UNITED STATES COURT OF APPEALS
FOR VETERANS CLAIMS

Vet. App. No. 19-1457

ROBERT HUDSON, JR.,

Appellant

v.

ROBERT L. WILKIE,

SECRETARY OF VETERANS AFFAIRS

Appellee.

APPELLANT'S BRIEF

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B. Whether the Board of Veterans' Appeals commits remandable error when it fails to provide an adequate statement of reasons and bases explaining its reliance on the inadequate medical exam record.

C. Whether the Board of Veterans' Appeals commits remandable error when it fails to provide an adequate statement of reasons and bases explaining why it discounted favorable evidence, but instead relied on the inadequate medical record.

II. STATEMENT OF THE CASE

A. Jurisdiction

Appellant Robert Hudson, Jr. (Hudson) invokes this Court's appellate jurisdiction granted through 38 U.S.C. § 7252 (2018).

B. Nature of the Case / Result Below

Hudson appeals the Board's November 2, 2018 decision, denying his claim to reopen (CTR) his seizure disorder claim; increased rating (IR) for left ear hearing loss; and IR for diabetes mellitus II (DM-II). [R 4-21 (decision)][1]

The veteran's seizure disorder was first denied via a February 2009 RD,

[1] The decision also remanded his left ear hearing loss EED claim; his RLE skin rash CTR; and, his tinnitus, PTSD, depressive disorder, sleep disorder, CAD, (reopened) hypertension, GERD and ED SC claims. Those claims are not on appeal.

and his claim to reopen is in appellate status from January 24, 2013.[2] The veteran's IR hearing loss claim is in appellate status from October 7, 2013.[3] The veteran's IR DM-II claim is in appellate status from February 11, 2015.[4]

C. Relevant Facts

Appellant is a U.S. Air Force veteran of the Vietnam War with honorable service from January 1968 to December 1971. He was awarded *inter alia* the Vietnam Campaign Medal, Vietnam Service Medal and the Good Conduct Medal – evidencing his good character. [R 2574 (DD-214)] He timely appeals the Board's November 2, 2018 decision. [R 4-21 (decision)]

III. ARGUMENTS & AUTHORITIES

SEIZURE DISORDER (CTR)

The Board failed to provide an adequate statement of reasons and bases explaining why it discounted favorable evidence which is both new and material to the claim as it relates to a new theory of recovery.

Appellant's original June 2008 seizures SC claim was denied because

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[2] R 2840-45 (February 2009 RD) (SC denied); 2679-80 (January 24, 2013 CTR); 2588-93 (September 2013 RD) (CTR denied); 2063-79 (June 2015 SOC) (reopened/SC denied); 2020 (June 2015 VAF9); 35 (September 2017 VAF8); 4-21 (decision).

[3] R 2577 (October 7, 2013 VAF21-4138); 2255-60 (June 2014 RD) (SC granted; 0% from May 20, 2014); 2041-60 (June 2015 SOC); 2020 (June 2015 VAF9); 35 (September 2017 VAF8); 4-21 (decision).

[4] R 2155 (February 11, 2015 lay statement); 2112-16 (April 2015 RD)(SC granted; 20% from February 11, 2015); 2016 (August 8, 2015 VAF21-526b); 1795-99 (November 2015 RD)(20% cont.); 1119-35 (May 2017 SOC); 42 (June 2017 VAF9); 35 (September 2017 VAF8); 4-21 (decision).

"[t]here [was] no evidence of complaints of or treatment for seizures while on active duty . . . [Appellant was] diagnosed with seizures in 1997, twenty six years after [his] discharge from service". [R 3108-22 (June 2008 VAF21-526); 2841-42 (2840-45) (February 2009 RD)]

In January 2013 appellant filed his CTR now on appeal. [R 2679-80 (January 24, 2013 CTR)] The veteran's CTR intermixed his seizure symptoms with his mental health symptoms. The AOJ/RO provided appellant VCAA notice, and classified the veteran's claim as "Seizures & Depression/sleep disorder." The VCAA notice also stated the veteran's original SC claim had been "previously denied because there was no evidence of complaints of treatment for seizures [in-service] . . . Your separation examination noted a normal neurological examination . . . [T]he evidence you submit must be new and relate to this fact." [R 2669 (2668-76) (July 2012 VCAA)]

After initially denying appellant's January 2013 CTR by a rating decision, the AOJ/RO reopened, and then denied his claim on its merits in the June 2015 Statement of the Case. [R 2588-93 (September 2013 RD); 2063-79 (June 2015 SOC)] Appellant substantively appealed the reopened / denied seizures SC claim to the Board. [R 2020 (June 2015 VAF9); 35 (September 2017 VAF8)]

In *de novo* denying appellant's seizures CTR in the decision now on appeal, the Board found, despite the fact the AOJ/RO's June 2015 Statement of the Case had reopened appellant's seizures SC claim, it was "unable to identify

new and material evidence to reopen his claim". Based thereon, the Board *de novo* denied appellant's CTR. [R 9-10 (4-21) (decision)] Appellant timely appeals.

