IN THE APPEAL OF
TIMOTHY S. HAVILAND

DOCKET NO. 10-25 840 ) DATE 26 FEB 2014

On appeal from the
Department of Veterans Affairs Regional Office in St. Louis, Missouri

THE ISSUES

1. Whether new and material evidence was received to reopen a claim for service connection for right eye hemifacial spasm, blepharospasm on a direct basis.

2. Whether new and material evidence was received to reopen a claim for service connection for headaches on a direct basis.

3. Whether new and material evidence was received to reopen a claim for service connection for a sleep disorder on a direct basis.

4. Entitlement to service connection for right eye hemifacial spasm, blepharospasm, claimed as secondary to service-connected posttraumatic stress disorder, and if reopened, on a direct basis.

5. Entitlement to service connection for headaches, claimed as secondary to service-connected posttraumatic stress disorder, and if reopened, on a direct basis.

6. Entitlement to service connection for a sleep disorder, claimed as secondary to service-connected posttraumatic stress disorder, and if reopened, on a direct basis.
7. Entitlement to a higher evaluation for PTSD, to include whether reduction of the disability rating for PTSD from 70 percent to 30 percent, effective from April 1, 2010, was proper.

8. Entitlement to a total disability rating based on individual unemployability due to service-connected disabilities (TDIU).

REPRESENTATION

Appellant represented by:  John Stevens Berry, Attorney

ATTORNEY FOR THE BOARD

D.S. Lee, Counsel

INTRODUCTION

The Veteran served on active duty from April 1987 through May 1991, to include service in Southwest Asia from December 1990 through April 1991.

This matter comes before the Board of Veterans’ Appeals (Board) on appeal from rating decisions issued in September 2009 and January 2010 by the Department of Veterans Affairs (VA) Regional Office (RO) in St. Louis, Missouri.

In the September 2009 rating decision, the RO declined to reopen the Veteran’s claims for direct service connection for right eye hemifacial spasm, blepharospasm; headaches; gastrointestinal problems; fibromyalgia; and sleep disorder. The RO also denied service connection for those disabilities on the newly raised theory that they were incurred secondary to the Veteran’s service-connected PTSD. The
Veteran’s claim for a TDIU was also denied. Subsequently, the Veteran perfected timely appeals as to these issues.

In the September 2009 rating decision, the RO also proposed a reduction of the disability rating assigned for the Veteran’s PTSD from 70 percent to 30 percent. In a subsequent January 2010 rating decision, the RO effectuated the proposed reduction, effective from April 1, 2010. The Veteran has also perfected a timely appeal of this issue.

The Board notes that the Veteran’s appeal also initially included the issues of entitlement to service connection for fibromyalgia and irritable bowel syndrome and a total disability rating based on individual unemployability due to service-connected disabilities (TDIU). Nonetheless, in March 2013, the Veteran wrote VA to notify it that he wished to withdraw his claim for a TDIU. In a December 2013 rating decision, the St. Louis RO granted service connection for fibromyalgia and irritable bowel syndrome, effective from September 29, 2008, with initial disability ratings of 40 percent and 10 percent respectively. In view of the foregoing, these issues do not remain on appeal before the Board.

Having determined below that new and material evidence has been received to warrant reopening the Veteran’s claim, the issue of the Veteran’s entitlement to service connection for right eye hemifacial spasm, blepharospasm on both a direct and secondary basis is addressed in the REMAND portion of the decision below and is REMANDED to the RO via the Appeals Management Center (AMC), in Washington, DC.

FINDINGS OF FACT

1. In a March 2013 letter, the Veteran advised that he wished to withdraw his appeal of the RO’s denial of a TDIU.

2. A June 2007 rating decision denied the Veteran’s claims for service connection on a direct basis for headaches, neurological problems associated with his right eye,
and sleep disturbance; notice of that decision was mailed to the Veteran on June 11, 2007; and the Veteran did not subsequently perfect a timely appeal of that decision.

3. The Veteran's current request to reopen his claims for service connection for headaches, right eye hemifacial spasm and blepharospasm, and sleep disorder were received in September 2008.

4. The evidence associated with the claims file since the RO's June 2007 rating decision, when considered with the evidence previously of record, relates to the previously unestablished questions of whether the Veteran has current headaches, right eye hemifacial spasm and blepharospasm, and sleep apnea; whether these disorders were incurred during or are related to his active duty service; and moreover, raises a reasonable possibility of substantiating the Veteran's claims on a direct basis.

5. The Veteran’s sleep apnea has not been shown as having been incurred during, caused by, or aggravated by the Veteran’s active duty service or by any of his service-connected disabilities.


7. A September 2009 rating decision proposed a reduction of the disability rating for the Veteran’s PTSD from 70 percent to 30 percent.

8. A January 2010 rating decision effectuated the proposed reduction for PTSD from 70 percent to 30 percent, effective April 1, 2010.

9. The RO complied with the procedural requirements under 38 C.F.R. § 3.105(e) for effectuating rating reductions.

10. The evidence following the assignment of the pre-reduction 70 percent initial disability rating for PTSD shows improvement of the Veteran’s PTSD symptoms.
11. For all periods relevant to this appeal, the Veteran’s PTSD was manifested by a degree of occupational and social impairment with an occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks; occupational and social impairment with reduced reliability and productivity, deficiencies in most areas, or total occupational and social impairment is not shown.

CONCLUSIONS OF LAW


2. The additional evidence associated with the claims file since the RO's final June 2007 decision is new and material, and the Veteran's claims for service connection for headaches, right eye hemifacial spasm and blepharospasm, and sleep apnea on a direct basis are reopened. 38 U.S.C.A. § 5108 (West 2002); 38 C.F.R. § 3.156(a) (2013).


Upon receipt of a complete or substantially complete application for benefits, VA is required to notify the claimant and his or her representative, if any, of any information, and any medical evidence or lay evidence that is necessary to substantiate the claim. 38 U.S.C.A. § 5103(a); 38 C.F.R. § 3.159(b); see also Quartuccio v. Principi, 16 Vet. App. 183 (2002). In accordance with 38 C.F.R. § 3.159(b)(1), proper notice must inform the claimant of any information and evidence not of record (1) that is necessary to substantiate the claim; (2) that VA will seek to provide; and (3) that the claimant is expected to provide.

VA’s notice requirements apply to all five elements of a service-connection claim: veteran status, existence of a disability, a connection between a veteran's service and the disability, degree of disability, and effective date of the disability. Dingess v. Nicholson, 19 Vet. App. 473 (2006). In rating cases, a claimant must be provided with information pertaining to assignment of disability ratings (to include the rating criteria for all higher ratings for a disability), as well as information regarding the effective date that may be assigned. Id. Such notice should be provided to a claimant before the initial unfavorable decision on a claim. Pelegrini v. Principi, 18 Vet. App. 112 (2004).

The Board has considered whether the foregoing notice requirements have been met in relation to the Veteran’s requests to reopen previous claims for service connection of right eye hemifacial spasm and blepharospasm, headaches, and sleep disorder. However, given the favorable actions taken below as to the claims to reopen, no further notification or assistance in developing the facts pertinent to those matters is required at this time. Indeed, any such action would result only in delay.
In relation to the issue concerning the propriety of the reduction of the Veteran’s PTSD rating, the Board notes that the appeal on that issue stems from disagreement with 38 C.F.R. § 3.105(e) reductions and is not based on a claim or application for benefits. As discussed more fully below, the regulations pertaining to the reduction of evaluations for compensation contain their own notification and due process requirements. See 38 C.F.R. § 3.105(e), (i). For this reason, the Board concludes that the VCAA does not apply to the claim regarding the propriety of reducing the Veteran's PTSD disability rating decided herein.

The Board has also considered whether VA has fulfilled the foregoing notice requirements in relation to the Veteran’s claim for service connection for a sleep disorder, to include sleep apnea. In that regard, a June 2009 pre-rating letter notified the Veteran of the information and evidence needed to substantiate his claim for service connection for a sleep disorder. Consistent with Dingess, this letter also notified the Veteran of the process by which a disability rating and an effective date are assigned. Thus, because the VCAA notice concerning the issue of service connection for a sleep disorder was legally sufficient, VA's duty to notify as to that issue has been satisfied.

