IN THE UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

ANTHONY HUERTA,

Appellant,

v.

ROBERT L. WILKIE,
Secretary of Veterans Affairs,

Appellee.

ON APPEAL FROM THE BOARD OF VETERANS' APPEALS

BRIEF OF THE APPELLEE SECRETARY OF VETERANS AFFAIRS

WILLIAM A. HUDSON, JR.
Acting General Counsel

MARY ANN FLYNN
Chief Counsel

ANNA WHITED
Deputy Chief Counsel

NICHOLAS R. ESTERMAN
Senior Appellate Attorney
U.S. Department of Veterans Affairs
Office of General Counsel (027F)
810 Vermont Avenue, NW
Washington, DC 20420
(202) 632-8392

Attorneys for Appellee

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	)	
Appellant,	)	
	)	
v.	)	Vet.App. No. 19-2805
	)	
ROBERT L. WILKIE,	)	
Secretary of Veterans Affairs,	)	
	)	
Appellee.	)	

ON APPEAL FROM THE
BOARD OF VETERANS' APPEALS

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ISSUE PRESENTED

Should the Court vacate and remand the March 18, 2019, decision of the Board of Veterans' Appeals (Board) that denied entitlement to an initial rating for osteomyelitis[1] of the left ilium in the excess of 20% from February 1, 1992, to June 3, 1994; in excess of 20% from July 6, 1995; and in excess of 10% from February 1, 1997?

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[1] Osteomyleitis is defined as "inflammation of none caused by infection, usually by a pyogenic organism, although any infectious agent may be involved." *Dorland's Illustrated Medical Dictionary* 1347 (32nd ed. 2012).

STATEMENT OF CASE

I. Nature of the Case

Appellant, Anthony Huerta, appeals the March 18, 2019, decision of the Board of Veterans' Appeals (Board) that denied entitlement to an initial rating for osteomyelitis of the left ilium in the excess of 20% from February 1, 1992, to June 3, 1994; in excess of 20% from July 6, 1995; and in excess of 10% from February 1, 1997. [Record Before the Agency [R.]. at 7 (1-22)].

The Secretary disagrees that reversal is warranted. Instead, the Secretary submits that remand is warranted for the Board to (1) address relevant evidence of record in the first instance and (2) obtain a new VA medical opinion that addresses whether Appellant's osteomyelitis is active, chronic, or otherwise reoccurring. The Secretary otherwise disputes that Appellant is entitled to a 100% rating for the periods on appeal based on the current record.

The Board granted entitlement to (1) an effective date of November 8, 1986, for the grant of service connection for right-sided rib fractures; (2) an effective date of November 8, 1986, for the grant of service connection for residuals of a right scapula fracture; and (3) an effective date of November 8, 1986, for the grant of service connection for trunk scarring, residuals of right pneumothorax. *Id*. These are favorable findings that should not be disturbed. *Medrano v. Nicholson*, 21 Vet.App. 165 (2007).

II. Statement of Facts and Procedural History

Appellant served on active duty from November 1983 to November 1986 and from June 1994 to July 1995. [R. at 724 (722-32); 2146].

In August 1985, Appellant was injured in a motor vehicle accident (MVA). [R. at 2521; 2524]. In treating those injuries, a bone graft was taken from his left iliac crest (left hip). [R. at 2521-23]. Appellant submitted a November 1986 claim for residuals of his MVA, [R. at 2627-28], underwent a December 1986 VA examination, [R. at 2509-10; 2527-28; 2519], and was denied service connection in a May 1987 rating decision finding that the MVA was a result of willful misconduct, [R. at 2492-96]; *see* [R. at 2498-99].

In June 1989, Appellant underwent a "[d]ebridement and rotation flap closure" for a "[c]hronic sinus tract from [the left] iliac bone graft." [R. at 1338-39]; *see* [R. at 1499]. The discharge summary noted that Appellant "developed a chronic draining sinus from the [left hip], which appeared to originate from the iliac bone." [R. at 1338]. No evidence of infection was noted post operatively. *Id*.