Firstly, distilled to its essence the Board's decision now on appeal denied appellant's CTR for lack of new and material evidence which showed appellant complained of or otherwise exhibited symptoms of a seizures disorder while in-service. The Board – like the AOJ/RO – has only considered appellant's claim on a theory of direct service-connection.

Favorable medical evidence relates appellant's conceded seizure disorder to a mental disorder, which includes visual hallucinations. Specifically, medical evidence reported appellant experienced visual hallucinations (related to a mental health disorder) immediately prior to the onset of his grand mal seizure. [R 667 (667- 70); 859 (859-62); 3013 (3012-15) (December 2005 VAMC – mental health intake note)] Additionally, the veteran himself intermingled his mental disorder symptoms with his seizure symptoms in his filings; and the VA at first considered the veteran's seizure and depression claims as one claim. [R 2679-80 (January 24, 2013 CTR); 2669 (2668-76) (July 2012 VCAA)] The above evidence shows that the veteran's seizure claim as secondary to his mental disorder claim is reasonably raised by the record; and that his seizure claim is inextricably intertwined with his mental disorder claim. *See Robinson v. Peake,* 21 Vet. App. 545 (2008) (regarding reasonably raised issues); *Tyrues v. Shinseki,* 23 Vet. App. 166,176 (2009) (issues are inextricably intertwined when a

referred claim could have a significant impact on a denied claim that is being appealed). An "equitable and just" reading of this evidence links the veteran's seizures to his remanded mental disorder claim, for the purposes of new and material evidence consideration. 38 C.F.R. § 4.6.

Appellant's companion mental disorder SC claims (including both PTSD and his conceded-as-diagnosed major depression disorders), both new to the file, have been remanded by the Board for new exams. [R 14-15 (4-21) (decision)] The veteran's seizure disorder claim should have been remanded with it, as new and material evidence in the theory that it is related to his mental disorder claim has been raised by the record.

The Board failed to provide an adequate statement of reasons and bases explaining why it discounted the favorable lay and medical evidence which links appellant's conceded-as-diagnosed seizure disorder to his remanded mental disorder SC claims. The evidence of the now recognized companion mental disorders, when combined with the existing evidence which shows a link between symptoms reasonably associated with the mental disorders and appellant's conceded seizure disorder, clears the "low threshold" of proof necessary to show a "reasonable possibility of substantiating" appellant's claim if, as and when it is reopened. *See Shade v. Shinseki,* 24 Vet. App. 110, 117-18 (2010); 38 C.F.R. § 3.156(a) (2019).

Absent an adequate explanation why the Board discounted the favorable

evidence, and instead narrowly considered the claim on a direct service-connection basis, the Court and appellant have been denied an opportunity for meaningful judicial review. *See* 38 U.S.C. § 7104(d) (2019).

LEFT EAR HEARING LOSS (IR)

The Board failed to provide an adequate statement of reasons and bases explaining its reliance on the inadequate medical exam record (comprised of the May 2014 and January 2016 exams).

Appellant is service-connected for "hearing loss, left ear", rated as noncompensable from May 20, 2014, pursuant to 38 C.F.R. § 4.85, Tables VI, VIA, and VII, DC 6100 (2019). [R 2255-60 (June 2014 RD) (SC granted; 0% from May 20, 2014)] He seeks an increased rating.

In denying appellant's IR claim in the decision now on appeal, the Board continued the noncompensable rating after it mechanically applied "the rating schedule to the numeric designations assigned after audiometric evaluations are rendered". The Board relied-on the May 2014 and January 2016 audio exams. [R 10-12 (4-21) (decision); 2274-78 (May 2014 exam); 1494-97 (January 2016 exam)] Appellant timely appeals.

Appellant was first examined in May 2014. The examiner reported both left ear hearing loss and tinnitus but opined only appellant's left ear hearing loss was related to service. [R 2274-78 (May 2014 exam)] Based on that exam, appellant was service-connected for left ear hearing loss. [R 2255-60 (June 2014 RD)][5]

[5] The Board simultaneously remanded the award of an earlier effective date for

Appellant was again examined in January 2016. [R 1494-97 (January 2016 exam)]

The May 2014 examiner reported:

	500 hz	1000 hz	2000 hz	3000 hz	4000 hz
LEFT EAR	15	25	35	40	40

The January 2016 exam reported:

	500	1000 hz	1000 hz	3000 hz	4000 hz
LEFT EAR	15	**30**	**40**	**50**	**55**

The objective medical evidence shows an increase in the severity of appellant's left ear hearing loss in the less than two years between the relied-on exams. There is no evidence of record showing appellant's left ear hearing loss has stabilized since the 3½ year old January 2016 audio exam. It is reasonable to assume (absent any medical evidence to the contrary) the left ear hearing loss has continued to increase in severity.

The Board failed to explain why it discounted the favorable medical evidence (being the only medical evidence cited by the Board) on its face shows appellant's hearing loss is a progressively worsening disability, and the medical exam record is most likely stale. *See Proscelle v. Derwinski,* 2 Vet. App. 629 (1992) (An increased rating exam must be thorough and contemporaneous with the rating); *Ardison v. Brown,* 2 Vet. App. 405 (1992) (An exam must show an

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appellant's left ear hearing loss, as well as his companion tinnitus SC claim. Those claims are not on appeal.

accurate picture of the to-be-rated disability).

