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Board of Veterans Appeals
P.O. Box 27063
Washington, DC 20038

4/06/2019

Re:
In reply to: (undated)

Rebuttal of SSOC Issued 3/28/2019
Opt in to New AMA

Appellant, through counsel hereby rebuts the SSOC dated 3/28/2018. A longitudinal review of the claims file and the VBMS electronic record shows the SSOC appears to be an updated answer to the VA 9 filed on 12/20/2018 as well as an update to the SOC issued 11/20/2018 (in reference to 216/BH). The Secretary also notes the 11/20/2018 SOC is an extremely belated response to the NOD filed 2/05/2016 in what appears on its face to ensure compliance with §19.29-19.30. A VAF 8 cannot be issued until a SOC has been issued. Here, it appears the submission of appellant's VA 9 has prompted extensive introspection of the 2015 claims' jurisdictional posture.

Initially, appellant filed his VA 9 begging the VBA to conserve scarce judicial resources and adjudicate *all* appellant's claims. Sadly, the Secretary has elected to pursue this in a piecemeal fashion and ignore his own regulations.

To begin with, the SSOC declares in the decision that a separate evaluation for PTSD, already a matter of record for almost four years (9/09/2015), is "denied". This begs the question of the absence in the claims file of any reduction notice, rating decision or due process notification discussing a denial of a "separate rating". This is a clear violation of §19.31 Supplemental Statement of the Case- to wit:

"In no case will a Supplemental Statement of the Case be used to announce decisions by the agency of original jurisdiction on issues not previously addressed in the Statement of the Case. §19.31 (2019)

Nowhere in the four corners of the 11/28/2018 SOC can appellant or counsel discern anything more than an increased grant of 50% for anything related to PTSD. Counsel will discuss this further below.

Application of §4.124a

"Regulatory interpretation begins with the language of the regulation, the plain meaning of which is derived from its text and its structure." Petitti v. McDonald, 27 Vet.App. 415, 422 (2015); see Good Samaritan Hosp. v. Shalala, 508 U.S. 402, 409 (1993) ("The starting point in interpreting a statute [or regulation] is its language.").

By operation of law, DC 8045 (Traumatic Brain Injury) clearly and unmistakably contains three distinct areas of cognitive impairment –i.e. "conditions"-to wit: Cognitive, Subjective and Emotional/ Behavioral symptoms. Continuing, under emotional/behavioral symptoms the Secretary's regulation states:

Evaluate emotional/behavioral dysfunction under § 4.130 (Schedule of ratings - mental disorders) when there **is** a diagnosis of a mental disorder. **When there is no diagnosis of a mental disorder, evaluate emotional/behavioral symptoms under the criteria in the table titled "Evaluation of Cognitive Impairment and Other Residuals of TBI Not Otherwise Classified."** (emphasis added).

The Secretary's regulations permits appellant two separate and distinct ratings for TBI and PTSD. As appellant currently has a separate rating for PTSD under DC 9411, it cannot be read any other way to conflate the two into one "disorder" as the VA examiner blithely attempts to do in the SSOC.

Additionally, in Note(1) following ratings criteria, the Secretary offers the following guidelines for TBI ratings:

Note (1): There may be an overlap of **manifestations of conditions** evaluated under the table titled "Evaluation Of Cognitive Impairment And Other Residuals Of TBI Not Otherwise Classified" with **manifestations of a comorbid mental** or neurologic or other physical **disorder that can be separately evaluated under another diagnostic code. In such cases, do not assign more than one evaluation based on the same manifestations**. If the manifestations of two or more conditions cannot be clearly separated, assign a single evaluation under whichever set of diagnostic criteria allows the better assessment of overall impaired functioning due to both conditions**. However, if the manifestations are clearly separable, assign a separate evaluation for each condition.**

The clear and unambiguous language of the diagnostic code for the "disorder" (i.e. DC 8045) comprehends pyramiding as evidenced in Note 1. The Diagnostic Code Note simply demands rating comorbidities once under one of appellant's SC diagnostic code- whichever results in the highest rating to preclude pyramiding. It would be error as a matter of law to arbitrarily combine two disabilities into one without due process.

