placed him on Prozac, but that he did not like the way it made him feel.

On examination, he was oriented to person, place and time. While his mood was anxious, he expressed no delusions and denied hallucinations and suicidal and homicidal ideation. Diagnosis was a generalized anxiety disorder. The VA examiner opined that the Veteran's anxiety symptoms were exacerbated by his experience driving vehicles in Iraq.

A May 2007 VA mental health clinic record noted that the Veteran still had intrusive thoughts of roadside bombs when he was driving. He complained of anxiety, sleep difficulties and poor appetite.

The Veteran underwent a VA mental examination in June 2007. The Veteran told the examiner that when he returned home from service he was happy, but began to notice anxiety while driving and going out to public places. He also reported difficulties with sleeping, but not with appetite or concentration. He did not have many friends, stayed home a lot, and was very self-conscious about his skin condition. He denied that any anxiety symptoms were in remission. On examination, the Veteran denied panic attacks, but did admit to sleep impairment and displayed symptoms of depression, depressed mood or anxiety. Diagnosis was a generalized anxiety disorder. The VA psychiatrist opined that, while the Veteran's chronic anxiety began when he returned home, it stemmed more from his overseas experiences while in service than to other life situations, such as his skin disorder.

In his July 2007 Notice of Disagreement, the Veteran claimed that he never complained about PTSD and that his psychiatric symptoms were typical of anyone in a combat area, especially those in convoys exposed to improvised explosive devices (IEDs) and sniper attacks.

The Veteran underwent an additional VA mental examination in September 2007. Since the last VA examination the Veteran had continued to experience anxiety when driving and he worried about four hours a day. He also had a problem falling asleep and could be irritable. He felt sad at times when he thought about his skin condition and felt depressed when people commented on his vitiligo, but the examiner noted that the Veteran was able to bounce back within minutes. On examination, difficulty falling asleep was noted. The Veteran denied panic attacks and suicidal or homicidal ideation. Diagnosis was a generalized anxiety disorder evidenced by poor concentration, worry and anxiety. The September 2007 VA examiner opined that the Veteran's anxiety disorder was not aggravated by his service-connected vitiligo because any anxiety or mood changes that arose because of his embarrassment over his skin condition were fleeting. This examiner did not opine whether the Veteran's generalized anxiety disorder was due to his period of active duty.

In an April 2008 signed statement, the Veteran asserted that his PTSD claim had been misrepresented as anxiety due to his service-connected vitiligo, but that his anxiety was really combat-related from his period of active duty in Iraq.

In his May 2008 VA Form 9, Substantive Appeal the Veteran asserted that from December 2004 to November 2005, almost every day on convoy, he drove a tank recovery semi-tractor trailer vehicle about 11 miles north of Baghdad. He also said that he had constant anxiety in doing so because he had to be alert due to sniper fire, grenades or IEDs.

In a July 2008 signed statement, the Veteran explained that while he told a doctor that upon the suicide of a high school classmate his fellow students were advised to see a counselor and that he was prescribed a mood stabilizer as many of his classmates were, he was given a "clean bill of health" to join the Army after high school.

Based on the evidence of record, the Board finds that the Veteran's psychiatric disorder is causally and/or etiologically related to active duty service. Initially, the Board notes that there is no clear and unmistakable evidence that the Veteran had a psychiatric disorder which pre-existed his entrance into active duty in November 2001. Though service personnel records, a security clearance application, and the Veteran's written submissions assert that the Veteran had received psychiatric counseling and medication in high school for grief issues when a classmate committed suicide, the Board's review of the claims file shows no clear and unmistakable medical evidence that the Veteran had an actual pre-existing psychiatric disorder before his period of active duty. Therefore, the Board will examine this claim as one for direct, presumptive, or secondary service connection rather than for service connection due to aggravation of a pre-existing condition.

Concerning direct service connection for an acquired psychiatric disorder, the Board notes that the Veteran has been diagnosed with a current psychiatric disorder; the June 2007 VA examiner and others diagnosed a generalized anxiety disorder. Further, medical and lay evidence in the record suggests that the Veteran had no significant psychiatric concerns before his active duty service in the Southwest Asia theater of operations. In fact, the report of the June 2007 VA examination noted that the Veteran did not begin to experience his anxiety symptoms until after he had been discharged from service.

However, in cases where a veteran asserts service connection for injuries or disease incurred or aggravated in combat, 38 U.S.C.A. § 1154(b) and its implementing regulation, 38 C.F.R. § 3.304(d), are applicable. This statute and regulation ease the evidentiary burden of a combat veteran by permitting the use, under certain circumstances, of lay evidence. If the veteran was engaged in combat with the enemy, VA shall accept as sufficient proof of service connection satisfactory lay or other evidence of service incurrence, if the lay or other evidence is consistent with the circumstances, conditions, or hardships of such service. 38 U.S.C.A. § 1154(b); 38 C.F.R. § 3.304(d). To establish service connection, however, there must be medical evidence of a nexus between the current disability and the combat injury. See Dalton v. Nicholson, 21 Vet. App. 23, 36-37 (2007); Libertine v. Brown, 9 Vet. App. 521, 523-24 (1996).

The Veteran's available service personnel records do not show the award of decorations and medals which would indicate his involvement in combat. However, his DD Form 214 reveals that the Veteran's primary military occupational specialty was as a motor transport operator, which is consistent with his lay evidence of driving heavy vehicles during his deployment in Iraq. Further, the DD Form 214 notes that the Veteran served in imminent danger pay areas during his period of active duty. In addition, in his December 2005 post-deployment health assessment he answered "yes" to the question whether he ever felt in great danger of being killed during the deployment. Therefore, the Board finds that the Veteran's account of driving in convoys in Iraq and anxiously looking out for snipers and IEDs will be accepted as such is consistent with the circumstances of the Veteran's service as a motor transport operator in Iraq in 2005. See 38 U.S.C.A. § 1154(b). Thus, the Board finds that the Veteran can be considered a combat veteran under the provisions of 38 U.S.C.A. § 1154(b) for purposes of this appeal. Therefore, the second requirement for establishing direct service connection has been met.