In addition, VA has fulfilled its duty to assist in obtaining identified and available evidence needed to substantiate the Veteran's claim for service connection for a sleep disorder. His claims submissions, lay statements, service treatment records, VA treatment records, and social security records have been associated with the record. A VA examination to determine the nature and etiology of his claimed sleep disorder were performed in August 2012. In November 2013, a supplemental record review and opinion was also obtained to further explore the question of the cause and origin of the Veteran’s sleep disorder. The reports from these opinions reflect that the examiners reviewed the Veteran's past medical history, recorded his current complaints, and conducted an appropriate evaluation of the Veteran. These reports include findings and explanations that are sufficient to allow the Board to make all determinations necessary for adjudicating the Veteran’s service connection claim. Thus, the Board concludes that the August 2012 examination and November 2013 opinion are adequate for purposes of rendering a decision in the instant appeal.
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Overall, there is no evidence of any VA error in notifying or assisting the Veteran that reasonably affects the fairness of this adjudication.

I. TDIU Withdrawal

An appeal consists of a timely filed Notice of Disagreement in writing, and after a Statement of the Case has been furnished, a timely filed substantive appeal. See 38 U.S.C.A. § 7105(a) (West 2002); 38 C.F.R. § 20.200 (2013). A substantive appeal may be withdrawn in writing at any time before the Board promulgates a decision. See 38 C.F.R. §§ 20.202, 20.204(b) (2013). Except for appeals withdrawn on the record at a hearing, appeal withdrawals must be in writing. See 38 C.F.R. § 20.204(b) (2013).

In September 2007, VA received the Veteran’s formal application for a TDIU. This claim was denied in the St. Louis RO’s September 2009 rating decision. Although the Veteran perfected an appeal as to this denial by filing a timely Notice of Disagreement and substantive appeal, he informed the Board in a March 2013 letter that he wished to withdraw his appeal concerning TDIU. The Board finds that the March 2013 letter qualifies as a valid withdrawal. See 38 C.F.R. § 20.204.

Under the circumstances, there remains no allegation of error of fact or law for appellate consideration as to the issue of the Veteran’s entitlement to a TDIU. As such, the Veteran's appeal as to that issue is dismissed.

II. Claims to Reopen

The Veteran’s original claims for service connection for various undiagnosed illnesses, to include headaches, neurological problems associated with his right eye, and sleep disruption were received in July 2006. These claims were denied by the RO in Phoenix, Arizona in a June 2007 rating decision. As basis for its denials, the RO determined that the evidence available at that time did not indicate any
etiological relationship between the Veteran’s claimed headaches and right eye neurological problems. Regarding the Veteran’s sleep disruption, the RO also determined that the evidence did not indicate any treatment or diagnoses pertinent to the Veteran’s claimed sleep disorder. The Veteran did not appeal this decision; hence, the June 2007 rating decision is final. 38 U.S.C.A. § 7105(c).

Generally, a final rating decision or Board decision may not be reopened and allowed, and a claim based on the same factual analysis may not be considered. 38 U.S.C.A. §§ 7104, 7105. Under 38 U.S.C.A. § 5108 however, "[i]f new and material evidence is presented or secured with respect to a claim which has been disallowed, the Secretary shall reopen the claim and review the former disposition of the claim."

Under 38 C.F.R. § 3.156(a), "new and material evidence" means evidence not previously submitted to agency decisionmakers which, by itself or in connection with evidence previously included in the record, "relates to an unestablished fact necessary to substantiate the claim." Such evidence must also "raise a reasonable possibility of substantiating the claim."

For the purpose of establishing whether new and material evidence has been submitted, the credibility of the evidence, although not its weight, is to be presumed. Justus v. Principi, 3 Vet. App. 510, 513 (1992).

The evidentiary record at the time of the Phoenix RO’s final June 2007 decision consisted of the Veteran’s service treatment records, VA treatment records dated from June 2005 through January 2007, an April 2007 VA psychiatric examination report, copy of a handwritten statement from the Veteran to Dr. J.M., and lay assertions stated in his July 2006 claim. Since that time, the claims file has been augmented by additional arguments expressed in the Veteran’s claims submissions, VA treatment records dated through October 2013, social security records, employment information, and reports from VA examinations performed in April 2007, August 2009, November 2009, May 2010, May 2012, August 2012, and November 2013.
The Veteran's current request to reopen his claims for service connection for headaches, right eye hemifacial spasms and blepharospasm, and sleep disorder were received in September 2008. In support of this request, the Veteran also asserted theories of entitlement for secondary service connection for each of these disabilities, asserting that each resulted from his service-connected PTSD.

The Board notes that the additional evidence received since the final June 2007 rating decision includes VA treatment records dated from July 2006 through October 2013 which reflect ongoing diagnoses of hemifacial spasms, chronic headaches, and sleep apnea. In medical histories provided by the Veteran during VA treatment, the Veteran alleges that his hemifacial spasms and headaches began after his service in Southwest Asia. Indeed, service treatment and personnel records show that the Veteran did serve in Saudi Arabia during Operation Desert Storm and Desert Shield, from December 1990 through April 1991. In reference to his claimed sleep apnea, the Veteran suggests in the medical history reported during an August 2012 VA examination that his sleep apnea “probably began during his active duty service.

Overall, the current evidentiary record appears to raise the possibility that the Veteran’s claimed headaches, hemifacial spasms, and sleep apnea are related to the Veteran’s active duty service. Hence, the Board finds that new and material evidence pertinent to the Veteran’s claims for direct service connection has been received. Accordingly, the Veteran's claims for service connection for headaches, hemifacial spasms and blepharospasms, and sleep apnea, each on a direct basis, are reopened. This claim will next be addressed by the Board on a de novo basis, an action that will not prejudice the Veteran in light of the ultimate outcome. See Bernard v. Brown, 4 Vet. App. 384, 394 (1993).

II. Service Connection for a Sleep Disorder

Service connection will be granted if the evidence demonstrates that a current disability resulted from an injury or disease incurred in or aggravated by active military service. 38 U.S.C.A. § 1110; 38 C.F.R. § 3.303(a). Establishing service connection generally requires competent evidence of three things: (1) a current
disability; (2) in-service incurrence or aggravation of a disease or injury; and (3) a causal relationship, i.e., a nexus, between the claimed in-service disease or injury and the current disability. Holton v. Shinseki, 557 F.3d 1362, 1366 (Fed. Cir. 2009); 38 C.F.R. § 3.303(a).

Service connection may also be granted for a disease first diagnosed after discharge when all of the evidence, including that pertinent to service, establishes that the disease was incurred in service. 38 C.F.R. § 3.303(d). Service connection may also be established for disability which is proximately due to or the result of a service-connected disability. 38 C.F.R. § 3.310(a). Further, a disability which is aggravated by a service-connected disability may be service-connected to the degree that the aggravation is shown. 38 C.F.R. § 3.310; Allen v. Brown, 7 Vet. App. 439 (1995).

In determining whether service connection is warranted for a disability, VA is responsible for determining whether the evidence supports the claim or is in relative equipoise, with the veteran prevailing in either event, or whether a preponderance of the evidence is against the claim, in which case the claim is denied. Gilbert v. Derwinski, 1 Vet. App. 49 (1990); 38 U.S.C.A. § 5107(b).

Regarding his claim for service connection for sleep apnea, the Veteran alleged in his September 2008 claim that he snored and felt constantly tired. In his October 2009 Notice of Disagreement, he asserted further that his sleep apnea is related to his service-connected PTSD.

The Veteran’s service treatment records are entirely silent for any reported sleep disturbances. In that regard, the Veteran did not report any pre-service history of sleep problems during his April 1986 enlistment examination. Similarly, he did not report any in-service history of sleep problems during his March 1991 separation examination. Physical examinations performed at the time of the Veteran’s enlistment and separation were grossly normal and were not indicative of any findings suggestive of sleep apnea or other sleep problems.
VA treatment records from April 2007 reference reported sleep problems; however, these complaints appear to be attributable to the Veteran’s service-connected PTSD. Indeed, subsequent VA treatment records through October 2013 show that sleep disturbances marked by frequent awakenings and recurring nightmares were a chronic manifestation of the Veteran’s PTSD. There is no indication in these records that these sleep disturbances are manifestation of a disability other than PTSD.