Appellant has been diagnosed with PTSD under DC 9411 with unique, separable symptoms not comprehended by diagnostic code criteria in DC 8045-to wit:

"suspiciousness, directly experiencing the traumatic event, flashbacks, recurrent involuntary and intrusive distressing memories of the traumatic events, recurrent distressing dreams, intense or prolonged distress at exposure to internal or

external stimuli that symbolize or resemble an aspect of the traumatic event, marked physiological reactions to same" (see the 11/26/2018 VES PTSD DBQ in VBMS (DBQ-05FDO88F-31F6-45F9-A7D2-1BF1E9D613EE-22618935255-16036.pdf System source DAS). See also **Exhibit A**

As these PTSD symptoms/conditions/ manifestations are not comprehended by the schedule in DC 8045 (i.e. co-morbid conditions), they are separate and distinct and may not be counted as residuals of neurological conditions under DC 8045.

The evidence of record clearly and unmistakably reveals appellant was awarded entitlement to PTSD for events relating to his combat experiences which have no commonality with his being struck by a jeep at An Khe on 9/21/1968. TBI and PTSD disorders are not related in any way to one another. While they may share one identified comorbidity, TBI and PTSD share no commonality.

Clear and Unmistakable Error

In the instant SSOC dated 3/28/2019, the Secretary misinterprets his own regulations. He attempts to reduce appellant's 50% rating for PTSD to not just zero but to remove it entirely from the confirmed ratings sheet. The problem is a simple dictionary mishap by conflating the term "disorder" with "condition". On the one hand, disorders are listed by diagnostic codes. Post-Traumatic Stress **Disorder** is a "disorder" just as it is described. Likewise, Traumatic Brain Injury is listed under §4.124a as Neurological Conditions and Convulsive **Disorders.** That makes these diseases "disorders".

Miriam Webster Dictionary defines disorder as a noun thusly:

"an abnormal physical or mental condition"

Likewise, Webster defines condition as :

"a usually defective state of health" as in *a serious heart condition.*

VA has chosen to list illnesses and injuries under diagnostic codes to include the major known disorders. Conditions necessarily can never rise to the level of a disorder. The Secretary lists conditions under the proper diagnostic code for the disorder which the condition most closely resembles.

"Conditions", or manifestations, are debilitating symptoms ranked to rate the severity of the diagnosed "disorder". Both DC 8045 and 9411 list "conditions" (aka manifestations, symptomology) which determine the correct rating percentage for their respective disorders. As the Secretary remarks in Note 1 of DC 8045, certain symptoms (conditions or manifestations)) have a commonality in mental disorders. The medical term is "comorbidity". The clear and unmistakable thrust of the note is to prevent pyramiding under two different diagnostic codes. See §4.14.

In the prelude of DC 8045 discussing emotional and behavioral dysfunction, the Secretary instructs the VA examiner to include *all* manifestations (i.e. symptoms or conditions) under DC 8045-but only when there is ***no*** diagnosis of a mental disorder. In the instant case, the appellant is rated 50% for Post-Traumatic Stress **Disorder** under DC 9411. Thus, the appellant is clearly and unequivocally entitled to an independent rating for a mental **disorder** separate and distinct from his Traumatic Brain Injury **Disorder.**

It would be Clear and Unmistakable error to simply eliminate entitlement to a 50% rating for PTSD and attempt to combine it with appellant's TBI disorder under color of law. Counsel eagerly awaits reading the rule of law or Federal precedental cite that permits this.

The 11/14/2018 Neurological C&P Review

On 11/14/2018, the VA examiner asked VES subcontractor Kidwai Sharoz, MD. to opine on whether appellant had both a diagnosed TBI and a co-existing **separate psychiatric disorder** (PTSD). The Examiner also asked the neurologist to state, to the extent possible, which emotional/behavioral signs and symptoms (i.e. "conditions") are parts of the co-existing mental disorder and which represent residuals of his TBI Disorder. See Exhibit A.

A second request was made that, if it was impossible to make such a determination without speculation, please so state and provide a supporting rationale for why differentiation for the condition is **not** possible without speculation.

