BOARD OF VETERANS' APPEALS
DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON, DC 20420

IN THE APPEAL OF [redacted]
JESUS G. ATILANO

DOCKET NO. 97-06 321) DATE *April 18, 2017*
) *TDG*
)

On appeal from the
Department of Veterans Affairs Regional Office in Waco, Texas

THE ISSUES

1. Entitlement to an initial evaluation in excess of 30 percent for coronary artery disease (CAD) status post coronary artery bypass graft (CABG).

2. Entitlement to an initial evaluation in excess of 50 percent for posttraumatic stress disorder (PTSD for the period prior to December 17, 2010, and 70 percent disabling for the period on and after December 17, 2010.

3. Entitlement to an initial compensable evaluation for residual surgical scar status post CABG.

4. Entitlement to an effective date earlier than August 31, 2010 for the grant of service connection for CAD status post CABG.

5. Entitlement to an effective date earlier than August 31, 2010 for the grant of service connection for residual surgical scar, status post CABG.

6. Entitlement to an effective date earlier than August 31, 2010 for the grant of entitlement to a total disability rating based upon individual unemployability (TDIU) due to a service-connected disability.

7. Entitlement to a temporary total evaluation for psychiatric hospitalizations for the Veteran's PTSD from January 9, 1997 to February 7, 1997; August 20, 1997 to October 29, 1997; and from August 7, 2000 to October 20, 2000.

REPRESENTATION

Appellant represented by: Sean Ravin, Esq.

ATTORNEY FOR THE BOARD

S. Keyvan, Counsel

INTRODUCTION

The Veteran had active service from February 1964 to January 1966. He also had service in the Republic of Vietnam from November 1965 until his separation from service.

These matters come before the Board of Veterans' Appeals (Board) on appeal from the September 2010 and September 2012 rating decisions of the Department of Veterans Affairs (VA) Regional Office (RO) in Waco, Texas. In the September 2010 decision, the RO granted service connection for PTSD and evaluated it as 50 percent disabling, effective July 31, 1995. In the September 2012 decision, the RO granted service connection for CAD status post CABG, and evaluated this disability as 30 percent disabling, effective August 31, 2010. The RO also granted service connection for residual surgical scar, status post CABG, and evaluated this disorder as noncompensably disabling. In addition, the RO continued the 50 percent

disabling rating for the Veteran's service-connected PTSD, and denied the claim of entitlement to a TDIU. In the January 2013 notice of disagreement (NOD), the Veteran disagreed with the disability ratings and effective dates assigned for his service-connected disorders, and further disagreed with the denial of his claim for a TDIU. The only submission or communication from the Veteran that may be construed as an NOD with the September 2010 rating decision was the December 2010 application for a TDIU. Also, VA was in receipt of new and material medical evidence within one year of the September 2010 rating decision which addressed the Veteran's psychiatric disorder, and therefore, must relate any subsequent decision back to this original claim. 38 C.F.R. § 3.156 (b) (2016); *see Buie v. Shinseki*, 24 Vet. App. 242, 252-52 (2010). As such, with regard to the Veteran's PTSD claim, both periods of appeal from July 31, 1995 to December 16, 2010, and from December 17, 2010 to the present time, are currently on appeal before the Board.

By way of the December 2014 rating decision, the RO increased the disability rating for the Veteran's PTSD to 70 percent disabling, effective December 17, 2010. *See Fenderson v. West*, 12 Vet. App. 119, 126 (1999) (where evidence indicates that the degree of disability increased or decreased during appeal period following the assignment of the initial rating, "staged" ratings may be assigned for separate periods of time based on facts found). In the January 2015 VA form 9, the Veteran did not express satisfaction with these ratings or effective dates assigned. Accordingly, these issues remain in appellate status for the entire appeal period. *AB v. Brown*, 6 Vet. App. 35 (in which the United States Court of Appeals for Veterans Claims (Court) stipulated that, unless a veteran expresses a desire for a specific rating for a service-connected disability, he/she is presumed to be seeking the maximum benefit permitted under the regulations).

The RO also granted the Veteran's claim for entitlement to a TDIU, effective August 31, 2010. In the August 2016 Appellant's Informal Brief, the Veteran, through his attorney, requested a TDIU for the period prior to August 31, 2010. *See Rice v. Shinseki*, 22 Vet. App. 447 (2009) (A claim for a TDIU, either expressly raised by the Veteran or reasonably raised by the record, involves an attempt to

obtain an appropriate rating for a disability and is part of the claim for an increased rating).

The issues of entitlement to an initial rating in excess of 30 percent for service-connected CAD status post CAGB, and an initial compensable rating for residual scar, status post CABG are addressed in the REMAND portion of the decision below and are REMANDED to the Agency of Original Jurisdiction (AOJ).

FINDINGS OF FACT

1. The Veteran's claim of service connection for a heart condition was received by VA on March 16, 2009; no formal or informal claim of service connection for a heart disability was received prior to that date.

2. By rating decision dated in September 2012, the RO granted service connection for CAD status post CABG, and awarded an effective date of August 31, 2010 pursuant to a liberalizing regulation change and a special review mandated by a class action settlement; the Veteran's service personnel records reflect that he had service in the Republic of Vietnam.

3. For the period prior to December 17, 2010, the Veteran's service-connected PTSD did not manifest as suicidal ideation that caused occupational and social impairment with deficiencies in most areas; or in obsessional rituals which interfere with routine activities; speech 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 work-like setting); inability to establish and maintain effective relationships, or symptoms of like kind.

4. For the period prior to December 17, 2010, the Veteran's service-connected PTSD resulted in less than severe impairment in his ability to establish and maintain

effective or favorable relationships with people and less than severe impairment in the ability to obtain and retain employment.

5. For the period on and after December 17, 2010, the Veteran's psychiatric disability did not result in total occupational and social impairment and did not result in more than some impairment in the ability to establish and maintain effective or favorable relationships with people and some impairment in the ability to obtain and retain employment.

6. For the period from March 16, 2009 through August 30, 2010, the Veteran's PTSD together with his CAD status post CABG rendered him unable to secure and follow a substantially gainful occupation.

7. For the period prior to March 16, 2009, the Veteran's service-connected disabilities did not render him unable to secure and follow a substantially gainful occupation.

8. From January 9, 1997 to February 7, 1997, the Veteran was hospitalized at the VA Medical Center (VAMC) in Big Spring, Texas, for his PTSD and symptoms associated with his PTSD.

9. From August 20, 1997 to October 29, 1997, and from August 7, 2000 to October 20, 2000, the Veteran was hospitalized at the VAMC in Waco, Texas, for his PTSD and symptoms associated with his PTSD.

10. For the period from March 16, 2009, the Veteran has a combined disability rating of 70 percent, which includes a 50 percent rating for PTSD, a 30 percent rating for CAD status post CABG, and a noncompensable rating for residual surgical scar, status post CABG.

CONCLUSIONS OF LAW

1. The criteria for an effective date of March 16, 2009 for the award of service connection for CAD status post CABG have been met. 38 U.S.C.A. §§ 5101 (a), 5103, 5103A, 5107, 5110 (West 2014); 38 C.F.R. §§ 3.1 (p), 3.102, 3.151, 3.155, 3.159, 3.314, 3.400, 3.816 (2016).

2. The criteria for an effective date of March 16, 2009 for the award of service connection for residual surgical scar, status post CABG have been met. 38 U.S.C.A. §§ 5101 (a), 5103, 5103A, 5107, 5110 (West 2014); 38 C.F.R. §§ 3.1 (p), 3.102, 3.151, 3.155, 3.159, 3.314, 3.400, 3.816 (2016).

3. The criteria for an initial disability rating greater than 50 percent for PTSD for the period prior to December 17, 2010, have not been met. 38 U.S.C.A. §§ 1155, 5107 (West 2014); 38 C.F.R. §§ 3.102, 4.7, 4.130, Diagnostic Code 9411 (2016); 38 C.F.R. § 4.132, Diagnostic Code 9411 (1996).

4. The criteria for an initial disability rating greater than 70 percent for PTSD for the period from December 17, 2010 have not been met. 38 U.S.C.A. §§ 1155 , 5107 (West 2014); 38 C.F.R. §§ 3.102 , 4.7, 4.130, Diagnostic Code 9411 (2016); 38 C.F.R. § 4.132, Diagnostic Code 9411 (1996).

5. The criteria for TDIU are met from the period from March 16, 2009 through August 30, 2010. 38 U.S.C.A. §§ 1155, 5107 (West 2014); 38 C.F.R. §§ 3.340, 3.341, 4.16(a), 4.19, 4.25 (2016).

6. For the period prior to March 16, 2009 a TDIU rating is not warranted; referral for extraschedular consideration is not warranted. 38 U.S.C.A. §§ 1155, 5107 (West 2014); 38 C.F.R. §§ 3.340, 3.341, 4.16, 4.19, 4.25 (2016).

7. From January 9, 1997 to February 7, 1997, the criteria for a temporary total evaluation for a hospitalization have been met. 38 U.S.C.A. §§ 1155, 5107(b); 38 C.F.R. §§ 3.321 (b)(1), 4.1, 4.2, 4.7, 4.10, 4.21, 4.29, 4.125, 4.126, 4.130, Diagnostic Code 9411.

8. From August 20, 1997 to October 29, 1997, the criteria for a temporary total evaluation for a hospitalization have been met. 38 U.S.C.A. §§ 1155, 5107(b); 38 C.F.R. §§ 3.321 (b)(1), 4.1, 4.2, 4.7, 4.10, 4.21, 4.29, 4.125, 4.126, 4.130, Diagnostic Code 9411.

9. From August 7, 2000 to October 20, 2000, the criteria for a temporary total evaluation for a hospitalization have been met. 38 U.S.C.A. §§ 1155, 5107(b); 38 C.F.R. §§ 3.321 (b)(1), 4.1, 4.2, 4.7, 4.10, 4.21, 4.29, 4.125, 4.126, 4.130, Diagnostic Code 9411.

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

Duties to Notify and Assist

VA has a duty to notify and assist claimants in substantiating claims for VA benefits. *See eg*. 38 U.S.C.A. §§ 5103, 5103A (West 2014) and 38 C.F.R. § 3.159 (2016). VA has a duty to assist a claimant in the development of a claim. This duty includes assisting the claimant in the procurement of relevant treatment records and providing an examination when necessary. 38 U.S.C.A. § 5103A; 38 C.F.R. § 3.159.

The Board notes that, during the pendency of this appeal, the Veterans Claims Assistance Act of 2000 (VCAA), was signed into law. 38 U.S.C.A. §§ 5100, 5102, 5103, 5103A, and 5107 (West 2014). The VCAA and implementing regulations essentially eliminated the concept of the well-grounded claim. 38 U.S.C.A. § 5107 (a) (West 2014). They also included an enhanced duty on the part of the VA to notify a claimant of the information and evidence needed to substantiate a claim. 38 U.S.C.A. § 5103 (West 2014); § 3.159 (b)). In addition, it defined the obligation of the VA with respect to its duty to assist the claimant in obtaining evidence. 38 U.S.C.A. § 5103A (West 2014); § 3.159 (c)).

The VA provided adequate notice in letters sent to the Veteran in March 2001, April 2004 and January 2011. Here, the above-referenced letters notified the Veteran of the information and evidence needed to substantiate his claims. In addition, the January 2011 letter provided the Veteran with information as to the evidence required to substantiate the TDIU claim and of the division of responsibilities between VA and a claimant in developing an appeal. The January 2011 also provided the Veteran with information regarding the general criteria for assigning disability ratings and effective dates. *See Dingess/Hartman v. Nicholson*, 19 Vet. App. 473 (2006), *aff'd, Hartman v. Nicholson*, 483 F.3d 1311 (Fed. Cir. 2007). It is noted that VA also provided notice as what was needed to substantiate the claim of entitlement to service connection for PTSD in letters sent in August 1995 and October 1997 – letters that predated enactment of the VCAA.

Although the March 2001, April 2004 and January 2011 letters were sent after the initial unfavorable adjudication of the claim for PTSD in the April 1996 rating decision by the AOJ, the Board finds that there was no prejudice to the Veteran because he has been given additional time to submit evidence and argument, and Veteran has had a meaningful opportunity to participate in the processing of his claim since the letters were sent and the AOJ most recently readjudicated these claims in the December 2014 Supplemental Statement of the Case (SSOC). Therefore, any timing defect has been cured. *See Pricket v. Nicholson*, 20 Vet. App. 370, 376 (2006).

The Board also finds that all necessary development has been accomplished, and therefore appellate review may proceed without prejudice to the Veteran. *See Bernard v. Brown*, 4 Vet. App. 384 (1993). The Veteran's service, VA, and private treatment records as well as records generated at the Social Security Administration (SSA) have been retrieved and associated with the electronic and paper claims file. There is otherwise no indication of relevant, outstanding records which would support the Veteran's claim. 38 U.S.C.A. § 5103A (c); 38 C.F.R. § 3.159 (c)(1)-(3).

VA afforded the Veteran examinations in connection to his psychiatric disability in February 1996, August 2010 and January 2011. Here, the Board finds that the VA examinations obtained in this case are adequate, as they were predicated on mental

status evaluations of the Veteran, as well as the Veteran's reported history and symptomatology. The examiners considered all of the pertinent evidence of record, to include statements given by the Veteran at the time of the VA examinations, and provided the findings necessary to apply pertinent rating criteria. As such, the Board finds that VA's duty to assist with respect to obtaining a VA examination concerning the claim for a higher rating for the service-connected PTSD claim decided herein has been met. 38 C.F.R. § 3.159 (c)(4). In addition, the VA examiner reviewed the relevant evidence of record and discussed the pertinent disability and its impact on the Veteran's employability. Therefore, the Board finds that the medical examination reports and opinions, along with his VA outpatient records and private treatment records, are adequate for purposes of rendering a decision in the instant appeal. 38 C.F.R. §4.2 (2016).

