An Overview of Precedential Cases of the Court of Appeals for Veterans Claims from 2017 to 2018

I. SERVICE CONNECTION

Frost v. Shulkin

Summarized by Dane Lauritzen

In *Frost v. Shulkin*,[1] the veteran appealed a decision of the Board of Veterans' Appeals (Board) denying a claim of entitlement to service connection for gunshot wound (GSW) residuals, including as secondary to service-connected posttraumatic stress disorder (PTSD) and depressive disorder.

The question at issue is whether, in a claim for secondary service connection based upon causation under § 3.310(a), the primary service-connected disability need be service connected or diagnosed at the time the secondary condition is incurred.[2]

The Veteran's medical history showed that he was involved in an in-service train accident, in which he injured his shoulder and leg. In November 1982, after his active duty service, he was involved in an altercation with a shop owner that resulted in a GSW to the neck.[3]

In June 2001, the veteran filed a claim for service connection for PTSD stemming from his involvement in the train accident.[4] The VA Regional Office (RO) granted service connection for PTSD, effective June 2001.[5] In December 2005, the veteran filed a claim for service connection for GSW residuals as secondary to his service-connected PTSD. He asserted that his PTSD caused him to become involved in the November 1982 dispute that resulted in the GSW to the neck.[6] The RO denied the claim, stating that the evidence did not show the GSW was related to a service-connected disability.[7]

In April 2015, the Board issued the decision denying service connection for GSW residuals, including as secondary to service-connected PTSD. The Board found that the veteran was first shown to be suffering from PTSD no earlier than June 2002, and that it could not reasonably associate his GSW residuals with the service-connected PTSD.[8]

On appeal to the United States Court of Appeals for Veterans Claims (CAVC), the veteran asserted that the Board failed to consider favorable evidence when it denied service connection for GSW residuals. He also argued that the Board erred by failing to obtain a medical opinion as to whether the GSW residuals were related to his service-connected PTSD.[9] The Secretary contended that secondary service connection must be denied because the veteran was not service-connected for a psychiatric disability when he was shot, and because his PTSD was not diagnosed until years after he was shot.[10]

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1 29 Vet. App. 131 (2017).
2 *Id.* at 134.
3 *Id.*
4 *Id.* at 135.
5 *Id.*
6 *Id.*
7 *Id.*
8 *Id.* at 136.
9 *Id.*
10 *Id.*

The CAVC rejected the Secretary's arguments as a matter of law. The CAVC explained that "the plain language of § 3.310(a) that a disability 'proximately due to or the result of a service-connected disease or injury shall be service connected'—does not establish such a temporal requirement."[11] The CAVC further noted that it would have reservations concerning the Secretary's interpretation since a temporal requirement made little sense given the protracted nature of claims adjudication. The CAVC found that the veteran was not precluded from receiving an award of secondary service connection for GSW residuals that were incurred years before the grant of service connection for, and diagnosis of, PTSD.[12]

After concluding its evaluation of secondary service connection, the CAVC found that remand was needed for the Board to conduct a *Mclendon* analysis to determine the need for a VA examination or opinion regarding whether the veteran's GSW residuals were at least as likely as not proximately due to or the result of his PTSD.[13]

Molitor v. Shulkin

Summarized by Cynthia Anderson

In *Molitor v. Shulkin*,[14] the veteran appealed a decision of the Board denying a claim of entitlement to service connection for PTSD due to military sexual trauma (MST).

The question at issue on appeal is to what extent the Duty to Assist (DTA) requires the Department of Veterans Affairs (VA) to obtain service treatment records (STRs) or other identified federal records for service members other than the claimant in order to corroborate a claimed in-service personal assault.[15]

The Veteran sought service connection for PTSD due to MST.[16] The veteran reported being raped at gunpoint by "at least" five military police officers (MPs) in an initiation or hazing ceremony associated with her unit in Frankfurt, Germany around February 1986. She fought back against a sergeant in the group but did not report the assault at the time because she was warned she would be killed if she did.[17]

A VA examiner indicated that the veteran's credibility was called into question because she denied a pre-existing history of mental illness, drug use, and alcohol abuse when she entered service "despite evidence of such in the record," and concluded that there were no markers of an in-service assault in the veteran's personnel records or STRs.[18] However, Vet Center records submitted documented extensive treatment and explained that while the veteran had repressed memories of her assaults, the memories were slowly becoming clear with treatment. Further, the Vet Center provider detailed behaviors such as dissociation and acting out that were "consistent with those assaults."[19]

[11] *Id.* at 137, *citing* Petitti v. McDonald, 27 Vet. App. 415, 422 (2015).
[12] *Id.* at 138.
[13] *Id.* at 141, *citing* McLendon v. Nicholson, 20 Vet. App. 79 (2006).
[14] 28 Vet. App. 397 (2017).
[15] *Id.* at 397.
[16] *Id.* at. 398.
[17] *Id.* at 398-99.
[18] *Id.* at 399.
[19] *Id.*

Eventually, after one of several remands, the VA Appeals Management Center issued a formal finding that the veteran's claimed in-service assaults could not be verified based upon the information provided, noting in part that she was not deployed to Germany until April 1986.[20]

Following a decrease in medication that reportedly lead to more lucidity, the veteran provided the names of several assailants and witnesses, including the injured sergeant. She also reported the names of several female MPs who she believed had also been victims of MST while stationed in Frankfurt, Germany at the same time, to include one who committed suicide in service.[21]

In accordance with subsequent Board remands, the veteran was provided with a Board hearing as well as two new VA examinations, and an expert medical opinion was obtained.[22] However, the VA never attempted to obtain the corroborating records for the other veterans identified by the veteran.

The Board denied service connection for PTSD in a May 2015 decision based on giving the highest probative weight to negative nexus opinions from the VA examiners. The Board determined that the veteran's statements were both internally inconsistent and inconsistent with the record because there were no markers for sexual assault during or shortly after service. The Board found that the Vet Center opinions were entitled to low probative value because they were based on the inconsistent statements and did not appear to be founded upon a full review of the record.[23]

As to the DTA, the Board concluded that the VA satisfied its duties to notify and assist, without discussing the veteran's request for the VA's help in obtaining records from fellow service members.[24]

Before the CAVC, the veteran argued that the VA General Counsel (G.C.) Precedent Opinion 05-14 required the VA to attempt to obtain the records from fellow servicemembers that would help corroborate her reported in-service MST.[25] The Secretary argued that the veteran did not adequately identify records such that G.C. Precedent Opinion 05-14 would have been invoked. And, even if she had, the VA was statutorily prohibited from obtaining those records without written consent of the service members or a court order. The Secretary argued that such efforts were "unreasonable" given the nature of the request and the lack of in-service markers.[26]

The CAVC summarized the requirements for granting service connection for PTSD, emphasizing the lowered evidentiary burden under 38 C.F.R. § 3.304(f) for claims based on personal assault. In particular, the CAVC found that § 3.304(f) codified the VA's "existing internal policies that provided for additional development assistance in claims for PTSD based on personal assault, . . . including 'a special obligation to assist a claimant . . . in producing corroborating evidence of an in-service stressor.'"[27]

In addition to the development assistance required for PTSD claims based on personal assault, the CAVC noted that the general DTA required the VA to make "reasonable efforts to obtain relevant records from [the] VA or other Federal departments or agencies" if adequately identified by the

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20 *Id.*
21 *Id.*
22 *Id.* at 400-401.
23 *Id.* at 401.
24 *Id.*
25 *Id.* at 402.
26 *Id.*
27 *Id.* at 403 (citing Patton v. West, 12 Vet. App. 272, 280 (1999); Gallegos v. Peake, 22 Vet. App. 329, 335 (2008)).

veteran.[28] Although the VA must make as many requests as necessary to obtain federal records once the DTA is triggered, the CAVC observed that such efforts are not required if, *inter alia*, no reasonable possibility exists that any further assistance would aid in substantiating the claim – which would include "[c]laims that are inherently incredible or clearly lack merit."[29]

The CAVC summarized the findings of G.C. Precedent Opinion 05-14, without reaching any conclusions as to the "propriety of its conclusions." In sum, G.C. Precedent Opinion 05-14 found: (1) the DTA requires the VA to make reasonable efforts to obtain the records of another individual if adequately identified by the claimant, relevant to the claim, and the records would aid in substantiating the claim; and (2) the VA's DTA is limited by whether disclosure of the other individual's records meets one of the three relevant enumerated exceptions to the Privacy Act – written consent from the third party, a court order, or disclosure for a "routine use" for which the record was collected (which has not been established at the VA, but may exist at other federal agencies).[30]

Among other findings not directly applicable to the case, the G.C. Opinion also concluded that the DTA under § 5103A and § 3.304(f)(5) does not require the VA to solicit written statements from fellow service members to attempt to corroborate a claimed personal assault stressor.[31] However, the CAVC explicitly found that the G.C. finding was incorrect "to the extent that the General Counsel categorically concluded that the duty to assist never requires the VA to solicit written statements from third parties to assist in corroborating a claimed stressor" based on several precedential CAVC cases.[32]

The CAVC found that the Board is bound by G.C. Precedent Opinion 05-14, and thus was required to address whether the DTA was satisfied if the veteran had adequately identified relevant records from fellow servicemembers.[33]

The CAVC found that the veteran's statements providing unit information and location related to her assault, names and ranks of witnesses and assailants involved in her assault, that she "beat up" the sergeant-assailant (suggesting he may have relevant STRs showing treatment for injuries), the name and rank provided for several women she believed were also raped (including the woman who committed suicide while also stationed in Germany), and an express request that the VA aid her in obtaining related records, were all sufficient to adequately identify outstanding records for DTA purposes.[34]

Next, the CAVC found that the types of records identified were relevant to the veteran's claim and may aid in substantiating the claim because: (1) STRs for the sergeant-assailant may show injuries caused by the veteran, which would corroborate her account of the rape; (2) service records and VA claims files for the women who the veteran identified as likely rape victims "may reflect reports of similar assaults or claims for service connection for residuals of MST that could establish a rape culture at the base;" (3) and service records related to the reported suicide may bolster the veteran's credibility if consistent with the veteran's report of other events on base in 1986.[35]