Dr. Sharoz replied and stated:

"*Veteran has co-existing PTSD, Panic attack with agoraphobia* and it's impossible to differential [sic] between two without speculation. Symptom overlap between PTSD/Panic disorder and TBI symptoms."

It should be noted that Dr. Sharoz did not offer any supporting rationale as to *why* it was impossible to differentiate between which disorder was responsible for the panic attack with agoraphobia. In fact, Dr. Sharoz stated his answer not in terms of multiple comorbid conditions- but as a *disorder and a condition.*

Reasonable minds can interpret this response to say "*Veteran has co-existing separate psychiatric disorder of PTSD. Regarding the condition of panic attacks due to agoraphobia, it is impossible to differentiate as to whether it is attributable to his PTSD or the TBI. I offer no supportive rationale for my opinion*". Absent any rationale for his conclusion, the opinion is entitled to no weight. A VA medical examination report is entitled to no weight if it contains only data and conclusions. Nieves-Rodriguez v. Peake, 22 Vet. App. 304 (2008)

The clear and unambiguous language of the diagnostic code for the TBI "disorder" (i.e. DC 8045) comprehends pyramiding as evidenced in Note 1. The Diagnostic Code Note simply demands rating comorbidities once under the diagnostic code which results in the highest rating to preclude pyramiding.

As the greater majority of the PTSD symptoms (conditions) are not comprehended by the schedule in DC 8045 (i.e. co-morbid conditions), they are separate and distinct and may not be counted under §4.124a's table. The evidence of record clearly and unmistakably reveals appellant was awarded entitlement to PTSD for events relating to his combat experiences in Vietnam which has no commonality with his being struck by a jeep at An Khe, Vietnam on 9/21/1968.

Presumption of Regularity

Appellant asks for the VA to invoke the presumption of regularity under Miley. The presumption of regularity of the competence of VA examiners is embodied in Sickels v. Shinseki, 643 F.3d, 1362, 1365-66 (Fed. Cir. 2011) (holding that the Board is "entitled to assume" the competency of a VA examiner and the adequacy of a VA opinion without "demonstrating why the medical examiners' reports were competent and sufficiently informed"); ("there is a presumption of regularity under which it is presumed that government officials 'have properly discharged their official duties."' Ashley v. Derwinski, 2 Vet. App. 307, 308 (1992) (quoting United States v. Chem. Found., Inc., 272 U.S. 1 (1926)).

The presumption of regularity provides that, in the absence of clear evidence to the contrary, the court will presume that public officers have properly discharged their official duties. Butler v. Principi, 244 F.3d 1337, 1339 (Fed.Cir. 2001). See also Miley v. Principi, 366 F.3d 1343, 1347 (Fed. Cir. 2004) quoting Butler.

Further, in Rizzo v. Shinseki, 580 F.3d 1288, 1290–91 (Fed. Cir. 2009), it was held: "what appears regular is regular and what appears irregular is irregular- the burden of proof of irregularity falling on the appellant to rebut."

Moreover, there is a presumption of regularity under which it is must be assumed that the RO would have associated the medical records with the claims file and acted on them in some manner if received. See Fithian v. Shinseki, 24 Vet. App. 146, 151 (2010).

Appellant presumes the competence of the VA examiner in the performance of his duties. The Secretary has issued a finding of fact that appellant is entitled to 50% for PTSD. This situation has been static for almost 4 years. Announcing a reduction via a SSOC of matters never discussed in the SOC is, however, a different matter. Likewise, refusal to adjudicate all appellant's claims to include reconsideration of his 5/29/1972 claims under §3.156(c) can only be seen as an arbitrary refusal to act.

Legal Standard of Review

The pendency of the appeals for PTSD and TBI have transcended almost four years. In that time, entitlement has been granted and indeed, PTSD was increased from 30% to 50%, all the while in the presence of a concurrent rating for TBI. At no time was there any note of co-morbidity of symptomatology. While the Secretary is free to opine on same, the evidence does not support the supposition that the mental dysfunctions are indistinguishable from the cognitive deficits. To support that, a finding of clear and unmistakable error would require reduction of one or both ratings but not wholesale conflation of two disorders into one. The Secretary's own regulations forbid this with any diagnostic code absent due process.