After the Veteran's claim was certified for appeal in February 2015, in an October 2015 statement, the Veteran, through his attorney, requested a central office hearing before a Veterans Law Judge (VLJ) of the Board in Washington, D.C. In this statement, it was also noted that E.T., Ph.D., CRD, a licensed psychologist and nationally certified rehabilitation counselor, would provide expert testimony regarding the issues on appeal.

In a February 2016 statement, the Veteran's attorney requested that his hearing be scheduled on April 6, 2016 and explained that the Veteran wished to present expert medical and vocational testimony from Dr. E.T. at the hearing. The Veteran's hearing was scheduled for May 2, 2016 at the Board's location in Washington, DC. In a March 2016 letter, the Veteran and his attorney were informed as to the date, time and location for his hearing. In April 2016, the Veteran's attorney submitted a Motion to Change the Hearing Date, and requested that the Veteran's hearing date be rescheduled for June 13, 2016. As good cause for this motion, the Veteran's attorney explained that the Veteran intended to present expert medical and vocational testimony from Dr. E.T. on the date of the hearing.

The Veteran's hearing was thereafter rescheduled for June 13, 2016, and he and his attorney were informed as such by way of a May 2016 letter. On the date of the hearing, the Veteran did not report to his hearing. Rather, the Veteran's attorney

and the expert witness, Dr. E.T., appeared at the Board central office in Washington, DC for the purpose of presenting expert testimony in support of the Veteran's claim. In a June 2016 letter, the Veteran's attorney explained that Dr. T. had travelled there to provide sworn expert testimony. At this time, the undersigned Veterans Law Judge (VLJ) decided not to hear the expert testimony of Dr. T. in support of the Veteran's claims. In light of the decision not to conduct the scheduled hearing, the Veteran's attorney requested a 60 day extension of time to submit evidence and legal argument in support of the appeal to the Board.

In a statement dated on June 29, 2016, the Veteran's attorney explained that the Veteran had been unable to travel to Washington DC to attend his scheduled hearing due to the severity of his disabilities. The Veteran's attorney argued that the Veteran has a right to a hearing before the VLJ presiding over his appeal, and there is no legal authority for the proposition that this right may be denied on any basis, including the absence of the Veteran. The Veteran's attorney is also arguing that the Veteran has been prejudiced by the Board's refusal to hear the sworn testimony of Dr. T. because he has been deprived of the opportunity to meaningfully participate in the processing of his claim - specifically "to present expert medical and vocational evidence in front of the ultimate decision maker in a way that could impact upon the analysis of the credibility and probative value of [Dr. T.'s] findings, conclusions, as well as her rationale for those conclusions." The Veteran's attorney argued that although Dr. T.'s written evaluation report and certification have been submitted to the Board, the VLJ deciding the Veteran's appeal has not heard the sworn testimony of Dr. T., and had she been allowed to testify, she would have been asked to discuss, explain and defend her findings and conclusions. According to the Veteran's attorney, there was no basis in law for the proposition that a VLJ has any discretion whatsoever to deny a hearing to a represented appellant who is not present but whose legal representative is present and ready to proceed with questions for a witness. The Veteran's attorney determined that the refusal of the VLJ to allow the hearing to proceed violated the Veteran's right to due process of law and was prejudicial.

In a June 2016 letter, the Board granted the Veteran's request for a 60 day extension. The Veteran's attorney thereafter submitted additional evidence in the

form of the August 2016 Appellant's Informal Brief. In a January 2017 letter, the Board acknowledged the Veteran's request for another hearing before a VLJ and gave him an option to schedule another hearing or withdraw his request for a hearing altogether. In the letter, the Veteran was informed that the Veteran could also submit written statements from his friends, family members, co-workers, representatives and/or medical professionals in support of his appeal instead of having a hearing. In a January 2017 response to this letter, the Veteran's attorney indicated that the Veteran did not wish to withdraw his request for a hearing, but he did wish that Dr. T. be given permission to present testimony on his behalf at a hearing before the Board. According to the Veteran's attorney, unless the Board reconsiders its previous refusal in conducting a hearing in which Dr. T. is allowed to testify, the Veteran requested for the Board to issue a decision with respect to the issues on appeal without any additional delay.

Pursuant to 38 C.F.R. §20.700 (b), the purpose of a hearing is to receive argument and testimony relevant and material to the appellate issue. It is contemplated that the appellant and witnesses, if any, "will be present." The regulatory provision further reflects that a hearing will not normally be scheduled solely for the purpose of receiving argument by a representative and such argument should be submitted in the form of a written brief. Indeed, the purpose of a hearing before a Board member is to hear the appellant's arguments and opinions, and to elicit testimony regarding the pertinent medical and historical facts of an appellant's claim. In this case, the Veteran was not present at the time of his scheduled hearing, but his attorney, and the expert witness, a person other than the appellant, were present at the hearing.

Under 38 C.F.R. § 20.702 (d), if an appellant fails to appear for a scheduled hearing and a request for postponement has not been received and granted, the case will be processed as though the request for a hearing had been withdrawn. The provision further reflects that "no further request for a hearing will be granted in the same appeal unless such failure to appear was with good cause and the cause for the failure to appear arose under such circumstances that a timely request for postponement could not have been submitted prior to the scheduled hearing." If the Veteran, either on his own or by way of his attorney, had provided good cause for

his failure to appear at the hearing, then the presiding Board member can allow for testimony from the Veteran's witnesses.

In this case, the Veteran's attorney simply indicated that the Veteran was too disabled to attend the scheduled hearing. Under the circumstances of this case, the Board finds that this explanation does not satisfy the good cause requirement. The central office hearing docket for June 13, 2016, the day of the scheduled hearing, included six appellants represented by the attorney, including the Veteran in this case. Of those six, only one of the hearings had been canceled at the request of the particular appellant to withdraw the hearing request. The attorney informed the undersigned that none of his clients, for which there was no withdrawal or request for postponement, were able to attend the hearing and gave the same reason for being unable to attend for all of them. The Board finds it extremely unlikely that all of the attorney's clients that had not withdrawn the hearing request or asked for a postponement, were all too ill or disabled to attend the hearing. In this regard, no evidence, in the form of medical records or statements from the Veteran and/or the Veteran's family members, was provided to corroborate this claim.

Furthermore, in light of the proffered reason for being unable to attend, the Board finds it questionable and unclear as to why his attorney requested a Central Office hearing in Washington, DC, when the option to provide testimony before a Board member at either Travel Board or videoconference hearings at his local Regional Office in Waco, Texas, which would have been easier for the appellant to attend, were available. The Board finds that the burden as to why a hearing should be held without the presence of the Veteran remains on the Veteran, and in this case, the Veteran has not satisfied that burden.

In *Bryant v. Shinseki*, the United States Court of Appeals for Veterans' Claims (Court) held that 38 C.F.R. § 3.103 (c)(2) requires that the VLJ who conducts a hearing fulfill two duties to comply with the regulation. They consist of (1) the duty to fully explain the issues and (2) the duty to suggest the submission of evidence that may have been overlooked. In order to comply with these duties, the VLJ would have to hear testimony from a fact witness - someone knowledgeable and familiar with the facts of the Veteran's claim. Although the expert witness may

have provided a recitation of the facts of the claim, her testimony would not have been based on her personal experiences and symptoms -facts relevant to the case that she has personal familiarity with, but rather on her specialized expertise in psychology and rehabilitation, and her understanding of the medical principles as applied to the facts of the claim. In this regard, the expert witness is not familiar with the facts of the claim in the same way the Veteran would be. Her recitation and testimony regarding the facts of the claim would be based on second-hand knowledge; namely her review of the claims file, as well as her interview with the Veteran, not her own personal experience or familiarity with the facts of the claim, the experiences the Veteran has encountered, and the symptoms he endures. In light of the fact that the expert witness is not a fact witness, the VLJ would not have been able to comply with 38 C.F.R. § 3.103 (c)(2), and the *Bryant* duties. In this regard, the Board member would not have been able to elicit hearing testimony regarding the facts of the claim, and help develop these facts by further explaining the issues and suggesting the submission of evidence that could help substantiate the claims.

As to the contention that Dr. T., had she been allowed to testify, would have been asked to discuss, explain and defend her findings and conclusions, the Board sees no reason why the Veteran's representative or the Veteran could not simply, prior to submission of a written expert opinion, have asked Dr. T. to discuss, explain, and defend her findings and conclusions in such opinion, instead of asking her on the record at a hearing. The attorney cites to no authority that the ability to observe the demeanor of an expert witness is important in the same way as the ability to observe the demeanor of a fact witness.

The Board again reiterates that the purpose of a hearing is to take testimony material to the issue from the appellant, and the available time slots reserved for these hearings are allotted for the appellants to have their day before the Board member so they can provide testimony relevant to the facts of their claim to the Board member. As of the end of 2016, there were 375,646 disability compensation and pension claims that have been received by the Veteran's Benefits Administration (VBA) that require development and a decision by a VBA claims processor. Over 97,000 of these claims have been awaiting a rating decision for

more than 125 days since receipt. *See* Veterans Benefits Administrative Reports (http://benefits.va.gov/reports). More than 81,000 certified appeals were pending before the Board, and in 2015, the Board held 12,738 hearings. *See* Board of Veterans' Appeals Annual Report, Fiscal Year 2015. Yet there are 72,000 veterans either waiting for their scheduled hearing or waiting to be scheduled for their hearings. It is common knowledge that there is a backlog of appeals waiting to be adjudicated and that government agencies, such as VA, do not have unlimited resources. The testimony sought to be offered in this case was expert testimony, and instead of reserving one of the limited slots for a hearing before a Board member, the expert testimony could have been provided in a more appropriate and effective manner, such as through a written document or file rather than ad hoc testimony. There are broader policy-based concerns that must be factored in when reserving a limited slot for a hearing before VLJ. Without unlimited resources, these additional complexities, (i.e. sending in an expert witness whose testimony can simply be provided by way of written documentation, to testify on behalf of a veteran) can further delay another veteran's opportunity for a hearing, and further prolong and postpone the backlog of appeals on the docket. The United States Court of Appeals for the Federal Circuit (Federal Circuit) has warned against the dangers of introducing complications from litigation in other areas of law. *See Forshey v. Principi*, 284 F.3d 1335, at 1364-1365 (Fed. Cir. 2002) (Mayer, C.J. and Newman, J., dissenting) (""This is another illustration of the old adage: "Be careful what you wish for, you just might get it." Veterans sought for over a hundred years to secure judicial review of the Secretary's decision" and "[n]ow that they have it, they are finding that judicialization is leading to prolonged delays, and a growing complexity of rules that rival the tax code in opaqueness.") *See also Walters v. National Association of Radiation Survivors*, 473 U.S. 305. In *Walters*, the Supreme Court observed that "Congress desired that the proceedings [in veterans' benefits cases] be as informal and nonadversarial as possible," and has warned that "additional [procedural] complexity w[ould] undoubtedly engender greater administrative costs, with the end result being that less Government money reaches its intended beneficiaries." 473 U.S. 305, 326 (1985).

By requesting and being scheduled for a central office hearing, the Veteran reserved an available slot that could have been afforded to another veteran or appellant that

would have made the effort to attend his or her hearing and provide testimony before a VLJ. His failure to appear served to further delay the Board's effort in reducing the backlog of appeals awaiting a hearing, and ultimately, adjudicating the claims and issuing decisions in a timely and efficient manner to help better serve our veterans. Furthermore, the Board has been warned against cross examination of a witness during a hearing so there would have been no need for Dr. T. to defend her medical findings. As such, there would have been no purpose for the Board member to be present when hearing the testimony of the expert witness because the expert witness is not well-versed in the facts of the case in the way that the Veteran would be given that the Veteran has been present throughout all aspects of his claim, from service to the present, and the VLJ would not have been able to help develop the facts of the claim based on the testimony provided. Ultimately, allowing an expert witness to provide testimony before a VLJ without the appellant subverts the purpose of a Board hearing, expends limited resources, and prevents another veteran or appellant from the opportunity to provide hearing testimony and thus have the merits of his or her case adjudicated in a timely and efficient manner.

The Board also notes that, in the January 2017 letter, the Veteran was given yet another opportunity to have a hearing before a VLJ, and thus, to provide testimony regarding the facts of his claim. However, while he did not withdraw his request for a hearing, through his attorney, he essentially indicated that unless Dr. T. was allowed to attend the hearing and provide expert testimony on his behalf, then there was no need for a hearing and the Board should issue a decision adjudicating the merits of his appeal without delay. This request was made despite the fact that his request to have Dr. T. present expert testimony at his last hearing was denied. In conclusion, the Board finds that the refusal of the Board member to allow the hearing to proceed did not violate the Veteran's right to due process of law. The Veteran was not refused a right to a hearing. His initial request for a hearing was granted, he was scheduled for a hearing, and provided with the date, time, and location of his hearing, but he failed to appear, and did not provide good cause for his failure to appear. The Veteran’s second request for a hearing was also granted, but in his January 2017 response, the Veteran indicated once again that he himself would not attend his hearing, and he had instructed his attorney and Dr. T. to present expert testimony on his behalf. The Veteran further indicated that if this

was not an option, he wished for the Board to issue a decision with respect to his claim without any additional delay. The Board further notes that the VLJ's decision not to allow the hearing was not prejudicial to the Veteran because the testimony that would have been provided by the expert witness was converted to a written document and has been taken into consideration in the Board member's adjudication of the Veteran's claim.

Under these circumstances, the Board finds that VA has complied with all duties to notify and assist required by 38 U.S.C.A. §§ 5103 (a), 5103A and 38 C.F.R. § 3.159.