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28 *Id.*
29 *Id.* at 403-04 (citing 38 C.F.R. § 3.159(d)(2) (2016)).
30 *Id.* at 405 (citing 5 U.S.C. § 552a(b) (2012)).
31 *Id.* at 407.
32 *Id.* at 407-08 (citing Forcier v. Nicholson, 19 Vet. App. 414, 422 (2006); Hornick v. Shinseki, 24 Vet. App. 50, 53 (2010)).
33 *Id.* at 408.
34 *Id.* at 409, *citing* Gagne v. McDonald, 27 Vet. App. 397, 402-03 (2015).
35 *Id.*

Based on the above findings, the CAVC concluded that the Secretary's argument that the Board's finding that the veteran was not credible "puts the cart before the horse" because, with the exception of 38 C.F.R. § 3.159(d), a claimant's credibility does not "extinguish the VA's duty to assist a claimant in developing his or her claim because such development may produce evidence that substantiates the claim or otherwise bolsters or rehabilitates a claimant's credibility."[36] The Board did not find that the claim was inherently incredible or clearly lacking merit. It simply found the veteran's statements lacked credibility based on lack of support in the record and internal inconsistency, both of which may be bolstered by the requested development.[37]

Thus, the CAVC found that the Board failed to provide adequate reasons and bases because it did not discuss whether the DTA was satisfied in relation to development for the identified third-party records. The CAVC determined remand was required for the Board to discuss the DTA and, if necessary, remand for further development in accordance with the CAVC decision.[38]

As a final matter, the CAVC noted an additional issue "for the sake of guidance to the Board on remand."[39] Specifically, VA cannot consider a lack of evidence that the veteran's behavior changed in service to be negative evidence against a claim for PTSD based on an in-service personal assault.[40] This is because such evidence must be expected to have been recorded in order to draw a negative inference. Though such a change in behavior can be used as positive evidence, both DSM-5 and VA regulations recognize that there can be a delay in onset of symptoms of "months, or even years" following a stressor incident.[41] "Because behavior changes do not necessarily manifest immediately after a personal assault, it cannot be expected that they would appear in service in every instance of an assault.[42]

Saunders v. Wilkie

Summarized by David Sebstead

In *Saunders v. Wilkie,*[43] the U.S. Court of Appeals for the Federal Circuit (Federal Circuit) overruled the case *Sanchez-Benitez v. West*, 13 Vet. App. 282, 285 (1999) (*Sanchez-Benitez I*) from the CAVC which held that "pain alone is not a disability for the purpose of VA disability compensation."

The question at issue in the case is whether pain can be a disability for the purpose of VA disability compensation when there is evidence showing that pain causes functional impairment.[44]

In 1994, the veteran initially sought service connection for a bilateral knee disability. The RO denied her claim for service connection for her knees because she failed to appear for an examination. In 2008, she filed a claim to reopen her compensation claim for a bilateral knee disability. The RO denied the claim to reopen due to lack of evidence of treatment for a knee condition.[45]

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36 *Id.*
37 *Id.* at 410.
38 *Id.*
39 *Id.*
40 *Id.*
41 *Id.*
42 *Id.* at 410-11.
43 886 F.3d 1356 (Fed. Cir. 2018).
44 *Id.* at 1358-60.
45 *Id.* at 1358.

The Veteran had an examination for her bilateral knee pain in 2011. The examiner found no anatomic abnormality, weakness, or reduced range of motion. However, the examiner noted that the veteran had functional limitations on walking, was unable to stand for more than a few minutes, and sometimes required use of a cane or brace. The examiner diagnosed the veteran with subjective bilateral knee pain and noted that her pain led to increased absenteeism and affected her ability to complete daily activities. The examiner also opined that the knee condition was at least as likely as not caused by, or a result of, the veteran's military service.[46]

The Board reopened the claim but denied it on the merits. The Board relied on *Sanchez-Benitez I* in concluding that pain alone is not a disability for the purposes of VA disability compensation and denied service connection for a knee condition because the examiner found no pathology to account for the veteran's reported knee pain.[47]

The case was appealed to the CAVC, which affirmed the Board's denial of service connection.[48]

On appeal to the Federal Circuit, the veteran argued that the CAVC erred as a matter of law in holding that pain alone, without an accompany pathology of an identifiable condition, cannot constitute a disability under 38 U.S.C. § 1110.[49]

The Federal Circuit found that "disability" under 38 U.S.C. § 1110 referred to the functional impairment of earning capacity, not the underlying cause of disability.[50] The Federal Circuit relied upon the plain language of the statute and dictionary definitions, noting that while a diagnosed condition may result in a disability, the disability itself need not be diagnosed. Additionally, the Federal Circuit found that the definition was consistent with the purpose of veterans' compensation, which is to compensate for impairment of a veterans' earning capacity.[51]

The Federal Circuit concluded that pain alone can serve as a functional impairment and therefore qualify as a disability because pain diminishes the body's ability to function.[52] The Federal Circuit further noted that pain need not be diagnosed as connected to an underlying condition to function as impairment.[53] The Federal Circuit based this determination upon dictionary definitions, as well as the terminology considering pain in numerous VA regulations, citing 38 C.F.R. §§ 4.10, 4.40, 4.45, 4.56, 4.66, 4.67.[54] Additionally, the Federal Circuit noted that "a physician's failure to provide a diagnosis for the immediate cause of a veteran's pain does not indicate that the pain cannot be a functional impairment that affects a veteran's earning capacity."[55] The Federal Circuit also noted that considering the general recognition that pain is a form of functional impairment, if Congress had intended to exclude pain from the definition of disability under 38 U.S.C. § 1110, it would have explicitly done so, and there is no indication that Congress intended such exclusion.[56]

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46 *Id.*
47 *Id.* at 1359.
48 *Id.*
49 *Id.* at1361
50 *Id.* at 1363.
51 *Id.*
52 *Id.* at 1364.
53 *Id.*
54 *Id.*
55 *Id.* at 1367.
56 *Id.* at 1365.

Additionally, the Federal Circuit noted that it was not holding that asserting subjective pain alone was enough to establish a disability. Rather, the Federal Circuit explained that to establish the presence of a disability for VA compensation purposes, a veteran would need to demonstrate that his or her pain reaches the level of a functional impairment of earning capacity.[57]

The Federal Circuit remanded the matter to the CAVC with instructions to remand the appeal to the Board to make specific factual findings regarding whether the veteran's bilateral knee condition amounts to functional impairment under the correct legal test for disability, and as to the other prongs of service connection as necessary, in the first instance.[58]

II. RATING ISSUES

Bankhead v. Shulkin

Summarized by Andrew Henessy-Strahs

In *Bankhead v. Shulkin*,[59] the veteran appealed a decision of the Board that granted in part and denied in part a higher rating for his major depressive disorder.

The question at issue on appeal is how suicidal ideation should be considered in rating a psychiatric disorder.[60]

The Veteran sought an increase in the initial rating of 30 percent assigned to his major depressive disorder claimed as PTSD.[61] Treatment records at the VA documented the presence of suicidal ideation; however, the veteran had never acted on his ideation. A December 2009 VA treatment record, for example, recorded that the veteran had been "chronically suicidal and low-grade" for many years.[62] A VA treatment record from January 2010 documented that the veteran had requested a gun from his wife to "blow his brains off."[63] During a September 2010 VA psychiatric examination, he denied having suicidal intent or a plan, but complained of chronic suicidal ideation, including "ruminative thoughts about death," feeling that "life is empty" and "wonder[ing] if it's worth living."[64] In January 2012, the veteran reported to a VA nurse practitioner that he had considered drinking antifreeze but ultimately decided against doing so on account of his devotion to his family and his religious beliefs, which instilled him with a fear of divine retribution.[65] In February 2013, he retrieved two knives and threatened to cut his son's head off.[66]

The Board reached a decision on the merits in April 2015, increasing the veteran's rating to 50 percent but no greater.[67] The Board recognized his suicidal ideation, but concluded that his

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[57] *Id.* at 1367-68.
[58] *Id.* at 1368-69.
[59] 29 Vet. App. 10 (2017).
[60] *Id.* at 13.
[61] *Id.* at 15.
[62] *Id.* at 14.
[63] *Id.*
[64] *Id.* at 15.
[65] *Id.* at 16.
[66] *Id.*
[67] *Id.* at 17.

symptoms did not manifest with sufficient frequency and severity to merit a higher rating.[68] Specifically, the Board determined that his suicidal ideation was "passive," that there were "no instances where he was hospitalized or treated on an inpatient basis or domiciliary care," and that "his treating sources have considered assurances that he would refrain from self-harm to be credible."[69] The Board also stated that he "retained some occupational functioning."[70] Hence, the Board found that the veteran was not entitled to a rating greater than 50 percent because he was "at sufficiently low risk of self-harm throughout the period," and his suicidal ideation did not rise to a level of occupational and social impairment contemplated by the 70 percent and 100 percent ratings.[71]

The CAVC set aside the Board's decision to the extent it denied a rating in excess of 50 percent for his major depressive disorder.[72] In doing so, the CAVC first provided background information on the disproportionate rate of Veterans who take their own lives, relative to the general population.[73] The CAVC relied on a policy argument to distinguish suicidal ideation from the other symptoms in the rating schedule, characterizing the frequency of suicide among Veterans as "disturbingly common," and suggesting that there may be an opportunity to reduce the rate of Veteran suicide by providing compensation to Veterans with suicidal ideation, specifically.[74] The CAVC evaluated the definition of suicidal ideation in medical treatises, noting that suicidal ideation was a continuum that ranged "from a passive wish not to awaken in the morning to thinking about specific ways to end one's life."[75] The CAVC noted that suicidal ideation is a symptom that the VA deems indicative of occupational and social impairment in most areas, and that "[t]here are no analogues at the lower evaluation levels."[76]