It's presumed the Secretary knew what he was doing when he awarded entitlement for both PTSD at 30% and TBI at 70% effective on the very same day (9/09/2015) (see Sickels *supra*). The award was a positive finding of fact and can only be overturned by a finding of CUE.

Litigating positions are accorded no weight when they consist of post hoc rationalizations. Martin v. Occupational Safety and Health Research Council (89-1541), 499 U.S. 144 (1991). Here, the VA attempts to gerrymander a rating into a de facto reduction under color of law. Nowhere in the SSOC is there any mention of due process guaranteed under §3.105(e). The legal standard of review demands there be an accounting of all the disabilities listed under each disease/injury and a weighing of the elements for comorbidity. This ensures there will be no pyramiding of conditions counted twice. Here, the VA examiner lists five symptoms which might be construed as being comorbid. As he is in not a doctor, this would be a subjective assessment in any scenario (See Colvin v. Derwinski 1 Vet.App. 171, 175 (1991). The VES neurologist found only one comorbidity- panic attacks. The Examiner attempts to inflate that to 5. However, this ignores appellant's service connected PTSD with few items similar from any listed in DC 4.124a- to wit: suspiciousness, directly experiencing the traumatic event, flashbacks, recurrent involuntary and intrusive distressing memories of the traumatic events, recurrent distressing dreams, intense or prolonged distress at exposure to internal or external stimuli that symbolize or resemble an aspect of

the traumatic event, marked physiological reactions to same. There are no subjective criteria in DC 8045 to comprehend these manifestations of mental debility-nor would there be. TBI and PTSD are separate and distinct disorders-each with its own set of manifestations/conditions/symptoms unique to the disorder.

Illegal Reduction Without Due Process

§3.105(e) is unequivocal on reductions of ratings:

(e)*Reduction in evaluation - compensation.* 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 will be prepared setting forth all material facts and reasons. The beneficiary will be notified at his or her latest address of record of the contemplated action and furnished detailed reasons therefor, and will be given 60 days for the presentation of additional evidence to show that compensation payments should be continued at their present level. Unless otherwise provided in paragraph (i) of this section, if additional evidence is not received within that period, 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 beneficiary of the final rating action expires.(Authority:38 USC§ 5112(b)(6)).

As the Secretary has made no proposal to reduce appellant's PTSD rating, let alone show unarguable supportive rationale for co-morbidity of symptomatology between his diagnosed TBI and PTSD disorders, any reduction or incorporation of the ratings into one diagnostic code is void ab initio. By operation of law, any attempt to do so would be a de facto reduction without due process guaranteed under §3.103(a)(b)(1).

Lastly, Dr. Sharoz has identified only one "comorbid" condition common to both appellant's PTSD and TBI- to wit: "panic attack with agoraphobia". The VA Examiner cites to as many as five but there is no supportive medical evidence to sustain the finding of fact. See page 8 of 9 of Review Evaluation of Residuals of TBI DBQ dated 11/14/2018. As such, the finding is erroneous. In order to sustain this finding, the Secretary must show a clear and unmistakable error was committed that manifestly changed the outcome. Appellant welcomes judicial review to discern any outcome determinative error. Cases "must be decided on the law as we find it, not on the law as we would devise it." Mitchell v. McDonald, 27 Vet.App. 431, 440 (2015).

Application of 38 CFR §3.156(c)

The 800 lb. elephant in the room is obvious here. The Secretary has finally elected to answer the NOD filed 2/05/2016 with the belated 11/20/2018 SOC which incorporated a continued denial of tinnitus as a subjective complaint under DC 8045. These arguments have been unavailing now for almost four years. Suddenly, with the introduction of service department records obtained from the William Beaumont Army Medical Center in June 2018, the Secretary has opted to grant belated entitlement to Tinnitus- albeit on a direct basis rather than as a subjective manifestation of his diagnosed TBI. This smacks of a post hoc rationalization for something that should have occurred in 1972. In addition, Counsel contacted the VA examiner on 11/28/2018 to discuss the import of service department records which had only now been associated with the claims file. The Examiner filed a Report of General Information wherein he acknowledged receipt of the additional service records. Thus the Secretary accepted constructive possession of service department records that had never been associated prior to 6/2018. See Bell v. Derwinski , 2 Vet. App. 611 (1992). See also McWhorter v. Derwinski, 2 Vet.App. 133, 136 (1991). However, the Secretary refuses to perform the reconsideration of the 1972 claims. See **Exhibit B** Report of General Information dated 11/28/2018.