Absent an adequate explanation why the Board ignored the favorable objective evidence showing appellant's left ear hearing loss is a deteriorating disability, and the January 2016 exam is reasonably assumed to be inadequate to now rate the disability 3 ½ years later, the Court and appellant have been denied an opportunity for meaningful judicial review. *See* 38 U.S.C. § 7104(d) (2019).

DM-II (IR)

The Board failed to provide an adequate statement of reasons and bases explaining why it discounted favorable evidence, but instead relied on the inadequate medical record.

Appellant is service-connected for diabetes mellitus, type II (DM-II), rated as 20 percent from February 11, 2015, pursuant to 38 C.F.R. § 4.119, DC 7913 (2019). He seeks an increased rating.

DC 7913 provides for the award of a 20 percent rating on the showing of DM-II which requires one or more daily injections of insulin and a restricted diet, or an oral hypoglycemic agent and restricted diet. An increased 40 percent rating is awarded on the showing of one or more daily injections of insulin, a restricted diet, and regulation of activities (*i.e.* avoidance of strenuous occupational and recreational activities). *See* 38 C.F.R. § 4.119 (2019).

In continuing the previously awarded 20 percent rating, the Board adopted the September 2015 and May 2017 exam findings appellant uses an oral

hypoglycemic agent and a restricted diet, but he does not use insulin, nor does he have a need to regulate his activities – two rating criteria associated with an increased 40 percent rating. Based thereon, the Board denied appellant's IR claim. [R 12-13 (4-21) (decision); 1839-41 (September 2015 DM exam); 1144-46 (May 2017 DM exam)]

Appellant is rated based on the severity of his DM-II as measured by the level of treatment necessary to manage his DM-II. A current, thorough and comprehensive understanding of the severity of appellant's DM-II is obviously necessary to rate the disability. *See Proscelle, supra; Ardison, supra.*

The relied-on September 2015 exam reported a "fasting plasma glucose" test score of 125 (May 2015 testing). [R 1840 (1839-41) (September 2015 DM exam)] The relied-on May 2017 examiner reported a "fasting plasma glucose" test score of 202 mg/dl (November 2016 testing). [R 1145-46 (1144-46) (May 2017 DM exam)]

Specifically:

Blood Glucose	May 2015 Testing	November 2016 Testing
September 2015 Exam	**125 mg/dl**	/
May 2017 Exam	/	**202 mg dl**

The relied-on exams both based their report on testing which predated the exams. The September 2015 exam adopted test results from May 2015 blood tests. The May 2017 exam adopted test results from November 2016 blood tests. Neither examiner conducted current blood testing. Neither examiner provided

care and treatment for appellant, but for their brief interactions in filling out the 3-page exam report. Both exams were based on a review of appellant's records available at the time of the exams – as expressly cited by the examiners. Specifically, the May 2016 and November 2018 blood tests.

A comparative review of the relied-on exams shows appellant's DM-II had significantly increased in severity between the relied-on exams. The September 2015 examiner (relying on May 2015 blood testing) reported a fasting glucose level of 125 mg/dl – a marginal D-II result. The May 2017 examiner (relying on now approaching three-year-old November 2016 blood testing) reported a fasting glucose level of 202 mg/dl – a significant increase in blood glucose, reasonably indicating a significant shift in the severity of appellant's disability.

There is no evidence showing appellant's service-connected DM-II has stabilized since the relied-on November 2016 blood tests. In fact, unexplainably, there are no treatment records (reporting fasting glucose levels, or treatment of the service-connected DM-II) since the November 2016 blood tests. The relied-on medical exam record shows a deteriorating DM-II disability, while the relied-on medical treatment record unexplainably ends at or about the time of the November 2016 blood testing – testing which showed the significant deterioration in appellant's DM-II since the prior September 2015 exam.

In adopting the exams as its decision's basis (in writing its less than one-page statement of reasons and bases), the Board ignored the well-documented

facts the medical record is incomplete (as it dates through November 2016); and, the medical exam record is stale.

While the Board applied the medical record as developed to DC 7913, the Board failed to explain why it ignored the fact the medical record was inadequate to decide the claim. Absent an adequate explanation why, the Court and appellant have been denied an opportunity for meaningful judicial review. *See* 38 U.S.C. § 7104(d) (2019).

CONCLUSION

The Board committed remandable error when it failed to provide adequate reasons and bases for failing to reopen appellant's seizure claim. Furthermore, the Board also committed remandable error when it failed to provide adequate reasons and bases for denying an increased evaluation for appellant's left ear hearing loss and diabetes mellitus II claims. Appellant moves this court to reverse the decision of the Board and remand all issues for further development.

Respectfully submitted,
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CERTIFICATE OF SERVICE

I hereby certify, to the best of my knowledge and ability, under penalty of perjury under the laws of the United States, that copy of the forgoing was served electronically to the attorney of record for the party below:

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on August 7, 2019.

/s/ Cameron Kroeger
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