Concurrently, VA treatment records from March 2010 note complaints by the Veteran and his spouse that he was snoring and had restless sleep. At that time, he was diagnosed with sleep apnea. The subsequent VA treatment records through October 2013 show that the Veteran managed his sleep apnea with the use of a CPAP machine.

During an August 2012 VA examination, the Veteran reported that he snored and experienced daytime fatigue. Although the Veteran asserted that these symptoms “probably” began during service, he was unable to state with any greater specificity when these symptoms began. The examiner provided an obstructive sleep apnea diagnosis, but determined that it was impossible, without resort to mere speculation, to determine whether the Veteran’s sleep apnea had its onset during active duty.

In November 2013, VA sought a claims file review and opinion as to whether the Veteran’s sleep apnea was related to his active duty service or to his service-connected disabilities. Following review of the claims file, the designated VA physician opined that the Veteran’s sleep apnea is not proximately due to or the result of PTSD. As rationale, the examiner noted that there are two types of sleep apnea: obstructive sleep apnea and central sleep apnea. Explained further that obstructive sleep apnea is caused by the relaxation of throat muscles which result in obstruction of respiration. The examiner noted that risk factors for obstructive sleep apnea include obesity; having a neck circumference greater than 18 inches; having a narrowed airway; being male; being of older age; family history; race; smoking; use of alcohol, sedatives, or tranquilizers; and nasal congestion. The examiner explained further that central sleep apnea is caused by the brain failing to send proper signals to the muscles which control breathing. According to the examiner,
identified risk factors for central sleep apnea include being male; being of older age; and having a history of a heart disorder, stroke, or brain tumor. Notably, the examiner pointed out sleep apnea is a condition with a clear and specific etiology and with no known connection to exposure to environmental hazards in Southwest Asia.

The examiner opined further that the Veteran’s PTSD did not aggravate his sleep apnea beyond its normal progression. In that regard, the examiner noted that nightmares and sleeplessness attributable to PTSD may work in conjunction with sleep apnea to produce more fatigue, but does not in and of itself worsen the severity of the sleep apnea. Despite the definitively stated opinion above, the examiner states later in his opinion that, “[i]t would be speculative to assume that the Veteran’s sleep apnea has been aggravated by his PTSD.” Nonetheless, in view of the earlier definitive opinion and rationale given by the examiner, the Board is of the opinion that a plain contextual reading of the examiner’s entire opinion shows that the examiner did not feel that it is at least as likely as not that the Veteran’s sleep apnea was aggravated by his PTSD. Rather, the examiner felt that any conclusion that the Veteran’s sleep apnea was aggravated by his PTSD would be speculative at best, given the foregoing rationale and the evidence in this case.

Overall, the evidence shows that the Veteran does have current obstructive sleep apnea; however, it does not show that the Veteran’s sleep apnea began during his active duty service or that it was incurred as a result of or aggravated by an in-service injury or illness or presently service-connected disability. Accordingly, service connection for sleep apnea, either on a direct or secondary basis, may not be granted in this case.

As noted above, the Veteran alleged during his August 2012 VA examination that symptoms of snoring and daytime fatigue “probably” began during his active duty service. The Board finds that this assertion is not credible and therefore not entitled to significant probative weight. In addressing lay evidence such as the Veteran’s assertions in this case and determining what probative value, if any, may be assigned to it, the Board must consider both the veteran’s competency (“a legal concept determining whether testimony may be heard and considered”) and
credibility ("a factual determination going to the probative value of the evidence to be made after the evidence has been admitted). See Layno v. Brown, 6 Vet. App. 465, 469 (1994).

As a general matter, a layperson such as the Veteran is not capable of opining on matters requiring medical knowledge. See 38 C.F.R. § 3.159(a)(2); see also Routen v. Brown, 10 Vet. App. 183, 186 (1997) ("a layperson is generally not capable of opining on matters requiring medical knowledge"). In certain circumstances, however, lay evidence may be sufficient to establish a medical diagnosis or nexus. See Davidson v. Shinseki, 581 F.3d 1313, 1316 (Fed. Cir. 2009). In that regard, lay evidence has been found to be competent with regard to a disease with "unique and readily identifiable features" that is "capable of lay observation." See Barr v. Nicholson, 21 Vet. App. 303, 308-09 (2007) (concerning varicose veins); see also Jandreau v. Nicholson, 492 F.3d 1372, 1376-77 (Fed. Cir. 2007) (a dislocated shoulder).

Certainly, the Veteran is competent to provide probative statements as to when observable symptoms such as snoring and daytime fatigue began and how long they continued. Nonetheless, to the extent that the Veteran has alleged that he “probably” experienced such symptoms during his active duty service, the credibility of such assertions are undermined by various inconsistencies in the record. In that regard, the Board notes that the Veteran’s assertions are contradicted by the absence of any noted sleep-related problems in the service treatment or service personnel records. Additionally, the Veteran’s current assertions that he had sleep-related symptoms or fatigue are wholly contradicted by the Veteran’s earlier inconsistent statements in which he expressly denied having any history of such symptoms during his separation examination.

The Board is mindful that it cannot determine that lay evidence lacks credibility merely because it is unaccompanied by contemporaneous medical evidence, but the Board may still consider the absence of contemporaneous medical evidence as a relevant factor in determining the credibility of lay evidence. Buchanan v. Nicholson, 451 F.3d 1331 (Fed. Cir. 2006). Mindful of the same, the Board also notes that the absence of any evidence of subjective complaints of snoring, fatigue,
or other sleep-related symptoms following his separation from service until 2010 (nearly 20 years after the Veteran was separated from service), and the absence of any diagnoses pertinent to sleep apnea over that period, when considered in conjunction with the aforementioned inconsistencies, would also weigh against the credibility of the Veteran’s assertions concerning the continuity of his symptoms. The Board also notes that, although the Veteran’s spouse attested during the March 2010 VA treatment that the Veteran slept poorly and snored a lot at that time, she stated that the Veteran was not demonstrating such symptoms as recently as two years before. The credible history provided by the Veteran’s spouse thus suggests that the Veteran’s sleep apnea symptoms first arose sometime in 2008; thus, this evidence also contradicts the Veteran’s contention that his sleep apnea symptoms “probably” began during service. For the foregoing reasons, the Board finds that the Veteran’s assertions are not credible and do not support the onset of sleep apnea during his period of active duty service.

By contrast, the negative opinions provided by the VA examiner in November 2013 are based upon an accurate understanding of the Veteran’s medical and treatment history which was gleaned from a review of the claims file, and, which is consistent with the facts shown in the record. Moreover, these opinions are supported by rationale that is also consistent with the Veteran’s medical history. Under the circumstances, the Board is inclined to assign far greater probative weight to the opinions expressed in the November 2013 report than the Veteran’s lay assertions.

Overall, the preponderance of the evidence is against the Veteran's claim for service connection for sleep apnea. Accordingly, this claim must be denied. In reaching this determination, the Board again acknowledges that VA is statutorily required to resolve the benefit of the doubt in favor of the Veteran when there is an approximate balance of positive and negative evidence regarding the merits of an outstanding issue. That doctrine, however, is inapplicable in this case because the preponderance of the evidence is against the Veteran’s claim. See Gilbert, 1 Vet. App. at 55; 38 U.S.C.A. § 5107(b).
III. Disability Rating for PTSD

Initially, the Board notes that where the reduction in evaluation of a service-connected disability or employability status is considered warranted and the lower evaluation would result in a reduction or discontinuance of compensation payments currently being made, a rating proposing the reduction or discontinuance and setting forth all material facts and reasons must be prepared. The appellant must be notified at his or her latest address of record of the contemplated action and furnished detailed reasons therefore, and will be given 60 days for the presentation of additional evidence to show that compensation payments should be continued at their present level. The appellant is also to be informed that he or she may request a predetermination hearing, provided that the request is received by the VA within 30 days from the date of the notice. If additional evidence is not received within the 60 day period and no hearing is requested, final rating action will be taken and the award will be reduced or discontinued effective the last day of the month in which a 60-day period from the date of notice to the veteran expires. 38 C.F.R. § 3.105(e) (2013).