Both the June 2007 VA examiner, and the February 2007 VA staff psychiatrist, attributed the Veteran's currently diagnosed generalized anxiety disorder to his period of active service in Iraq. The February 2007 psychiatrist opined that the Veteran's anxiety symptoms were exacerbated by his experience driving in convoys in Iraq and the June 2007 VA examiner opined that his anxiety stemmed more from his overseas service posting experiences than to other life situations. Therefore, the Board finds that both the February 2007 and the June 2007 examiners found that the Veteran suffered from psychological trauma in service that ultimately is responsible, in whole or in part, for the currently diagnosed generalized anxiety disorder. Accordingly, the Board finds that the Veteran has a psychiatric disorder, currently diagnosed as a generalized anxiety disorder, that is related to active duty service.

In view of the above, and in affording the Veteran the benefit of the doubt as the law requires, the Board finds that direct service connection is warranted for the Veteran's psychiatric disorder. As the Board finds that as there is sufficient evidence that the Veteran's psychiatric disorder was incurred in or aggravated by active service, the claim for service connection for an acquired psychiatric disorder, diagnosed as a generalized anxiety disorder, is granted.

Neck Disorder

The Veteran seeks service connection for a neck disorder, claimed as cervical strain and neuropathy of the neck. In written submissions, the Veteran contends that he drove tank-recovery semi-tractor trailer vehicles while stationed in Iraq on most days from December 2004 to November 2005 and that the heavy trucks bouncing over rough terrain caused cervical strain because he was wearing a heavy Kevlar helmet. He does not contend, and the evidence does not suggest, that his claimed neck disorder is a manifestation of an undiagnosed illness warranting application of 38 U.S.C.A. § 1117 and 38 C.F.R. § 3.317.

As noted above, most of the Veteran's service treatment records are lost. However, according to his December 2005 post-deployment assessment, the Veteran had back pain during deployment to Iraq. When he was asked about current health concerns, the Veteran listed bilateral knee pain. The examiner did not refer the Veteran for any post-service clinical evaluation.

Post-service, according to a February 2007 VA history and physical, the Veteran complained of cervical neck pain while on active duty. He was assessed with cervical neck pain.

March 2007 VA X-ray studies revealed an unremarkable radiographic examination of the cervical spine.

The Veteran underwent a VA general examination in June 2007. The VA examiner found that the Veteran developed neck pain around 2003 or 2004 without antecedent event, apparently during his first deployment to the Southwest Asia theater of operations in either Turkey or Afghanistan. The examiner noted that the neck pain was intermittent, perhaps 15 days per month, and that the Veteran had not undergone physical therapy or been prescribed medication for this complaint. On examination, range of motion measurements of the cervical spine were normal. While the examiner provided a diagnosis-mild intermittent cervical strain-the Board notes that the examiner added to his written diagnosis the comment that this condition existed by subjective complaints only. In view of this statement and the contemporaneous unremarkable X-ray reports, there is a lack of objective medical evidence indicating a underlying pathology responsible for the claimed neck pain. Thus, the Board can fairly characterize the June 2007 VA examination as showing that the Veteran does not have a currently diagnosed objective neck disability.

Based on the evidence of record, the Board finds that service connection for a neck disorder, claimed as cervical strain and neuropathy of the neck, is not warranted. There is no medical evidence of record demonstrating that the Veteran currently has a diagnosed disability of the neck or cervical spine. The Board acknowledges that the Veteran has complained of neck pain since service and that the June 2007 VA examiner also found a current complaint of neck pain. The Veteran is competent to describe symptoms he experiences, such as pain. Jandreau v. Nicholson, 492 F.3d 1372 (Fed. Cir. 2007); Barr v. Nicholson, 21 Vet. App. 303 (2007). As a combat veteran, he is competent to provide evidence about sustaining neck pain as a result of driving trucks in convoy in Iraq in 2005 and his testimony is credible and consistent with his service as a motor transport operator in Iraq in 2005. See 38 U.S.C.A. § 1154(b).

However, "pain alone, without a diagnosed or identifiable underlying malady or condition, does not in and of itself constitute a disability for which service connection may be granted." Sanchez-Benitez v. West, 13 Vet. App. 282, 285 (1999), dismissed in part and vacated in part on other grounds, Sanchez-Benitez v. Principi, 239 F.3d 1356 (Fed. Cir. 2001). As noted above, March 2007 X-ray studies revealed an unremarkable radiographic examination of the cervical spine and the VA examiner stated that any cervical strain was based only on the Veteran's subjective complaints and not on any objective criteria. Absent any evidence of a current disability, there can be no valid service connection claim. Brammer v. Derwinski, 3 Vet. App. 223, 225 (1992). Therefore, entitlement to service connection for a neck disability, claimed as cervical strain and neuropathy of the neck, is denied.

Disorder of the Lower Extremities

The Veteran seeks service connection for a bilateral disorder of the lower extremities, to include a peripheral disorder or knee disorder. In written submissions, the Veteran contends that crepitus in each knee began in service, perhaps due to jumping to the ground several times a day from the tank-recovery semi-tractor trailer he drove in Iraq. He does not contend, and the evidence does not suggest, that his claimed leg or knee disorder is a manifestation of an undiagnosed illness warranting application of 38 U.S.C.A. § 1117 and 38 C.F.R. § 3.317.

As noted above, most of the Veteran's service treatment records are lost. However, according to his December 2005 post-deployment assessment, the Veteran had painful and swollen joints during his deployment to Iraq, but denied numbness or tingling in his hands or feet. He also admitted to medical problems that developed during his deployment, but conceded that he was not then on profile or light duty. When he was asked about current health concerns, the Veteran listed bilateral knee pain; however, the examiner did not refer the Veteran for any post-service clinical evaluation.

Post-service, according to a February 2007 VA history and physical, the Veteran complained of bilateral knee pain while on active duty. He was assessed with bilateral knee pain.

March 2007 VA X-ray studies revealed essentially normal knees with no synovial effusions or calcifications.

The Veteran underwent a VA general examination in June 2007. He complained of a peripheral disorder of both knees and denied any symptoms related to the left or right foot. The VA examiner found that all four extremities, including peripheral pulses, were normal.