Analysis - Earlier Effective Date for service connection for CAD status post CABG and for residual surgical scar.

The Veteran contends that the effective date assigned for the grant of service connection for CAD status post CABG, and the grant of service connection for residual surgical scar, status post CABG, is incorrect and should be earlier than the effective date (August 31, 2010) assigned.

Generally, the effective date of an evaluation and award of pension, compensation, or dependency and indemnity compensation based on an original claim, a claim for increase, or a claim reopened after final disallowance, will be the date of receipt of the claim or the date entitlement arose, whichever is the later. 38 U.S.C.A. § 5110 (a) (West 2014); 38 C.F.R. § 3.400 (2014). Unless otherwise provided, the effective date of compensation will be fixed in accordance with the facts found, but will not be earlier than the date of receipt of the claimant's application. 38 U.S.C.A. § 5110 (a).

Prior to March 24, 2015, VA recognized formal and informal claims. [Effective March 24, 2015, VA amended its rules as to what constitutes a claim for benefits; claims are now required to be submitted on a specific claim form, prescribed by the Secretary, and available online or at the local RO.] A claim is a formal or informal communication in writing requesting a determination of entitlement or evidencing a

belief in entitlement to a benefit. 38 C.F.R. § 3.1 (p). A formal claim is the use of the appropriate designated VA form to seek specific benefits. 38 C.F.R. § 3.151 (a). Any communication or action indicating an intent to apply for VA benefits from a claimant or representative may be considered an informal claim. Such an informal claim must identify the benefit sought. 38 C.F.R. § 3.155 (a). VA is required to identify and act on informal claims for benefits. 38 U.S.C.A. § 5110 (b)(3); 38 C.F.R. §§ 3.1 (p), 3.155(a). However, VA is not required to anticipate any potential claim for a particular benefit where no intention to raise it was expressed. *See Brannon v. West*, 12 Vet. App. 32, 35 (1998) (holding that before VA can adjudicate a claim for benefits, "the claimant must submit a written document identifying the benefit and expressing some intent to seek it"). *See also Talbert v. Brown*, 7 Vet. App. 352, 356-57 (1995).

The essential elements for any claim, whether formal or informal, are: (1) an intent to apply for benefits; (2) an identification of the benefits sought; and (3) a communication in writing. *Brokowski v. Shinseki*, 23 Vet. App. 79, 84 (2009); *see also MacPhee v. Nicholson*, 459 F.3d 1323, 1326-27 (Fed. Cir. 2006) (holding that the plain language of the regulations requires a claimant to have intent to file a claim for VA benefits).

A pending claim is an application, formal or informal, which has not been finally adjudicated. 38 C.F.R. § 3.160 (c); *Adams v. Shinseki*, 568 F.3d. 956, 960 (Fed. Cir. 2009). A finally adjudicated claim is defined as "an application, formal or informal, which has been allowed or disallowed by an agency of original jurisdiction." 38 C.F.R. § 3.160 (d). Such an action becomes "final" by the expiration of one year after the date of notice of an award or disallowance, or by denial on appellate review, whichever is the earliest. *Id*. The pending claims doctrine provides that a claim remains pending in the adjudication process - even for years - if VA fails to act on it. *Norris v. West*, 12 Vet. App. 413, 422 (1999).

The Court has confirmed that raising a pending claim theory in connection with a challenge to the effective-date decision is procedurally proper. *Ingram v. Nicholson*, 21 Vet. App. 232, 249, 255 (2007) (recent Federal Circuit cases have not overruled the pending claim doctrine articulated in Norris); *Myers v. Principi*, 16

Vet. App. 228, 236 (2002) (since VA failed to issue a statement of the case (SOC) after a valid NOD was filed, the original claim was still pending and is relevant to determining the effective date of a service connection award); *McGrath v. Gober*, 14 Vet. App. 28, 35 (2000) (a claim that has not been finally adjudicated remains pending for purposes of determining the effective date for that disability).

Upon receipt of an informal claim for which a formal claim has not already been filed, an application for VA benefits (VA Form 21-526) must be forwarded to the claimant for execution. If received within one year after the date it was sent to the claimant, that signed application will be considered filed as of the date of receipt of the informal claim. 38 C.F.R. § 3.155; *Norris v. West*, 12 Vet. App. 413 (1999).

Where compensation is awarded pursuant to a liberalizing law or a liberalizing VA issue, the effective date of the increase shall be fixed in accordance with facts found, but shall not be earlier than the effective date of the act or administrative issue. 38 U.S.C.A. § 5110 (g) (West 2014); 38 C.F.R. § 3.114 (a) (2016). *See also McCay v. Brown*, 9 Vet. App. 183, 187 (1996) ("plain language of section 5110(g) prohibits a retroactive award prior to the effective date of the legislation"), *aff'd*, 106 F.3d 1577 (Fed. Cir. 1997).

If a claim is reviewed on the initiative of VA within one year from the effective date of the law or VA issue, or at the request of a claimant received within one year from that date, benefits may be authorized from the effective date of the law or VA issue. 38 C.F.R. § 3.114 (a)(1). However, if a claim is reviewed on the initiative of VA more than one year after the effective date of the law or VA issue, benefits may be authorized for a period of one year prior to the date of administrative determination of entitlement. 38 C.F.R. § 3.114 (a)(2). Finally, if a claim is reviewed at the request of the claimant more than one year after the effective date of the law or VA issue, benefits may be authorized for a period of one year prior to the date of receipt of such request. 38 C.F.R. § 3.114 (a)(3). In order to be eligible for a retroactive award, the claimant must show that all eligibility criteria for the benefits existed at the time of the effective date of the law or administrative issue and continuously thereafter. 38 C.F.R. § 3.114 (a).

Ordinarily, under the above provisions for liberalizing laws, awards based on presumptive service connection established under the Agent Orange Act of 1991 can be made effective no earlier than the date VA issued the regulation authorizing the presumption. *Id*. Ischemic heart disease (to include coronary artery disease) was included as a presumptive Agent Orange disease under 38 C.F.R. § 3.309 (e), which was made effective by VA as of August 31, 2010.

However, with respect to earlier effective date claims for service connection for diseases presumed to be caused by herbicide or Agent Orange exposure, VA has promulgated special rules to implement orders of a United States District Court in the class action of *Nehmer v. United States Department of Veteran's Affairs*. 38 C.F.R. § 3.816 (2016). *See Nehmer v. U.S. Veterans Admin*., 32 F. Supp. 1404 (N.D. Cal. 1989) (Nehmer I); *Nehmer v. U.S. Veterans Admin*., 32 F. Supp. 2d 1175 (N.D. Cal 1999) (Nehmer II); *Nehmer v. Veterans Admin. of the Gov't of the U. S*., 284 F.3d 1158 (9th Cir. 2002) (Nehmer III); *Nehmer v. U.S. Veterans Admin*., 494 F.3d. 846 (2007) (Nehmer IV). The regulation, 38 C.F.R. § 3.816, defines *Nehmer* class members and sets forth effective date rules for Vietnam veterans that currently have a "covered herbicide disease," or have died from a "covered herbicide disease." In short, the *Nehmer* litigation has created an exception to the generally applicable effective date rules contained in 38 U.S.C.A. § 5110 (g) and 38 C.F.R. § 3.114.

In pertinent part, a "Nehmer class member" is defined as a Vietnam veteran who has a covered herbicide disease. 38 C.F.R. § 3.816 (b)(1)(i). According to 38 C.F.R. § 3.816 (b)(2), a "covered herbicide disease" includes a disease for which the Secretary of Veterans Affairs has established a presumption of service connection before October 1, 2002 pursuant to the Agent Orange Act of 1991. As noted above, ischemic heart disease, to include coronary artery disease, was not added to the list of presumptive disabilities until August 31, 2010. *See* 75 Fed. Reg. 53,202 (August 31, 2010). Notwithstanding the language of 38 C.F.R. § 3.816, however, notice accompanying the issuance of the final August 31, 2010 rule specifically notes the *Nehmer* provisions apply to the newly covered diseases, to include ischemic heart disease. *Id*.; *see also Garza v. Shinseki*, 480 Fed. Appx. 984, 987 (Fed. Cir. 2012)

(specifically associating ischemic heart disease with Nehmer despite the language of 38 C.F.R. § 3.816).

The *Nehmer* regulation provides for situations where the effective date can be earlier than the date of the liberalizing law, assuming a "Nehmer class member" has been granted compensation from a covered herbicide disease. Either (1) VA denied compensation for the same covered herbicide disease in a decision issued between September 25, 1985 and May 3, 1989; or (2) the class member's claim for disability compensation for the covered herbicide disease was either pending before VA on May 3, 1989, or was received by VA between May 3, 1989 and the effective date of the statute or regulations establishing a presumption of service connection for the covered disease (here August 31, 2010). In these situations, the effective date of the award will be the later of the date such claim was received by VA or the date the disability arose. 38 C.F.R. § 3.816 (c)(1), (c)(2).

A prior decision will be construed as having denied compensation for the same disease if the prior decision denied compensation for a disease that reasonably may be construed as the same covered herbicide disease for which compensation has been awarded. Minor differences in the terminology used in the prior decision will not preclude a finding, based on the record at the time of the prior decision, that the prior decision denied compensation for the same covered herbicide disease. 38 C.F.R. § 3.816 (c)(1).

A claim will be considered a claim for compensation for a particular covered herbicide disease if: (i) The claimant's application and other supporting statements and submissions may reasonably be viewed, under the standards ordinarily governing compensation claims, as indicating an intent to apply for compensation for the covered herbicide disability; or (ii) VA issued a decision on the claim, between May 3, 1989, and the effective date of the statute or regulation establishing a presumption of service connection for the covered herbicide disease (August 31, 2010), in which VA denied compensation for a disease that reasonably may be construed as the same covered herbicide disease for which compensation has been awarded. 38 C.F.R. § 3.816 (c)(2)(i), (ii).

As to 38 C.F.R. § 3.816 (c)(3), if the class member's claim was received within one year of his or her separation from service, the effective date of the award shall be the day following the date of the class member's separation from active service.

If the requirements of paragraph (c)(1) or (c)(2) listed above are not met, the effective date of the award shall be determined in accordance with liberalizing law and general effective date provisions of 38 C.F.R. §§ 3.114 and 3.400. *See* 38 C.F.R. § 3.816 (c)(4).

When there is an approximate balance of positive and negative evidence regarding any issue material to the determination, the benefit of the doubt is afforded the claimant. 38 U.S.C.A. § 5107 (b).

A summary of the facts of the claim reflect that the Veteran was discharged from active duty in January 1966, and his service personnel records reflect that he had service in the Republic of Vietnam from November 1965 through the end of January 1966, prior to his discharge from service. As such it is accepted that he had exposure to herbicides while serving there. Accordingly, the Board concludes that the Veteran is a "Nehmer class member" as defined in the law because he is a Vietnam Veteran who has been diagnosed with a covered herbicide disease - ischemic heart disease. Review of the claims file reflects that the Veteran initially filed a claim seeking service connection for PTSD in July 1995, and continued his attempts have service connection granted for this disorder throughout the years after appealing the initial denial of the claim. The Veteran's initial informal claim for service connection for ischemic heart disease, to include CAD, was first received at the VA on March 29, 2010.

A summary of the medical findings reflect that during a December 2008 VA consultation, it was noted that the Veteran had a history of exertional neck and retrosternal chest tightness, and aching discomfort of one year duration that was precipitated whenever he walked one block or less, and continued as he exercised. Results of a coronary angiogram revealed evidence of high grade triple vessel disease "with relatively preserved left ventricular function (LVEF 53 [percent])." A coronary artery bypass surgery was thereafter recommended.

The Veteran was subsequently admitted to William Beaumont Army Medical Center (WBAMC) several weeks later (also in December 2008) where he underwent a coronary artery bypass grafting procedure. The operative report reflects that his preoperative and postoperative diagnoses were coronary artery disease and angina pectoris. In the December 2008 discharge report, the physician summarized the Veteran's medical history noting that upon his admission, the Veteran reported that his chest discomfort had been occurring for several weeks prior to his admission. The Veteran described the discomfort as a burning sensation in his throat that extends throughout his body substernally. It was noted that these symptoms had initially been reported by the Veteran in June 2008, during which time he had refused cardiac catheterization in favor of medical management. Since this time, he has experienced progressive angina refractory to medications. He underwent a myocardial perfusion study in November 2008, the results of which revealed a large perfusion defect that was reversible in the inferolateral wall, as well as some myocardial necrosis versus diaphragmatic attenuation of the inferior wall. The results also reflected a normal ejection fraction. The Veteran underwent a cardiac catheterization, the results of which showed severe obstructive three vessel atherosclerotic coronary artery disease, as well as preserved left ventricular systolic function with ejection fraction (LVEF) of approximately 50 percent. Report of a chest x-ray was negative for evidence of acute cardiopulmonary disease, and it was noted that the cardiac silhouette and pulmonary vasculature were within normal limits, with no evidence of pleural effusions or focal airspace opacities.

Prior to, and following this procedure, the Veteran underwent a series of chest x-rays, the results of which revealed an impression of postoperative changes, and an appearance of atelectasis in the left lower lobe with associated pleural effusion. There was no evidence of pneumothorax or significant pleural effusion, nor were there any signs of cardiac decompensation. A chest x-ray that was conducted the next day also revealed postoperative changes, and it was noted that the midline sternotomy sutures were in place. There was no evidence of confluent pneumonia or cardiac decompensation. A chest x-ray taken several days later revealed an increase in atelectasis at both hilar areas. Results of the electrocardiogram (ECG) were shown to be abnormal, with a normal sinus rhythm, and "[p]ossible [i]nferior

infarct, age undetermined". The ECG results also documented notations reflecting "ST elevation, consider early repolarization, pericarditis or injury" and evidence of "ST & T wave abnormality, consider inferior ischemia."