The pertinent sections of §3.156(c) state in no uncertain terms:

> **(1) Notwithstanding any other section in this part, at any time after VA issues a decision on a claim, if VA receives or associates with the claims file relevant official service department records that existed and had not been associated with the claims file when VA first decided the claim, VA will reconsider the claim**, notwithstanding paragraph (a) of this section. Such records include, but are not limited to:
>
> > **(i**) Service records that are related to a claimed in-service event, injury, or disease, regardless of whether such records mention the veteran by name, as long as the other requirements of paragraph (c) of this section are met;
>
> **(2)**Paragraph (c)(1) of this section does not apply to records that VA could not have obtained when it decided the claim because the records did not exist when VA decided the claim, **or because the claimant failed to provide sufficient information for VA to identify and obtain the records from the respective service department,** the Joint Services Records Research Center, or from any other official source.
>
> **(3) An award made based all or in part on the records identified by paragraph (c)(1) of this section is effective on the date entitlement arose or the date VA received the previously decided claim, whichever is later,** or such other date as may be authorized by the provisions of this part applicable to the previously decided claim.
>
> **(4)** A retroactive evaluation of disability resulting from disease or injury subsequently service connected on the basis of the new evidence from the service department must be supported adequately by medical evidence. Where such records clearly support the assignment of a specific rating over a part or the entire period of time involved, a retroactive evaluation will be assigned accordingly, except as it may be affected by the filing date of the original claim. (§3.156(c) (2019) (emphasis added)

Appellant satisfies §3.156(c)(2). Please note on page 3 of his VAF 21-526, dated 5/31/1972, that he explicitly identified Wm. Beaumont Army Medical Center as a repository for medical records in Box 25 C. See **Exhibit G** VAF 21-526 dated 5/31/1972

Reconsideration of the 5/31/1972 claim

It has long been a matter of record that appellant was struck from behind on 9/21/1968 by a one quarter-ton M 151 jeep traveling approximately 35 mph. The force of the collision tore off the bottom of appellant's jungle boot. Numerous injuries were noted and appellant has credibly attested to them under oath in great detail. He was medically evacuated to Camp Drake (249th Army Evac Hospital in Japan). The records are now associated with the claims file as are the medical records from Wm. Beaumont Army Medical Center where he was an inpatient for sixteen weeks. See STRs in VBMS uploaded 6/2018.

Appellant is capable of testifying to that which comes to him via his five senses. See Layno v. Brown, 6 Vet. App. 465, 470 (1994) (a Veteran is competent to report on that of which he or she has personal knowledge). Given the vast amount of new evidence recently associated with the claims file, the benefit of the doubt as to the effective date is for application. The nature of the injuries appellant claims is not incredible given the facts of the accident. In fact, it would be virtually impossible to be struck in such a fashion and not sustain traumatic brain injuries from it.

One of the documents recently obtained from the PIES request, authored by one James I. Freeman MD, Lt. Col, dated 10/04/1968 discusses the x ray report. Dr. Freeman stated the following about the x ray results on 10/04/1968 :

"There is a missile tract passing through the anterior Lt. mandible just medial to the mental foramen. An undisplaced fracture line extends superiorly and inferiorly from this missile injury. Some small bone fragments are displaced inferiorly into the soft tissues. The upper and lower teeth are wired together."

For the record, a "missile injury", as defined in §4.56(d)(3)(i) is defined as a moderately severe muscular disability:

(3)Moderately severe disability of muscles -

(i)Type of injury. Through and through or deep penetrating wound by small high velocity missile or large low-velocity missile, with debridement, prolonged infection, or sloughing of soft parts, and intermuscular scarring.

(ii)History and complaint. Service department record or other evidence showing hospitalization for a prolonged period for treatment of wound. Record of consistent complaint of cardinal signs and symptoms of muscle disability as defined in paragraph (c) of this section and, if present, evidence of inability to keep up with work requirements.