A separate VA orthopedic examination also was undertaken in June 2007. The Veteran complained of bilateral knee pain secondary to wear and tear. It was noted that the Veteran denied specific trauma to the knees. The Veteran complained of pain, stiffness, and flare-ups and indicated that he had been on profile while in service. Examination revealed no patella-femoral crepitance and stable ligaments. X-ray studies and diagnosis revealed normal bilateral knees. The VA examiner opined that the Veteran's bilateral knee pain was unrelated to service.

A separate VA peripheral nerves examination also was undertaken in June 2007. The Veteran complained that sometimes he had stiffening of the left calf and the fingers of the right hand, but denied any bowel or bladder problems. Motor, reflexes, and sensory examinations were all within normal limits. X-ray studies of the knees

were unremarkable.

In light of the evidence of record, the Board finds that entitlement to service connection for a bilateral disorder of the lower extremities, to include a peripheral disorder or knee disorder, is not warranted in this case. There is no medical evidence of record demonstrating that the Veteran currently has a diagnosed disability of either lower extremity or of either knee. One June 2007 VA examiner specifically found there was no objective evidence of a current peripheral nerve disorder and another June 2007 VA examiner found bilateral normal knees. Indeed, X-rays of the Veteran's knees in March 2007 were normal. As such, there is no evidence that the Veteran currently is diagnosed with a specific disability of either lower extremity or of either knee for which the Veteran may receive compensation for service connection.

The Board acknowledges that the Veteran has complained of bilateral knee pain since service. The Veteran is competent to describe symptoms he experiences, such as pain. Jandreau v. Nicholson, 492 F.3d 1372 (Fed. Cir. 2007); Barr v. Nicholson, 21 Vet. App. 303 (2007). As noted above, the Veteran also can be considered a combat Veteran for purposes of this appeal and his comments about frequent daily jumping from his truck to the ground while on convoy duty in Iraq is credible and consistent with the Veteran's service as a motor transport operator in Iraq in 2005. See 38 U.S.C.A. § 1154(b).

However, "pain alone, without a diagnosed or identifiable underlying malady or condition, does not in and of itself constitute a disability for which service connection may be granted." Sanchez-Benitez, 13 Vet. App. at 285 (1999). Absent any evidence of a current disability, there can be no valid service connection claim. Brammer, 3 Vet. App. at 225. Therefore, entitlement to service connection for a bilateral disorder of the lower extremities, to include a peripheral disorder or knee disorder, is denied.

[Continued on Next Page]

ORDER

Service connection for an acquired psychiatric disorder, diagnosed as a generalized anxiety disorder, is granted, subject to the laws and regulations governing monetary awards.

Service connection for a neck disorder, claimed as cervical strain and neuropathy of the neck, is denied.

Service connection for a bilateral disorder of the lower extremities, to include a peripheral disorder or knee disorder, is denied.

_____

JONATHAN B. KRAMER
Veterans Law Judge, Board of Veterans' Appeals

Department of Veterans Affairs

Citation Nr: 1231445
Decision Date: 09/13/12 Archive Date: 09/19/12

DOCKET NO. 09-00 244) DATE
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On appeal from the
Department of Veterans Affairs Regional Office in Reno, Nevada

THE ISSUES

1. Entitlement to service connection for chronic sinusitis, claimed as sinus problems.

2. Entitlement to service connection for a left leg disability, claimed as swelling, to include as secondary to a service-connected right foot bunionectomy.

3. Entitlement to service connection for a right leg disability, claimed as swelling, to include as secondary a service-connected left foot bunionectomy.

4. Entitlement to an initial disability evaluation in excess of 10 percent for gastroesophageal reflux disease (GERD).

5. Entitlement to an initial disability evaluation in excess of 10 percent for status post left foot bunionectomy.

6. Entitlement to an initial disability evaluation in excess of 10 percent for status post right foot bunionectomy.

7. Entitlement to an initial compensable disability evaluation for chronic allergic rhinitis.

REPRESENTATION

Appellant represented by: The American Legion

ATTORNEY FOR THE BOARD

T. Adams, Counsel

INTRODUCTION

The Veteran served on active duty from April 1999 to April 2005, including service in the Southwest Asia theater of operations.

This case comes before the Board of Veterans' Appeals (Board) on appeal from a June 2007 rating decision and November 2008 Decision Review Officer (DRO) decision of the Department of Veterans Affairs (VA) Regional Office (RO) in San Diego, California and Reno, Nevada, respectively. The June 2007 rating decision, inter alia, granted service connection and assigned a noncompensable disability evaluation each for status post bunionectomy with residual scar of the left and right foot, effective January 22, 2007; and denied service connection for chronic rhinitis, sinusitis/allergies, esophageal reflux, and bilateral leg swelling and numbness. The November 2008 DRO decision, inter alia, granted service connection for gastroesophageal reflux (GERD) and assigned a 10 percent disability evaluation, effective from January 22, 2007; granted service connection and assigned a noncompensable disability evaluation for chronic allergic rhinitis, effective January 22, 2007, and increased the disability evaluation from 0 percent to 10 percent each for status post left and right foot bunionectomy, effective from January 22, 2007. However, as those grants do not represent a total grant of benefits sought on appeal, the claims for increase remain before the Board. AB v. Brown, 6 Vet. App. 35 (1993).

During the course of the appeal, jurisdiction of this case was transferred to the RO in Reno, Nevada.

The Board notes that the Veteran was granted service connection for a tender scar, status post left foot bunionectomy, effective from October 9, 2008, in a February 2010 DRO decision. There is no documentation in the claims file or Virtual VA showing that the Veteran has appealed that decision to date. Accordingly, that issue is not currently before the Board.

In the Veteran's December 2008 substantive appeal, she requested a Travel Board hearing before the Board. A hearing was scheduled to be held in May 2010. However, she failed to report for her hearing. Thus, her Board hearing request is deemed withdrawn. See 38 C.F.R. § 20.704 (2011). In January 2010 the Veteran testified before a DRO at the RO with regard to her increased rating claims. A transcript of that hearing is of record.

The Board notes that, in addition to the paper claims file, there is a Virtual VA electronic claims file associated with the Veteran's claims. A review of the documents in the electronic file reveals that they are either duplicative of the evidence in the paper claims file or are irrelevant to the issues on appeal.

The issues of entitlement to service connection for left and right leg disabilities; entitlement to an initial disability evaluation in excess of 10 percent for GERD, for left and right foot bunionectomies; and entitlement to an initial compensable disability evaluation for chronic allergic rhinitis are REMANDED to the RO via the Appeals Management Center (AMC), in Washington, DC.