In this case, in a statement date-stamped as received at the RO on March 16, 2009, the Veteran indicated that he developed a heart condition as a result of his service-connected psychiatric disability. In a letter dated on March 10, 2010, the RO acknowledged receipt of this letter, and asked the Veteran for clarification as to whether he wished to file a claim for service connection for a heart condition as secondary to a service-connected disability. In a statement dated on March 23, 2010, and date-stamped as received on March 29, 2010, the Veteran, through his representative, confirmed that he wished to file a claim for service connection for a cardiac condition secondary to his PTSD.

In the July 2012 VA examination in connection to the Veteran's claimed heart condition, the examiner diagnosed the Veteran with having atherosclerotic cardiovascular disease, coronary artery disease and stable angina, and determined that said disorder was less likely as not related to his service-connected PTSD. The VA examiner also determined that the Veteran had surgical scars as a result of the coronary artery bypass graft procedure he underwent in December 2008. According to the examiner, the scars were neither painful nor unstable, and the total area of all related scars was not greater than 39 square centimeters.

In a September 2012 rating decision, the RO granted service connection for coronary artery disease (CAD) status post coronary artery bypass graft (CABG). This disability was presumptively service-connected on the basis of Agent Orange exposure. 38 U.S.C.A. § 1116 (a)(2); 38 C.F.R. § 3.309 (e). The RO established an effective date of August 31, 2010, which was the date ischemic heart disease, including coronary artery disease, was included as a presumptive disease under 38 C.F.R. § 3.309 (e). The RO also granted service connection for residual surgical scar, status post coronary artery bypass graft as secondary to the service-connected coronary artery disease, evaluating it as noncompensably disabling, effective August 31, 2010.

As noted above, pursuant to 38 C.F.R. § 3.155(a), an informal claim must be followed up with the formal VA Form 21-526 within one year of the informal claim to "preserve" the "date of claim" otherwise the date of claim becomes the date of receipt of the formal claim. Upon receipt of an informal claim for which a formal claim has not already been filed, an application for VA benefits (VA Form 21-526) must be forwarded to the claimant for execution. In this case, it does not appear that an application for VA benefits was forwarded to the Veteran. If VA does not send a formal claim, then the one-year period could not begin to run and accordingly, the proper effective date is the date of the informal claim. *Jernigan v. Shinseki*, 25 Vet. App. 220 (2012); *Quarles v. Derwinski*, 3 Vet. App. 129, 137 (1992).

In this case, the *Nehmer* provisions do provide relief for the Veteran as there was a claim pending for service connection for a heart disability between May 3, 1989 and August 31, 2010. Although the RO asked the Veteran for clarification as to the March 16, 2009 statement, the Board finds the March 16, 2009 statement to show an intent to file a claim for VA compensation benefits for disability due to heart disease. In that statement the Veteran was continuing to disagree with the RO's denial of compensation benefits for PTSD and was identifying additional disability due to heart disease that he believed was due to his PTSD. The Board finds this statement sufficient to show an intent to apply for benefits for the heart condition.

Given that the Veteran filed an informal claim for service connection for a heart condition on March 16, 2009, the Board finds that an effective date earlier than August 31, 2010, but no earlier than March 16, 2009, is warranted. Review of the claims file for the period prior to March 16, 2009 reflects that the Veteran sought ongoing mental health treatment for his PTSD, and other psychiatric disorders, throughout the years, as well as medical care for his heart condition in December 2008. However, there is no document in the evidence of record prior to the March 16, 2009 claim from which it could be inferred that the Veteran sought to file a claim for service connection for coronary artery disease, or any type of heart condition. *See* 38 C.F.R. § 3.155 (a)(as in effect prior to March 24, 2015). *See also MacPhee v. Nicholson*, 459 F.3d 1323, 1326-27 (Fed.Cir.2006) (holding that the plain language of the regulations requires a claimant to have an intent to file a claim

for VA benefits); *Rodriguez v. West*, 189 F.3d 1351, 1354 (Fed.Cir.1999) (noting that even an informal claim must be in writing).

In this case, the available medical evidence reflects that the Veteran was first diagnosed with severe obstructive three-vessel atherosclerotic CAD in December 2008, and subsequent hospital records, also dated in December 2008, reflect that he underwent a coronary artery bypass grafting procedure for his heart condition, and received follow-up treatment for this disorder in the weeks following this procedure. The Veteran first filed a claim for service connection for a heart disorder on March 16, 2009.

The March 16, 2009 claim was received by VA between May 3, 1989 and the effective date of the regulation establishing the presumption of service connection for coronary artery disease. [As noted above, VA added ischemic heart disease, including coronary artery disease, to the disabilities listed in 38 C.F.R. § 3.309 (e) that are presumptively related to herbicide exposure effective August 31, 2010. 75 Fed. Reg. 53,202-53,216 (Aug. 31, 2010).] The Board observes that although the evidence indicates that the earliest diagnosis of heart disease was in December 2008, applicable regulations clearly stipulate that the effective date of service connection must be the date of claim or the date the disability arose, whichever is later.

As the later of those dates in this case is March 16, 2009, an earlier effective date for the grant of service connection for CAD is warranted as a matter of law. Accordingly, the Board finds that an earlier effective date of March 16, 2009 (though no earlier) is warranted for the grant of service connection for CAD status post CABG, as this was the date of receipt of the Veteran's claim for service connection for a heart condition. In addition, since the effective date of entitlement for service connection for CAD status post CABG is March 16, 2009, and the Veteran has not ever filed a claim, formal or informal, for his residual scar status post CABG, the earliest date on which VA may construe the claim of entitlement to service connection for residuals surgical scar status post CABG graft as secondary to service-connected CAD status post CABG is also March 16, 2009.

With reasonable doubt resolved in the claimant's favor, the Board finds the submission of the claim for service connection for a heart disorder, dated on March 16, 2009, constituted an informal claim pursuant to the provisions of 38 C.F.R. § 3.155 (a)(in effect prior to March 24, 2015). *See* 38 U.S.C.A. § 5107 (b); 38 C.F.R. § 3.102. Since the informal claim was not followed up with the formal VA Form 21-526 within one year of the informal claim to "preserve" the "date of claim," the proper effective date is the date of the informal claim. *Jernigan v. Shinseki*, 25 Vet. App. 220 (2012); *Quarles v. Derwinski*, 3 Vet. App. 129, 137 (1992). As such, an earlier effective date of March 16, 2009, is warranted for the grant of service connection for CAD status post CABG, and residual surgical scar, status post CABG associated with CAD status post CABG.

Increased Rating - PTSD

Disability ratings are determined by applying the criteria set forth in the VA's Schedule for Rating Disabilities, which is based on the average impairment of earning capacity. Individual disabilities are assigned separate diagnostic codes. 38 U.S.C.A. § 1155; 38 C.F.R. § 4.1. The basis of disability evaluations is the ability of the body as a whole, or of the psyche, or of a system or organ of the body to function under the ordinary conditions of daily life including employment. 38 C.F.R. § 4.10.

In determining the severity of a disability, the Board is required to consider the potential application of various other provisions of the regulations governing VA benefits, whether or not they were raised by the Veteran, as well as the entire history of the Veteran's disability. 38 C.F.R. §§ 4.1, 4.2; *Schafrath v. Derwinski*, 1 Vet. App. 589, 1991). 595

If the disability more closely approximates the criteria for the higher of two ratings, the higher rating will be assigned; otherwise, the lower rating is assigned. 38 C.F.R. § 4.7. It is not expected that all cases will show all the findings specified; however, findings sufficiently characteristic to identify the disease and the disability therefrom and coordination of rating with impairment of function will be expected in all instances. 38 C.F.R. § 4.21.

In deciding this appeal, the Board has considered whether separate ratings for different periods of time, based on the facts found, are warranted, a practice of assigning ratings referred to as "staging the ratings." *See Fenderson v. West*, 12 Vet. App. 119 (1999)

The Veteran's service-connected PTSD is presently assigned a 50 percent rating for the period prior to December 17, 2010 and 70 percent from December 17, 2010. The Veteran filed his claim for service connection for PTSD in July 1995. During the pendency of the Veteran's appeal, the rating criteria for evaluating psychiatric disorders were changed, effective November 7, 1996. Rating Schedule Mental Disorders, 61 Fed. Reg. 52,695 (1996) (codified at 38 C.F.R. § 4.130). When the regulations concerning entitlement to a higher rating are changed during the course of an appeal, the veteran is entitled to resolution of his or her claim under the criteria which are more to his or her advantage. *See Karnas v. Derwinski*, 1 Vet. App. 308 (1991) (holding that where a law or regulation changes after a claim has been filed, but before the administrative or judicial appeal process has been concluded, the version most favorable to the appellant should apply). The old criteria may be applied for the full period of the appeal. The new rating criteria, however, may only be applied to the period of time after their effective date. VAOPGCPREC 3-2000, 65 Fed. Reg. 33422 (2000). Therefore, in this case, the Board has evaluated the veteran's service-connected PTSD under the old criteria both prior to and from November 7, 1996, and under the new criteria as well from November 7, 1996.

Under the former rating criteria for evaluating PTSD, effective before November 7, 1996, PTSD was evaluated under the General Rating Formula for Neuropsychiatric Disorders found in 38 C.F.R. § 4.132. *See* 38 C.F.R. § 4.132, DC 9411 (effective before November 7, 1996). Under these criteria, a 10 percent evaluation was warranted where the symptoms are less than what is required for a 30 percent rating with emotional tension or other evidence of anxiety productive of mild social and industrial impairment. A 30 percent evaluation was warranted for definite impairment in the ability to establish or maintain effective and wholesome relationships with people. The psychoneurotic symptoms resulted in such reduction

in initiative, flexibility, efficiency and reliability levels as to produce definite industrial impairment. The General Counsel of VA provides that "definite" is construed as "distinct, unambiguous, and moderately large in degree." It represents a degree of social and industrial inadaptability that is "more than moderate but less than rather large." VAOPGCPREC 9-93. The Board is bound by this interpretation of the term "definite." 38 U.S.C.A. § 7104 (c) (West 2002).

A 50 percent evaluation was warranted where the ability to establish or maintain effective or favorable relationships with people is considerably impaired. By reason of psychoneurotic symptoms, the reliability, flexibility and efficiency levels are so reduced as to result in considerable industrial impairment. A 70 percent evaluation was warranted where the ability to establish and maintain effective or favorable relationships with people is severely impaired, or the psychoneurotic symptoms are of such severity and persistence that there is severe impairment in the ability to obtain or retain employment. A maximum 100 percent rating was assigned under the former rating criteria for PTSD where the attitudes of all contacts except the most intimate were so adversely affected as to result in virtual isolation in the community. Totally incapacitating psychoneurotic symptoms bordering on gross repudiation of reality were present with disturbed thought or behavioral processes associated with almost all daily activities such as fantasy, confusion, panic and explosions of aggressive energy resulting in profound retreat from mature behavior and the Veteran was demonstrably unable to obtain or retain employment. *Id.* Under the criteria in effect from November 7, 1996, an evaluation of 30 percent is warranted for PTSD with occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal), due to such symptoms as: depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment, mild memory loss (such as forgetting names, directions, recent events). *See* 38 C.F.R. § 4.130, Diagnostic Code 9411 (2016).

An evaluation of 50 percent is warranted for PTSD with occupational and social impairment with reduced reliability and productivity due to such symptoms as: 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; difficulty in establishing and maintaining effective work and social relationships. *See Id*.

A 70 percent evaluation is warranted for PTSD with 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 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 work-like setting); inability to establish and maintain effective relationships. *See Id*.

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

The U.S. Court of Appeals for the Federal Circuit (Federal Circuit) has emphasized that the list of symptoms under a given rating is a non exhaustive list, as indicated by the words "such as" that precede each list of symptoms. *Vazquez-Claudio v. Shinseki*, 713 F.3d 112, 115 (Fed. Cir. 2013). In *Vazquez-Claudio*, the Federal Circuit held that a veteran may only qualify for a given disability rating under § 4.130 by demonstrating the particular symptoms associated with that percentage or others of similar severity, frequency, and duration. *Id*. at 118. Other language in the decision indicates that the phrase "others of similar severity, frequency, and

duration," can be thought of as symptoms of like kind to those listed in the regulation for a given disability rating. *Id*. at 116.

For purposes of considering the evidence in connection with the PTSD issue, the Board notes that the Global Assessment of Functioning (GAF) scale is a scale from 0 to 100, reflecting the "psychological, social, and occupational functioning on a hypothetical continuum of mental health illness." Diagnostic and Statistical Manual of Mental Disorders 32 (4th ed. 1994) ("DSM-IV") (100 representing superior functioning in a wide range of activities and no psychiatric symptoms). *See also* 38 C.F.R. §§ 4.125 , 4.126, 4.130.

In this regard, the Board acknowledges that effective August 4, 2014, VA amended the regulations regarding the evaluation of mental disorders by removing outdated references to "DSM-IV," AMERICAN PSYCHIATRIC ASSOCIATION: DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 4th Edition (1994). The amendments replace those references with references to the recently updated "DSM-5," and examinations conducted pursuant to the DSM-5 do not include GAF scores. Although the Veteran's case was certified post-DSM-5, a majority of his treatment visits and evaluations were conducted prior to that time and therefore include a relevant GAF score. The Board will consider these GAF scores in adjudicating the claim, as doing so is most advantageous to the Veteran in this case.

A GAF score of 31-40 indicates some impairment in reality testing or communications or major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood. A GAF of 41-50 denotes serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning. A GAF of 51-60 denotes moderate symptoms (e.g. flat affect, circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or coworkers). A GAF of 61-70 denotes some 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, has some meaningful interpersonal relationships.