In this case, a September 2009 letter provided the Veteran with appropriate notice of a proposed reduction of his PTSD rating from 70 percent to 30 percent. During the ensuing 60 day period, the Veteran responded by providing medical evidence and a lay statement expressing his disagreement with the proposed reduction. He did not request a predetermination hearing. This evidence was considered by the RO before it issued the January 2010 rating decision which effectuated the proposed reduction, effective from April 1, 2010. Based upon these facts, the Board finds that the RO's reduction of the Veteran’s PTSD rating was procedurally in accordance with the provisions of 38 C.F.R. § 3.105.

Records in the claims file show that service connection for PTSD had been in effect for the Veteran since July 28, 2006. The pre-reduction 70 percent disability was undisturbed until the reduction at issue, which, as noted above, was effective from April 1, 2010. Accordingly, the pre-reduction 70 percent disability rating for PTSD was in effect for less than five years before it was effectively reduced. See Brown v. Brown, 5 Vet. App. 413, 418 (1993) (noting that the duration of a rating must be
measured from the effective date assigned that rating until the effective date of the actual reduction). Accordingly, the special provisions pertaining to reductions of ratings that have been in effect for five years or more under 38 C.F.R. § 3.344 (a) and (b) are not applicable to this case.

As noted in the June 2007 rating decision, the initial pre-reduction 70 percent disability rating was based essentially upon findings expressed in an April 2007 VA examination. During that examination, the Veteran reported having the following symptoms: problems with anger; anxiety; sleep difficulty marked by nightmares and distressing thoughts; dislike and distrust of other people which caused him to work alone as a mobile home close-up workman; depression; intense anxiety and distress at seeing reminders of his stressor events; avoidance of thoughts and feelings related to his stressors; emotional numbing and maintaining a distance from others; lack of interest in day to day activities; difficulty in experiencing loving feelings and closeness with others; difficulty with concentration; episodes in which he heard voices in his home; exaggerated startle responses; and hypervigilence marked by sweating, fast heart rate, and anxiety.

During mental status examination, the Veteran reported that he was a little bit anxious, but overall, feeling as though he were on an even keel. Demonstrated affect was constricted with some apparent anxiety; however, the remaining aspects of the mental status examination were essentially within normal limits. Based upon the reported symptoms and objective findings from the examination, the examiner characterized the Veteran’s PTSD as being “chronic and severe” and opined that the Veteran was impaired in social and occupational areas due to his temperament and isolative tendencies. Interestingly, the examiner opined, “[the Veteran’s] ability to adapt effectively to work stressors will weaken over time, and his condition will worsen as a result.” A GAF score of 44 was assigned at that time.

In this case, the RO’s proposed reduction was initially triggered largely by findings expressed in an August 2009 VA examination. During that examination, the Veteran reported symptoms which included ongoing nightmares occurring once or twice a week, particularly during the spring; frequent thoughts and memories related to his active duty service; memories triggered by specific smells and seeing
people of Asian or Middle Eastern descent; disliking crowds; constantly looking over his shoulder; and being easily startled by loud and sudden noises. Overall, he stated that he had good days and bad days.

Occupationally, the Veteran reported that after service he worked for a private security company for six months before becoming a housepainter. He stated that he began working for himself as a housepainter from 2000 through 2007. The Veteran stated that since 2007, he had been working as a gas station clerk while maintaining a side job in general construction. The Veteran related some concern that he might be laid off due to a recent buyout by “foreigners.” Nonetheless, there is no indication that the Veteran attributed these concerns to his PTSD symptoms. Indeed, he denied having any current problems or difficulties at work.

Socially, the Veteran reported that he was living with his current spouse and their four children and one niece. He described the relationship with his spouse as being good. He described that his days were generally spent working or tending to the buildings and livestock on his 50-acre property and stated that he will also occasionally help with household chores. Recreationally, he stated that he went out to eat and to the movies with his spouse, but acknowledged that it was difficult to do so because of the children. He reported previous legal problems associated with carrying a concealed weapon, but did not report any history of actual assault or other violent behavior.

A mental status examination performed at that time revealed some restless behavior marked by the Veteran bouncing his right leg. Otherwise, however, the mental status examination was free of other observed abnormalities. Based upon the Veteran’s reported symptoms and findings from the examination, a Global Assessment of Functioning (GAF) scale score of 65 was assigned.

Subsequent VA treatment records from September 2009 through March 2010 reflect ongoing complaints of depression, irritability, anger, nightmares, flashbacks, and some isolative behavior marked by difficulty getting along with his boss. Although these records indicate that symptoms such as nightmares, irritability, and anger appeared to increase and decrease over that period, they show that the overall
symptomatology remained the same. Indeed, repeated mental status examinations over that time were grossly normal and unchanged. Although the Veteran did endorse having some difficulty getting along with his boss, he generally maintained that he enjoyed his work, which entailed working outdoors and caring for trophy deer and elk. GAF scores assigned over that time consistently remained at 65.

In a mental health questionnaire completed in April 2010, the Veteran endorsed having disturbing thoughts and memories related to his stressors; disturbing dreams; feeling as though he were reacting or reliving his stressors; feeling upset at reminders of his stressors; avoiding thoughts and conversations related to his stressors; avoiding activities and situations which reminded him of his stressors; feeling distant or cut off from others; difficulty falling and staying asleep; irritability and anger outbursts; difficulty concentrating; and feeling jumpy or easily startled. During a VA psychiatric examination, he stated that he felt that his symptoms were becoming worse. Socially, he stated that he remained estranged from his parents and brother; however, reported that he and his spouse were doing well. Occupationally, he continued to report that he was enjoying his work. Once again, a mental status examination performed at that time was grossly normal. A slightly decreased GAF score of 60 was assigned.

During VA treatment in July 2010, the Veteran reported that he had been laid off from work. The Veteran reported having a flashback at work after military jets flew over his workplace; however, it is unclear as to whether this episode was the impetus for his reported layoff. Despite his employment status, the Veteran stated that he felt that he was doing “pretty well” with regard to his depression. Although he related that he was irritable around his children, he stated that he did not believe that he was excessively so. Notably, he denied having any suicidal or homicidal ideation. A clinical mental status examination continued to indicate normal findings. Based upon the foregoing, a GAF score of 65 was assigned. Interestingly, a listing of recorded GAF scores over the period from August 2007 through April 2010 indicate improving GAF scores ranging from 55 to 73. Indeed, for the period pertinent to the reduction at issue, GAF scores from January 2008 through April 2010 range consistently from 65 to 73.
During VA treatment in November 2010, the Veteran reported that he was having increased irritability and that he was more withdrawn. He also reported that he still watched his perimeter; avoided crowds, such as at stores and at movies; and felt down, hopeless, and helpless. Occupationally, he stated that he was working at a new job as a driver and was able to spend a lot of time alone. Again, he denied having any suicidal or homicidal ideation and a mental status examination was within normal limits. A GAF score of 60 assigned.

A December 2010 VA treatment record indicates that the Veteran continued to be distancing himself from other people and was experiencing ongoing depression. Nonetheless, the record appears to show that the Veteran’s symptoms were generally well-managed and that the Veteran enjoyed a relatively high activity level. In that regard, he reported that he was involved in various projects which included remodeling his home. He also stated that he wanted to take his sons hunting. Once again, a mental status examination was normal.

During VA treatment in February 2011, the Veteran reported the recent social stressor of the suicide death of his cousin, who was a combat veteran. At that time, the Veteran reported ongoing sleep problems and depression; however, a repeat mental status examination was normal. Once again, a GAF score of 60 was assigned. The following month, in March 2011, the Veteran reported that he was still working for an auto parts store while attending classes. Socially, he stated that his relationship with his spouse and children were okay, and indeed, appeared to voice affection for his family, stating that his wife and children were “what keep him going.” The Veteran also continued to report a high activity level, stating that he enjoyed fishing and being on the river. Concerning his symptoms, he reported ongoing nightmares and depression, and also stated that he was hearing noises. A mental status examination was once again within normal limits.