FINDING OF FACT

Sinusitis has not been present at any time during the pendency of this claim.

CONCLUSION OF LAW

Sinusitis was not incurred in or aggravated by active duty. 38 U.S.C.A. §§ 1110, 1131 (West 2002); 38 C.F.R. § 3.303 (2011).

REASONS AND BASES FOR FINDING AND CONCLUSION

VCAA

VA's duties to notify and assist claimants in substantiating a claim for VA benefits are found at 38 U.S.C.A. §§ 5100, 5102, 5103, 5103A, 5107, 5126 and 38 C.F.R. §§ 3.102, 3.156(a), 3.159, 3.326(a). See also 73 Fed. Reg. 23,353 -23,356 (April 30, 2008) (concerning revisions to 38 C.F.R. § 3.159). Upon receipt of a complete or substantially complete application for benefits, VA is required to notify the claimant and his or her representative, if any, of any information, and any medical evidence or lay evidence that is necessary to substantiate the claim. 38 U.S.C.A. § 5103(a); 38 C.F.R. § 3.159(b) ; see also Quartuccio v. Principi, 16 Vet. App. 183 (2002). In accordance with 38 C.F.R. § 3.159(b)(1), proper notice must inform the claimant of any information and evidence not of record (1) that is necessary to substantiate the claim; (2) that VA will seek to provide; and (3) that the claimant is expected to provide. Notice should be sent prior to the appealed rating decision or, if sent after the rating decision, before a readjudication of the appeal. A Supplemental Statement of the Case, when issued following a notice letter, satisfies the due process and notification requirements for an adjudicative decision for these purposes. See Mayfield v. Nicholson, 444 F.3d 1328 (Fed. Cir. 2006).

In this appeal, the RO provided notice to the Veteran in a March 2007 letter that explained what information and evidence was needed to substantiate the claim for service connection, as well as what information and evidence must be submitted by the Veteran, and what information and evidence would be obtained by VA. This letter also provided the Veteran with information pertaining to the assignment of disability ratings and effective dates, as well as the type of evidence that impacts those determinations, consistent with Dingess/Hartman v. Nicholson, 19 Vet. App. 473 (2006).

The record also reflects that VA has made reasonable efforts to obtain or to assist in obtaining all relevant records pertinent to the matter on appeal. Pertinent medical evidence associated with the claims files consists of service and VA treatment records, private treatment records, and the report of an October 2008 VA examination. A review of that report of examination reveals that all subjective and objective findings necessary for evaluation of the Veteran's claim were observed and recorded. Thus, the examination appears complete and adequate. Barr v. Nicholson, 21 Vet. App. 303 (2007).

The Board acknowledges that while the Veteran has been afforded a VA examination in response to her claimed sinusitis, a VA medical opinion has not been obtained, but has determined that VA has no duty to obtain medical opinion in response to this claim. In this case, while the Veteran was diagnosed with sinusitis during service, there is no competent evidence reflecting the presence of a current diagnosis of sinusitis. As the Veteran has not presented a prima facie case for service connection for sinusitis, a remand for an opinion is not required at this point. See 38 U.S.C.A. § 5103A(d); 38 C.F.R. § 3.159(c)(4). See also Wells v. Principi, 326 F. 3d. 1381, 1384 (Fed. Cir. 2003); Duenas v. Principi, 18 Vet. App. 512 (2004) (per curiam).

Overall, there is no evidence of any VA error in notifying or assisting the Veteran that reasonably affects the fairness of this adjudication.

Legal Principles

Service connection may be granted for disability resulting from disease or injury incurred in or aggravated by active military service. 38 U.S.C.A. §§ 1110, 1131; 38 C.F.R. § 3.303. Service connection may be granted for any disease initially diagnosed after service when all the evidence, including that pertinent to service, establishes that the disease was incurred in service. 38 C.F.R. § 3.303(d).

For the showing of chronic disease in service, there is required a combination of manifestations sufficient to identify the disease entity, and sufficient observation to establish chronicity at the time, as opposed to merely isolated findings or a diagnosis including the word "chronic." When the fact of chronicity in service (or during any applicable presumptive period) is not adequately supported, then a showing of continuity after discharge is required to support the claim. 38 C.F.R. § 3.303(b).

Service connection may be granted for any disease initially diagnosed after service, when all the evidence, including that pertinent to service, establishes that the disease was incurred in service. 38 C.F.R. § 3.303(d).

Except as otherwise provided by law, a claimant has the responsibility to present and support a claim for benefits under laws administered by the Secretary. The Secretary shall consider all information and lay and medical evidence of record in a case before the Secretary with respect to benefits under laws administered by the

Secretary. When there is an approximate balance of positive and negative evidence regarding any issue material to the determination of the matter, the Secretary shall give the benefit of the doubt to the claimant. 38 U.S.C.A. § 5107 (West 2002); 38 C.F.R. § 3.102 (2011); see also Gilbert v. Derwinski, 1 Vet. App. 49, 53 (1990). To deny a claim on its merits, the evidence must preponderate against the claim. Alemany v. Brown, 9 Vet. App. 518, 519 (1996), citing Gilbert, 1 Vet. App. at 54.

For Veterans with service in the Southwest Asia Theater of operations during the Persian Gulf War, service connection may also be established under 38 U.S.C.A. § 1117; 38 C.F.R. § 3.317. Under this law and regulation, service connection may be warranted for a Persian Gulf Veteran who exhibits objective indications of a qualifying chronic disability that became manifest during active military, naval or air service in the Southwest Asia theater of operations during the Persian Gulf War, or to a degree of 10 percent or more not later than not later than December 31, 2011. 38 C.F.R. § 3.317(a)(1). In this case, the Veteran claims that she has sinusitis that is related to her service. However, there is no evidence that the Veteran has been diagnosed with this disability during the pendency of this claim. In addition, she has not claimed, nor does the evidence raise the issue of, any other undiagnosed illness that manifested to a degree of 10 percent or more following discharge from service. Accordingly, this provision is inapplicable to this case.

Analysis

The Veteran contends that she has sinusitis, claimed as sinus problems, that is related to her service.