The CAVC held that suicidal ideation does not include an implicit risk assessment whereby suicidal ideation without intent or a plan cannot result in occupational and social impairment contemplated by a 70 percent rating. The CAVC also held that the Board must not rely on the absence of hospitalization or inpatient treatment in discounting suicidal ideation or the speculation of clinicians as to how likely a Veteran is to take his or her own life. Lastly, the CAVC held that the Board improperly blended the criteria for 70 percent ratings and 100 percent ratings when finding that the veteran "retained some occupational functioning," as the 70 percent rating criteria contemplate the veteran retaining some occupational functioning.[77]

The CAVC concluded this part of its analysis by emphasizing that the presence or absence of any particular symptom, including suicidal ideation, is not dispositive of any particular disability level. Rather, the Board must conduct a holistic analysis in which it assesses the severity, frequency, and duration of the signs and symptoms of the veteran's service-connected mental disorder, quantifies the level of occupational and social impairment, and assigns a rating that most nearly approximates that level of impairment faced by the veteran.[78]

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[68] *Id.*
[69] *Id.* at 20.
[70] *Id.*
[71] *Id.*
[72] *Id.* at 10.
[73] *Id.* at 19.
[74] *Id.*
[75] *Id.* at 19-20.
[76] *Id.* at 20 (citing Vazquez-Claudio v. Shinseki, 713 F.3d 112, 116 (Fed. Cir. 2013)).
[77] *Id.* at 20-22.
[78] *Id.* at 22 (citing *Vazquez-Claudio,* 713 F.3d at 115-17).

Doucette v. Shulkin

Summarized by Alyssa Keninger

In *Doucette v. Shulkin*,[79] the CAVC affirmed the Board's decision that extraschedular referral for entitlement to a compensable rating for service-connected bilateral hearing loss was not warranted.

The takeaway of this case is that the schedular rating criteria for hearing loss contemplate the functional effects of decreased hearing and difficulty understanding speech and other sounds, but the rating criteria do not otherwise address other functional effects such as dizziness, vertigo, or ear pain.[80]

The Veteran sought a compensable rating for his service-connected bilateral hearing loss. The Board denied a compensable rating and found that referral for extraschedular consideration was not warranted.[81]

In this case, the veteran claimed that his hearing loss included symptoms such as difficulty in distinguishing sounds in crowded environments, locating the source of sounds, understanding conversational speech, hearing the television, and using the telephone.[82]

The CAVC, in affirming the Board's decision, first assessed whether the schedular rating criteria for hearing loss contemplate specific functional effects of hearing impairment as the criteria for hearing loss do not specifically list any symptoms or functional effects, but, rather, the criteria uses two audiometric tests to assign a rating.[83] These two tests, the CAVC noted, "measure[] the veteran's ability to hear certain frequencies at specific volumes and to understand speech, using rating tables to correlate the results of the audiometric testing with varying degrees of disability."[84] As such, the CAVC held that "the rating criteria for hearing loss contemplate the functional effects of decreased hearing and difficulty understanding speech . . . as these are precisely the effects that VA's audiometric tests are designed to measure."[85] Thus, the functional loss resulting in an inability to understand speech or other sounds is contemplated by the schedular rating criteria.[86]

In this case, the veteran did not report any symptoms associated with his hearing loss other than difficulty hearing and understanding speech and sound in various scenarios. The Board did an analysis finding referral was not warranted for extraschedular consideration, the CAVC found such an analysis was not necessary because such an analysis is only necessary when the evidence of record reveals exceptional or unusual circumstances or where the veteran has asserted that that the schedular rating criteria are inadequate.[87]

The CAVC went on to say that the rating criteria did not contemplate symptoms such as dizziness, vertigo, or ear pain, and, if such symptoms result in "exceptional or unusual circumstances or where the veteran has asserted that a schedular rating is inadequate" extraschedular consideration may be warranted.[88]

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[79] 28 Vet. App. 366 (2017).
[80] *Id.* at 369.
[81] *Id.* at 367.
[82] *Id.* at. 371.
[83] *Id.* at 368.
[84] *Id.* at 369.
[85] *Id.*
[86] *Id.*
[87] *Id.* at 371.
[88] *Id.* at 371.

Citing to *Martinak v. Nicholson*,[89] the veteran asserted that the section on the VA examination report assessing functional loss, in which the veteran's difficulty hearing was documented, was an indication that extraschedular criteria were present.[90] While the CAVC noted that this section could aid the Board in making an extraschedular determination, this section is not intended to hold that the Board has a duty to engage in an extraschedular analysis for all hearing loss claims as this would be contrary to the purpose of extraschedular ratings.[91]

Nevertheless, as the Board did contemplate whether referral for extraschedular consideration was warranted, the CAVC assessed whether the Board provided adequate reasons and bases for denying such a referral.[92] The Board denied referral as the veteran's symptoms were not unusual or exceptional and were reasonably described by the rating criteria, failing the first step of *Thun v. Peake*,[93] as the resultant effect of his reported symptoms was difficulty hearing, which the audiometric tests in the rating criteria are designed to measure. The CAVC concluded that the Board adequately discussed the veteran's entire disability picture and ultimately determined that the disability was not exceptional or unusual such that the rating criteria did not adequately contemplate his symptoms.[94]

The Veteran also asserted that the Board misapplied the second step of *Thun*.[95] However, the CAVC held that a review of the evidence did not suggest that the veteran's hearing loss markedly interfered with his employment or resulted in frequent periods of hospitalization. Furthermore, the CAVC held that as the Board properly determined that the first step of *Thun* was not satisfied, any error in the analysis of the second step was harmless error.[96]

In a dissent, Judge Schoelen, opined that the "rating criteria [for hearing loss] are inadequate to contemplate a veteran's functional effects and entire disability picture" and that the Board failed to provide adequate reasons and bases in regard to the refusal to refer the claim for extraschedular consideration. As there are no symptoms listed in the rating criteria for hearing loss, Judge Schoelen found there was "no way to adequately compare the 'level of severity and symptomatology' to the rating criteria as *Thun* requires." Judge Schoelen noted that this was why *Martinak* required VA audiologists to fully describe the functional effects of hearing loss in the examination report, and that *Martinak* did not absolve the Board of its responsibility to assess those functional effects and provide an adequate statement of reasons or bases.[97]

English v. Wilkie

Summarized by Marquel Sheree Macaraeg Ramirez

In *English v. Wilkie*,[98] the veteran appealed a decision of the Board denying a claim of an initial rating in excess of 10 percent for his service-connected patellofemoral syndrome of the right knee for the period from January 15, 2008, to April 14, 2010.

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89 21 Vet. App. 447 (2007).
90 *Doucette*, 28 Vet. App, at 371.
91 *Id.* at 371.
92 *Id.* at 372.
93 22 Vet. App. 111 (2008),
94 *Doucette*, 28 Vet. App, at 372-73.
95 *Id.* at 373.
96 *Id.*
97 *Id.* at 373-75 (Schoelen, J., dissenting).
98 30 Vet. App. 347 (2018).

The question at issue is whether there must be objective medical evidence to establish knee instability to include whether it is permissible to afford categorically more probative weight to objective medical evidence over lay evidence to establish knee instability without supportive reasons or bases.[99]

The veteran sought an increased initial rating for right knee instability. The record contained his favorable lay statements and unfavorable medical findings as to the presence of knee instability. Medical examiners in February 2008, August 2009, April 2010, and November 2016 considered the veteran's statements yet concluded that he had no knee instability.[100]

The Board issued a decision in May 2017 that put an "emphasis" on the medical evidence in the claims file.[101] The CAVC stated that it "appears that the Board determined that objective medical evidence is *categorically* more probative than lay evidence under [38 C.F.R. § 4.71a, Diagnostic Code (DC)] 5257with respect to lateral instability of the knee."[102] However, the CAVC interpreted DC 5257 to not require or favor objective medical evidence over lay evidence.[103] The CAVC found that the Board erred because it did not provide an adequate explanation for favoring objective medical evidence over lay evidence.[104]

Additionally, the CAVC stated that if the Board had not found the medical evidence more probative than the veteran's lay statements, the Board still erred if it found that his lay statements were not competent, unless it provided a thorough explanation.[105] Under this rationale, the Board is cautioned not to violate *Colvin v. Derwinski*,[106] which held that if the Board makes medical conclusions, then "the basis for the inference must be independent and cited."[107] Furthermore, the CAVC found that the veteran was prejudiced by the Board's error. At the October 2015 Board hearing, the veteran testified about his knee instability and its effects. In addition, he discussed the instability during the February 2008 and August 2009 VA examinations.[108] Therefore, the CAVC determined that the veteran's lay evidence must be weighed against the medical evidence, a task best left to the Board in the first instance.[109]

Under 38 C.F.R. §§ 4.40 and 4.45, the Board must provide an adequate rationale for denying an increased rating based on functional loss. The Veteran asserted that the Board did not consider flare-ups, restrictions on physical activity, weakness on weight bearing, reduced joint speed, minimal flexibility, and assistive device use. The Board may consider these factors when deciding on a higher rating.[110] The CAVC noted that the Board failed to assess functional loss during flare-ups and whether the functional loss resulted in a limitation of motion to satisfy the next higher rating, which is potentially favorable evidence.[111]

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99 *Id.* at 349.
100 *Id.* at 350.
101 *Id.* at 351.
102 *Id.* at 352 (emphasis in original).
103 *Id.* at 352-53 (citing Petitti v. McDonald, 27 Vet. App. 415, 427 (2015) (finding that the DC "does not . . . restrict evidence to 'objective' evidence")).
104 *Id.* at 352.
105 *Id.*
106 1 Vet. App. 171, 175 (1991).
107 *English*, 30 Vet. App. at 353 (citing Kahana v. Shinseki, 24 Vet. App. 428, 435 (2001)).
108 *Id.* at 354.
109 *Id.*
110 *Id.* at 355 (citing Mitchell v. Shinseki, 25 Vet. App. 32, 36-37 (2011)); *see also* Deluca v. Brown, 8 Vet. App. 202, 206 (1995).
111 *Id.* at 355 (citing Thompson v. McDonald, 815 F.3d 781, 784-86 (Fed. Cir. 2016)); *see also* Caluza v. Brown, 7 Vet. App. 489, 506 (1995), *aff'd per curiam*, 78 F.3d 604 (Fed. Cir. 1996).