VA treatment records from August 2011 indicate reported worsening in the Veteran’s symptomatology, as the Veteran related that he was having anxiousness, episodes of anger, feeling like slapping or yelling, being withdrawn, nightmares, and flashbacks. Despite these reported symptoms, the treating psychiatrist opined that the Veteran was not violent, grossly paranoid, or grossly psychotic. The
Veteran continued to describe having fair relationships with his spouse and children. A mental status examination performed at that time revealed anxious mood, anxiety, and hypervigilence. A GAF score of 60 was assigned.

During VA treatment in September 2011, the Veteran continued to report increased anger, irritability, explosive behavior, and inability to tolerate being around his children. According to the Veteran, his spouse still complained that he had mood swings and problems with irritability and anger. A mental status examination continued to reveal anxious mood, constricted affect, and episodes of irritability and moodiness. A reduced GAF score of 50 was assigned.

In January 2012, the Veteran returned for VA treatment, reporting that he was feeling better despite ongoing problems with sleep. The Veteran was apparently accompanied by his spouse, who also stated that the Veteran still became angry easily and was irritable. The treating VA psychiatrist opined that the Veteran was not a danger to himself or others and recommended ongoing individual counseling sessions. A mental status examination continued to show anxious mood with episodes of anger and irritability and constricted affect. A GAF score of 60 was assigned.

Subsequent VA treatment records through April 2012 reflect that the Veteran was seen on a monthly basis for psychiatric counseling. Records pertinent to this treatment generally indicate that the Veteran was feeling better with improvement in his symptoms. In that regard, he stated during treatment in February and March of 2012 that he was feeling and sleeping better and felt less angry. GAF scores ranging from 64 to 65 were assigned.

In May 2012, the Veteran attended a VA examination while accompanied by his spouse and three of his children. At that time, he reported ongoing symptoms of anger, dreams and nightmares occurring two or three times per week, recollections about his military experiences, problems falling and remaining asleep, and episodes in which he kicked and struck his spouse during his sleep. He also stated that he was somewhat guarded and vigilant and sensitive to sudden and loud noises. In that regard, he shared an anecdote in which he recently heard a loud noise outside of his
home, which prompted him to run outside in his underwear with his gun in his hand.

Socially, he reported that he avoided interacting with his parents and most of his siblings “because there is always too much drama.” He stated that he only maintained contact with one of his older half-sisters.Occupationally, he stated that he remained employed at an auto parts store, where he now worked at the counter. The Veteran also reported that he was in school. Recreationally, he reported that he helped with household chores; primarily outdoor yard work and gardening. He also reported that he went fishing and was in the process of restoring an automobile. He stated that he also spent time playing outside with his children and that he took his children fishing with him. He related that he occasionally went out to eat with his spouse. The Veteran also reported that he was active in a veterans group and that he had recently been elected treasurer. He also stated that he attended church on a regular basis. Although the Veteran reported that he did not socialize frequently with friends, he stated that he did socialize with an older neighbor who lived nearby. Again, the Veteran denied having any legal problems other than a fine for carrying a concealed weapon in 2002.

A mental status examination performed at that time revealed constricted facial expressions but was otherwise normal. A GAF score of 64 was assigned.

In June 2012, the Veteran returned for psychiatric counseling. At that time, he continued to report that he was doing better overall with improvement in his nightmares, flashbacks, anger, irritability, startle responses, and hypervigilence. A mental status examination was grossly normal. A GAF score of 65 was assigned.

An October 2013 VA treatment record suggests that the Veteran’s PTSD symptoms were increasing at that time. In that regard, the Veteran reported that his nightmares were occurring once or twice a week, that he was having flashbacks of stressor events triggered by specific smells such as eggs and by seeing vehicle accidents, sleep disturbances, checking the perimeters of his home at night, and was sensitive to loud and sudden noises. Despite these symptoms, he reported that he was still working on a full time basis at an auto parts store and that he was having good
relationships with his spouse and children. He reported that he was active in attending veteran’s support groups, church groups with his 16 year old son, and planned to go bow hunting with his 10 year old and 16 year old children. A mental status examination was grossly normal.

As discussed above, a veteran's disability rating shall not be reduced unless an actual improvement in the disability is shown to have occurred. Upon consideration of the foregoing evidence, and a comparison of the demonstrated symptomatology at the time of the assignment of the Veteran’s pre-reduction 70 percent disability rating versus the demonstrated symptomatology demonstrated since that time, the Board concludes that the evidence does show actual improvement in the Veteran’s condition which justifies the effectuated reduction of the disability rating from 70 percent to 30 percent.

In support of the foregoing conclusion, the Board acknowledges that the evidence indicates that there has been some waxing and waning of the Veteran’s PTSD symptoms since the time that the initial 70 percent disability rating was assigned. Nonetheless, the Board finds that the evidence generally shows that, since the time that the 70 percent disability rating was assigned, the Veteran’s symptoms were generally diminished in severity to the extent that the Veteran was able to maintain good and enriching relationships with his family while maintaining a high level of social and occupational functioning. In that regard, and as noted above, the Veteran was able to continuously maintain employment. Indeed, in contrast to his pre-reduction employment as a self-employed mobile home close-up workman (which allowed the Veteran to work alone), the evidence shows that the Veteran has been able to maintain employment which required him to work with others. Most notably, the Board points out that the Veteran presently works behind the counter at an auto parts store; a job which would appear to place the Veteran in routine contact with customers, colleagues, and supervisors. Recreationally, the record shows that the Veteran has also been able to maintain a relatively high level of function. In that regard, he has engaged in various activities which include going out to eat or to the movies with his spouse and children, restoring an automobile, performing home remodeling and other household chores, taking his children hunting, fishing, attending church on a regular basis, participating regularly in meetings of veteran’s
groups, and obtaining an elected position within his veteran’s group. The Board also notes that the Veteran was able to attend classes in accounting while maintaining the aforementioned employment and functioning.

The Board also notes that, whereas the Veteran’s demonstrated symptoms appeared to warrant the assignment of a GAF score of 44 at the time that the pre-reduction 70 percent rating was assigned, the GAF scores assigned since then range generally from 55 to 73, with assigned scores ranging most frequently in the mid-60s. In assessing the degree of psychiatric disability, GAF scores are for application and reflect the "psychological, social, and occupational functioning on a hypothetical continuum of mental health- illness." Richard v. Brown, 9 Vet. App. 266, 267 (citing DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 4th ed. (DSM-IV) at 32). According to the DSM-IV, a GAF score ranging from 71 to 80 denotes symptoms that are transient with expectable reactions to psychosocial stressors (e.g., difficulty concentrating after a family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork). GAF scores which range from 61 to 70 denote mild symptoms (e.g., depressed mood and mild insomnia) or some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well with some meaningful interpersonal relationships. Finally, GAF scores falling in the range of 51 to 60 indicate the presence of moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) or moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers). See Carpenter v. Brown, 8 Vet. App. 240, 242-244 (1995).

The Board admonishes that GAF scores are not conclusively dispositive as to a veteran's level of psychiatric impairment. Rather, GAF scores are merely parts of a whole body of evidence that must be and has been considered in arriving at a decision. Subject to the foregoing, the Board finds that the demonstrated symptomatology is essentially consistent with GAF scores ranging from 61 to 70. In that regard, and as noted above, the Veteran appeared to maintain a relatively high level of social and occupational functioning. Although the Board acknowledges that the Veteran’s assessed GAF score occasionally decreased to
scores ranging from 51 to 60, the Board concludes that these lower scores appear to reflect periods in which the Veteran’s symptoms waxed, and were manifested by increased symptoms which included flat affect and periods of increased isolation. Indeed, and as pointed out earlier, the recorded GAF scores reflect a clear increasing trend which, when considered in conjunction with the other evidence outlined above, is reflective of general improvement in the Veteran’s symptomatology.