(iii)Objective findings. Entrance and (if present) exit scars indicating track of missile through one or more muscle groups. Indications on palpation of loss of deep fascia, muscle substance, or normal firm resistance of muscles compared with sound side. Tests of strength and endurance compared with sound side demonstrate positive evidence of impairment. §4.56(2019)

Dr. Freeman determined an external object struck and penetrated appellant's jaw with such force as to not only break it but to separate and shatter the jaw bone. This injury alone to the head would be productive of TBI in its own right. Based on this medical observation, it is unarguable a "missile", independent of the M 151 jeep, struck appellant in the jaw. See **Exhibit F** 10/04/1968 STR X ray results. The bone fragments eventually migrated through appellant's mouth. He still has a leak into the sinus passage.

A medical record dated 10/08/1968 recently associated with the c file from Beaumont Army Medical Center mentions "dressings under window" for a left hip injury. It would be reasonable to assume a cataclysmic event such as appellant suffered resulted in numerous musculoskeletal injuries-both visible and invisible –and not all of which were annotated in his records. The mention of a need for dressings for left hip would confirm this. See **Exhibit C** 10/08/1968 STR.

Another record dated the day of the injury (9/21/1968) notes "c/o[complains of] pain in Lt face, Lt leg and Lt buttocks." Another note on the same record states " Contusions Lt buttocks Lt knee. Swelling over medial malleolus Lt ankle." See **Exhibit D** STRs dated 9/21/1968.

To say the injuries were strictly a broken ankle and broken jaw, as the Secretary contends, ignores the new and material evidence in the service department records recently associated with the claims file in 2018.

The Rating Decision, dated 3/07/1973 states under section F paragraph two: **"There is no evidence of any complaint or treatment for a right thigh or buttocks disorder**, curvature of the spine or earaches." This is now clearly rebutted by the newly associated service department records. (emphasis added) **Exhibit E** Rating Decision 3/07/1973.

A longitudinal review of the VBMS shows the Secretary sent out PIES requests to Fort Rucker, Alabama, Camp Drake, Asaka, Japan and to William Beaumont Army Medical Center in 2018. The requests yielded numerous probative service department records which had never been associated with appellant's claims file. As such, these required a brand new reconsideration of the original 5/31/1972 claim for the same injuries pursuant to the Secretary's very own regulations. The Secretary refuses to comply with §3.156(c) and even goes so far as to arbitrarily ignore the legal standard of review required for same in the 3/28/2019 SSOC. It should be remembered that the admonition in the preamble of §3.156(c)(1) is compulsory.

"***At any time after VA issues a decision on a claim***, if VA receives or associates with the claims file relevant official service department records that existed and had not been associated with the claims file when VA first decided the claim, **VA will reconsider the claim**." To date the Secretary has yet to acknowledge the service department records have any bearing on a new decision.

As the Secretary insists the decision to grant entitlement to Tinnitus is on a **direct basis** rather than as subjective symptomology of his TBI, it can only be surmised that the recent addition of the service department records was the predicate for the 3/27/2019 grant. There have been no new additions to the claims file in

the form of compensation and pension examinations within the pendency of the claims filed on 5/23/1972 and 9/15/2015 that would support a grant of these entitlements. In point of fact, the Secretary baldly states in the 3/27/2019 decision granting SC for tinnitus:

"We received additional information and evidence for reconsideration. Additional examinations were conducted based on a discovery new and relevant evidence [sic] in the form of entrance and separation audio shifts, the likelihood of military noise exposure, and additional information submitted for our review.

In reviewing the evidence, it was shown that there was a positive opinion linking tinnitus to your military noise exposure and your hearing loss. Although you were shown to have this as part of your complaint of traumatic brain injury, the VA has granted this issue on a direct basis based on the preponderance of the evidence shown upon objective examination findings.

A favorable finding was shown in the form of a current diagnosed condition, a diagnosed hearing loss condition and the likelihood of military noise exposure."