Therefore, the CAVC held that the Board erred because it did not provide sufficient reasons and bases for its denial of a higher initial rating for the veteran's right knee instability.[112]

Golden v. Shulkin

Summarized by Danielle Ragofsky

In *Golden v. Shulkin*,[113] the veteran appealed a decision of the Board denying a claim for a rating in excess of 70 percent for his PTSD.

The questions at issue are whether, with respect to claims certified after August 4, 2014, the Board may use Global Assessment of Functioning (GAF) scores to assign disability ratings for acquired psychiatric disorders and whether symptoms should be the fact finder's primary focus when deciding entitlement to a given disability rating.[114]

The veteran sought a rating in excess of 70 percent for PTSD. He underwent three VA examinations, two in 2010 and one in 2012, and GAF scores were assigned at each. His claim was certified to the Board on June 17, 2015.[115]

In December 2015, the Board issued a decision denying a rating in excess of 70 percent for PTSD. In its decision, the Board acknowledged that the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (2013) (DSM-5) applied to claims certified to the Board after August 4, 2014 and eliminated the use of GAF scores. However, as reflected in its reasons and bases, the Board based its decision to deny the veteran a higher rating on the fact that his GAF scores did not support a rating in excess of 70 percent.[116]

On appeal, the veteran argued that the Board failed to provide an adequate statement of reasons or bases when it failed to discuss favorable DSM-5 provisions. Specifically, he contended that he believed that the GAF scores were still relevant to his appeal even though the DSM-5 applied. He also argued that the Board erred by failing to remand the matter of extraschedular consideration.[117]

The CAVC wrote that the Board is not permitted to rely on GAF scores when deciding claims certified after August 4, 2014, as the American Psychiatric Association has found GAF scores lacking in clarity and usefulness.[118] The CAVC also determined that a medical examination is adequate "where it is based upon consideration of the veteran's prior medical history and examinations and also describes the disability, if any, in sufficient detail so that the Board's evaluation of the claimed disability will be a fully informed one."[119] The adequacy of a psychiatric examination is not dependent on the inclusion of a GAF score.[120]

112 *Id.* at 347.
113 29 Vet. App. 221 (2018).
114 *Id.* at 222.
115 *Id.* at 222-23.
116 *Id.* at 223.
117 *Id.*
118 *Id.* at 225.
119 *Id.* at 226.
120 *Id.*

As the Board did not explain whether its consideration of the veteran's GAF scores prompted its decision to deny a higher rating, the CAVC remanded the case to the Board for an adequate statement of reasons and bases for the denial that specifically showed what evidence it relied on to deny the veteran's claim.[121] The CAVC also instructed the Board to address the veteran's arguments pertaining to extraschedular consideration.[122]

Johnson v. Shulkin

Summarized by Angeline DeChiara

In *Johnson v. Shulkin*,[123] the Federal Circuit reversed the CAVC's decision in *Johnson v. McDonald*,[124] which held that DC 7806, under 38 C.F.R. § 4.118, unambiguously defines a topical corticosteroid treatment as "systemic therapy" rather than "topical therapy."[125]

This matter stems from an April 2014 Board decision that denied the veteran's claim for a rating in excess of 10 percent for his service-connected tinea corporis.[126] The Board found that he was not entitled to an increased 30 percent disability rating under DC 7806 because the medical evidence of record did not establish that at least 20 percent of his entire body, or 20 percent of his exposed areas, were affected.[127] Although the Board found that the veteran treated his service-connected skin disability with "constant or near-constant topical corticosteroids and other topical medications," it found that this use did not constitute "systemic therapy" because he treated his skin condition with topical creams.[128]

In *Johnson v. McDonald*, the CAVC reversed the Board's decision and held the plain meaning of DC 7806 to be unambiguous in that systemic therapy "includes the use of corticosteroids without any limitation to such use being oral or parenteral as opposed to topical."[129] The CAVC reasoned that corticosteroids are explicitly listed as an example of "systemic therapy" in DC 7806 with no distinction being made as to the method of application.[130] The CAVC rejected the Secretary's reliance on medical dictionaries, including *Dorland's Illustrated Medical Dictionary*, to support the proposition that a topical application is not a systemic treatment, indicating that "systemic" and "topical" treatments were not defined as being mutually exclusive.[131]

The Federal Circuit, in reversing *Johnson v. McDonald*, held that the CAVC "incorrectly read DC 7806 as unambiguously elevating any form of corticosteroid treatment, including any degree of *topical* corticosteroid treatment, to the level of 'systemic therapy.'"[132] The Federal Circuit held that the structure and content of the rating criteria makes clear that DC 7806 contemplates two types of therapy—"systemic therapy" and "topical therapy."[133] The use of the term "such as" in rating criteria

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121 *Id.*
122 *Id.*
123 862 F.3d 1351 (Fed. Cir. 2017).
124 27 Vet. App. 497 (2016).
125 *Johnson*, 862 F.3d at 1352.
126 *Id.*
127 *Id.* at 1353.
128 *Id.*
129 *Johnson*, 27 Vet. App. at 504.
130 *Id.* at 502.
131 *Id.* at 502-03.
132 *Johnson*, 862 F.3d at 1354 (emphasis in original).
133 *Id.*

indicates its use as an exemplary reference and does not mean that all forms of treatment with corticosteroids would constitute "systemic therapy."[134]

In support of its holding, the Federal Circuit turned to the plain meaning of the terms "systemic," "topical," and "therapy," as ascertained from *Dorland's*.[135] Combing these definitions, the Federal Circuit determined the term "systemic therapy" to mean "treatment pertaining to or affecting the body as a whole" whereas "topical therapy" meant "treatment pertaining to a particular surface area, as a topical antiinfective applied to a certain area of the skin and affecting only the area to which it is applied."[136] The Federal Circuit noted that nothing in DC 7806 circumvents these accepted definitions to allow for a topical therapy affecting only the area to which it is applied to constitute a systemic therapy under this code.[137]

Finally, the Federal Circuit noted that a topical corticosteroid treatment could be administered on a large enough scale to affect the body as a whole, and thus constitute a systemic therapy.[138] However, this is not to mean that all applications of topical corticosteroids constitute systemic therapy.[139] Thus, the use of a topical corticosteroid could constitute either a systemic therapy or a topical therapy, under DC 7806, depending on the factual circumstances of the case.[140]

Here, as the veteran did not challenge the Board's factual finding that he used topical corticosteroids to treat his service-connected tinea corporis, which only affected the area where he applied the treatment and not his body as a whole, the Federal Circuit credited these findings, reversed the CAVC's 2016 holding in *Johnson v. McDonald*, and remanded the matter for reinstatement of the Board's otherwise unchallenged factual findings.[141]

Johnson v. Wilkie

Summarized by Samantha Seserman

In *Johnson v. Wilkie*,[142] the veteran appealed an August 2016 decision of the Board denying a rating in excess of 30 percent for his service-connected migraine headaches. In this case, the Board found that the veteran's headaches manifested as characteristically prostrating on average once a month.[143]

The question at issue is whether 38 C.F.R. § 4.124a, DC 8100's rating criteria are successive, thereby rendering 38 C.F.R. §§ 4.7 (higher of two ratings) and 4.21 (all elements of rating schedule need not be present) inapplicable.[144]

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134 *Id.*
135 *Id.*
136 *Id.* at 1354-55 (quoting DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1865, 1911, 1940 (32d ed. 2012)).
137 *Id.* at 1355.
138 *Id.*
139 *Id.*
140 *Id.* at 1356.
141 *Id.*
142 30 Vet. App. 245 (2018).
143 *Id.* at 254.
144 *Id.* at 247.

The CAVC ruled that there are three factors that must be used to determine whether a DC contains successive rating criteria: (1) the degree to which the criteria in lesser disability ratings are repeated or reincorporated into the higher disability rating under consideration; (2) whether awarding a disability rating on less than all the rating criteria would render a lesser disability rating superfluous (in other words, whether a claimant can fulfill the criteria of the higher rating without fulfilling those of the next lower rating); and (3) whether the higher rating employs a conjunctive "and" in a manner that signals bundling of all the rating factors in that disability rating.[145] After analyzing DC 8100 in accordance with the above-mentioned factors, the CAVC found that it does, in fact, contain successive rating criteria.[146]

Additionally, the CAVC found that the Board improperly decided the veteran's claim as there are several words and phrases in the DC that are not defined and at various rating levels different terms are used to label similar concepts.[147] The CAVC observed that the Board did not explain how some of its conclusions were inconsistent with the evidence of record.[148] For example, the Board found that the veteran's headaches manifest as characteristically prostrating on average once a month; however, a September 2012 examination reflected that his usual occurrences of headaches ranged from once every six to twenty-one days.[149]

Furthermore, the CAVC held that the Board must support its assignment of a disability evaluation with a statement of reasons or bases that enables a claimant to understand the precise basis for its decision and that facilitates review by the CAVC.[150] Said statement must explain the Board's reasons for discounting favorable evidence and discuss all issues raised by the claimant or the evidence of record.[151] The CAVC rejected the Secretary's assertion "that the Board may make [subjective] determinations without any obligation to disclose the standard under which it is operating."[152] The CAVC also rejected the Board's reasoning that it could rely on the veteran's description of his headaches as "prostrating" rather than "completely prostrating' as there had been no showing that, as a lay person, the veteran understood the legal definitions of certain terms as described in the DC and could use them advisedly.[153]

In his concurrence, Judge Allen noted that without definitions in the Board's decisions, there is no meaningful notice to the claimant, rendering it inconsistent with the Constitution's promise of due process.[154] He stated that "[w]ithout a definition a veteran will have no means of knowing what he or she must establish in order to receive a benefit" and furthermore "without the Board defining the critical terms it uses to deny a benefit to a claimant, this Court cannot provide meaningful judicial review."[155] He indicated that the Board must do better because to not provide notice of the definitions on which the veterans Law Judge relied is a due process error, and to not have a definition at all renders the decision arbitrary and capricious.[156]

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145 *Id.* at 250-251.
146 *Id.* at 252.
147 *Id.* at 251.
148 *Id.* at 254.
149 *Id.*
150 *Id.* (citing 38 USC § 7104(d)(1) (2018) and Gilbert v. Derwinski, 1 Vet. App. 49, 57 (1990)).
151 *Id.* (citing Thompson v. Gober, 14 Vet. App. 187, 188 (2000); Robinson v. Mansfield, 21 Vet. App. 545, 552 (2008), *aff'd sub nom.* Robinson v. Shinseki, 557 F.3d 1355 (Fed. Cir. 2009)).
152 *Id.* at 255.
153 *Id.*
154 *Id.* at 256 (Allen, J., concurring).
155 *Id.*
156 *Id.* at 257.