PTSD is rated in accordance with 38 C.F.R. § 4.130, DC 9411, which states that PTSD is to be rated under the General Rating Formula for Mental Disorders (General Formula). Under the General Formula, a 30 percent disability rating is appropriate where the evidence shows that PTSD is productive of occupational and social impairment with an occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and normal conversation), due to such symptoms as depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment, or mild memory loss (i.e., forgetting names, directions, and recent events).

A 50 percent disability rating encompasses PTSD that is manifested by occupational and social impairment with reduced reliability and productivity due to such symptoms as a flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short and long-term memory (e.g., retention of only highly learned material, forgetting to complete tasks); impaired judgment; impaired abstract thinking; disturbances of motivation and mood; or difficulty in establishing and maintaining effective work and social relationships.

A 70 percent disability rating is appropriate for PTSD that is manifested by occupational and social impairment, with deficiencies in most areas such as work, school, family relations, judgment, thinking or mood, due to such symptoms as suicidal ideation; obsessional rituals which interfere with routine activities; speech that is intermittently illogical, obscure or irrelevant; near-continuous panic or depression affecting the ability to function independently, appropriately, and
effectively; impaired impulse control (such as unprovoked irritability with periods of violence); spatial disorientation; neglect of personal appearance and hygiene; difficulty in adapting to stressful circumstances (including work or a worklike setting); or the inability to establish and maintain effective relationships.

A 100 percent disability evaluation is assigned where PTSD is productive of total occupational and social impairment due to such symptoms as gross impairment in thought processes or communication; persistent delusions or hallucinations; grossly inappropriate behavior; persistent danger of hurting himself or others; intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene); disorientation to time and place; or memory loss for the names of close relatives, own occupation, or own name.

Mindful of the foregoing criteria, the Board finds that the symptomatology shown by the evidence since April 1, 2010 corresponds to the assignment of a 30 percent disability rating for PTSD under the General Formula. In that regard, the evidence shows that the Veteran’s PTSD was productive of a degree of occupational and social impairment with an occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and normal conversation), due to symptoms including depressed mood, anxiety, irritability, suspiciousness, chronic sleep impairment marked by nightmares and frequent awakenings, flashbacks and intrusive thoughts and memories triggered by reminders of his stressors, intermittently flattened affect, and some reported auditory hallucinations.

Although the Board acknowledges that symptoms such as flattened affect and auditory hallucinations may be indicative of symptomatology that warrants a 50 percent disability rating, the Board concludes that the overall disability picture is not consistent with occupational and social impairment marked by reduced reliability and productivity. Moreover, the Board points out that the Veteran’s PTSD has not been productive of other symptoms identified in the criteria for a 50 percent disability rating, such as circumstantial, circumlocutory, or stereotyped speech; panic attacks; difficulty in understanding complex commands; memory impairment; impaired judgment; impaired abstract thinking; or disturbances of
motivation. Toward that end, the Board notes again that the Veteran has remained married to his second spouse since 2002 and has reportedly maintained good relationships with his spouse and four children. Also, he has been able to maintain ongoing employment while attending courses in accounting, thus demonstrating a high degree of occupational and social functioning. In general, the evidence does not support the conclusion that the Veteran's PTSD was manifested by any symptoms, other than intermittently flattened affect and reported audio hallucinations, which are associated with a disability rating higher than 30 percent under the General Formula.

After considering the pertinent medical history, as detailed above, the Board finds that the RO's January 2010 rating action to reduce the Veteran's disability rating for his PTSD from 70 percent to 30 percent, effective from April 1, 2010, was proper. To that extent, this appeal is denied.

The Board has also considered the provisions under 38 C.F.R. § 3.321(b)(1), which govern the assignment of extra-schedular disability ratings. However, in this case, the record does not show that the severity of the Veteran's PTSD is so exceptional or unusual such as to warrant the assignment of a higher rating on an extra-schedular basis. See 38 C.F.R. § 3.321(b)(1) (2013).

The threshold factor for extra-schedular consideration is a finding that the evidence presents such an exceptional disability picture that the available schedular evaluations for that service-connected disability are inadequate. See Thun v. Peake, 22 Vet. App. 111 (2008). In this regard, there must be a comparison between the level of severity and symptomatology of the claimant's service-connected disability with the established criteria found in the rating schedule for that disability. If the criteria reasonably describe the claimant's disability level and symptomatology, then the claimant's disability picture is contemplated by the rating schedule and the assigned schedular evaluation is therefore adequate, and, no extra-schedular referral is required. Id., see also VAOGCPREC 6-96 (Aug. 16, 1996). Otherwise, if the schedular rating does not contemplate the claimant's level of disability and symptomatology and is found inadequate, VA must determine whether the claimant's exceptional disability picture exhibits other related factors, such as those
provided by the extra-schedular regulation (38 C.F.R. § 3.321(b)(1)) as "governing norms" (which include marked interference with employment and frequent periods of hospitalization).

The evidence in this case does not show that the Veteran's PTSD presents an exceptional disability picture that renders inadequate the available schedular ratings. A comparison between the level of severity and symptomatology of the Veteran's assigned rating with the established criteria found in the rating schedule shows that the rating criteria reasonably describe the Veteran's disability level and symptomatology. As discussed above, there are higher ratings available under the applicable diagnostic code; however, the Veteran's PTSD is not productive of the manifestations required for a rating in excess of 30 percent. As such, it cannot be said that the available schedular ratings for the Veteran's PTSD are inadequate.


The Board has also considered whether "staged" disability ratings, beyond those already provided, are warranted by the evidence. The symptomatology shown upon examination and treatment, however, has been essentially consistent and fully contemplated by the assigned disability ratings. As such, there is no basis for further staged disability ratings in connection with the Veteran's PTSD.

**ORDER**

New and material evidence has been received, and the Veteran’s previously denied claim for service connection for right eye hemifacial spasm, blepharospasm on a direct basis is reopened.

New and material evidence has been received, and the Veteran’s previously denied claim for service connection for headaches on a direct basis is reopened.
New and material evidence has been received, and the Veteran’s previously denied claim for service connection for sleep disorder, to include sleep apnea, on a direct basis, is reopened.

Entitlement to service connection for a sleep disorder, to include sleep apnea, on both a direct and secondary basis, is denied.

Reduction of the disability rating for PTSD from 70 percent to 30 percent, effective from April 1, 2010, was proper.

The Veteran’s appeal as to the issue of entitlement to a TDIU is dismissed.

**REMAND**

In relation to his claims for service connection for headaches and right eye hemifacial spasm and blepharospasm, the Veteran has alternatively claimed that this disorder resulted from exposure to environmental hazards during service in Southwest Asia and/or as a result of his service-connected PTSD.

Concerning his claimed facial spasms, VA treatment records dated July 2006 reflect that the Veteran reported that his facial spasms began sometime in 1996, possibly in conjunction with a grand mal seizure that was experienced by the Veteran that same year. Repeated examinations performed during VA treatment through January 2008 document objective observations of right-sided facial twitching which affected the right eyelid and mouth and occurred approximately every few seconds.

During VA examination in May 2010, the Veteran reported that the frequency of his right-sided facial spasms had decreased and was apparently replaced by numbness in the area of his right eye and cheek. Overall, the Veteran stated that the right-sided facial spasms occurred only a few times a day, whereas they had previously been constant. Indeed, no spasms were seen during physical examination. Neurological examination, however, indicated decreased sensation to touch and
pinprick in the area of the Veteran’s right eye and cheek. The examiner diagnosed an “undiagnosed illness” and stated that he was unable to provide an opinion as to its etiology without resorting to mere speculation. No explanation was provided by the examiner as to why a definitive etiology opinion could not be provided. To date, VA has neither scheduled the Veteran for a new VA examination of his claimed hemifacial spasms and numbness, nor sought an addendum opinion from the May 2010 VA examination for additional explanation or elaboration.