As a side note, the neurological examination review by Dr. Sharoz on 11/14/2018 *unequivocally* attributed appellant's hearing loss/tinnitus *not* to his service exposure but to the Traumatic Brain Injury incurred in service on 9/21/1968. Nevertheless, The VA examiner ignored this and granted entitlement based on a *direct* basis. There is no explanation for this disparity. (See page 6 of 9 of the 11/14/2018 DBQ). As this is a positive finding of fact that supports the contention that it was predicated on the recent addition of service department records, appellant is copacetic with the finding.

It has long been a matter of record that appellant was a crew member on a UH-1 Huey gunship during his military service. He often operated M 60A1 .308 caliber machineguns in the performance of his duties. He served two tours of duty in Vietnam in this capacity. His DD 214 unequivocally shows his MOS was

helicopter aircrew member. This has been a matter of record for 49 years since his separation on 5/03/1970. There is nothing new here to base a grant of tinnitus on and notably it hasn't been granted in 49 years.

Reasonable minds can only concur that the "additional evidence and information" is none other than the introduction on the service department records from Beaumont Army Medical Center as the pivotal reason for this sudden decision to grant entitlement on a direct basis after forty seven years of denials. As such, §3.156(c)(3),(4) is for application. See Blubaugh v. McDonald 773 F.3d 1310 (2014).

Application of 38 USC §1154b

Appellant has never been accorded 38 USC 1154b recognition as a combat Veteran. His revised DD215, issued only recently on 06/15/2017, shows, inter alia, awards for the Bronze Star and the Army Commendation Medal during a period of combat. 38 USC §1154b holds:

(b) In the case of any veteran who engaged in combat with the enemy in active service with a military, naval, or air organization of the United States during a period of war, campaign, or expedition, **the Secretary shall accept as sufficient proof of service-connection of any disease or injury alleged to have been incurred in or aggravated by such rvice satisfactory lay or other evidence of service incurrence or aggravation of such injury or disease, if consistent with the circumstances, conditions, or hardships of such service, notwithstanding the fact that there is no official record of such incurrence or aggravation in such service, and, to that end, shall resolve every reasonable doubt in favor of the veteran.** Service-connection of such injury or disease may be rebutted by clear and convincing evidence to the contrary. The reasons for granting or denying service-connection in each case shall be recorded in full.

Towards that end, appellant wishes to point out a recently received service department record that rebuts the 3/07/73 rating decision's finding of fact that there is no evidence of a right buttock injury relating to the 9/21/1968 jeep accident. **Exhibit D** 9/21/1968 STRs. Appellant's credibility should not be in contention.

While appellant's injuries occurred during a lull in combat during the refueling of his helicopter preparatory to additional engagement with the enemy, the service department medical records are unequivocal that the TBI was incurred in the line of duty. As both tinnitus and headaches are a long-known subjective symptom of TBI, the benefit of the doubt was for application-both then and now. Part IV, VA Schedule for Rating Disabilities, published in the Federal Register on 5/22/1964 lists the following under DC 8045 Brain Disease due to Trauma:

Purely subjective complaints, such as headaches, dizziness and insomnia, tinnitus etc., recognized as symptomatic of brain trauma, will be rated 10% and no more under Diagnostic code 9304. (VASRD §4.124a, DC 8045(1964))

Thus the effective date for the recent award of Tinnitus should be reconsidered under §3.156(c) rather than reopened and awarded under §3.156(a). Appellant complained of "earaches" for want of a better term to describe his ear troubles. Lacking medical training, appellant was unable to articulate his tinnitus and hearing loss adequately in 1972. See Clemons v. Shinseki , 23 Vet. App. 1,5 (2009) (Although an appellant who has no special medical expertise may testify as to the symptoms he can observe, he generally is not competent to provide a diagnosis that requires the application of medical expertise to the facts presented, which includes the claimant's description of history and symptomatology). Appellant was also unrepresented which should have heightened the duty to construe the claims sympathetically.