The Veteran's STRs include a November 2003 emergency physician record which reflects symptoms of a cough with phlegm and green sputum and a diagnosis of acute sinusitis.

VA treatment records include an August 2009 CT scan of the sinuses that was provided in response to the Veteran's complaints of chronic nasal congestion and post nasal drip that caused sore throats. The CT scan revealed that the frontal, sphenoid, maxillary, and ethmoid sinuses were clear without evidence of concha bullosa.

The Veteran had a VA nose, sinus, larynx, and pharynx examination in October 2008 at which time she presented with a history of chronic sinusitis since her service in Afghanistan in 2003. On examination, she was diagnosed with allergic rhinitis for which she was later granted service connection. However, she was not diagnosed with sinusitis or any other sinus-related disability.

"Congress specifically limits entitlement to service-connected disease or injury where such cases have resulted in a disability ... in the absence of a proof of present disability there can be no claim." Brammer v. Derwinski, 3 Vet. App. 223, 225 (1992). The Court has held that the requirement for service connection that a current disability be present is satisfied when a claimant has a disability at the time a claim for VA disability compensation is filed or during the pendency of that claim even though the disability resolves prior to the Secretary's adjudication of the claim. See McClain v. Nicholson, 21 Vet. App. 319, 321 (2007). In this case, there is no medical evidence showing that any sinusitis has been present at any time during the pendency of the claim and the report of a current VA examination shows the Veteran does not have sinusitis; she has accordingly not shown a current disorder for which service connection can be granted.

VA must consider all favorable lay evidence of record. 38 U.S.C.A. § 5107(b); Caluza v. Brown, 7 Vet. App. 498 (1995). Accordingly, in addition to the medical evidence above the Board has considered the lay evidence submitted by the Veteran in the form of her correspondence to VA.

A layperson is competent to testify in regard to the onset and continuity of symptomatology. Heuer v. Brown, 7 Vet. App. 379, 384 (1995); Falzone v. Brown, 8 Vet. App. 398, 403 (1995); Caldwell v. Derwinski, 1 Vet. App. 466 (1991). However, lay persons are not competent to opine as to medical etiology or render medical opinions. Barr v. Nicholson, 21 Vet. App. 303 (2007); see Grover v. West, 12 Vet. App. 109, 112 (1999); see also Espiritu v. Derwinski, 2 Vet. App. 492, 494 (1992). Rather, it is the province of trained health care professionals to enter conclusions that require medical expertise, such as opinions as to diagnosis and causation. Jones v. Brown, 7 Vet. App. 134, 137 (1994); Degmetich v. Brown, 104 F.3d 1328 (1997). As discussed above, there is no medical evidence of the presence of sinusitis during the pendency of this claim.

For the foregoing reasons, the claim for service connection for sinusitis must be denied. The Board has considered the applicability of the benefit-of-the-doubt doctrine. However, as the preponderance of the evidence is against the claim, that doctrine is not applicable. See 38 U.S.C.A. § 5107(b); 38 C.F.R. § 3.102; Gilbert v. Derwinski, 1 Vet. App. 49, 53- 56 (1990).

ORDER

Service connection for sinusitis is denied.

REMAND

The Board finds that further development is necessary prior to final adjudication of the Veteran's claims of entitlement of service connection for a left and right leg disability, claimed as swelling, to include as secondary to service-connected bilateral bunionectomy; entitlement to an initial compensable disability evaluation for chronic allergic rhinitis; and entitlement to an initial disability evaluation in excess of 10 percent for GERD, a left bunionectomy, and a right bunionectomy.

Service Connection Claims

The Veteran contends that he has a bilateral leg disability, claimed as swelling of the right and left leg, to include as secondary to her service-connected bilateral bunionectomy.

Separate theories in support of a claim for a particular disability are to be adjudicated under one claim. See Robinson v. Mansfield, 21 Vet. App. 545, 550- 51 (2008), citing, Bingham v. Principi, 421 F.3d. 1346, 1349 (Fed. Cir. 2005). The Veteran has not been apprised of the information and evidence necessary to substantiate her claims for service connection for a left and right leg disability on a secondary basis, to include aggravation. The Board notes that effective October 10, 2006, 38 C.F.R. § 3.310 (2011), which pertains to secondary service connection, was amended to implement the decision in Allen v. Principi, 7 Vet. App. 439 (1995), that addressed the subject of the granting of service connection for the aggravation of a nonservice-connected condition by a service-connected condition.
Accordingly, upon remand, the Veteran should be notified of the information and evidence not of record that is necessary to substantiate her claims for service connection for a left and right leg disability on a secondary basis.

On review of the claims file, the STRs are void of findings, complaints, symptoms, or any diagnosis of a disability of either the left or right leg.

On October 2008 VA feet examination, the Veteran presented with complaints of pain and swelling in her legs. The examiner diagnosed status post bilateral bunionectomy with residual pain and leg swelling and degenerative joint disease.
VA is obliged to provide an examination or obtain a medical opinion if the evidence of record: contains competent evidence that the claimant has a current disability, or persistent recurrent symptoms of a disability; and establishes that the Veteran suffered an injury or disease in service; indicates that the claimed disability or symptoms may be associated with the established injury or disease in service or with another service-connected disability, but does not contain sufficient medical evidence for the Secretary to make a decision on the claim. See 38 C.F.R. § 3.159 (c)(4).

The threshold for finding that there "may" be a nexus between current disability or persistent or recurrent symptoms of disability and service is low. Locklear v. Nicholson, 20 Vet. App. 410 (2006); McLendon v Nicholson, 20 Vet. App. 79 at 83 (2006).

Under the circumstances, the Board finds that the duty to assist set forth at 38 C.F.R. § 3.159 requires that the Veteran be scheduled for a VA examinations in response to her claim for service connection for a bilateral leg disability, as it is unclear to the Board whether the Veteran currently has a currently diagnosed bilateral leg disability and the record does not include an opinion as to whether any current bilateral leg disability is proximately due to the service-connected bilateral bunionectomy.

Increased Rating Claims

With regard to the Veteran's service-connected GERD, a December 2009 VA treatment record reflects complaints of burning in the mid-chest with regurgitation. While she had been able to control these symptoms with Tums and Alka-seltzer along with a special diet, she reported that her symptoms had worsened.