A January 1992 private treatment record noted evaluation of Appellant's left pelvis following "persistent drainage for quite some time," and that Appellant reported "the tract closed in December [1991]." [R. at 1479]. The record recorded an impression of "[o]ld septic arthritis and osteomyelitis, left [sacroiliac] joint" based on x-ray examination. *Id*. The record recommended conservative

treatment including medication until February 1992 with re-examination in two months. *Id*.

A January 1994 treatment record assessed cellulitis[2] at the left hip site that resolved later that month with antibiotics and drainage. [R. at 1750]. In February 1994, a private doctor noted that he was "able to pass a probe quite a distance up into the subcutaneous tissue" and stated that an investigation of whether Appellant has osteomyelitis may be warranted but noted that Appellant's condition was "improved with antibiotic treatment." [R. at 1753]. Later in February 1994, another private doctor commented that Appellant recalled being told a prior culture indicated his condition was related to staphylococcus and that he recalled that it responded to antibiotics, which the private doctor commented "suggests very strongly that this is caused by Staph aureus and that is a form of osteomyelitis." [R. at 1756 (1756-57)]. However, the private doctor noted that "[t]his is very strange since flat bone osteomyelitis is extremely uncommon," and that he "reviewed the x-rays and [found] no foreign body or area that might appear to be osteomyelitis of the iliac crest." *Id*. The private doctor proposed further evaluation with the assistance of Appellant obtaining relevant treatment records and performing further cultures. [R. at 1757].

Appellant returned to active duty from June 1994 to July 1995. [R. at 724]. Appellant's service treatment records from this period, including his entrance

[2] Cellulitis is defined as "an acute, diffuse, spreading, edematous, suppurative inflammation of the dep subcutaneous tissues and sometimes muscle, sometimes with abscess formation." *Dorland's*, at 325.

examination, do not note any complaints or treatment related to his left hip. *See* [R. at 2436-64].

In June 2016, Appellant sought to reopen his claim for residuals of the in-service MVA. [R. at 2044-47 (2024-47)]. The following month, the RO issued an administrative decision finding that the in-service MVA was not the result of willful misconduct. [R. at 1847-55].

Appellant underwent an August 2016 VA examination. [R. at 1630-33]. Based on an in-person examination and a review of Appellant's file, the examiner opined that Appellant's osteomyelitis had resolved following the 1989 debridement procedure with no additional episodes or recurring infections of osteomyelitis following the initial infection. [R. at 1631]. The examiner also found Appellant had no current signs or symptoms attributable to osteomyelitis or treatment for osteomyelitis. *Id*.

Later that month, Appellant submitted a private medical opinion that diagnosed chronic, recurrent osteomyelitis that is refractory to surgical treatment, that will require lifelong antibiotic treatment, and that resulted in five or more recurrent infections of osteomyelitis following the initial infection. [R. at 1482-83 (1482-91)]. The private opinion documented current symptoms of pain, swelling, tenderness, warmth, malaise, and muscle atrophy. [R. at 1484]. The private opinion also documented dates of reoccurring infections as January 1, 1989; January 1, 1991; January 1, 1992; January 1, 1993; and January 1, 1994. [R. at 1483, 1487-88]. Attached to the private opinion was an August 2016 medical

imaging report of the left hip that noted an impression of "[p]unctate metallic foreign body in the left hip posterior superficial soft tissues with associated metallic artifact." [R. at 1491].

In March 2017, a VA medical opinion was obtained to resolve the conflict between the August 2016 medical opinions about whether the Appellant's osteomyelitis was resolved or whether it is chronic, recurrent and refractory to medical and surgical treatment. [R. at 1039 (1038-41)]. The summary of the requested opinion noted that Appellant had refused to participate in another VA examination and declined to submit any additional medical evidence in support of his claim, so the opinion would be limited to the evidence of record. *Id*. That summary also noted that there were no records of VA treatment since the 1989 debridement procedure and that the record was limited to private treatment reports and VA examinations. *Id.*

Based on a review of the medical evidence of record, the examiner opined that "the previous [private] opinion of 08/31/2016 was in error, it is less likely than not [] that [Appellant] has a diagnosis of inactive and chronic osteomyelitis." [R. at 1041]. The examiner explained that Appellant's most recent flare-up was in 1992, which was documented as being fully recovered with septic arthritis due to the previous infection. *Id*. The examiner also explained that two instances of cellulitis in the early 1990's were not related to osteomyelitis. *Id*. The examiner concluded that "[t]here have been no signs of osteomyelitis since 1992" and that Appellant has been fully recovered since then. *Id*.