Considering the nature of the injury, a full neurological and psychiatric examination was required by law under §4.42 (1972). In addition, §§4.40,4.41 were implicated and ignored even though the Examiner was well aware of the etiology of the injury. (The importance of complete medical examination of injury cases at the time of the first medical examination by the Veterans Administration cannot be overemphasized.) §4.42(1972)

New Independent Medical Opinion

Counsel for appellant has submitted new and material evidence in the form of an Independent Medical Opinion (IMO) and asked that it be reviewed by a Veterans Law Judge at the Board of Veterans Appeals. This has been annotated in the VBMS and the Secretary has agreed to allow the trier of fact to make the decision. Based on this, the medical opinions voiced by the Subject Matter Expert cannot be a predicate for any revised opinions announced by the Secretary in the SSOC. In any event, the Secretary makes no assertion the IMO was instrumental in changing the decisions to grant entitlement to the two conditions in the SSOC nor integration of the PTSD disorder with the TBI disorder. As such, it remains new and material evidence which has not been incorporated into the decision-making process requiring de novo review by the trier of fact. Appellant hereby waives review of this document by the Agency of Jurisdiction in the first instance.

Application of AB v. Brown, 6 Vet. App. 35 (1993)

Appellant notes with dismay that the recently issued SSOC which is being rebutted here, seems to have the unintended effect of fencing him out of not only a new reconsideration of his 1972 original claim under the aegis of §3.156(c), but also a gross misreading of plain meaning of DC 8045. In addition,

deprivation of consideration of all claims prior to 6/15/2017 under 38 USC §1154b casts a pall as well. AB v Brown (1993) (applicable law mandates that when a veteran seeks an original or increased rating, it will generally be presumed that the maximum benefit allowed by law and regulation is sought, and it follows that such a claim remains in controversy where less than the maximum benefit available is awarded.) In addition, it is the Secretary's duty under §3.103(a) "to render a decision which grants every benefit that can be supported in law while protecting the interests of the Government.

From past adjudications, it would appear appellant was not accorded this due process guarantee. In spite of identifying the records at Wm. Beaumont Army Hospital and obtaining them in a timely manner in 1972, the Secretary has dawdled for 49 years. The duty to assist demands more. Admittedly, appellant did not have adequate legal counsel for the last fifty years but it still would not forgive the more recent attitude of the rating officers (see §4.23 (2019)). See also Comer v. Peake, 552 F. 3d 1362, 1367 (Fed. Cir 2009) (Although we have held that the duty to construe a veteran's filings sympathetically does not necessarily apply when a veteran is represented by an attorney, Andrews v. Nicholson, 421 F.3d at 1283, the assistance provided by the DAV aide is not the equivalent of legal representation).

Considering just the denial for headaches and tinnitus, which were suddenly granted, in conjunction with the arbitrary reduction and conflation of an entire Diagnostic Code into another- without so much as the hyphenation required by §4.27- indicates a ratings procedure run amuck. Appellant was granted an increase from 30% to 50% for his PTSD under DC 9411 less than four months ago. Now the rating has been incorporated into another "disorder" in clear violation of law. The 50% increase for PTSD is a favorable finding of fact and cannot be disturbed absent proof of clear and unmistakable error that manifestly changed the outcome. See also §3.105(e). Absent a legally constructed, coherent SSOC

with which to respond to the Secretary, and without a reconsideration under §3.156(c) in the immediate appeal, it is apparent appellant will be on the VA's hamster wheel for decades to come.

Lastly, as the matter of entitlement to reconsideration under §3.156(c) arose during the pendency of this appeal, the two matters can only be viewed as inextricably intertwined with one another and case law would suggest they be adjudicated simultaneously. See Harris v. Derwinski, 1 Vet. App. 180 (1991). (where a decision on one issue would have a 'significant impact' upon another, and that impact in turn 'could render any review by the Court of the decision [on the claim] meaningless and a waste of judicial resources,' the two claims are inextricably intertwined).

Respectfully submitted,

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Gordon A. Graham
Counsel for Appellant

Attachments:

Exhibit A 11/14/2018 VES Dr.

Exhibit B 11/28/2018 Report of Contact

Exhibit C 10/08/1968 Service Dept. Record (§3.156(c))

Exhibit D 9/21/1968 STRs 17th Field Hospital An Khe, RVN APO 96294

Exhibit E 3/07/1973 Rating Decision

Exhibit F 10/04/1968 X ray results

Exhibit G 5//31/1972 VAF 21-526