With regard to the Veteran's service-connected chronic allergic rhinitis, in a January 2010 statement she stated that she had an episode of rhinitis in December 2009 and included a photo which she contends showed redness with swelling of the face and around the eyes, nose, and lips. During the January 2010 DRO hearing, she testified that she experienced episodes of rhinitis a couple of times a month and that the December 2009 episode lasted six hours.

With regard to the Veteran's service-connected bilateral bunionectomy, during the January 2010 DRO hearing, she testified that since her surgery she has experienced right foot pain rated a six out of ten on the pain scale when walking up a flight of stairs. She stated that her right foot is not as bad as her left foot which she rated nine out of ten on the pain scale when active. As regards loss of motion of her feet, she indicated that she cannot "go up on the balls of my feet" and that she has to put her feet up at the end of the day. She also testified that she now wears shoe inserts.

The record reflects that the Veteran was last afforded VA examinations regarding her GERD, chronic allergic rhinitis, and bunionectomies in October 2008. Given the reported worsening of the Veteran's disabilities since her last VA examinations, the Board finds that new VA examinations are necessary in order to decide the Veteran's claims. See 38 U.S.C.A. § 5103A(d) (West 2002 and Supp. 2011); 38 C.F.R. § 3.159(c)(4) (2011). See also Snuffer v. Gober, 10 Vet. App. 400 (1997); Green v. Derwinski, 1 Vet. App. 121 (1991).

Finally, the Board notes that post-service treatment records that have been associated with the claims file pertain to VA medical treatment received by the Veteran through December 2009. However, in addition to the paper claims file, there is a Virtual VA electronic claims file associated with the Veteran's claims. A review should be conducted of the electronic file, and if documents contained therein are deemed to be relevant to the issues on appeal and are not duplicative of those already found in the paper claims file, action should be taken to assure that those records are made available (whether by electronic means or by printing) to any medical provider who is asked to review the claims files and provide medical opinions in conjunction with the development requested herein. 38 C.F.R. § 3.159(c)(1) and (2).

Accordingly, the case is REMANDED for the following actions:

1. The RO or the AMC should send the Veteran a Veteran Claims Assistance Act (VCAA) notice that notifies her of the information and evidence not of record that is necessary to substantiate her claims for service connection for a left and right leg disability on a secondary basis, to include by aggravation. This notice must also inform the Veteran of which information and evidence, if any, that she is to provide to VA and which information and evidence, if any, that VA will attempt to obtain on her behalf. See 38 U.S.C.A. § 5103(a) (West 2002); 38 C.F.R. § 3.159 (2011).

2. The Veteran should be requested to provide the names, addresses and approximate dates of treatment of all non-VA medical care providers who have treated her for the disability on appeal. After the Veteran has signed the appropriate releases, those records should be obtained and associated with the claims folders. All attempts to procure records should be documented in the file. If the RO cannot obtain records identified by the Veteran, a notation to that effect should be inserted in the file. The Veteran is to be notified of unsuccessful efforts in this regard, in order to allow her the opportunity to obtain and submit those records for VA review.

Appropriate efforts must also be made to obtain all available VA treatment records since December 2009. A review should be conducted of the electronic file, and if documents contained therein are deemed to be relevant to the issues on appeal and are not duplicative of those already found in the paper claims folder, action should be taken to assure that those records are made available (whether by electronic means or by printing) to any medical provider who is asked to review the claims folder and provide medical opinions in conjunction with the development requested herein.

3. Then, schedule a VA examination to determine the current severity of the Veteran's service-connected GERD. The claims folder must be made available to and reviewed by the examiner. Any indicated studies should be performed.

The RO should ensure that the examination report or reports provide all information required for rating purposes and should specifically indicate the presence, and if so, frequency and severity, of the following symptoms: epigastric distress, dysphagia, pyrosis, regurgitation, vomiting, hematemesis, melena, material weight loss, anemia or other nutritional insufficiency, or pain in the arm, shoulder, or substernal area. The examiner should then indicate whether the symptoms, collectively, are productive of considerable or even severe impairment of health.

The examiner should also provide an opinion concerning the effect of the Veteran's service-connected GERD on her ability to work. The supporting rationale for all opinions expressed must be provided.

4. Then, schedule a VA examination to determine the current severity of the Veteran's service-connected chronic allergic rhinitis. The claims folder must be made available to and reviewed by the examiner. Any indicated studies should be performed.

The RO should ensure that the examination report or reports provide all information required for rating purposes, to include whether the Veteran has polyps, a greater than 50 percent obstruction of nasal passage on both sides, or complete obstruction on one side.

The examiner should also provide an opinion concerning the impact of the Veteran's service-connected chronic allergic rhinitis on her ability to work.

5. Then, schedule a VA examination to determine the current severity of the Veteran's service-connected left and right bunionectomies. The claims folder must be made available to and reviewed by the examiner. Any indicated studies should be performed.

The RO should ensure that the examination report or reports provide all information required for rating purposes and should identify any objective evidence of pain and the specific excursion(s) of motion, if any, accompanied by pain. To the extent possible, the examiner should assess the degree of severity of any pain.

The extent of any incoordination, weakened movement and excess fatigability on use of the left and right foot should also be described by the examiner. If feasible, the examiner should assess the additional functional impairment due to weakened movement, excess fatigability, and/or incoordination in terms of the degree of additional range of motion loss.

The examiner should also express an opinion concerning whether there would be additional limits on functional ability of the left and right foot on repeated use or during flare-ups, and, to the extent possible, provide an assessment of the functional impairment on repeated use or during flare-ups. If feasible, the examiner should assess the additional functional impairment on repeated use or during flare-ups in terms of the degree of additional range of motion loss.

The examiner should state whether there is severe hallux valgus, equivalent to amputation of the great toe of the left and right foot. The examiner should also state whether the hallux valgus has been operated with resection of the metatarsal head.

The examiner should also provide an opinion concerning the effect of the Veteran's service-connected bilateral bunionectomy on her ability to work. The supporting rationale for all opinions expressed must be provided.

6. Then, schedule a VA examination to determine the nature and etiology of any current left and right leg disability. The claims folder should be reviewed and that review should be indicated in the examination report. The rationale for all opinions should be provided. Specifically, the examiner should provide the following

information:

(a) Diagnose any current disability of the left and right leg, to include swelling.