Petermann v. Wilkie

Summarized by Sarone Solomon

In *Petermann v. Willkie*,[157] the veteran appealed a decision of the Board denying extraschedular consideration for his diabetes mellitus, rated as 40 percent disabling.

The question at issue is whether the availability of a higher schedular rating that contemplates a specific manifestation of a disability precludes consideration of an extraschedular evaluation if that manifestation is not contemplated by the lower rating criteria assigned to the disability.[158]

The Veteran sought an increased rating for his diabetes, which the RO had rated at 20 percent rating under DC 7913.[159] In February 2016, the Board increased the rating to 40 percent but declined extraschedular consideration.[160] The Board concluded that the manifestations of the veteran's diabetes have been contemplated by the schedular criteria and that he is compensated for his loss of earning capacity due to his service-connected diabetes.[161] The Veteran appealed the Board's decision to the CAVC.

On appeal to the CAVC, the veteran conceded that DC 7913 is successive in nature in that to establish a given disability rating, all the rating criteria for the rating assigned and for lower rating must be met. The Veteran did not dispute that he does not have all the symptoms under the rating criteria for 60 percent and 100 percent ratings under DC 7913. He recognized that he is not entitled to receive a higher rating based on a disability picture that nearly approximates a higher rating in the rating schedule. Rather, the veteran argued that the Board erred in failing to refer his claim for extraschedular consideration because he has symptoms that are not contemplated by the 40 percent rating assigned. Therefore, he argued that he has not been compensated for all of his symptoms and is entitled to extraschedular consideration.[162]

The CAVC agreed with the veteran that the Board erred as a matter of law when it found that all manifestations of his diabetes have been contemplated by the 40 percent disability rating assigned under the schedular criteria. The CAVC explained that because DC 7913 is successive in nature, a 40 percent rating only contemplates the specific manifestations of diabetes listed under that criteria. Accordingly, the 40 percent rating criteria considers the veteran's insulin use, his restricted diets, and regulation of his activities. However, the veteran testified that he has ketoacidosis and hypoglycemia, and that he requires an insulin pump. Although these symptoms are contemplated by 60 percent and 100 percent ratings under DC 7913, they are not specifically listed under the 40 percent rating criteria. The CAVC noted that the Board found the veteran's testimony credible but did not explain how the manifestations he described are adequately compensated by a 40 percent rating. The CAVC concluded that the availability of higher ratings that contemplate symptoms that are not compensated under the rating assigned to the disability does not preclude extraschedular consideration.[163]

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[157] 30 Vet. App. 150 (2018).
[158] *Id.* at 152-53.
[159] *Id.* at 152.
[160] *Id.*
[161] *Id.*
[162] *Id.* at 152-53.
[163] *Id.* at 155.

In doing so, the CAVC disagreed with the Secretary's argument that the appropriate comparison in an extraschedular analysis was between the symptoms experienced and the entre DC at issue, stating that "such an interpretation solely contemplates mere symptomatology" and eliminates the requirement in extraschedular referral analysis to compare the type of symptoms experienced by the veteran with the rating criteria.[164] Judge Toth dissented, stating that it is clear from "cumulative language and structure of DC 7913 that each rating contemplates the successive criteria of the whole DC" and that if a specific rating does not explicitly list a criterion it cannot be said that the rating "fails to contemplate that criterion.[165]

III. TOTAL DISABILITY RATINGS

Harper v. Wilkie

Summarized by Edward Lent

In *Harper v. Wilkie*,[166] the veteran appealed a decision of the Board finding that the Board lacked jurisdiction over the issue of entitlement to a total disability rating based on individual unemployability (TDIU).[167]

The question at issue is whether a claim for a TDIU, which has been awarded, remains in appellate status if the TDIU award is not effective from the date of the underlying claim that is on appeal.[168]

In February 2014, the veteran filed a claim for a TDIU. The RO, in December 2015, awarded a 70 percent evaluation for PTSD from December 2015. In May 2016, the RO awarded a TDIU effective February 11, 2016. The Veteran did not file a notice of disagreement (NOD) in response to the TDIU award.[169]

The Board, in July 2016, denied a disability evaluation for PTSD in excess of 50 percent prior to December 2015 and concluded that the TDIU issue was not part of the underlying appeal because the veteran did not appeal the May 2016 RO decision that awarded TDIU effective February 11, 2016.[170]

The Veteran argued before the CAVC that the Board erred in concluding that the issue of entitlement to a TDIU prior to February 11, 2016, was not on appeal. The Veteran asserted that, pursuant to *Rice v. Shinseki*,[171] the issue of entitlement to a TDIU became "part and parcel" of his appeal for a higher initial disability rating for PTSD in February 2014 when he explicitly raised the issue while his appeal was pending.[172]

The CAVC concluded that the Board had jurisdiction over the issue of entitlement to a TDIU prior to February 2016 because the issue became part and parcel of the underlying PTSD claim and the RO's grant of a TDIU did not bifurcate the appeal. The CAVC explained that the veteran did not need to appeal the May 2016 RO decision awarding a TDIU because the RO's grant of TDIU served only as a

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164 *Id.*
165 *Id.* at 156-57 (Toth, J., dissenting).
166 30 Vet. App. 356 (2018).
167 *Id.* at 357.
168 *Id.*
169 *Id.* at 358.
170 *Id.*
171 22 Vet. App. 447 (2009).
172 *Harper*, 30 Vet. App. at 358.

partial grant of his request for a TDIU as part of his PTSD claim. The CAVC determined that, under *Rice*, the issue of entitlement to a TDIU prior to February 11, 2016, remained part and parcel of the veteran's underlying PTSD claim and was properly before the Board for adjudication. Once the PTSD claim was in appellate status by virtue of the December 2008 NOD, the issue of entitlement to a TDIU became part of the underlying PTSD claim when he filed an application for a TDIU in February 2014.[173]

The CAVC noted that the facts in the present case were similar to a 2015 nonprecedential decision of the Federal Circuit, *Palmatier v. McDonald*,[174] in which the Federal Circuit held that the issue of entitlement to a TDIU, which was awarded in 2011, was not bifurcated from the veteran's low back disability evaluation appeal, as the veteran's requests for TDIU subsequent to the initial June 2002 filing for the low back claim were part and parcel of the low back disability claim. The 2011 TDIU award was only a partial grant.[175]

Similar to *Palmatier*, in the present case the TDIU issue was not bifurcated from the veteran's PTSD claim. Once the veteran's PTSD claim was in appellate status by virtue of the December 2008 NOD, the TDIU issue became part and parcel of that claim when the veteran filed an application for a TDIU in February 2014. Thus, the TDIU issue was also in appellate status, and because the veteran did not withdraw the TDIU issue from his pending appeal he did not bifurcate his appeal. As in *Palmatier*, the RO's grant of a TDIU in May 2016 did not serve to bifurcate his appeal, but instead served simply to partially grant the request for a TDIU.[176]

The CAVC reversed the portion of the Board's July 2016 decision that found that it lacked jurisdiction over the TDIU issue. The CAVC also set aside that portion of the Board decision that denied an initial disability rating in excess of 50 percent for PTSD prior to December 17, 2015, and remanded the matter for proceedings consistent with its decision.[177]

Moody v. Wilkie

Summarized by Zaheer Maskatia

In *Moody v. Wilkie*, [178] the veteran appealed a decision of the Board denying a rating increase for his low back disability and associated bilateral peripheral neuropathy and a service connection claim for a psychiatric disorder.

The question at issue is whether, pursuant to 38 C.F.R. § 4.16(a),which does not provide express guidance on how to "consider" multiple disabilities "as one disability," the Board must use the Combined Ratings table when considering whether multiple disability ratings meet the schedular threshold for a TDIU.[179]

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173 *Id.* at 359.
174 626 F. App'x 991 (Fed. Cir. 2015).
175 *Harper*, 30 Vet. App. at 360.
176 *Id.*
177 *Id.* at 363.
178 30 Vet. App. 329 (2018).
179 *Id.* at 332.