Later in March 2017, the regional office (RO) awarded Appellant's current ratings for service-connected osteomyelitis of the left ilium, following several requests for review by Decision Review Officers (DRO). [R. at 910-39]; *see*, *e.g.*, [R. at 1182-89; 1419-42; 1541-56]. Appellant filed a timely notice of disagreement (NOD). [R. at 759-74]; *see* [R. at 614-16].

In June 2017, the author of the August 2016 private medical opinion submitted a rebuttal letter in response to the March 2017 VA medical opinion. [R. at 635-36]. The letter noted that his medical opinion remained unchanged. [R. at 635]. The private doctor stated that Appellant's "osteomyelitis of the pelvis was likely secondary to his surgery in 1985 and an incidental bacteremia that led to the subsequent infection(s)." *Id*. The private doctor noted that it was "questionable whether [Appellant] had nine years of a single-poly-microbial infection or 5+ separate infections." *Id*. The private doctor also noted that a 2016 MRI showed retained metal fragments at the site of the 1985 surgery. *Id*. The private doctor questioned the treatment methods surrounding the 1989 debridement procedure and noted that, "even with adequate treatment, chronic osteomyelitis in adults is more refractory to therapy." *Id*. Appellant's osteomyelitis was described as consisting of a "long history of intractability and debility" and constitutional symptoms of pain, tenderness, decreased rating of motion, and instability. *Id*.

In October 2017, the RO issued a statement of the case (SOC) continuing the findings of the March 2017 rating decision. [R. at 430-46]. The following

month, Appellant perfected his appeal to the Board arguing, in part, that he was entitled to a 100% rating under 38 C.F.R. § 4.71A, Diagnostic Code (DC) 5000, because he has osteomyelitis of the pelvis. [R. at 239-46].

In August 2018, Appellant opted-in to the Rapid Appeals Modernization Program (RAMP), electing higher-level review. [R. at 122]; *see* [R. at 126-36]. In November 2018, a decision continuing Appellant's ratings was issued under RAMP. [R. at 47-55]. The following month, Appellant appealed to the Board selecting the direct review option, which limits the Board's review to the evidence of record at the time of the prior decision. [R. at 31 (29-46)]; *see* [R. at 27-28].

On March 18, 2019, the Board denied entitlement to an initial rating for osteomyelitis of the left ilium in the excess of 20% from February 1, 1992, to June 3, 1994; in excess of 20% from July 6, 1995; and in excess of 10% from February 1, 1997. [R. at 7]. The Board concluded that "the probative evidence of record [] documents that [Appellant's] osteomyelitis has largely been resolved since 1992, such that his claim for an increased disability rating is denied for the entire period." [R. at 16]. The Board found the VA medical opinions more probative than the private medical opinions of record. [R. at 17-18]. In finding the private medical opinions less probative, the Board noted, in part, multiple times that a February 1994 private doctor opined that it would be "very strange" to have osteomyelitis in the hip given the lack of supporting diagnostic findings. [R. at 16; 17].

The Board also rejected Appellant's argument that he is entitled to a 100% rating for the entire appeal period just because his osteomyelitis occurred in the pelvis. [R. at 18]. The Board explained that "DC 5000 explicitly contemplates diagnostic criteria for 'acute, subacute, or chronic' osteomyelitis based upon its active or inactive status." *Id*. The Board concluded that "the most probative evidence of record suggests that [Appellant's] osteomyelitis has been resolved without further residuals conclusively attributable to osteomyelitis since 1992" and that "it is unreasonable to assume that an automatic 100 percent disability rating is warranted for osteomyelitis, which initially manifests in 'the pelvis, vertebrae' or extends 'into major joints,' but which is later resolved without residual symptoms." *Id*. The Board reiterated that "the most probative evidence of record suggests that [Appellant's] osteomyelitis has been resolved without further residuals conclusively attributable to osteomyelitis since 1992." *Id*.