(b) Is it at least as likely as not (50 percent or more probability) that any current left or right leg disability was incurred in or aggravated by the Veteran's active service? The examiner must consider the Veteran's statements regarding the incurrence of a bilateral leg disability, in addition to any statements regarding the continuity of symptomatology. Dalton v. Nicholson, 21 Vet. App. 23 (2007).

(c) Is it at least as likely as not (50 percent or more probability) that any current disability of the left or right leg is proximately due to or was aggravated by the service-connected bilateral bunionectomy?

If the examiner determines that he or she cannot provide an opinion on the issue at hand without resorting to speculation, the reviewer should explain the inability to provide an opinion, identifying precisely what facts could not be determined. In particular, the examiner should comment on whether an opinion could not be rendered because the limits of medical knowledge have been exhausted or whether additional information could be obtained that would lead to a conclusive opinion.

7. Thereafter, determine whether any additional development is required based upon any additional evidence obtained by virtue of the foregoing actions.

Thereafter, readjudicate the Veteran's claims. If any benefit sought on appeal remains denied, the Veteran and her service representative should be provided a supplemental statement of the case, to include consideration of all of the evidence associated with the claims file since the February 2010 statement of the case, pertaining to the Veteran's increased rating claims and February 2010 supplemental statement of the case, pertaining to the Veteran's service connection claims. An appropriate period of time should be allowed for response before the case is returned to the Board.

The appellant has the right to submit additional evidence and argument on the matter or matters the Board has remanded. Kutscherousky v. West, 12 Vet. App. 369 (1999).

These claims must be afforded expeditious treatment. The law requires that all claims that are remanded by the Board of Veterans' Appeals or by the United States Court of Appeals for Veterans Claims for additional development or other appropriate action must be handled in an expeditious manner. See 38 U.S.C.A. §§ 5109B, 7112 (West Supp. 2011).

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MICHAEL A. PAPPAS
Veterans Law Judge, Board of Veterans' Appeals

Department of Veterans Affairs

Citation Nr: 1512386
Decision Date: 03/24/15 Archive Date: 04/01/15

DOCKET NO. 12-28 876) DATE
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On appeal from the
Department of Veterans Affairs Regional Office in Winston-Salem, North Carolina

THE ISSUES

1. Entitlement to service connection for a left hip disorder.

2. Entitlement to service connection for right shoulder disorder.

3. Entitlement to service connection for left shoulder disorder.

4. Entitlement to service connection for blurred vision with pain in the eyes.

5. Entitlement to service connection for cardiac conduction system.

6. Entitlement to service connection for right knee disorder.

7. Entitlement to service connection for a left knee disorder.

ATTORNEY FOR THE BOARD

A.M. Ivory, Counsel

INTRODUCTION

The Veteran served on active duty from January 1982 to September 2009.

This matter comes before the Board of Veterans' Appeals (Board) on appeal from a February 2010 rating decision issued by the Department of Veterans Affairs (VA) Regional Office (RO) in Winston-Salem, North Carolina.

The February 2010 rating decision also granted service connection for alopecia and assigned an initial noncompensable rating, effective October 1, 2009, and denied service connection for keratitis. While the Veteran submitted a notice of disagreement as to the propriety of the assigned rating for alopecia and the denial of service connection for keratitis in January 2011 and a statement of the case was issued in July 2012, she limited her substantive appeal (VA Form 9) to the issues listed on the title page. Therefore, such issues are not properly before the Board.

This appeal was processed using the Veterans Benefit Management System (VBMS) and Virtual VA paperless electronic claims processing systems.

The appeal is REMANDED to the Agency of Original Jurisdiction (AOJ). VA will notify the Veteran if further action is required.

REMAND

Although the Board regrets the additional delay, a remand is necessary to ensure that due process is followed and that there is a complete record upon which to decide the Veteran's claims so that she is afforded every possible consideration. 38 U.S.C.A. § 5103A (West 2014); 38 C.F.R. § 3.159 (2014).

At the outset, the Board notes that, while service treatment records dated during the Veteran's military career are on file, the AOJ determined that her complete service treatment records were not available in a May 2011 memorandum. In such a situation, VA has a heightened duty to consider the applicability of the benefit of the doubt rule and to assist in the development of a claim. Cromer v. Nicholson, 19 Vet. App. 215, 217-18 (2005) citing Russo v. Brown, 9 Vet. App. 46, 51 (1996). See also Cuevas v. Principi, 3 Vet. App. 542, 548 (1992); O'Hare v. Derwinski, 1 Vet. App. 365, 367 (1991).

The Board notes that the Veteran originally claimed that she has current diagnoses of left hip, bilateral shoulder, and bilateral knee disorders, blurred vision with pain in the eyes, and cardiac conduction system that are due to her military service. As such, the basis of the AOJ's denials in the February 2010 rating decision and July 2012 statement of the case was that there were no current diagnoses related to such claimed conditions and, as relevant to her claimed cardiac conduction system, such was not an actually disabling condition. However, in subsequent communications, to include her January 2011 notice of disagreement and September 2012 substantive appeal, the Veteran alleged that such disorders were due to undiagnosed illnesses associated with her service in Southwest Asia during the Persian Gulf War.

In this regard, the Board notes that "Southwest Asia" is defined as Iraq, Kuwait, Saudi Arabia, the neutral zone between Iraq and Saudi Arabia, Bahrain, Qatar, the United Arab Emirates, Oman, the Gulf of Aden, the Gulf of Oman, the Persian Gulf, the Arabian Sea, the Red Sea, and the airspace above these locations during the Persian Gulf War era (August 2, 1990, through the present) or in Afghanistan after September 19, 2001. 38 C.F.R. § 3.317(c)(3)(ii), (e). As relevant to her new theory of entitlement, the Board finds that a remand is necessary in order to obtain the Veteran's service personnel records, to include a copy of her DD 214, so as to verify her service in Southwest Asia. In this regard, the Veteran reported in her initial application that she was stationed in the Gulf after August 1, 2009, for Operation Iraqi Freedom. Additionally, in her substantive appeal, she stated that she was deployed for Operation Iraqi Freedom during the initial invasion into Iraq in 2003. Additionally, her service treatment records reflect that she completed a Pre-Deployment Health Assessment in January 2003 in which she indicated that her location of operation was unknown, but drew an arrow to Southwest Asia. Records dated in February 2003 reflect that she obtained appropriate vaccinations for deployment, to include smallpox and anthrax. However, such records do not confirm service in Southwest Asia. Additionally, at her August 2009 VA examination, she only reported deployments to Turkey, Korea, and Bosnia, which are not considered to be in Southwest Asia per VA regluations.