The record includes VA examination reports, VA outpatient treatment records, SSA records, treatment records from the William Beaumont Army Medical Center (WBAMC), a June 2016 opinion from Dr. T, and lay statements from the Veteran. All of these records have been reviewed by the Board, although they will not all be discussed in assessing the rating assigned to the Veteran's psychiatric disability.

A historical overview of the facts of the claim reflects that at the May 1995 VA Agent Orange examination, the Veteran provided his military and medical history and specifically described his military duties while serving in Vietnam. It was noted that the Veteran had been prompted to undergo an Agent Orange examination due to medical problems that he had been experiencing –specifically with this stomach. With regard to whether he had experienced any readjustment problems since returning from Vietnam, the Veteran reported occasional nightmares since his return and noted that he was a hyper individual who used to drink to help calm his nerves. The Veteran also admitted to experiencing past thoughts of suicide but added that these thoughts were fleeting in nature with no actual concrete plans. He denied the occurrence of any recent suicidal or homicidal ideations, and stated that in addition to discontinuing his alcohol use, he had also discontinued tobacco in the 1970s. Socially, the Veteran reported that he had been married to his wife for about twenty-eight years, and had three children who were grown and married. The Veteran also stated that he and his wife have legal custody of his nephew and niece. With respect to his marriage, the Veteran stated that relationship problems had existed in the past due to his alcohol use – however, he denied any major difficulties currently. Upon mental evaluation of the Veteran, the social worker observed no signs of distress and no evidence of a thought disorder. The Veteran was described as alert and oriented to person, place and time, and friendly and cooperative during the interview. According to the social worker, the Veteran did not reveal any symptoms at present that would suggest he might be suffering from PTSD.

A November 1995 VA treatment report reflects that the Veteran was seeking treatment to stop drinking. It was noted that the Veteran had a “physical

confrontation with his wife…two weeks ago while drinking." According to the Veteran, he proceeded to leave the house and was stopped by the police for driving while intoxicated (DWI). The Veteran stated that he owned his own automotive business and was proud of the work he did. According to the Veteran, while he drinks on weekends to have fun and socialize, alcohol does cause problems for him emotionally and physically. He also complained that his wife was jealous person, and always thinks he is "doing things with women when [he is] drinking."

The Veteran was afforded a VA psychiatric examination in February 1996, during which time he described the events of his childhood as well as the traumatic events he encountered in service. The Veteran described his period of service in Vietnam as a very "scary time" for him. With respect to his occupational history, the Veteran reported that he started working with his brothers at their auto body shop after his separation from service, and sixteen years prior, he opened up his own automotive business. According to the Veteran, while the business was successful at one point, it currently was not doing very well. With respect to his interpersonal relationships, the Veteran stated that he had been married to his current wife for twenty-nine years, and they had three children together who were grown and married, as well as legal custody of his niece and nephew. The Veteran further stated that he used to drink a lot, and his alcohol use had been a source of conflict in his marriage.

With respect to his psychiatric symptoms, the Veteran endorsed symptoms of irritability, and added that he tends to lose his temper quickly and is easily frustrated. He also reported difficulty falling and staying asleep, and added that he awakens very easily and has a difficult time returning to sleep. The Veteran further reported to experience frequent nightmares that do not have a specific Vietnam related theme. According to the Veteran, he has become withdrawn and has little interest in going out and socializing with others, although he and his wife used to go out together and socialize in the past. The Veteran denied experiencing recurrent and intrusive recollections of his time in Vietnam, but noted that he does avoid talking about his time there. He also avoids arguments and discussions because he does not want to lose his temper. According to the Veteran, he has become less interested in his normal activities over the past few years. He also reported to have

difficulty concentrating, and maintaining a proper sleep regimen. He denied experiencing hypervigilant behavior or an exaggerated startle response, adding that while loud noises such as ambulance sirens frustrate and anger him, they do not elicit any type of startle response. Based on his discussion with, and evaluation of the Veteran, the VA examiner diagnosed the Veteran with alcohol dependence in partial remission and determined that the Veteran did not meet the full criteria for PTSD at this time. She (the examiner) also assigned him a GAF score of 60.

A VA discharge reported dated in February 1997 reflects that the Veteran was admitted to the VA hospital from January 1997 to February 1997 due to the fact that he had been experiencing nervous symptoms on a regular basis. The VA physician summarized the Veteran's medical history and psychiatric condition throughout his inpatient treatment. It was noted that upon admission, the Veteran reported increasing symptoms of nervousness, anxiety attacks, paranoia, and sleep impairment. He reported to feel "panicky" and "extremely fearful" at times. The treatment provider noted that the Veteran's mental status on admission was that of an anxious person who was well developed. The Veteran admitted to some paranoid ideation and related panic attacks, and his mood was described as depressed but not suicidal. The Veteran was oriented to person, place and time, and he denied experiencing any hallucinations or delusional thoughts. With respect to the Veteran's hospitalization, it was noted that that the Veteran exhibited decreasing symptomatology with treatment, which included group therapy and medication. He was evaluated for admission to the Vietnam veteran PTSD program, but the psychologist determined that he was not in need of that. He improved with medication, and after significant improvement, the Veteran was discharged to return to his home and instructed to follow-up with an appointment at the El Paso clinic with a private physician. He was given a prescription for medication sufficient for two months until he scheduled outpatient appointment. Based on his discussion with, and evaluation of the Veteran, the VA physician diagnosed him with having generalized anxiety disorder with depression and history of PTSD. The Veteran was also assigned a GAF score of 40.

In a letter dated in May 1997 and issued from the William Beaumont Army Medical Center (WBAC), the Chaplain of the U.S. Army expressed familiarity with the

Veteran's medical history, noting that he first met the Veteran in 1994 during his hospitalization at that facility for bleeding ulcers. It was also noted that the Veteran suffered from a nervous condition and stomach problems since his experience in Vietnam. The Chaplain recommended that the Veteran be sent to the PTSD Rehabilitation Program in Waco, Texas.

In an August 1997 Social Work Database/Assessment report it was noted that the Veteran's only source of income was rental income in the amount of $14,000 annually for the automotive business he sold. The Veteran worked with his brothers who owned an auto body shop both prior to and after his service, until he started his own automotive business in 1979. According to the Veteran, he last worked there in June 1995, at which point, his ulcers and anxiety precluded employment, and he leased the shop to one of his employees. It was noted that the Veteran completed six years of education in Mexico and one-and-a-half years of education in the United States after he moved to El Paso before dropping out of school. When it came to special educational training or skills, it was noted that the Veteran had extensive experience in auto body repair. The Veteran reported to receive emotional support from his wife and children, and stated that while he is close to his siblings, he does not have a lot of contact with them. The Veteran also described his relationship with his children as very good, and noted that they were supportive of his treatment.

Upon conducting a psychosocial assessment of the Veteran, the treatment provider noted that his PTSD symptoms included anxiety, depression, anger, isolation, guilt/grief, intrusive thoughts, impaired sleep patterns, to include trouble falling and staying asleep, and nightmares. His other medical problems included gout in his hands, right foot and knee, as well as ulcers for which he had undergone treatment and been hospitalized for twice. The social worker noted that the Veteran presented as a neatly dressed and well-developed man who maintained good eye contact, and was friendly and cooperative with normal speech and mood. The Veteran did report a history of suicidal and homicidal ideation as well as some auditory hallucinations wherein he hears unidentifiable voices and sounds. According to the Veteran, his last homicidal ideation was eighteen months prior during a bar room altercation, and his last suicidal thought was in December 1996 after a family altercation. The

Veteran's insight was described as "fairly good" as he had recently become aware of PTSD as the cause of his problems; something he had self-medicated with alcohol in the past. The social worker noted that the Veteran was highly motivated for treatment, but his rehabilitation potential was questionable due to the limitations noted above.

An October 1997 discharge report reflects that the Veteran was admitted to the VA hospital in Waco, Texas again where he completed a ten week PTSD inpatient program. The discharge report provides a recitation of the Veteran's medical and military history and it was noted that since returning from Vietnam, he had experienced ongoing nightmares, outbursts of anger, depression, recurrent suicidal ideations, anxiety, intrusive thoughts and guilt. The Veteran admitted to attempting suicide twice in the past when he purposefully wrecked his car and reported to isolate himself. His source of enjoyment was usually staying at home alone watching television or working in his yard. With respect to his hospitalization, the treatment provider noted that the Veteran attended all of his scheduled assignments, behaved properly during his stay in the unit, and participated well in any scheduled activities of the program. It was further noted that the Veteran attended the multiple groups of the PTSD program, and participated well in his group therapy. On mental status evaluation, the Veteran's mood was shown to be depressed, and he reported to have problems with anger and depression. The remainder of the examination findings was negative for signs of hallucinations, delusional thoughts or looseness of associations. He denied any current suicidal or homicidal ideations, but he did complain of intrusive memories and sleep disturbances. The Veteran was thereafter diagnosed with having PTSD and assigned a GAF score of 50.

During a March 1998 VA psychiatric evaluation, the Veteran stated that after working at automotive businesses for the past thirty years, he gradually grew "sick with anxiety" and underwent treatment and hospitalization for ulcer related problems. He explained that he began drinking, and almost on a daily basis, which led to his involvement in physical fights. It was noted that the Veteran had been in jail on an overnight basis at least four to five times for disturbing the peace and for domestic violence. It was also noted that he had been admitted to the hospital for detoxification at which point he had been diagnosed with alcohol dependency and

PTSD. The treatment provider noted that it soon became evident that symptoms of his suspicious behavior at night, isolative nature, outbursts of anger, and aggressive behavior were attributed to PTSD, and the Veteran received treatment through a PTSD program for two-and-a-half months.

According to the Veteran, even after falling asleep early on in the evening, he awakens an average of four times a night due to the fear that someone is trying to break into his home and kill him. The Veteran also reported to experience hallucinations during his sleep, and stated that when he awakens and opens his eyes, "he cannot move or talk, because he sees someone breaking into his house with the sole purpose of killing him." He further stated that upon awakening in the mornings, he tends to stay at home and prefers to be alone in his room. According to the Veteran, he lost a large number of friends from his past due to his anxious and hypervigilant behavior. Although he attends church regularly, he stays home after church on Sundays and avoids socializing. According to the Veteran, when his wife goes out, he closes the door and windows, "and goes into his room and turns the lights off." The Veteran also stated that although he had been sober for the last eighteen months since starting his treatment, he had not been able to return to work because every time he attempted to do so, he was unable to tolerate being around others. According to the Veteran, he becomes hypervigilant and distrustful in that atmosphere. The Veteran stated that for the times when he becomes hyperalert, "he keeps a gun handy, because he is afraid that someone will come and try to kill him."

On mental status evaluation, the treatment provider described the Veteran as apprehensive but oriented in person, place, time and circumstances, and observed no ideas of reference, thought broadcasting or thought insertions. The Veteran's affect was described as sad, depressed, tearful and apprehensive. However, his short and long-term memory was described as intact, and he denied any current suicidal or homicidal plans or intentions, as well as any hallucinations or delusions thoughts. According to the treatment provider, the Veteran's assets included his ability to articulate himself, his supportive family system, and the fact that he had access to medical care. His liabilities were that he had chronic mental illness with marginal improvement. Based on his discussion with, and evaluation of the

Veteran, the treatment provider diagnosed the Veteran with major depression that is chronic in nature and PTSD. The treatment provider also assigned the Veteran a GAF score ranging from 40 to 50.

A September 1998 letter reflects that the Veteran was granted entitlement to disability benefits through the SSA commencing on October 1, 1997. An August 1998 Disability Determination and Transmittal Sheet reflects that the Veteran has a primary diagnosis of degenerative joint disease, and a secondary diagnosis of PTSD.

The record reflects that the Veteran sought treatment for his PTSD symptoms at the El Paso VAMC on a regular basis. During a March 2000 VA treatment visit, he reported to feel depressed, and complained of ongoing nightmares and impaired sleep. He also stated that his marriage was not very stable due to the fact that his wife continued to bring up the past and had a difficult time forgetting his "drinking, running around, [and] physical abuse she suffered at the hands of the [Veteran]. According to the Veteran, the negative aspect of their marriage only makes his symptoms worse. He stated that while he enjoys time with his wife and was grateful for her, her accusations put a strain on their marriage and kept him from spending time with her. He requested additional inpatient treatment to help him deal with PTSD symptoms.

The record again reflects that the Veteran was admitted to the PTSD unit at the VA Hospital in Waco, Texas where he received inpatient treatment from August 2000 until October 2000. In an August 2000 pyschological assessment form, it was noted that the Veteran experienced intrusive thoughts about the deaths of his friends and comrades, and these thoughts contributed to his depression, isolation and disturbance in self-concept. It was noted that the Veteran had attempted suicide twice in the past, and had entertained thoughts of shooting himself. It was also noted that the Veteran's psychiatric symptoms included anger, depression, nightmares four times a week and isolation. The Veteran stated that he was non-communicative with his spouse for fear of getting mad or losing his temper. The October 2000 discharge report reflects that he "Veteran was admitted due to the fact that he was experiencing difficulty falling and staying asleep, and he was having

recurring nightmares." The Veteran reported to feel chronically depressed, irritable and angered easily. He also stated that he isolates himself, and avoids crowded situations and talking about Vietnam. In addition, the Veteran reported to have problems with interpersonal relationships, and it was noted throughout the past few years, he had been hospitalized at the Big Springs VAMC and the Central Texas Veterans Healthcare system in Waco, Texas. A summary of the Veteran's hospital course reflects that he was prescribed with Sertraline, with a recommended dosage of 100 milligrams (mg) once a day for his depression and PTSD symptoms. Despite the fact that his prescription for his medication was increased to twice a day for augmentation purpose, the Veteran remained depressed. During his stay at the unit, the Veteran was pleasant, cooperative and well-behaved and he attended the "multiplus group of the PTSD program," and ultimately participated well in his group therapy. Mental status examination findings revealed an alert, pleasant, cooperative and well-behaved Veteran whose speech was spontaneous, and whose conversation was relevant and coherent. The Veteran's affect was shown to be anxious while his mood was shown to be depressed. He reported to have problems with anger and depression, but he denied any suicidal or homicidal ideation. The Veteran was free of audiovisual hallucinations, and his thinking was without delusions or loose association. The Veteran reported multiple sleep disturbances, social isolation and avoidant behavior. The VA physician diagnosed the Veteran with having PTSD and assigned him a GAF score of 55.