This appeal followed.

ARGUMENT

This case presents conflicting evidence, based on a limited evidentiary record, about whether Appellant has an active, chronic, or recurring osteomyelitis infection warranting an increased rating. In June 1989, Appellant was treated with a bone debridement procedure for a "[c]hronic sinus tract from [the left] iliac bone graft." [R. at 1338]. In late 1991 and early 1992, there was another instance of a sinus tract that was resolved with further treatment, and x-ray examination showed "[o]ld septic arthritis and osteomyelitis, left SI joint." [R. at

1479]. In early 1994, Appellant was seen and treated for issues with his left hip, and additional investigation of the cause of these issues was encouraged by private examiners; however, the results of any additional investigation are not of record. *See* [R. at 1750; 1753; 1756-57]. Appellant returned to active duty in mid-1994 until July 1995 with no mention in his service treatment records of any left hip complaints or treatment. *See* [R. at 2436-64]. The record does not contain any VA, service, or private treatment records for the next twenty years.

Then, in August 2016, a VA examiner opined, based on an examination of Appellant and review of the available evidence, that the status of Appellant's current osteomyelitis condition was resolved with no additional episodes or recurring osteomyelitis infections since the initial infection. [R. at 1631]. That same month, a private doctor opined that Appellant's osteomyelitis was chronic, recurrent, and refractory to medical and surgical treatment. [R. at 1483]. A March 2017 VA medical opinion was ordered to resolve the conflict between the two August 2016 medical opinions, *see* [R. at 1039-40], and it concluded that Appellant has been fully recovered from his osteomyelitis condition since 1992, [R. at 1041]. Appellant submitted a June 2017 rebuttal opinion that described Appellant's osteomyelitis condition as "chronic" with a "long history of intractability and debility" and constitutional symptoms of pain, tenderness, decreased rating of motion, and instability. [R. at 635-36]. It is in this limited, conflicting evidentiary universe that this case is presented for review.

Contrary to Appellant's plea, *see* Appellant's Brief (App. Brf.) at 27, remand, not reversal, is the appropriate remedy here because the record presents a conflict about whether Appellant's osteomyelitis condition is active, which is a critical to higher ratings under 38 C.F.R. § 4.71A, Diagnostic Code (DC) 5000. *See Gutierrez v. Principi,* 19 Vet.App. 1, 10 (2004) (holding that reversal is an appropriate remedy only in the narrow circumstances where the sole permissible view of the evidence is contrary to the Board's decision). Because there are factual, and evidentiary, questions outstanding, as discussed below and highlighted in Appellant's brief, remand of all three periods on appeal to the Board for further factual development and readjudication is appropriate.

First, the Board failed to address relevant evidence in its March 2019 decision. *See* App. Brf. at 16-17. The Board is required to consider all relevant evidence of record. *See Schafrath v. Derwinski,* 1 Vet.App. 589, 593 (1991). Specifically, the Board failed to address the August 2016 medical imaging report of the left hip, attached to the August 2016 private medical opinion, that noted an impression of "[p]unctate metallic foreign body in the left hip posterior superficial soft tissues with associated metallic artifact." [R. at 1491]; *see* [R. at 15; 17-18]. The Secretary notes that the Board relied on a February 1994 private treatment note that commented "[Appellant's recollection of a diagnosis of staphylococcus] is very strange since flat bone osteomyelitis is extremely uncommon" and, that he "reviewed the x-rays and find no foreign body or area that might appear to be osteomyelitis of the iliac crest." [R. at 1756]; *see* [R. at 16; 17]. The August 2016

diagnostic report appears to conflict with the February 1994 x-ray evidence about whether there are foreign bodies present in the left hip such that the Board should have addressed that conflict in determining the current status of Appellant's osteomyelitis. Thus, remand is warranted for the Board to address the August 2016 diagnostic report in the first instance.