Therefore, a remand is necessary in order to obtain the Veteran's service personnel records, to include a copy of her DD 214, so as to verify her service in Southwest Asia. Furthermore, if such service is verified, the Board finds that the Veteran should be afforded VA examination(s) to determine if her claimed disorders are a chronic qualifying disability pursuant to 38 C.F.R. § 3.317, and her claims should be readjudicated under such provisions.

Furthermore, as indicated previously, the Veteran's claims were denied on the basis that were no current diagnoses related to such claimed conditions and, as relevant to her claimed cardiac conduction system, such was not an actually disabling condition. Specifically, the record reflects that she underwent a VA examination in connection with her claims in August 2009. However, at such time, the examiner determined that, as referable to her claimed left hip, bilateral shoulder, and bilateral knee disorders, there was no pathology or etiology found to render a diagnosis and there were only subjective reports of pain. Additionally, in regard to the Veteran's claimed eye disorder, she was diagnosed with myopia, presbyopia, and dry eye syndrome. Subsequently, service connection for blepharitis with dry eyes was granted. Furthermore, her vision was 20/20 bilaterally corrected. The Board notes that congenital or developmental defects, such as refractive error of the eye, are not considered "diseases or injuries within the meaning of applicable legislation" and, hence, do not constitute disability for VA compensation purposes. See 38 C.F.R.
§§ 3.303(c), 4.9. However, a congenital defect can still be subject to superimposed disease or injury. VAOPGCPREC 82-90. If such superimposed disease or injury does occur, service connection may be warranted for the resulting disability; however, there is no indication that the Veteran currently has a superimposed disease or injury as the only other currently diagnosed eye disability is blepharitis with dry eyes and service connection for such has already been granted. Finally, pertaining to her claimed cardiac conduction system, the examiner determined that she had borderline abnormal ECGs with recent normal ECGs, and did not have any cardiac symptoms at present.

While the Veteran has maintained that she has current symptoms related to her claimed disorders, there is no medical evidence demonstrating a current diagnosis or disability associated with such subjective complaints. Therefore, on remand, the Veteran should be given an opportunity to identify any records relevant to the claims on appeal that have not been obtained. Thereafter, all identified records should be obtained. Furthermore, if any such records demonstrate a current disability associated with the Veteran's claimed left hip, bilateral shoulder, and bilateral knee disorders, blurred vision with pain in the eyes, and cardiac conduction system, she should be afforded new VA examinations to determine whether such disorders are related to her military service.

Accordingly, the case is REMANDED for the following action:

1. The AOJ should take all appropriate steps to obtain the Veteran's service personnel records, to include a copy of her DD 214, so as to verify her service in Southwest Asia. All reasonable attempts should be made to obtain such records. If any records cannot be obtained after reasonable efforts have been made, issue a formal determination that such records do not exist or that further efforts to obtain such records would be futile, which should be documented in the claims file. The Veteran must be notified of the attempts made and why further attempts would be futile, and allowed the opportunity to provide such records, as provided in 38 U.S.C.A. § 5103A(b)(2) and 38 C.F.R. § 3.159(e).

2. The Veteran should be given an opportunity to identify any outstanding VA or non-VA treatment records referable to her left hip, bilateral shoulder, and bilateral knee disorders, blurred vision with pain in the eyes, and cardiac conduction system. After obtaining any necessary authorization from the Veteran, all outstanding records should be obtained.

For private treatment records, make at least two (2) attempts to obtain records from any identified sources. If any such records are unavailable, inform the Veteran and afford him an opportunity to submit any copies in her possession.

For federal records, all reasonable attempts should be made to obtain such records. If any records cannot be obtained after reasonable efforts have been made, issue a formal determination that such records do not exist or that further efforts to obtain such records would be futile, which should be documented in the claims file. The Veteran must be notified of the attempts made and why further attempts would be futile, and allowed the opportunity to provide such records, as provided in 38 U.S.C.A. § 5103A(b)(2) and 38 C.F.R. § 3.159(e).

3. After obtaining all outstanding records, the AOJ should review the record in order to determine whether the Veteran has verified service in Southwest Asia and/or the newly received medical records reflect current diagnoses referable to her claimed disorders.

If the Veteran has verified service in Southwest Asia, she should be afforded appropriate VA examination(s) so as to determine if her claimed disorders are a chronic qualifying disability pursuant to 38 C.F.R. § 3.317.

Additionally, if the newly received medical records reflect current diagnoses referable to her claimed disorders, the Veteran should be afforded appropriate VA examinations to determine the current nature and etiology of such disorders, to include whether such are related to her military service.

4. After completing the above, and any other development as may be indicated by any response received as a consequence of the actions taken in the preceding paragraphs, the Veteran's claims should be readjudicated based on the entirety of the evidence. If service in Southwest Asia is verified, the AOJ should consider whether such claimed disorders are the result of an undiagnosed illness pursuant to 38 C.F.R. § 3.317. If the claims remain denied, the Veteran should be issued a supplemental statement of the case. An appropriate period of time should be allowed for response.

The Veteran has the right to submit additional evidence and argument on the matters the Board has remanded. Kutscherousky v. West, 12 Vet. App. 369 (1999).

These claims must be afforded expeditious treatment. The law requires that all claims that are remanded by the Board or by the United States Court of Appeals for Veterans Claims for additional development or other appropriate action must be handled in an expeditious manner. See 38 U.S.C.A. §§ 5109B, 7112 (West 2014).

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A. JAEGER
Veterans Law Judge, Board of Veterans' Appeals

Under 38 U.S.C.A. § 7252 (West 2014), only a decision of the Board of Veterans' Appeals is appealable to the United States Court of Appeals for Veterans Claims. This remand is in the nature of a preliminary order and does not constitute a decision of the Board on the merits of your appeal. 38 C.F.R. § 20.1100(b) (2014).