The Veteran sought a rating in excess of 40 percent for a thoracolumbar spine disorder, ratings in excess of 10 percent for right and left leg neurological impairment, service connection for an acquired psychiatric disorder, and entitlement to a TDIU.[180]

The Veteran filed a claim in 2007 for mental and physical injuries sustained during his active service from February 1973 to June 1974.[181] He also filed a claim for a TDIU.[182]

In service, the veteran was diagnosed with inadequate-type personality and "immature personality, severe, manifested by impulsive judgment and immature decision making and extreme explosive behavior." His 2010 VA psychiatric examiner opined that his current intermittent explosive disorder and personality disorder were a "a continuation of his psychiatric condition noted in service." The RO thus denied entitlement to service connection for a psychiatric disorder.[183]

Regarding his back disorder, the RO awarded a 40 percent rating for thoracolumbar arthritis, and two 10 percent ratings for peripheral neuropathy of the lower extremities. The claim for a TDIU was denied. He filed a timely Notice of Disagreement, and a Statement of the Case (SOC) was issued in April 2012.[184]

At a July 2015 Board hearing, the veteran testified that his low back symptoms had worsened. Specifically, he reported that since his last examination in February 2011, service-connected back pain had impeded his ability to get out of bed, ride his bicycle, and play with his dogs. He also attested to pain on extended standing and sitting, as well as on lateral rotation. Finally, he stated that he now felt severe pain in the legs, especially at night, and that his recent depression diagnosis was brought on by the pain interfering with sleep and other daily functions.[185]

In a January 2016 decision, the Board denied service connection for an acquired psychiatric disability, reasoning that the only in-service psychiatric disability was a personality disorder, which is not eligible for service connection, and that no mental disorder diagnosed in the veteran was superimposed on the veteran's personality disorder. The Board also denied service connection on a secondary basis.[186]

In denying increased ratings for the veteran's thoracolumbar spine disability and bilateral peripheral neuropathy, the Board concluded under *McLendon* that new examinations were not required and that it could rate the veteran's disabilities on the available evidence.[187] In denying a TDIU, the Board combined the veteran's 40 percent, 10 percent, and 10 percent disability ratings using the Combined Ratings table, and reached 50 percent, refuting his argument that the percentages could simply be added together to reach 60 percent for a single disability.[188]

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[180] *Id.* at 333.
[181] *Id.* at 332.
[182] *Id.* at 333.
[183] *Id.* at 332-33.
[184] *Id.*
[185] *Id.* at 333-334.
[186] *Id.* at 334.
[187] *Id.* at 335.
[188] *Id.*

As to the possibility of a schedular TDIU, the CAVC likewise considered the veteran's ratings as one disability arising from a "common etiology or single accident" as directed in 38 C.F.R. § 4.16(a).[189] The CAVC remarked that the purpose of the Combined Ratings table is to capture the true occupational impairment of a veteran disabled by more than one condition.[190] The CAVC also noted the presumption that words not defined in VA regulations employ their ordinary dictionary definitions at the time they were enacted.[191]

Interpreting § 4.16(a) in this light, the CAVC examined the regulatory scheme to determine how the statute should "consider" multiple disability ratings.[192] Finding no help in the ordinary dictionary definition of the word "consider" at the time the regulation was first enacted, the CAVC looked to a recent Federal Circuit decision for guidance. In *Gazelle v. Shulkin* (*Gazelle II*),[193] the Federal Circuit held that a Veteran seeking Special Monthly Compensation (SMC) could not simply mathematically add his disability ratings to reach the required 60 percent threshold, explaining that when 38 U.S.C. § 1114(s) was enacted, Congress was presumed to be aware that the Combined Ratings table was the exclusive method of determining whether a veteran had met the required threshold.[194]

Here, the CAVC applied the same reasoning as the Federal Circuit did in *Gazelle II*. Specifically, it held that because a combined ratings table has been continuously reauthorized by Congress and employed by the VA to aggregate multiple service-connected disabilities, the combined ratings table is "plainly and unambiguously" the only method to combine disabilities to determine whether they met the appropriate threshold for schedular TDIU purposes.[195]

The CAVC elaborated that the "canons of construction" described in Gazelle II apply not only to statutes, but also to regulations, and indeed any legal text.[196] The CAVC then explained that because the purpose of rating a veteran's disability was to compensate for lost earning capacity in a veteran who was operating at less than 100 percent, a veteran's ratings could not be simply added up to a percentage that may be greater than 100 percent.[197]

Despite the rejection of the veteran's method of calculating his combined disability rating, the CAVC vacated the Board's decision and remanded the TDIU, as the issue of whether he met the schedular threshold was inextricably intertwined with other ratings on appeal.[198]

The CAVC also vacated and remanded the Board's decision as to the veteran's claims for increased ratings and service connection. Specifically, the CAVC reviewed the issues under the deferential "arbitrary, capricious, and abuse of discretion, or otherwise not in accordance with law" standard of review.[199] The CAVC determined that the Board's finding that there was no evidence beyond the veteran's "bare assertion" that his depression had its onset due to the pain from his service-connected back disorder and peripheral

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189 *Id.*
190 *Id.* at 336.
191 *Id.*
192 *Id.* at 336-37.
193 868 F.3d. 1006 (Fed. Circ. 2017).
194 *Moody*, 30 Vet. App. at 335-36.
195 *Id.* at 337.
196 *Id.*
197 *Id.* at 38-39.
198 *Id.*
199 *Id*. at 340 (citing *McLendon*, 20 Vet. App. at 83).

neuropathy, clearly erroneous.[200] The CAVC responded by identifying evidence, to include July 2015 hearing testimony and April 2012 and May 2013 medical records, among others supporting the veteran's assertion that his depression onset was a result of his inability to work – or in other words, his TDIU.[201]

The CAVC thus vacated the Board's denial of service connection and remanded the case to the Board to apply all four *McLendon* factors to determine whether an examination is warranted.[202]

The CAVC vacated and remanded the Board's denial of increased ratings due to several ambiguities in the decision. Specifically, the Board did not specify the standard it applied in determining that the veteran was not entitled to another examination to increased ratings for his spine and bilateral foot disabilities.[203] Furthermore, the Board used language that could be interpreted as either requiring a showing that the veteran already meets the criteria for a higher rating before ordering an examination or as a finding that the evidence of record was adequate to decide the claim without another examination.[204] Thus, the CAVC concluded a remand was necessary for the Board to more clearly define its reasons and bases for its decision.[205] Finally, the CAVC noted that the veteran's assertions as to the period of worsening of his disabilities was unclear and needed to be clarified by the Board on remand.[206]

Judges Pietsch and Toth wrote opinions dissenting in part. Judge Pietsch concurred with the CAVC's holding and analysis, except for the portion interpreting the word "consider" in 38 C.F.R. § 4.16(a). Judge Pietsch's dissent reasons that it is unnecessary to interpret the plain meaning of 38 C.F.R. § 4.16(a), given that on remand the veteran will likely meet the threshold anyway. To avoid wasting judicial resources, Judge Pietsch argued, it is more efficient to let the veteran's increased rating claims be decided before interpreting the plain meaning of 38 C.F.R. § 4.16(a).[207] Judge Toth also wrote a partial dissent, objecting to the CAVC's direct evaluation of evidence, rather than deferring to the Board's determinations of the weight of the medical and lay evidence.[208]

Sharp v. Shulkin

Summarized by Sheila Harrell

In *Sharp v. Shulkin*,[209] the veteran appealed a decision of the Board denying evaluations in excess of 10 percent for right and left shoulder, hand, and elbow/forearm disabilities.

The question at issue is whether, in commenting on the extent of disability caused by musculoskeletal disabilities having a history of flare-ups, but which are not shown on physical examination, an examiner must ascertain adequate information—*i.e.*, frequency, duration, characteristics, severity, or functional loss—regarding the flare-ups by alternative means.[210]

200 *Id.*
201 *Id.*
202 *Id.* at 339-40.
203 *Id.* at 342.
204 *Id.*
205 *Id.*
206 *Id.*
207 *Id.* at 342-43 (Pietsch, J. dissenting).
208 *Id.* at 343-44 (Toth, J., dissenting).
209 29 Vet. App. 26 (2017).
210 *Id.* at 34.

The Veteran served on active duty in the United States Army from March 1952 to March 1954, including combat service in Korea. In June 2004, he sought service connection for "arthritis to include bursitis." In August 2005, the RO denied service connection for disabilities of the right and left shoulders, hands, and elbow/forearms. The Veteran timely appealed the RO's decision. The Board subsequently affirmed the RO's decision in June 2008. The Veteran appealed to the CAVC.[211]

In March 2009, the CAVC granted the parties' Joint Motion for Remand in which they agreed that the Board failed to provide sufficient reasons or bases for its conclusions. In August 2009, the Board, in turn, remanded the claims for further development. Pursuant to the remand, the veteran was afforded various VA examinations in May 2010. The VA examiner opined that the veteran's musculoskeletal disabilities were at least as likely as not related to his service. In April 2012, based on the May 2010 opinion, the RO granted service connection for right and left shoulder arthritis, assigning 10 percent evaluations for each. In addition, the RO granted service connection for right and left hand and elbow/forearm conditions, assigning noncompensable evaluations for each. The Veteran disagreed with the evaluations assigned and perfected an appeal to the Board. In November 2014, the Board remanded the claims, ordering that he be afforded another VA examination, with detailed remand instructions for the examiner.[212]

The Veteran ultimately underwent the ordered examinations in September 2015. With respect to each disability, the September 2015 VA examiner documented the veteran's reports of having experienced periodic flare-ups, indicated that the examination was not taking place during a flare-up, and recorded the functional impairment articulated by the veteran during those flare-ups.[213] In September 2015, the RO granted 10 percent evaluations for the right and left elbow/forearm and hand disabilities effective September 8, 2015. However, because the RO decision resulted in less than a total grant of the benefits sought, the matters eventually were appealed and returned to the Board.[214]

In his appeal, the veteran asserted that: (1) the Board clearly erred in accepting the September 2015 examination as adequate, (2) that it clearly erred in finding substantial compliance with the November 2014 remand instructions, and (3) that it also offered inadequate reasons or bases to support its determinations. The veteran argued, most significantly, that the Board's November 2014 remand order mandated the September 2015 VA examiner to offer an estimate of additional functional loss during flare-ups regardless of whether the veteran was undergoing a flare-up at the time of the examination, and that the VA examiner failed to adhere to the remand instructions.[215]