In the absence of any explanation as to why an opinion concerning the etiology of the Veteran’s hemifacial spasms and numbness could not be rendered without resort to speculation, it remains unclear as to whether the examiner has invoked the phrase “without resort to mere speculation” merely as a substitute for full consideration of all pertinent and available medical facts. For this reason, the May 2010 VA opinion is deficient. Jones v. Shinseki, 23 Vet. App. 382, 387 (2010). As such, the Veteran should be arranged to undergo a new VA examination to determine whether his right-sided hemifacial spasms, blepharospasms, and associated numbness resulted from or was aggravated by the Veteran’s active duty service, to include exposure to environmental hazards during his service in Southwest Asia. The examination should also determine whether the Veteran’s hemifacial spasms, blepharospasms, and associated numbness were caused or aggravated by any of his service-connected disabilities, to include PTSD, fibromyalgia, irritable bowel syndrome, and tinnitus. 38 C.F.R. § 3.159(c)(4).

In relation to his claim for service connection for headaches, the Veteran alleges theories of both direct and secondary service connection. In relation to his claim for direct service connection, the Veteran does not raise any specific allegations. Regarding his claim for secondary service connection, he asserts in his September 2008 claim and October 2009 Notice of Disagreement that his headaches are a neurological disorder that has resulted from his service-connected PTSD.

Similarly, with regard to the Veteran’s claim for service connection for headaches, the May 2010 VA examination notes complaints of ongoing headaches which began behind the Veteran’s eyes and occurred one to three times per week. According to the Veteran, these headaches lasted for periods of up to half an hour to an hour.
Although the examiner noted that the Veteran’s description was consistent with a migraine headache, the examiner also observed that the examination was negative for findings that would suggest a migraine. Similar to the Veteran’s claimed facial spasms, the examiner also diagnosed the Veteran’s headaches as an “undiagnosed illness.” Also in reference to the headaches, the examiner stated that he was unable to provide an opinion as to their etiology without resorting to speculation.

In a November 2013 opinion which was prepared in conjunction with a claims file review, but not live physical examination of the Veteran, a different VA examiner opined that the Veteran’s headaches were most likely due to his sleep apnea. As rationale, the examiner noted that headaches are a very common sequelae of sleep apnea due to a lack of oxygen to the brain during sleep. The examiner acknowledged that people with fibromyalgias may also have headaches; nonetheless, the examiner simply reiterated without additional explanation and rationale that the more likely cause of the Veteran’s headaches was the reduction of oxygen supply to the brain due to sleep apnea. In the absence of any rationale or explanation as to why the examiner believed that the Veteran’s headaches were more likely related to sleep apnea than fibromyalgia, the November 2013 is also incomplete. In view of the same, the Veteran should also be afforded a VA examination of his headaches to determine whether the headaches resulted from or were aggravated by the Veteran’s active duty service, to include exposure to environmental hazards during his service in Southwest Asia. The examination should also determine whether the Veteran’s headaches were caused or aggravated by any of his service-connected disabilities, to include PTSD, fibromyalgia, irritable bowel syndrome, and tinnitus. 38 C.F.R. § 3.159(c)(4).

Prior to arranging the examinations directed above, and in order to insure that the most complete and up-to-date evidence has been associated with the claims file, the Veteran should also be asked to identify any private or VA treatment providers who have rendered treatment for his hemifacial spasms, blepharospasms, facial numbness, and headaches since October 2013. VA must then also make efforts to obtain any treatment records that are identified by the Veteran. 38 C.F.R. § 3.159.
Accordingly, the case is REMANDED for the following action:

1. A letter should be sent to the Veteran explaining, in terms of 38 U.S.C.A. §§ 5103 and 5103A, the need for additional evidence regarding his claims of entitlement to service connection for right eye hemifacial spasm and blepharospasm and headaches. This letter must also inform the Veteran about the information and evidence that is necessary to substantiate his claim and provide notification of both the type of evidence that VA will seek to obtain and the type of evidence that is expected to be furnished by the Veteran.

The letter must also notify the Veteran that VA is undertaking efforts to arrange VA examinations of his hemifacial spasm and headaches. The Veteran should be advised that it remains his responsibility to report for any scheduled VA examinations and to cooperate with the development of his claim; failure to report without good cause may result in denial of his claim.

The Veteran should also be provided a VA 21-4142 release and be asked to identify the name(s) and current address(es) for any private and/or VA treatment providers who have provided treatment for his hemifacial spasms, blepharospasms, facial numbness, and headaches since October 2013.

2. Make efforts to obtain records for any treatment identified by the Veteran. Any records obtained as a result of such efforts should be associated with the claims file. If such efforts yield negative results, a notation to that effect should be inserted in the file. The Veteran and his representative are to be notified of unsuccessful efforts
in this regard, in order to allow the Veteran the opportunity to obtain and submit those records for VA review.

3. After the above development has been completed to the extent possible, the Veteran should be afforded a VA examination, performed by an appropriate physician, to determine whether the Veteran’s right eye hemifacial spasm, blepharospasm, and facial numbness were caused or aggravated by his periods of active duty service, to include exposure to environmental hazards during service in Southwest Asia, and/or whether such disabilities were caused or aggravated by the Veteran’s service-connected disabilities, to include PTSD, fibromyalgia, irritable bowel syndrome, and tinnitus. The claims folder must be made available to the examiner, and, the examiner must review the entire claims file in conjunction with the examination.

All tests and studies deemed necessary by the examiner should be performed. The examiner should provide a diagnosis pertinent to the Veteran’s claimed hemifacial spasm, blepharospasm, and facial numbness and identify any manifestations and symptoms associated with the diagnosed condition. The examiner should also provide opinions as to:

a) whether it is at least as likely as not (i.e., at least a 50 percent probability) that the diagnosed condition was incurred during or caused or aggravated by the Veteran’s active duty service from April 1987 through May 1991, to include service in Southwest Asia from December 1990 through April 1991; and
b) whether it is at least as likely as not (i.e., at least a 50 percent probability) that the diagnosed condition was caused or aggravated by any of the Veteran’s service-connected disabilities, to include PTSD, fibromyalgia, irritable bowel syndrome, and tinnitus;

All relevant findings from the Veteran's medical history, clinical findings, subjectively reported symptoms, and associated functional impairment should be reported.

A report of the examination should be prepared and associated with the Veteran's VA claims file. A complete rationale which includes citation to any relevant facts, evidence, or medical principles must be provided for all opinions rendered. If the examiner cannot provide any of the requested opinions without resorting to speculation, he or she should expressly indicate this and provide a supporting rationale as to what additional information is necessary and why the opinion sought cannot be given without resorting to speculation.

4. The Veteran should be afforded a VA examination, performed by an appropriate physician, to determine whether the Veteran’s claimed headaches were caused or aggravated by his periods of active duty service, to include exposure to environmental hazards during service in Southwest Asia, and/or whether such disabilities were caused or aggravated by the Veteran’s service-connected disabilities, to include PTSD, fibromyalgia, irritable bowel syndrome, and tinnitus. The claims folder must be made available to the examiner, and, the examiner must
review the entire claims file in conjunction with the examination.

All tests and studies deemed necessary by the examiner should be performed. The examiner should provide a diagnosis pertinent to the Veteran’s claimed headaches and identify any manifestations and symptoms associated with the diagnosed condition. The examiner should also provide opinions as to:

a) whether it is at least as likely as not (i.e., at least a 50 percent probability) that the diagnosed condition was incurred during or caused or aggravated by the Veteran’s active duty service from April 1987 through May 1991, to include service in Southwest Asia from December 1990 through April 1991; and

b) whether it is at least as likely as not (i.e., at least a 50 percent probability) that the diagnosed condition was caused or aggravated by any of the Veteran’s service-connected disabilities, to include PTSD, fibromyalgia, irritable bowel syndrome, and tinnitus;

All relevant findings from the Veteran's medical history, clinical findings, subjectively reported symptoms, and associated functional impairment should be reported.

A report of the examination should be prepared and associated with the Veteran's VA claims file. A complete rationale which includes citation to any relevant facts, evidence, or medical principles must be provided for all opinions rendered. If the examiner cannot provide any of
the requested opinions without resorting to speculation, he 
or she should expressly indicate this and provide a 
supporting rationale as to what additional information is 
necessary and why the opinion sought cannot be given 
without resorting to speculation.

5. If the Veteran fails to report to the scheduled 
examination(s), the RO must obtain and associate with the 
claims file a copy of any notice(s) of the dates and times 
of the examinations sent to the Veteran by the pertinent 
VA medical facility.