Subsequent VA treatment records reflect that the Veteran continued seeking mental health treatment at the VAMC for his PTSD. These records show that the Veteran attended group therapy on a regular basis throughout the years.

At his January 2002 hearing, which was conducted prior to the September 2010 rating decision granting his claim for service connection for PTSD, the Veteran testified that he was currently taking the medication to help alleviate his anxiety and sleep difficulties. When asked how his PTSD affected his daily activities, the Veteran explained that since his in-service experiences, he had experienced an ongoing nervous condition which made it difficult for him to remain someplace if there were too many people there. The Veteran also asserted that the stress of any job was too difficult to handle because he becomes very nervous and starts

problems with people. He also testified that his social and community activities had become very limited as a result of his PTSD, and explained that he had no friends as he had lost them due to the fact that he would start fighting with them. The Veteran also testified that he left his job at the automotive business in 1995 due to his PTSD symptoms.

During a May 2009 VA mental health treatment visit, the Veteran reported symptoms of depression due to his situation. He specifically reported having financial issues and noted that "his wife pressures him." During the mental status evaluation, he was shown to be alert and oriented to person, place, time and situation. He also exhibited normal motor activity and coherent speech with normal rate and rhythm, and was described as cooperative, with an adequate attention span and concentration level. In addition, the Veteran did not exhibit any suicidal or homicidal ideations. The Veteran was thereafter assessed with having PTSD per history and major depression that is recurrent. The treatment provider also assigned him a GAF score of 65. At a November 2009 VA mental health treatment visit, the Veteran stated that he is doing "much better with the assistance of his psychiatric medication - sertraline and clonazepam." According to the Veteran, he brought up getting a divorce to his wife, but she did not want that. The Veteran stated that while their relationship had improved somewhat, he still remained skeptical. He did show interest in participating in group and individual therapy.

The Veteran was afforded a VA psychiatric examination in August 2010 during which time it was noted that he was currently receiving outpatient care through the El Paso VA Healthcare system. The examiner noted that the Veteran continued taking antidepressants and anti-anxiety medication, to include Sertraline and Clonazepam to help alleviate his psychiatric symptoms. The Veteran was also participating in group and individual therapy, which he described as helpful despite ongoing symptoms of nervousness. The Veteran specifically reported symptoms of a depressed mood, sleep difficulties and anxiety but noted that the frequency of these symptoms vary. According to the Veteran, he remained married to his wife, but the marriage was hard for her because of his psychiatric symptoms and mood shifts. The Veteran denied having any social relationships but did report to enjoy watching television. He also denied a history of suicide attempts, but did report a

history of violence, recalling recent verbal outbursts. The examiner determined that the Veteran was experiencing moderate impairment in his psychosocial functional status, as reflected by his reported marital discord, lack of a social support system, and verbal outbursts. The Veteran also admitted to increased alcohol use after the military and stated that it was only when he got sick that he stopped.

Upon conducting a mental status evaluation of the Veteran, the examiner described the Veteran's psychomotor activity as fatigued and his speech as unremarkable. The Veteran's mood was anxious and depressed and his affect was congruent to his mood. It was noted that the Veteran displayed attention and concentration difficulties as he was easily distracted with a short attention span. Although he was oriented to person, place and time, and displayed an unremarkable thought process, when it came to his thought content, he exhibited some suicidal ideation, but denied any current plans or intentions. The Veteran also endorsed symptoms of chronic sleep impairment, and reported to sleep approximately five hours a night, and feel fatigued the following day due to lack of quality sleep. When asked whether the Veteran experienced panic attacks or exhibited obsessive/ritualistic behavior, the examiner responded that he did not. The examiner also described the Veteran's impulse control as fair, and noted that the Veteran endorsed symptoms of short and long-term memory difficulties.

With respect to the PTSD symptoms, the examiner noted that the Veteran exhibited avoidant behavior, a diminished interest or participation in significant activities, feelings of detachment or estrangement from others, and a restricted range of affect. It was also noted that the Veteran had difficulty falling/staying asleep as well as difficulty concentrating. In addition, he had a hypervigilant nature, and exhibited signs of irritability, outbursts of anger, and an exaggerated startle response. Behavioral changes attributed to his PTSD included verbal outbursts, marital and interpersonal discord, an exaggerated startle response, hypervigilant behaviors and a history of alcohol dependence now in sustained full remission. Cognitive changes included attention and concentration difficulties as well as short and long-term memory impairment, hypervigilant thoughts, and ruminating thoughts. The Veteran also exhibited interpersonal discomfort with crowds and strangers, interpersonal conflict, and "isolative preferences, aside from [his] family." In addition, affective

changes associated with his disorder include emotional dysregulation in the form of recurrent anxiety, anger/irritability and depression. Somatic changes include chronic sleep disturbance with combat-related nightmares, and chronic health problems which lessen the quality of life. Based on her discussion with, as well as her evaluation of the Veteran, the VA examiner determined that the Veteran met the DSM-IV criteria for a diagnosis of PTSD and alcohol dependence that is in sustained full remission. According to the examiner, the Veteran appeared to be experiencing "moderate negative changes in psychosocial functional status and quality of life following traumatic combat deployment in Vietnam" and these negative changes had impacted his performance when it came to his employment, routine responsibilities of self-care, family role functioning, physical health, social/interpersonal relationships and recreation/leisure pursuits. With respect to the effect of his PTSD on his occupational and social functioning, the examiner noted that Veteran's psychiatric disorder resulted in deficiencies in his judgment, thinking, work, family relationships and his mood.

At the January 2011 VA psychiatric examination, after reviewing the Veteran's medical history, the examiner noted that the Veteran had been seeking outpatient treatment for his PTSD at the El Paso VAMC from 2000 to the present time. It was noted that the Veteran was taking antidepressants (Sertraline) and anti-anxiety (Clonazepam) medication for treatment of his symptoms, and participated in individual therapy which he described as helpful for his anxiety, PTSD and depression. The Veteran reported to experience nightmares about the war twice a week, and stated that most of his dreams are about being in danger. He did state that he was now sleeping eight hours at night. According to the Veteran, he lacks the desire to have fun or go out, and noises and crowds bother him. With respect to his interpersonal relationships, the Veteran remained married to his first wife, and described their relationship as fair. He reported to have a good relationship with his children and grandchildren. He denied a history of suicide attempts or violence/assaultiveness. When asked to comment on the Veteran's current psychosocial status, the examiner found that the Veteran had been functioning within normal limits in areas such as self-care, employment, schooling, family functioning, physical health, social interacting and recreational pursuits.

On mental status evaluation, the Veteran's psychomotor activity was unremarkable, and his attitude towards the examiner was shown to be friendly and cooperative. The Veteran's affect was appropriate and constricted, and his mood was described as dysphoric. According to the examiner, the Veteran's judgment and insight were shown to be intact, as he understood that he had a problem, and further understood the outcome of his behavior. The examiner did note that the Veteran continued suffering from chronic sleep impairment as he had nightmares and vivid dreams about his in-service experiences twice a week. It was further noted that the Veteran exhibited obsessive/ritualistic behavior as reflected by the fact that he frequently checked and locked the doors at his home at night. The Veteran denied experiencing any panic attacks, but did admit to having occasional homicidal and suicidal thoughts. However, he commented that he would never take any action or follow through on these thoughts because of his children. Although it was noted that the Veteran had problems with his activities of daily living, he did not report any difficulty carrying out basic activities of daily living, to include bathing, grooming, dressing and feeding himself independently. It was noted that he experienced moderate problems engaging in sports/exercises, travelling and driving – however it is unclear whether these activities have been hindered by his PTSD, or his coronary artery disease.

The examiner noted that the Veteran's PTSD symptoms include recurrent distressing dreams of the traumatic in-service event, a markedly diminished interest in significant activities, hypervigilant behavior, an exaggerated startle response, depression, anxiety, irritability, nightmares, moderate impairment in his short-term memory, and difficulty concentrating. It was also noted that he had passive thoughts of self-harm without plan or intent, and he preferred to isolate himself and avoid crowded situations. With regard to the Veteran's occupational history, the examiner noted that the Veteran retired in 1995 due to his stomach ulcer and psychiatric problems. She (the examiner) noted that the Veteran was under a great deal of stress while running his own business, and drank excessively at the time, and developed a stomach ulcer. Based on her evaluation of the Veteran, she diagnosed him with having chronic PTSD, and assigned him a GAF score of 65.

The Veteran also submitted an evaluation report issued by a certified Rehabilitation counselor and licensed psychologist, Dr. T., Ph.D., dated in May 2016. The evaluation report was based on Dr. T.'s detailed review of the Veteran's medical records, as well as several conversations with the Veteran. According to Dr. T., the Veteran's current symptoms include difficulty falling and staying asleep, and at times he wakes up with physical reactions such as sweating. He reports daily intrusive and involuntary thoughts of Vietnam, and experiences flashbacks that are elicited with certain triggers such as the sight or sound of helicopters or loud noises or the smell of diesel. According to Dr. T., the Veteran has felt emotionally numb and void of feeling since his return from the military and he has difficulty trusting others, has few close friends and "rocky" interpersonal relationships. He reported frequent bouts of irritability and outbursts of anger not always related to the issues at hand. According to Dr. T., the Veteran's symptoms of difficulty concentrating, short and long-term memory loss, flashbacks/intrusive thoughts, insomnia, withdrawn nature, and bouts of moderately severe depression severely impairs his social, personal and occupational functioning. Dr. T. noted that as a result of his symptoms, the Veteran began to drink heavily and was diagnosed with a bleeding ulcer in 1994 due to his drinking. She noted that the Veteran underwent inpatient PTSD treatment in 1997 and 2000, and underwent a three-way coronary artery bypass procedure in 2008.

After reviewing, and providing a recitation of the Veteran's medical records and medical history, Dr. T. determined that the Veteran's PTSD symptoms ranged from moderately severe to severe for the period prior to August 2010. She also determined that the Veteran's service-connected disabilities have prevented him from securing and maintaining substantially gainful employment since 1995 "when he stopped working as a self-employed paint and bump shop owner." In reaching this conclusion, she observed from the record that the Veteran had difficulties getting along with customers and employees, and most of the time, he worked by himself. She also noted that the Veteran left school in the sixth grade, had no additional educational or vocational training beyond this, and learned how to work with cars while working with his brothers. She further reasoned that he did not possess any transferable skills to less exertional work.

The Board notes that, when it is not possible to separate the effects of the service-connected disability from a nonservice-connected disability, such signs and symptoms shall be attributed to the service-connected disability. *See* 38 C.F.R. § 3.102 (2008); *Mittleider v. West*, 11 Vet. App. 181 (1998) *citing Mitchem v. Brown*, 9 Vet. App. 136, 140 (1996) (the Board is precluded from differentiating between symptomatology attributed to a nonservice-connected disability and a service-connected disability in the absence of medical evidence which does so). In this case, the Veteran has been diagnosed with having PTSD, major depressions, and dysthymic disorder. However, his treatment providers and VA examiners have not distinguished between the symptoms attributed to each disorder. In light of the fact that the objective medical findings does not differentiate between the psychiatric symptoms associated with each psychiatric disorder, the Board considers all psychiatric symptoms and level of occupation and social impairment due to such symptoms as attributable to the Veteran's service-connected PTSD for all periods on appeal.

A. For the period prior to December 17, 2010

Under the PTSD rating criteria in effect prior to November 7, 1996, the Board finds that, for the period prior to December 17, 2010, the evidence does not approximate the level of occupational and social impairment contemplated by a 70 percent rating. In this regard, the Veteran's PTSD has been manifested by symptoms of irritability, difficulty sleeping, frequent nightmares, avoidant behavior, a hypervigilant nature, anxiety, paranoia and outbursts of anger. The record reflects that the Veteran's marriage with his wife has been strained at times, and the Veteran had to undergo inpatient treatment for his PTSD and alcoholism on three separate occasions between January 1997 and October 2000. However, the objective medical findings do not show the Veteran's psychiatric symptoms to be of such severity to warrant a 70 percent rating. In this regard, at the May 1995 VA evaluation, the Veteran reported symptoms of nervousness, occasional nightmares and past thoughts of suicide. However, he described the suicidal thoughts as fleeting in nature, and denied any recent suicidal or homicidal ideations. During this evaluation, the Veteran reported that he was self-employed and had been working with automobiles since he was eighteen years of age. He did not report

having any difficulty working alongside his staff or performing the duties necessary to maintain his business. The VA social worker at the time found that the examination findings did not reveal any symptoms suggestive of PTSD. At the February 1996 VA examination, the Veteran indicated that he was still working at his automobile paint shop, and although business was not going very well, he did not indicate that he was unable to perform his duties as a result of his PTSD. Although the Veteran reported to experience symptoms of irritability and anger, as well as nightmares and difficulty sleeping, he reported to love his wife and children and appeared to have a good relationship with his family. Based on her evaluation of the Veteran, the VA examiner again found that while the Veteran had mild PTSD symptoms.