In its ruling, the CAVC held that when conducting evaluations for musculoskeletal disabilities, VA examiners must inquire whether there are periods of flare-ups, and if the response is affirmative, are to state the severity, frequency, and duration of the flare-ups; name the precipitating and alleviating factors; and estimate to what extent, if any, these flare-ups affect functional impairment.[216] The CAVC maintained that whether the VA is obliged to attempt to schedule an examination during a flare-up depends on the specifics of the disability in a particular case.[217] The CAVC also recognized

[211] *Id.* at 29.
[212] *Id.* at 29-30.
[213] *Id.* at 30.
[214] *Id.*
[215] *Id.* at 30-31.
[216] *Id.* at 32.
[217] *Id.*

circumstances in which an examiner's conclusion that an "opinion is not possible without resort to speculation is a medical conclusion just as much as a firm diagnosis or a conclusive [medical] opinion."[218] The CAVC held that the Board failed to provide adequate reasons or bases for its determination that the September 2015 VA examinations were adequate for evaluation purposes and, hence, did not ensure substantial compliance with its November 2014 remand instructions.[219]

In summary, the CAVC ruled that the veteran was correct when he argued that the September 2015 examination was inadequate because the VA examiner, although acknowledging that the veteran was not then suffering from a flare-up of any of his conditions, failed to ascertain adequate information—*i.e.*, frequency, duration, characteristics, severity, or functional loss—regarding his flare-ups by alternative means. Because the VA examiner did not elicit relevant information as to the veteran's flare-ups or ask him to describe the additional functional loss, if any, he suffered during the flare-ups and then estimate the veteran's functional loss due to flare-ups based on all of the evidence of record, the September 2015 examination was inadequate for evaluation purposes and the Board's finding to the contrary was clearly erroneous.[220] Because the record was not adequate to permit the Board to decide the veteran's claims in excess of 10 percent for right and left shoulder, hand, and elbow/forearm disabilities, the CAVC set aside the March 2016 decision and remanded the matters, ordering the Board to obtain another VA medical examination and opinion that both adequately addressed additional functional loss, if any, experienced during flare-ups and substantially complied with the Board's November 2014 remand orders.[221]

Withers v. Wilkie

Summarized by Philip Yoffee

In *Withers v. Wilkie*,[222] the veteran appealed a decision by the Board denying a TDIU.

The question at issue is the meaning of the phrase "sedentary work" and its application in the context of TDIU determinations.[223]

The Veteran's service-connected disabilities included GSW residuals of the right arm, leg and lower back disabilities, and PTSD. These caused both physical limitations and psychological issues. Prior to his termination in 2004, he worked as an office manager for many years.[224]

The Board denied a TDIU in 2016, relying upon findings of multiple VA examiners that the veteran could undertake limited or sedentary employment and that his education (college degree) and work history showed he could perform sedentary or light work.[225] The CAVC opinion reported that the Board did not explain the connection between the phrase "sedentary employment" and the evidence of record in its decision.[226]

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[218] *Id.* at 32-33 (citing Jones v. Shinseki, 23 Vet. App. 382 (2010)).
[219] *Id.* at 33-35 (citing Donnellan v. Shinseki, 24 Vet. App. 167, 176 (2010); Dyment v. West, 13 Vet. App. 141, 147 (1999); Stegall v. West, 11 Vet. App. 268, 271 (1998)).
[220] *Id.* at 34-35 (citing D'Aries v. Peake, 22 Vet. App. 104 (2008); Stefl v. Nicholson, 21 Vet App. 123 (2007); Mitchell v. Shinseki, 25 Vet. App. 44 (2011); Deluca v. Brown, 8 Vet. App. 206-07 (1995)).
[221] *Id.* at 36.
[222] 30 Vet. App. 139 (2018).
[223] *Id.* at 142.
[224] *Id.*
[225] *Id.* at 143-44.
[226] *Id.* at 142.

On appeal to the CAVC, the veteran argued that the Board should use an objective standard in order to define sedentary employment. The Veteran argued that the Board should use the Social Security Administration's definition or explain why this definition was not persuasive in determining whether a veteran is capable of sedentary work. The VA argued for use of the ordinary meaning of sedentary, *i.e.*, employment marked by or requiring much sitting, and that the CAVC should presume this was how the Board understood and used the term.[227]

The CAVC did not adopt either definition and instead found that the term sedentary employment has no independent legal significance.[228] The CAVC noted that the term sedentary employment is not defined in any pertinent regulation or statute.[229] If the Board bases a denial of a TDIU on the conclusion by a VA examiner that a veteran can undertake sedentary work, the Board must show that this finding is supported by the medical evidence of record as a whole.[230] Further, "[t]he Board must explain this meaning . . . as well as how the concept of sedentary work factors into the veteran's overall disability picture and vocational history, and the veteran's ability to secure or follow a substantially gainful occupation."[231] Therefore, if a VA examiner describes functional limits and finds a veteran is capable of sedentary work, the Board may determine whether, in each individual case, "a common-sense inference can be drawn that the concept of sedentary work, as understood by the examiner," includes acts that a veteran is capable of performing.[232]

The CAVC vacated the Board decision and remanded the matter for the Board to readjudicate the claim with adequate reasons and bases in line with the opinion of the CAVC.[233]

IV. NEW AND MATERIAL EVIDENCE (NME)

Turner v. Shulkin

Summarized by Grace Raftery

In *Turner v. Shulkin*,[234] the veteran appealed a decision of the Board denying reopening of finding that the veteran had failed to submit new and material evidence to reopen a previously denied claim of entitlement to service connection for epilepsy.

The question at issue is the extent to which VA treatment records may be "received" constructively under 38 C.F.R. § 3.156(b), such that the requirements of that regulatory provision are triggered.[235]

The Veteran's claim of entitlement to service connection for epilepsy was initially denied in February 2006.[236] In July 2006, he submitted a claim of entitlement to service connection for PTSD and

227 *Id.* at 145.
228 *Id.* at 142.
229 *Id.*
230 *Id.* at 148.
231 *Id.* at 147.
232 *Id.* at 147-48.
233 *Id.* at 149.
234 29 Vet. App. 207 (2018).
235 *Id.* at 209.
236 *Id.* at 210.

epilepsy seizures.[237] In August 2006, the VA sent him a letter informing him that new and material evidence was needed to reopen his claim, given the February 2006 denial.[238] There is no indication he replied to the letter.[239]

Meanwhile, the veteran continued to receive VA treatment for PTSD.[240] In October 2007, VA treatment records were added to his claims file in connection with his PTSD claim.[241] This evidence included a June 2006 record noting that his PTSD and depression were "intertwined with his epilepsy."[242] The Veteran submitted a new claim for service connection for epilepsy in June 2010.[243] The RO reopened the claim but denied it on the merits.[244] He disagreed and initiated an appeal.[245]

In a January 2016 decision, the Board denied the veteran's claim to reopen, finding that evidence added to the record since the final February 2006 decision did not relate to "the unestablished facts as to whether his epilepsy permanently worsened as a result of service."[246] The Veteran appealed the matter to the CAVC.[247]

The Veteran argued that the Board erred in finding that new and material evidence had not been received to reopen the previously denied claim of entitlement to service connection for epilepsy.[248] He contended that the VA constructively received VA treatment records created within a year of the February 2006 rating decision and therefore erred when it failed to consider them.[249] Alternatively, he argued that evidence received after the February 2006 denial became final was new and material to reopen the claim.[250]

The Secretary conceded that remand was warranted for the Board to provide an adequate statement of reasons or bases that addressed the June 2006 treatment records suggesting the veteran's PTSD and epilepsy were intertwined.[251] However, the Secretary argued that the medical records had not been received until October 2007, after the one-year period had ended.[252] He also contended that constructive receipt did not apply in the context of 38 C.F.R. § 3.156(b) because the plain language of the regulation required actual receipt of new and material evidence within the one-year period.[253] The Secretary further argued that applying constructive receipt in this context would impose a significant burden on the VA by requiring it to constantly review VA treatment records every time a claim is adjudicated to determine whether readjudication was warranted.[254]

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237 *Id.*
238 *Id.*
239 *Id.*
240 *Id.*
241 *Id.*
242 *Id.*
243 *Id.*
244 *Id.*
245 *Id.*
246 *Id.* at 210-11.
247 *Id.* at 211.
248 *Id.*
249 *Id.*
250 *Id.* at 211-12.
251 *Id.* at 212.
252 *Id.*
253 *Id.*
254 *Id.*

Ultimately, the CAVC held that actual receipt is not required, and that VA treatment records may be "received" constructively under 38 C.F.R. § 3.156(b).[255] The CAVC explained that to be constructively received, the records must have been generated by a VA medical facility, and VA adjudicators must have "sufficient knowledge, within the one-year appeal period following an RO decision, that the records exist, although they need not know the contents of such records."[256] The CAVC noted that constructive receipt is not dependent on the relevance of the documents to the claim.[257] The CAVC also noted that the only limitation on the DTA is provided by 38 C.F.R. § 3.159(c); that is, the VA will refrain from obtaining evidence "if there is no reasonable possibility that any assistance the VA would provide to the claimant would substantiate the claim."[258]

The CAVC also stated that the question of what level of knowledge is required to trigger constructive receipt is a factual determination for the Board to address.[259] The CAVC highlighted 38 U.S.C. § 5103A(c)(1)(B) and 38 C.F.R. § 3.159(c), as well as the Federal Circuit's ruling in *Sullivan v. McDonald*, as "useful guideposts" for making a constructive receipt determination.[260] The CAVC cautioned that a determination that constructive receipt applies in a particular case does not automatically mean that the claimant is granted benefits; just that the VA must make a determination as to whether the evidence is new and material.[261]

Applying its holding to the instant case, the CAVC concluded that the veteran provided the RO with sufficient knowledge of the existence of VA treatment records within one year of the rating decision at issue, such that those records were "constructively received."[262] The CAVC found that this triggered the VA's obligation to comply with the requirements of § 3.156(b); therefore, the CAVC set aside the January 2016 Board decision and remanded the matter for the VA to comply with its duties under 38 C.F.R. § 3.156(b).[263]

V. CLEAR AND UNMISTAKABLE ERROR

Simmons v. Wilkie

Summarized by Sheila Harrell

In *Simmons v. Wilkie*,[264] the veteran appealed a decision of the Board finding that a September 1974 RO rating decision denying service connection for an acquired psychiatric disorder did not contain clear and unmistakable error (CUE).