Relatedly, the March 2017 VA medical opinion did not address the August 2016 diagnostic report when it opined that "[t]here have been no signs of osteomyelitis since 1992." [R. at 1041]; *see* App. Brf. at 22-23; *D'Aries v. Peake*, 22 Vet.App. 97, 104 (2008) (holding that medical opinion must be based on veteran's prior medical history). That examiner was directed to review the August 2016 private examination and its attachments. [R. at 1039-40]. While the VA examiner appears to have reviewed the August 2016 private medical opinion, *see* [R. at 1041], it is not clear whether the VA examiner considered the attachments to that private medical opinion, including the August 2016 diagnostic report, *id*.

Moreover, the August 2016 VA examination does not appear to consider evidence of a December 1991 infection that was resolved with additional treatment in early 1992. *See* App. Brf. at 21-22; *D'Aries*, 22 Vet.App. at 104. That examiner opined, based on an examination of Appellant and review of the available evidence, that the status of Appellant's current osteomyelitis condition was resolved with no additional episodes or recurring osteomyelitis infections since the initial infection in 1985. [R. at 1631]. However, the VA examiner does

not appear to account for a January 1992 private treatment record that evaluated Appellant's left pelvis following "persistent drainage for quite some time" after "the tract closed in December [1991]" with an impression of "[o]ld septic arthritis and osteomyelitis, left [sacroiliac] joint" based on x-ray examination. [R. at 1479]. The Secretary notes, however, that, while the August 2016 VA examiner's finding that Appellant had no additional episodes or reoccurring infections after the initial infection conflicts with the January 1992 private treatment record, the August 2016 VA examiner's finding that Appellant's current osteomyelitis condition is "resolved" was based, in part, on an in-person examination of Appellant. *See* [R. at 1630-31]. Thus, because August 2016 VA examination and the June 2017 VA medical opinion appear to have overlooked relevant portions of Appellant's medical history, remand is warranted for a new VA medical opinion, or examination if Appellant is willing to participate, that addresses whether Appellant has active, chronic, or recurring osteomyelitis in his left hip.

Despite these concessions about the adequacy of the VA medical opinions, the remaining private medical evidence also leaves much to be desired on the question of the current status of Appellant's osteomyelitis. Notably, while the August 2016 private medical opinion describes the current status of Appellant's osteomyelitis as "chronic" with 5 or more additional episodes or recurring infections following the initial infection, [R. at 1483], it only identifies dates of recurrent infection in 1989, 1991, 1992, 1993, and 1994, [R. at 1483;

1487-88]. Indeed, the medical history provided does not identify a single instance of additional episodes or recurring infections in the twenty years prior to the August 2016 private medical opinion. *See* [R. at 1486-87]. The same goes for the June 2017 private rebuttal opinion that only comments on infections between 1991 and 1994, notwithstanding its conclusory comment that, "[t]oday, [Appellant] continues to have Osteomyelitis of the Pelvis with a long history of intractability and debility." [R. at 635]. It is thus unclear how Appellant's condition can be "chronic" if there have been no additional episodes or recurring infections since at least 1994, according to the private opinion medical history. At a minimum, the private medical opinions lack clarity on this point.

Additionally, as the Board found, the August 2016 and June 2017 private opinions continue to conflict with the evidence of record that indicates that Appellant's infection resolved in 1992 and that it would be "very strange" to develop osteomyelitis in the flat bone of the pelvis because such infections are "extremely uncommon." *See* [R. at 17-18]. The June 2017 private rebuttal opinion also relies heavily on generalities that are not tethered to Appellant's specific medical history. *See* [R. at 635-36] ("Patients with pelvic osteomyelitis frequently develop abbesses in the soft tissues adjacent to the bony pelvis or the infection dissects into areas that are quite distant from the site of bony involvement," "chronic osteomyelitis in adults is more refractory to therapy," and osteomyelitis "is often recurring because it is difficult to treat definitively."). Most curious is that neither private medical opinion, which purportedly come from a

doctor that is actively treating Appellant, describe the current state of the past infection site or identify any current treatment Appellant is undergoing for his "chronic" osteomyelitis, to include the noted "lifelong" need for "IV/PO antibiotic treatment." *See* [R. at 635-36; 1484-91]. Thus, because the August 2016 and June 2017 private opinions also leave relevant medical questions unanswered, these private medical opinions alone are insufficient to assign an increased rating. Remand is appropriate for necessary development to allow the Board to make an informed decision on the status and extent of Appellant's osteomyelitis. *Acevedo v. Shinseki*, 25 Vet.App. 286, 293 (2012) (providing that an adequate examination "must rest on correct facts and reasoned medical judgment so as inform the Board on a medical question and facilitate the Board's consideration and weighing of the report against any contrary reports.").