Although the Veteran was admitted to the VA hospital for inpatient treatment for his PTSD in January 1997, August 1997, and then again in August 2000, he displayed improvement with treatment. At the time of his February 1997 discharge, the Veteran was described as pleasant and cooperative with decreasing symptomatology with treatment. He was evaluated for the Vietnam veteran PTSD program, but the psychologist determined that he was not in need of this at the time. Based on his discharge report, the Veteran "had less symptoms of [PTSD] than was necessary to treat" and he improved with medication. During his inpatient treatment from August 1997 to October 1997, the Veteran's treatment records reflected steady improvement in his psychiatric condition. During a few treatment sessions, he described the closeness he was developing with his daughter, and he was shown to be friendly and cooperative with the staff and peers there. He interacted well and socialized with other veterans during the group therapy sessions and while at the dining hall for meals. He exercised, slept and ate well, and although he admitted to attempting suicide twice during his inpatient treatment from August 1997 to October 1997, his discharge report reflected an improvement in his symptoms throughout his hospitalization, and at the time of his discharge he denied any current suicidal or homicidal ideation. Moreover, he was assigned a GAF score of 50 at the time of his discharge.

During the March 1998 psychiatric evaluation, although the Veteran indicated that he had lost a number of friends from his past due to his irritable nature and temper,

he did report to attend church regularly. He also reported to have a good relationship with his siblings, children and grandchildren. At the time of his August 2000 admission for inpatient PTSD treatment, report of the acute psychiatric admission nursing assessment evaluated the Veteran's depression and anxiety to be moderate in severity, and his daily functioning was rated as "fairly good." The Veteran was not considered a danger to others, his attitude was described as cooperative, and results of the mental status evaluation revealed intact mental functioning. At the time of his October 2000 discharge, when summarizing the Veteran's hospital course, the treatment provider noted that the Veteran participated well in any scheduled activity of the unit and he related well to the other patients, as well as the unit staff. It was also noted that the Veteran participated well in group therapy. Upon mental status examination, the Veteran was shown to be alert, pleasant, cooperative and well-behaved, and although his affect was anxious and his mood depressed, he denied suicidal or homicidal ideation, and his conversation was relevant and coherent. Moreover, the Veteran was assigned a GAF score of 55 at this time.

The available evidence of record does not reflect any treatment subsequent to his October 2000 discharge until 2008 when the Veteran began seeking treatment for his heart condition at the El Paso VA Healthcare system. During a February 2009 VA mental health treatment visit, the Veteran reported to feel hopeful and satisfied with his treatment. He did not report any suicidal or homicidal ideation, and he was described as having "normal motoric activity, coherent speech with normal rate and rhythm, cooperative, good reliability of answers, adequate concentration, adequate attention span, decreased affect and mood [and] capable of insight [with] no [signs of] psychosis." He was diagnosed with having PTSD per history and major depression that is recurrent. At the May 2009 VA treatment visit, although the Veteran reported some difficulties between himself and his wife, he showed interest in participating in group, individual and marital therapy and did not display any thoughts of harm to himself or others. He was again diagnosed with PTSD per history and major depression that is recurrent in nature. The Veteran was also assigned a GAF score of 65.

Although in the May 2016 opinion, Dr. T. noted that, for the period prior to August 2010, the Veteran's symptoms ranged from moderately severe to severe, the objective medical findings reviewed (and referenced by her in her report) do not support this determination. Although the Veteran has described his marriage as a strained one, he is still married to, and continues to reside with, his wife, and they have been married for at least fifty-two years now. He has also reported to have a good relationship with his children and grandchildren, and during his inpatient hospitalizations, his progress notes and treatment reports reflected that he got along with the other patients as well as with the staff. Additionally, the majority of the treatment records for the period prior to December 17, 2010 reflect GAF scores ranging from 50 to 65, which is reflective of symptoms that are more moderate than severe in nature. The Board acknowledges that the Veteran was assigned a GAF score of 40 following his hospitalization in February 1997, as well as a GAF score between 40 and 50 at the March 1998 psychiatric evaluation. However, as reflected above, the majority of his GAF scores for this period range denote moderate symptoms or impairment in social, occupational or school functioning. The Board finds that the GAF scores indicating more moderate symptoms are more consistent with the medical evidence of record. In light of these findings, the Board finds that the Veteran's ability to establish and maintain effective or favorable relationships with people is moderately, but not severely impaired.

The Board also acknowledges that the Veteran stopped working at his automotive business in 1997. Although he contends that he stopped working as a result of his PTSD symptoms, this assertion is not consistent with the medical evidence of record. Indeed, the medical findings recounted above reflect that for the period prior to December 17, 2010, the Veteran's PTSD symptoms were moderate in severity, and not so debilitating as to result in significant occupational impairment. As discussed above, the Veteran appeared to get along well with his children, and his hospitalization records reflect that he got along and related well with the other patients, veterans and hospital staff members. His GAF scores were predominantly in the 55 to 62 range, and although he described a somewhat fractious relationship with his wife, these issues appear to stem from external factors, such as personal marital issues specific to the two of them; not so much as a result of his PTSD.

Furthermore, the Veteran is receiving SSA disability benefits in part due to his PTSD, and in part due to another non-service-connected disorder, so any impairment with regard to his ability to work, for SSA purposes, is not solely related to his PTSD. Indeed, none of the Veteran's treatment providers or examiners has indicated that his inability to obtain and maintain employment is solely due to his PTSD. It has always been noted that various factors, to include his arthritis, bleeding ulcers and psychiatric symptoms were contributing factors to his decision to retire. Although Dr. T., in the May 2016 report, determined that the Veteran's service-connected disabilities prevented him from securing and maintaining substantially gainful employment as of 1995, the objective medical findings recounted above (and referenced by her in her report), to include the VA treatment records and VA examination reports, as well as records issued from the WBAMC, do not support this determination. A review of the medical findings, and specifically, medical findings pertaining to the Veteran's mental condition, do not paint a picture of someone whose PTSD symptoms were so weakening in nature, that they resulted in severe impairment with respect to his ability to maintain employment. In this regard, although the Veteran's PTSD may have been a factor that led to his decision to retire, his psychiatric condition alone was not so impaired as a result of his PTSD to severely impair his ability to obtain or retain employment.

The Board also finds it significant that the Veteran had continued working steadily post-service, and had been self-employed for at least 18 years at the time of his retirement in 1997. Indeed, it was not until he developed and received treatment for a bleeding ulcer sometime between 1994 and 1995 that he quickly took measures to retire. Also, report of the February 1996 VA examination conducted to determine whether the Veteran had residuals of dioxin exposure, it was noted that not only did the Veteran begin receiving treatment for his ulcers in September 1994, but he also began experiencing pain in his feet, knees and lower back, and was subsequently diagnosed with degenerative arthritis in these joints, in 1995. Had his PTSD symptoms been severe enough to impact his employment throughout the years post-service, the Board finds it likely that that he would have reported these difficulties and undergone treatment, and possibly retired sooner than when he did. However, the record reflects that the Veteran only began receiving treatment for his mental health condition following his treatment for his bleeding ulcer, which led to his

decision to retire. Indeed, the Veteran asserted during a number of his treatment visits that he retired very soon after he was treated for a bleeding ulcer, and this was the precipitating factor that led to his quick decision to retire and sell his business. Furthermore, the January 2011 VA examiner determined that the Veteran's inability to work was more likely than not related to his lack of physical strength and endurance, and only minimally or mildly related to his PTSD and anxiety.

As such, the Board accords more probative weight to the VA examination reports and VA treatment records throughout the years because, collectively, they provide an accurate description, and are better reflective of the Veteran's psychiatric symptoms and how these symptoms affect the his social and occupational functioning post-service and for the period prior to December 17, 2010. *See Gabrielson v. Brown*, 7 Vet. App. 36, 39-40 (1994) (providing that the Board is obligated under 38 U.S.C. § 7104 (d) to analyze the credibility and probative value of all evidence, account for the evidence which it finds to be persuasive or unpersuasive, and provide reasons for its rejection of any material evidence favorable to the veteran). In this regard, while the Veteran may experience functional impairment in various facets of his life as a result of his PTSD, the impairment is the result of symptomatology less severe than contemplated by the 70 percent rating criteria under the PTSD rating criteria in effect prior to November 7, 1996

The evidence further does not reflect that the Veteran is entitled to a 100 percent rating under the rating criteria in effect before November 7, 1996. In this regard, the Veteran has consistently been described as someone who is oriented to person, place, and time, with intact judgment and insight, and average intelligence. The records reflect that the Veteran not only understands that he has a problem, but also understands the outcome of his behavior. While his relationship with his wife has been described as strained, they remain committed to one another, and the Veteran has described his relationship with his children and grandchildren as good. Indeed, one of the Veteran's treatment providers noted that one of the Veteran's assets is that he has a strong support system at home. In addition, he reports to attend church regularly. Moreover, the Board finds that throughout the period on appeal, although the Veteran has sought treatment for various PTSD symptoms that have ranged in

severity and include irritability, intrusive thoughts, difficulty coping, outbursts of anger, and passive suicidal ideation, he has not exhibited behavior that would amount to "gross repudiation of reality with disturbed thought or behavioral processes associated with almost all daily activities such as fantasy, confusion, panic and explosions of aggressive energy resulting in profound retreat from mature behavior." As such, a 100 percent disability rating is also not warranted for the Veteran's PTSD under the criteria in effect prior to November 7, 1996 for the period prior to December 17, 2010. Accordingly, the Board finds that for the period prior to December 17, 2010, the competent medical evidence does not reflect an evaluation in excess of 50 percent under the criteria for PTSD in effect prior to November 7, 1996. A higher initial evaluation in excess of 50 percent for the period prior to December 17, 2010 is not warranted under the criteria before the regulations were amended. 38 C.F.R. § 4.13, Diagnostic Code 9411 (1996).

The Board also finds that for the period prior to December 17, 2010, under the criteria in effect after November 7, 1996, the assigned 50 percent rating is appropriate, and a higher rating is not warranted in this case. In that regard, the Board notes that, prior to December 17, 2010, the type of symptoms contemplated by 70 and 100 percent ratings are not present in this case. Specifically, there is no evidence of symptoms such as obsessional rituals which interfere with routine activities; speech 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 periods of violence; persistent danger of hurting self or others, delusions or hallucinations, disorientation to place and time, neglect of personal appearance and hygiene, inability to establish and maintain effective relationships, or grossly inappropriate behavior. The Board has not failed to consider the Veteran's reports of domestic violence and violence in general. However, he has described his "violence" as verbal, and it is reasonable to find that his description of verbal violence does not constitute violence within the ordinary meaning of the word. For example a dictionary definition of violence is "physical force employed so as to violate, damage or abuse. Wester's II New College Dictionary (1986) p. 1233. Additionally, there is no indication that he responded violently in situations in which there was not provocation.

As opposed to the serious symptoms contemplated by a 70 percent rating, the Board finds that prior to December 17, 2010, the Veteran's PTSD has been manifested by more symptoms either listed or of like kind to those listed in the criteria for ratings less than 50 percent, to include nightmares, intrusive thoughts, avoidant behaviors, depressive symptoms, anxiety, social isolation, strained personal relationships, hypervigilant behavior, chronic sleep disturbance, memory problems, and difficulty concentrating.

Although he has endorsed thoughts of suicide in the past, he described these thoughts as passive and fleeting in nature, and while he reportedly attempted suicide twice in the past during his August 1997 hospitalization, he denied having any suicidal or homicidal ideation at the time of his discharge in October 1997. Moreover, the majority of the Veteran's treatment records are negative for any suicidal ideation, and while he has reported occasional suicidal thoughts throughout his medical history, he consistently denies any plan or intent to follow through with these thoughts. The Board also acknowledges the Veteran's reports of occasional homicidal thoughts during the August 1997 evaluation, but notes that this was just before he was admitted for inpatient PTSD treatment, and the Veteran's psychological condition improved throughout the course of his hospitalization. Moreover, the Veteran has not followed through or acted upon any of these thoughts and appears to understand that when he reaches such a level he needs to seek additional treatment, as reflected by the fact that he voluntarily admitted himself at the hospital for treatment of his PTSD. Furthermore, although the Veteran reported to experience auditory hallucinations during the August 1997 evaluation, as well as hallucinations in his sleep during the March 1998 psychiatric evaluation, these appear to be isolated in nature, as his psychiatric condition improved with group and individual therapy, inpatient treatment and medication. Indeed, the majority of his previous and more recent treatment records are negative for any audio/visual hallucinations or delusional thought patterns.