6. After completion of the above development, the issues 
of entitlement to service connection for right eye 
hemifacial spasm and blepharospasm and headaches 
should be readjudicated. If the determination remains 
adverse to the Veteran, he and his representative should be 
furnished with a supplemental SOC and be given an 
opportunity to respond.

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

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

_____________________________________
DAVID L. WIGHT
Veterans Law Judge, Board of Veterans’ Appeals
YOUR RIGHTS TO APPEAL OUR DECISION

The attached decision by the Board of Veterans’ Appeals (BVA or Board) is the final decision for all issues addressed in the “Order” section of the decision. The Board may also choose to remand an issue or issues to the local VA office for additional development. If the Board did this in your case, then a “Remand” section follows the “Order.” However, you cannot appeal an issue remanded to the local VA office because a remand is not a final decision. The advice below on how to appeal a claim applies only to issues that were allowed, denied, or dismissed in the “Order.”

If you are satisfied with the outcome of your appeal, you do not need to do anything. We will return your file to your local VA office to implement the BVA's decision. However, if you are not satisfied with the Board's decision on any or all of the issues allowed, denied, or dismissed, you have the following options, which are listed in no particular order of importance:

- Appeal to the United States Court of Appeals for Veterans Claims (Court)
- File with the Board a motion for reconsideration of this decision
- File with the Board a motion to vacate this decision
- File with the Board a motion for revision of this decision based on clear and unmistakable error.

Although it would not affect this BVA decision, you may choose to also:

- Reopen your claim at the local VA office by submitting new and material evidence.

There is no time limit for filing a motion for reconsideration, a motion to vacate, or a motion for revision based on clear and unmistakable error with the Board, or a claim to reopen at the local VA office. None of these things is mutually exclusive - you can do all five things at the same time if you wish. However, if you file a Notice of Appeal with the Court and a motion with the Board at the same time, this may delay your case because of jurisdictional conflicts. If you file a Notice of Appeal with the Court before you file a motion with the BVA, the BVA will not be able to consider your motion without the Court's permission.

How long do I have to start my appeal to the Court? You have 120 days from the date this decision was mailed to you (as shown on the first page of this decision) to file a Notice of Appeal with the Court. If you also want to file a motion for reconsideration or a motion to vacate, you will still have time to appeal to the Court. As long as you file your motion(s) with the Board within 120 days of the date this decision was mailed to you, you will then have another 120 days from the date the BVA decides the motion for reconsideration or the motion to vacate to appeal to the Court. You should know that even if you have a representative, as discussed below, it is your responsibility to make sure that your appeal to the Court is filed on time.

How do I appeal to the United States Court of Appeals for Veterans Claims? Send your Notice of Appeal to the Court at:

Clerk, U.S. Court of Appeals for Veterans Claims
625 Indiana Avenue, NW, Suite 900
Washington, DC 20004-2950

You can get information about the Notice of Appeal, the procedure for filing a Notice of Appeal, the filing fee (or a motion to waive the filing fee if payment would cause financial hardship), and other matters covered by the Court's rules directly from the Court. You can also get this information from the Court's website on the Internet at: http://www.uscourts.cavc.gov, and you can download forms directly from that website. The Court's facsimile number is (202) 501-5848.

To ensure full protection of your right of appeal to the Court, you must file your Notice of Appeal with the Court, not with the Board, or any other VA office.

How do I file a motion for reconsideration? You can file a motion asking the BVA to reconsider any part of this decision by writing a letter to the BVA clearly explaining why you believe that the BVA committed an obvious error of fact or law, or stating that new and material military service records have been discovered that apply to your appeal. It is important that such letter be as specific as possible. A general statement of dissatisfaction with the BVA decision or some other aspect of the VA claims adjudication process will not suffice. If the BVA has decided more than one issue, be sure to tell us which issue(s) you want reconsidered. Issues not clearly identified will not be considered. Send your letter to:

Director, Management, Planning and Analysis (014)
Board of Veterans’ Appeals
810 Vermont Avenue, NW
Washington, DC 20420

CONTINUED
Remember, the Board places no time limit on filing a motion for reconsideration, and you can do this at any time. However, if you also plan to appeal this decision to the Court, you must file your motion within 120 days from the date of this decision.

How do I file a motion to vacate? You can file a motion asking the BVA to vacate any part of this decision by writing a letter to the BVA stating why you believe you were denied due process of law during your appeal. For example, you were denied your right to representation through action or inaction by VA personnel, you were not provided a Statement of the Case or Supplemental Statement of the Case, or you did not get a personal hearing that you requested. You can also file a motion to vacate any part of this decision on the basis that the Board allowed benefits based on false or fraudulent evidence. Send this motion to the address above for the Director, Management, Planning and Analysis, at the Board. Remember, the Board places no time limit on filing a motion to vacate, and you can do this at any time. However, if you also plan to appeal this decision to the Court, you must file your motion within 120 days from the date of this decision.

How do I file a motion to revise the Board's decision on the basis of clear and unmistakable error? You can file a motion asking that the Board revise this decision if you believe that the decision is based on "clear and unmistakable error" (CUE). Send this motion to the address above for the Director, Management, Planning and Analysis, at the Board. You should be careful when preparing such a motion because it must meet specific requirements, and the Board will not review a final decision on this basis more than once. You should carefully review the Board's Rules of Practice on CUE, 38 C.F.R. 20.1400 -- 20.1411, and seek help from a qualified representative before filing such a motion. See discussion on representation below. Remember, the Board places no time limit on filing a CUE review motion, and you can do this at any time.

How do I reopen my claim? You can ask your local VA office to reopen your claim by simply sending them a statement indicating that you want to reopen your claim. However, to be successful in reopening your claim, you must submit new and material evidence to that office. See 38 C.F.R. 3.156(a).

Can someone represent me in my appeal? Yes. You can always represent yourself in any claim before VA, including the BVA, but you can also appoint someone to represent you. An accredited representative of a recognized service organization may represent you free of charge. VA approves these organizations to help veterans, service members, and dependents prepare their claims and present them to VA. An accredited representative works for the service organization and knows how to prepare and present claims. You can find a listing of these organizations on the Internet at: http://www.va.gov/vso. You can also choose to be represented by a private attorney or by an "agent." (An agent is a person who is not a lawyer, but is specially accredited by VA.)

If you want someone to represent you before the Court, rather than before VA, then you can get information on how to do so by writing directly to the Court. Upon request, the Court will provide you with a state-by-state listing of persons admitted to practice before the Court who have indicated their availability to represent appellants. This information, as well as information about free representation through the Veterans Consortium Pro Bono Program (toll free telephone at: (888) 838-7727), is also provided on the Court's website at: http://www.uscourts.capec.gov.

Do I have to pay an attorney or agent to represent me? An attorney or agent may charge a fee to represent you after a notice of disagreement has been filed with respect to your case, provided that the notice of disagreement was filed on or after June 20, 2007. See 38 U.S.C. 5904; 38 C.F.R. 14.636. If the notice of disagreement was filed before June 20, 2007, an attorney or accredited agent may charge fees for services, but only after the Board first issues a final decision in the case, and only if the agent or attorney is hired within one year of the Board’s decision. See 38 C.F.R. 14.636(c)(2).

The notice of disagreement limitation does not apply to fees charged, allowed, or paid for services provided with respect to proceedings before a court. VA cannot pay the fees of your attorney or agent, with the exception of payment of fees out of past-due benefits awarded to you on the basis of your claim when provided for in a fee agreement.

Fee for VA home and small business loan cases: An attorney or agent may charge you a reasonable fee for services involving a VA home loan or small business loan. See 38 U.S.C. 5904; 38 C.F.R. 14.636(d).

Filing of Fee Agreements: In all cases, a copy of any fee agreement between you and an attorney or accredited agent must be sent to the Secretary at the following address:

Office of the General Counsel (022D)
810 Vermont Avenue, NW
Washington, DC 20420

The Office of the General Counsel may decide, on its own, to review a fee agreement or expenses charged by your agent or attorney for reasonableness. You can also file a motion requesting such review to the address above for the Office of the General Counsel. See 38 C.F.R. 14.636(i); 14.637(d).