To the extent Appellant also argues that the Board overlooked portions of the August 2016 and June 2017 private opinions, *see* App. Brf. at 18-20, the Board appears to have accurately summarized and considered the private opinions, except for not addressing the August 2016 diagnostic report addressed above, *see* [R. at 15-18]. However, even if the Board failed to adequately consider portions of the August 2016 and June 2017 private opinions, that concern is moot given the proposed remand above and de novo review the Board would be required to conduct on remand.

Finally, because the record is unsettled about whether Appellant's osteomyelitis of the left hip is active, chronic,[3] or otherwise recurring, Appellant has not established that he is entitled to a 100% rating under DC 5000 for active, or chronic, osteomyelitis of the pelvis. *See* App. Brf. at 10-16. DC 5000 provides the following:

5000 Osteomyelitis, acute, subacute, or chronic:	
Of the pelvis, vertebrae, or extending into major joints, or with multiple localization or with long history of intractability and debility, anemia, amyloid liver changes, or other continuous constitutional symptoms	100
Frequent episodes, with constitutional symptoms	60
With definite involucrum or sequestrum, with or without discharging sinus	40
With discharging sinus or other evidence of active infection within the past 5 years	20
Inactive, following repeated episodes, without evidence of active infection in past 5 years	10

38 C.F.R. § 4.71A.

The Secretary agrees that DC 5000 provides independent alternatives to establish a 100% rating, including osteomyelitis of the pelvis. *See* App. Brf. at 12. However, the text and structure of DC 5000 make clear that osteomyelitis "acute, subacute, or chronic" is rated, in part, on its active or inactive status, and given the graduated structure of DC 5000, a 100% rating requires evidence of *active* osteomyelitis. *See King v. St. Vincent's Hosp.*, 502 U.S. 215 (1991) (holding that, when interpreting a statute or regulation, courts must read the

[3] Chronic is defined as "persisting over a long period of time." *Dorland's,* at 359.

provisions of the law as a whole and in context); *Imazio Nursery, Inc. v. Dania Greenhouses*, 69 F.3d 1560, 1564 (Fed. Cir. 1995) (holding that all parts of a statute must be construed together without according undue importance to a single or isolated portion); *Meeks v. West*, 12 Vet.App. 352, 354 (1999) ("[E]ach part or section [of a statute] should be construed in connection with every other part or section so as to produce a harmonious whole." (quoting 2A *N. Singer Sutherland on Statutory Construction* § 46.05 (5th ed.1992)) (second alteration in original)), *aff'd*, 216 F.3d 1363 (Fed. Cir. 2000).

For example, a 10% rating is appropriate for *inactive* osteomyelitis, following repeated episodes, without evidence of active infection in the past 5 years. 38 C.F.R. § 4.71A, DC 5000; *see also id.* at Note (2). A 20% rating is appropriate for *inactive* osteomyelitis with evidence of an active infection in the past 5 years. *Id.* A 40% rating is appropriate for osteomyelitis with definite involucrum[4] or sequestrum,[5] with or without discharging sinus or, in other words, evidence of an *active* infection process. *Id.* A 60% rating is appropriate for osteomyelitis with evidence of *frequent* episodes, with constitutional symptoms or, in other words, evidence of an *active* infection process. *Id.*

A 100% rating is appropriate for osteomyelitis (1) of the pelvis, vertebrae, or extending into major joints, (2) or with multiple localization (3) or with long

[4] Involucrum is defined as “a covering or sheath, such as contains the sequestrum of a necrosed bone.” *Dorland’s*, at 956.
[5] Sequestrum is defined as “a piece of dead bone that that has become separated during the process of necrosis from the sound bone.” *Id*. at 1969.