The question at issue is whether failure of the adjudicator to apply statutory presumptions is automatically CUE.[265]

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255 *Id.* at 210.
256 *Id.*
257 *Id.* at 218.
258 *Id.* (quoting Sullivan v. McDonald, 815 F.3d 786, 792 (Fed. Cir. 2016);, 38 C.F.R. § 3.159(c) (2018)).
259 *Id.*
260 *Id.* at 218-19.
261 *Id.* at 219.
262 *Id.* at 220.
263 *Id.*
264 30 Vet. App. 267 (2018).
265 *Id.* at 271.

The CAVC ruled that the errors committed by the Board did not either prevent the veteran from participating in the processing of his CUE motion or did not affect the overall fairness of the adjudicative process. Consequently, the CAVC concluded that the Board's errors did not affect its ultimate determination that there was not CUE in the September 1974 RO decision denying service connection for an acquired psychiatric disorder and posited that even if it had not made those errors, the Board would still not have found CUE in the September 1974 RO decision.[266]

When a prior final RO or Board decision contains CUE, that decision may be reversed or revised, resulting in correction of the error effective the date of its commission.[267] CUE is established when the following factors are present: (1) Either the correct facts as they were known at the time were not before the adjudicator, the adjudicator made an erroneous factual finding, or the statutory or regulatory provisions extant at the time were incorrectly applied; (2) the alleged error is "undebatable" not merely a "disagreement as to how the facts were weighed or evaluated"; and (3) the error "manifestly changed the outcome" of the prior decision.[268]

The veteran argues that the Board made clear errors of law as to 38 U.S.C. §§ 105(a) and 1111 (formerly 38 U.S.C. § 311 (1970)) when it determined there was no CUE in the RO's failure to apply the presumptions of service incurrence and soundness. The veteran argues, consistent with evidence that was in existence in 1974, that the Board made favorable findings of fact regarding his in-service diagnosis of an acquired psychiatric disability not noted upon service entry, and therefore the Board should have found that the RO erred in 1974 in not affording him the presumptions under §§ 105(a) and 1111.[269]

The veteran served on active duty in the United States Navy from November 1968 to January 1970. His entry examination makes no mention of psychiatric issues or disorders. However, in April 1969, he was hospitalized for two days for psychiatric observation. The service clinician provided diagnostic impressions of "depressive reaction" and "attempted suicide." The hospital discharge summary noted that the veteran had a "long history of nerve problems [with] several episodes of 'home sickness' and depression since coming aboard [the ship] in November [1968]." The Veteran was later diagnosed with "situational depression." For the duration of his military career he was diagnosed with various psychiatric disorders. The service clinician recommended an administrative discharge due to unsuitability. However, the veteran's separation examination report reflects a normal clinical examination with no psychiatric symptoms noted.[270]

In June 1974, the veteran requested disability compensation for rheumatoid arthritis as he believed that there was a reasonable presumption that his rheumatoid arthritis was manifested as a direct result of his mental depression in service, which ultimately culminated in his administrative discharge. His private physician produced a positive nexus statement.[271]

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[266] *Id.* at 285.
[267] *Id.* at 274 (citing 38 U.S.C. §§ 5109A, 7111); *see* DiCarlo v. Nicholson, 20 Vet. App. 52, 54-58 (2006); 38 C.F.R. §§ 3.105, 20.1400-1411 (2018).
[268] *Id.* at 274 (citing Russell v. Principi, 3 Vet. App. 310, 313-14, 319 (1992)); *see* King v. Shinseki, 26 Vet. App. 433, 439 (2014); Bouton v. Peake, 23 Vet. App. 70, 71-72 (2008); Demrel v. Brown, 6 Vet. App. 242, 245 (1994); *see also* Bustos v. West, 1979 F.3d 1378, 1380-81 (Fed. Cir. 1999).
[269] *Id.* at 275.
[270] *Id.* at 271-72.
[271] *Id.* at 272.

In September 1974, the RO denied service connection for the rheumatoid arthritis and nervous condition, stating that it found no evidence that he had experienced arthritis during service or within one year of service. Likewise, the RO found that the veteran had experienced no chronic neurosis during service and noted that he was administratively discharged due to "immature personality disorder." The RO concluded that neither the arthritic condition nor the anxiety reaction was incurred during service, and that the currently diagnosed anxiety reaction was not related to the immature personality disorder that resulted in his separation.[272]

In December 2005, the veteran filed a CUE claim as to the September 1974 RO decision that denied service connection for rheumatoid arthritis and a nervous condition with depressive features. In March 2015, the Board determined that the September 1974 RO decision was subsumed by the February 1991 adverse Board decision, and, therefore, was not subject to a CUE challenge. The Veteran appealed to the CAVC. In a 2016 Joint Motion for Remand, the parties agreed that readjudication was necessary because the Board erred in finding that the February 1991 Board decision subsumed the September 1974 RO decision. This was so since the February 1991 decision did not involve a de novo review of the same issue before the RO in 1974.[273]

In the May 2016 decision on appeal, the Board found no CUE in the September 1974 RO decision. The Board specifically reasoned that neither the presumption of soundness nor the presumption of service connection applied.[274]

The CAVC found that the Board erred as a matter of law when it concluded that the RO in 1974 need not have considered the presumptions found in sections 105(a) and 1111. It also explained that merely finding an error is not enough for the veteran to prevail. The CAVC noted that it was statutorily required to consider whether those errors prejudiced him.[275]

The CAVC ruled that although the Board erred in its analysis of whether the presumptions of soundness and service incurrence applied in 1974, its error neither affected a substantial right that disrupted the fundamental fairness of the adjudication nor affected its ultimate determination. Because even with correction of its error with regard to sections 1111 and 105(a), the Board could not have found CUE in the September 1974 decision, the Board's error is harmless.[276] The CAVC subsequently affirmed the May 2016 Board decision.[277]

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[272] *Id.* at 272-73.
[273] *Id.* at 273.
[274] *Id.* at 274.
[275] *Id.* at 277.
[276] *Id.* at 286 (citing Shinseki v. Sanders*,* 556 U.S. 396, 411-412 (2010); Vogan v. Shinseki*,* 24 Vet. App. 159, 163 (2010)).
[277] *Id.* at 286.

VI. OTHER CONSIDERATIONS

Harvey v. Shulkin

Summarized by Marcella Coyne

In *Harvey v. Shulkin*,[278] the veteran appealed a decision of the Board denying service connection for obstructive sleep apnea and a petition to reopen a claim of entitlement to service connection for tinnitus.

The question at issue is whether the Board was required to address part of a legal brief submitted by the veteran's VA-accredited representative, who is both an attorney and a medical doctor, on the basis that it constituted a medical opinion.[279]

The Veteran sought entitlement to service connection for obstructive sleep apnea to include as secondary to his service-connected psychiatric disability and reopening of his service connection claim for tinnitus.[280]

In support of a nexus for the obstructive sleep apnea claim, the veteran's attorney submitted a December 2014 document in which he identified himself as both a "J.D." and an "M.D." on both his letterhead and his signature block. The header of the document indicated it was an "appeal brief" and the text of the document contained a discussion of favorable evidence and legal argument in support of a higher rating for depressive disorder to include citation to case law.[281] The December 2014 submission also discussed the veteran's diagnosis of obstructive sleep apnea and stated that "[t]he veteran's sleep apnea is more likely than not secondary to his service-connected MDD/PTSD," citing a medical article that stated that recent evidence suggested that the increased incidence of sleep disturbances among redeployed military personnel is potentially related to various mental health disorders, and included footnote citations to numerous other scholarly articles.[282] Finally, the submission discussed excerpts from an Institute of Medicine Report relevant to the veteran's tinnitus claim and concluded by requesting a grant of all three claims.[283]

In a January 2016 decision, the Board denied service connection for obstructive sleep apnea to include as secondary to service-connected depressive disorder based on a lack of medical nexus, and in doing so specifically addressed the medical article discussed in the December 2014 submission as supporting only correlation between sleep apnea and PTSD, rather than causation and found it unpersuasive on this basis.[284]

On appeal to the CAVC the veteran argued that the Board failed to address a positive nexus opinion provided by his attorney-physician representative in the December 2014 submission in support of his service connection claim for sleep apnea, and that the Board erroneously relied on its own medical judgment when it determined that the medical article in the December 2014 submission addressed only correlation.[285]

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278 30 Vet. App. 10 (2018).
279 *Id.* at 12.
280 *Id.*
281 *Id.* at 13.
282 *Id.*
283 *Id.* at 14.
284 *Id.*
285 *Id.*

The CAVC found that the December 2014 submission did not constitute a medical opinion. In doing so, the CAVC explained that such determinations must be made on a case-by-case basis, and that in this case the CAVC had concluded that December 2014 submission did not include a "discernable" medical opinion. The CAVC further explained that its conclusion was based "on the text of the submission and the indicators of legal advocacy and legal argument therein," and "the absence of indicators that [the veteran's representative] was acting in the role of a medical expert" to include the "lack of an identifiable medical opinion containing medical judgment and rationale."[286]

The CAVC also commented on the implications of Rule 3.7 of the Model Rules of Professional Conduct, which prohibits an attorney from acting both as a witness and a representative for a client, and its potential application to adjudication before the Board.[287]

As to the veteran's argument that the Board erroneously relied on its own medical judgment, the CAVC found no error, noting that it is within the Board, as factfinder may interpret a medical treatise's meaning and assess its probative value as evidence.[288]

[286] *Id.* at 17.
[287] *Id.* at 17-19.
[288] *Id.* at 20.