history of intractability and debility, anemia, amyloid liver changes, or other continuous constitutional symptoms. While the word "active" does not appear in the 100% criterion, its position at the top of the graduated structure of DC 5000 evidences that a 100% rating be assigned for active infection processes only, consistent with the independent alternatives enumerated in that criterion, given that the 60% and 40% criterion below it reflect the need for an active infection process. Indeed, terms such as "long history" and "other continuous" in the 100% criterion reflect the need for an active infection process. Thus, the plain language of DC 5000 requires evidence of an active infection process to assign a 100% rating. *See Hudgens v. Gibson*, 26 Vet.App. 558, 561 (2014) ("Regulatory interpretation begins with the plain meaning of the words used."). If the Court finds that the plain language of DC 5000 is ambiguous, then the Court should defer to VA's reasonable interpretation of the regulation. *See Kisor v. Wilkie*, 139 S. Ct. 2400 (2019); *Auer v. Robbins*, 519 U.S. 461 (1997).

The very application of DC 5000 outlined above was used to assign Appellant a 100% rating for active osteomyelitis of the left ilium from November 8, 1986, to February 1, 1992, before the infection resolved with debridement and antibiotic treatment. *See* [R. at 936]. Then Appellant's current staged 20% and 10% ratings were assigned based on the length of time since the last active infection process consistent with those criteria and Note (2) of DC 5000. *Id*.; *see also* [R. at 8]. Thus, contrary to Appellant's argument, the Board's interpretation of DC 5000 was not incorrect, as it was simply explaining that

resolved, or inactive, osteomyelitis of the pelvis would not be entitled to a 100% rating. *See* [R. at 18]. Instead, inactive osteomyelitis is limited to a 20% or 10% rating. *See* 38 C.F.R. § 4.71A, DC 5000, Note (2).

To the extent that Appellant argues this view of DC 5000 is inconsistent with 38 C.F.R. § 4.43 because that regulation "expressly provides that once diagnosed, osteomyelitis is a continuously disabling disease warranting a rating consistent with the evaluation criteria of DC 5000, absent amputation of the affected bone," App. Brf. at 13, the regulation does not provide that once osteomyelitis is diagnosed it is a continuously disabling disease; it must be chronic or recurring for the regulation to apply, *see* 38 C.F.R. § 4.43 ("Chronic, or recurring, suppurative osteomyelitis, once clinically identified. . . ."). As discussed above, the record does not show that Appellant's osteomyelitis is chronic or reoccurring, especially given lack of evidence of a reoccurring infection since at least 1994, and, unless or until that is established, section 4.43 is not for application. To the extent Appellant relies on a statement from an SOC as evidence that VA has found his osteomyelitis to be "chronic," *see* App. Brf. at 13 (citing [R. at 445]), it is well settled that, in its review of the record, the Board may disregard apparent favorable findings made by the agency of original jurisdiction. *McBurney v. Shinseki*, 23 Vet.App. 136, 139 (2009) ("The Board, as the final trier of fact, is not constrained by favorable determinations below."), *aff'd per curium*, 407 F. App'x 480 (Fed. Cir. 2011). The Board has not found Appellant's

osteomyelitis to be active, chronic, or otherwise reoccurring. *See* [R. at 7-19]. Thus, a 100% rating based on the record as it stands would be inappropriate.

CONCLUSION

Wherefore, for the foregoing reasons, Appellee, Robert L. Wilkie, Secretary of Veterans Affairs, respectfully urges the Court to vacate and remand the Board's March 18, 2019, decision, consistent with the above.

Respectfully submitted,

WILLIAM A. HUDSON, JR.
Acting General Counsel

MARY ANN FLYNN
Chief Counsel

/s/ Anna Whited
ANNA WHITED
Deputy Chief Counsel

/s/ Nicholas R. Esterman
NICHOLAS R. ESTERMAN
Senior Appellate Attorney
U.S. Department of Veterans Affairs
Office of General Counsel (027F)
810 Vermont Avenue, NW
Washington, DC 20420
(202) 632-8392

Counsel for the Secretary