In evaluating the severity of the Veteran's PTSD during the relevant time period, the Board is cognizant of the fact that "it is not the symptoms, but their effects, that determine the level of impairment." *Mauerhan v. Principi*, 16 Vet. App. 436, 443 (2002). However, the type of symptoms experienced by the Veteran is an important

consideration in determining whether his disability picture warrants a 70 percent disability rating, as the rating criteria specifically requires "occupational and social impairment, with deficiencies in most areas, such as work, school, family relationships, judgment, thinking, or mood, due to such symptoms as . . . ." 38 C.F.R. § 4.130, DC 9411 (emphasis added). As held by the United States Court of Appeals for the Federal Circuit, entitlement to a 70 percent rating "requires sufficient symptoms of the kind listed in the 70 percent requirements, or others of similar severity, frequency or duration, that cause occupational and social impairment with deficiencies in most areas such as those enumerated in the regulation." *Vazquez-Claudio v. Shinseki*, 713 F.3d 112, 118 (Fed. Cir. 2013). Thus, to warrant a 70 percent rating, the evidence must demonstrate PTSD manifested by the symptoms listed in the rating criteria for a 70 percent rating or by ones equivalent in severity to those associated with that disability rating and must reveal that such symptoms have resulted in deficiencies in most areas. *Id.*

Notably, while the evidence suggests that prior to December 17, 2010, the Veteran's PTSD resulted in deficiencies in personal relationships, work, and mood, the examples of pertinent symptoms experienced by the Veteran are not the type of severe symptoms contemplated by the 70 percent rating criteria. Indeed, the type of symptoms experienced by the Veteran are those that are listed in the criteria for a 50 percent rating for PTSD. Simply put, while the Veteran may experience deficiencies in several areas as a result of his PTSD, the deficiencies are the result of symptomatology less severe than contemplated by the 70 percent rating criteria. Even the evidence cited by the Veteran's attorney, as well as his expert witness Dr. T., in support of the assignment of a higher rating does not suggest a disability picture contemplated by a 70 percent rating. As discussed above, during his February 1996 VA examination, the VA examiner interviewed the Veteran regarding his symptoms but found that he had only mild symptoms. Although subsequent VA treatment records generated during his inpatient PTSD treatment document his reported symptoms of anger, difficulty coping, social isolation, nightmares, sleep impairment and irritability, as well as his marital discord and the strain this places on him, the records reflected steady improvement in the Veteran’s condition through treatment. Moreover, the records show that the Veteran related very well with others during group therapy, and interacted well with other veterans

in group situations as well as with the hospital staff during his hospitalizations. The symptoms reported by the Veteran, and documented in his records, are contemplated in the 50 percent disability rating assigned. The Board has reviewed the various VA examination reports and VA treatment records dated prior to December 17, 2010, but finds that the information contained therein does not support an earlier assignment of a 70 percent rating, as the records do not reveal that the Veteran was experiencing the severe symptoms contemplated by the 70 percent rating criteria. *See Vazquez-Claudio*, *supra*.

The Board also notes that prior to December 17, 2010, the Veteran had predominantly been assigned GAF scores ranging from 50 to 65. The GAF is a scale reflecting the "psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness." Diagnostic and Statistical Manual of Mental Disorders 32 (4th ed.1994) (DSM-IV). A GAF score of 51-60 is defined as: "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)." The Board finds that the assignment of the GAF scores ranging from 51-65 falls in line with the assignment of 50 percent. Although the Veteran was assigned a GAF score of 40 a few times, as reflected above, the majority of the treatment records and examination reports reflect GAF scores of 55 or higher. Indeed, the Veteran was assigned a GAF score of 60 at the February 1996 VA examination, a GAF score of 65 during a December 1999 VA treatment visit, a GAF score of 55 upon being discharged from the hospital in October 2000, a GAF score of 58 during the March 2000 VA treatment visit and GAF scores ranging from 62 to 65 during the more recent VA treatment visits (dated in 2008 and 2009) and at the August 2010 examination.

Also, the Board notes that GAF scores are just one component of the Veteran's disability picture, and there is no set 'formula' followed in assigning evaluations. Rather, the Board considers the Veteran's entire disability picture, including GAF scores, when rendering its determination. Under such circumstances, Veterans with identical GAF scores may be assigned different evaluations based on each individual's symptomatology and level of functioning. Furthermore, the Board need not accept a GAF score as probative. *See Evans v. West*, 12 Vet. App. 22, 30

(1998), *citing Owens v. Brown*, 7 Vet. App. 492, 433 (1995) (it is the responsibility of the Board to weigh the evidence, including the medical evidence, and determine where to give credit and where to withhold the same and, in so doing, the Board may accept one medical opinion and reject others). Accordingly, in the instant case, the Board finds that for the period from November 7, 1996 to December 17, 2010, under the rating criteria in effect from November 7, 1996, the Veteran's PTSD has been manifested by moderate underlying symptomatology as reflected by the medical and lay evidence of record and that that the Veteran's overall disability picture has not been shown to more nearly approximate occupational and social impairment with deficiencies in most areas due to the symptoms contemplated by the 70 percent rating criteria, including any of like kind, at any point prior to December 17, 2010. *See* 38 C.F.R. §§, 4.7, 4.130, DC 9411.

The Board has also considered whether the Veteran's PTSD has resulted in total social and occupational impairment, such that a 100 percent schedular evaluation is warranted, but finds that it has not. As noted above, the Veteran had been married to his wife for more than 50 years, and although he described their relationship as strained, he reports to have a good relationship with his children, and he interacts with his family and does have a few hobbies he enjoys (yardwork and watching television). In addition, the Veteran reported an improvement in his relationship with his wife during the November 2009 VA treatment visit. Furthermore, the Veteran's medical records have consistently shown his cognitive evaluations to be normal, his mental functioning to be intact, and his thought process to be coherent and goal-directed. The Veteran is able to conduct his basic activities of daily living independently, and he is able to help with the household chores. Moreover, he has consistently maintained his personal appearance and hygiene to a socially acceptable level, and has been described as someone who has good insight and who is well-groomed and oriented to person, place, time and situation. Therefore, the Board finds that for the period from November 7, 1996 to December 17, 2010, the criteria for a 100 percent schedular evaluation are not met, and a total schedular evaluation is not warranted under the criteria in effect after November 7, 1996. *See* 38 C.F.R. §§, 4.7, 4.130, DC 9411.

B. For the period on and after December 17, 2010

Under the rating criteria in effect on and after November 7, 1996, the Board finds that a rating in excess of 70 percent is not warranted for the period on and after December 17, 2010. The evidence of record does not reflect that the Veteran's contacts (except with those most intimate) have been so adversely affected as to result in virtual isolation in his community. Although the Veteran has exhibited an isolative nature and prefers to be alone, he still reports to have a very good relationship with his children. As noted above, at the January 2011 VA examination, he reported to socialize on a minimal, yet regular, basis outside of his family contacts, noting that he attends church on a regular basis and enjoys walking around the lake in the summer time. Also, although the Veteran has reported occasional homicidal and suicidal thoughts, an exaggerated startle response, outbursts of anger and increasingly obsessive behavioral patterns, the Board finds that such symptoms are contemplated by the 70 percent criteria, and have not resulted in total incapacitation, gross repudiation of reality, or profound retreat from mature behavior as required to rise to the 100 percent level under the former rating criteria.

Indeed, the January 2011 VA examiner noted that the Veteran had been functioning within normal limits in areas such as self-care, employment, schooling, family functioning, physical health, social interacting and recreational pursuits. On mental status examination, his attitude towards the examiner was shown to be friendly and cooperative, and his affect was appropriate and constricted. Although the Veteran was easily distracted, his thought process and thought content were negative for any abnormalities, and his insight and judgment were shown to be intact in that he understood both that he had a problem, as well as the outcome of his behavior. The more recent treatment records, to include the January 2011 VA examination report, are negative for signs of audiovisual hallucinations and delusional thought patterns. He was still able to conduct most of his activities of daily living, and the only activities he had difficulty completing were those that required exercising, participating in sport activities, travelling and driving. In addition, the Veteran was deemed mentally competent to manage his finances. Also, during an August 2012 VA mental health treatment visit, the Veteran's attention and concentration were

shown to be within normal limits, his abstraction was good, his judgment and insight were shown to be good, and he denied any audio/visual hallucinations.

Accordingly, the Board finds that for the period on and after December 17, 2010, the competent medical evidence does not reflect an evaluation in excess of 70 percent under the PTSD criteria in effect prior to November 7, 1996. A higher initial evaluation in excess of 70 percent for the period on and after December 17, 2010 is not warranted under the criteria before the regulations were amended. 38 C.F.R. § 4.132, Diagnostic Code 9411 (1996).

Under the criteria in effect from November 7, 1996, the Board also observes that for the period from December 17, 2010, an initial rating in excess of 70 percent is not warranted because the competent evidence of record does not demonstrate that the Veteran's symptomatology more closely approximates a 100 percent evaluation. In this regard, the Board notes that the Veteran's medical records do not contain evidence that supports a finding that he exhibits grossly inappropriately behavior, intermittent inability to perform activities of daily living, or disorientation as to time or place. The more recent treatment records and examination report is negative or absent for any complaints or signs of auditory or visual hallucinations, and are therefore better reflective of the Veteran's current symptomatology. Indeed, the record establishes that the Veteran has maintained fairly steady relationships with his wife and children. Although his relationship with his wife is strained, they remain committed to one another and he described their relationship as fair during the January 2011 VA examination. Additionally, the Veteran has continued seeking treatment in an effort to improve their interactions with one another and is motivated to continue doing so. Moreover, the Veteran’s functional level with respect to areas such as self-care, employment, schooling, family functioning, physical health, social interacting and recreational pursuits is shown to be within normal limits, and he has not reported to require assistance with basic activities such as grooming, feeding bathing and dressing himself. The Veteran is also able to assist his wife with the household chores, and the record reflects that he has consistently exhibited intact insight and good judgment. His treatment providers have found that he is able to express himself in a coherent and logical manner, and have described him as well-groomed, cooperative, pleasant and calm in manner.

Although the Veteran's symptoms include constant irritability, a socially isolative nature, hypervigilant behavior, paranoia, and extreme anxiety, review of the VA treatment records reflect that the Veteran has continued seeking treatment at the El Paso VA Healthcare system, and is making every attempt to try to alleviate his symptoms. Indeed, at the January 2011 VA examination, the Veteran reported to attend church on a regular basis, and he stated that he enjoys walking around the lake during the summertime. As such, although the Veteran continues to experience recurrent PTSD symptoms that range in frequency and severity, his ability to function when it comes to various facets of his life is within normal limits, and has demonstrated the ability to break free of these symptoms on occasion in an attempt to engage in outside activities. As such, the Board finds that, based on the PTSD criteria in effect from November 7, 1996, the overall picture for the period on and after December 17, 2010, based on the medical evidence of record corresponds more closely with the 70 percent disability evaluation. Therefore, the Board finds that the criteria for a 100 percent schedular evaluation are not met, and a total schedular evaluation is not warranted for the period on an after December 17, 2010.

Temporary Total Ratings For Periods of Hospitalization for PTSD

As noted above, the Veteran has been hospitalized for his service-connected PTSD at VA medical treatment facilities from January 9, 1997 to February 7, 1997; August 20, 1997 to October 29, 1997; and from August 7, 2000 to October 20, 2000.

A temporary total rating may be assigned pursuant to 38 C.F.R. § 4.29 or 38 C.F.R. § 4.30. Pursuant to 38 C.F.R. § 4.29, a total disability rating (100 percent) will be assigned without regard to other provisions of the rating schedule when it is established that a service-connected disability has required hospital treatment in a VA or an approved hospital for a period in excess of 21 days or hospital observation at VA expense for a service-connected disability for a period in excess of 21 days. 38 C.F.R. § 4.29. Subject to the provisions of paragraphs (d), (e), and (f) of § 4.29, this increased rating will be effective the first day of continuous hospitalization and

will be terminated effective the last day of the month of hospital discharge (regular discharge or release to non-bed care) or effective the last day of the month of termination of treatment or observation for the service-connected disability. 38 C.F.R. § 4.29(a). In light of the fact that a temporary total rating for hospitalization in excess of 21 days for a service-connected issue is an increased rating issue, and given that the Board has jurisdiction over both periods of appeal, then the issues of whether the Veteran is entitled to temporary total evaluations for hospitalizations for his PTSD from January 9, 1997 to February 7, 1997; from August 20, 1997 to October 29, 1997; and from August 7, 2000 to October 20, 2000, are also on appeal before the Board.

Notwithstanding that hospital admission was for disability not connected with service, if during such hospitalization, hospital treatment for a service-connected disability is instituted and continued for a period in excess of 21 days, the increase to a total rating will be granted from the first day of such treatment. If service connection for the disability under treatment is granted after hospital admission, the rating will be from the first day of hospitalization if otherwise in order. 38 C.F.R. § 4.29(b).

The assignment of a total disability rating on the basis of hospital treatment or observation will not preclude the assignment of a total disability rating otherwise in order under other provisions of the rating schedule, and consideration will be given to the propriety of such a rating in all instances and to the propriety of its continuance after discharge. Particular attention, with a view to proper rating under the rating schedule, is to be given to the claims of veterans discharged from hospital, regardless of length of hospitalization, with indications on the final summary of expected confinement to bed or house, or to inability to work with requirement of frequent care of physician or nurse at home. 38 C.F.R. § 4.29(c).

The VA hospital records reflect that the Veteran was hospitalized, and underwent inpatient psychiatric treatment, for his service-connected PTSD at the Big Spring VAMC from January 9, 1997 to February 7, 1997, as well as at the Waco VAMC from August 20, 1997 to October 29, 1997, and from August 7, 2000 to October 20, 2000. A recitation of the inpatient medical records has been provided in the

increased rating section above. These records reflect that the Veteran was treated for, and diagnosed with having, PTSD and/or a history of PTSD, during the course of these three hospitalizations. Moreover, the Board notes that the Veteran sought inpatient treatment all three times to help treat and alleviate his psychiatric symptoms. Therefore, the Board finds that entitlement to temporary total ratings pursuant to 38 C.F.R. § 4.29 based on hospitalization for the Veteran's PTSD from January 9, 1997 to February 7, 1997; as well as from August 20, 1997 to October 29, 1997, and from August 2000 to October 20, 2000 is warranted.

Extraschedular Consideration

Consideration has also been given to whether the schedular evaluations are inadequate, thus requiring that the AOJ refer a claim to the Under Secretary for Benefits or the Director, Compensation Service, for consideration of "an extra-schedular evaluation commensurate with the average earning capacity impairment due exclusively to the service-connected disability or disabilities." 38 C.F.R. § 3.321 (b)(1); *Barringer v. Peake*, 22 Vet. App. 242, 243-44 (2008) (noting that the issue of an extraschedular rating is a component of a claim for an increased rating and referral for consideration must be addressed either when raised by the veteran or reasonably raised by the record). In determining whether an extra-schedular evaluation is for consideration, the Board must first consider whether there is an exceptional or unusual disability picture, which occurs where the diagnostic criteria do not reasonably describe or contemplate the severity and symptomatology of a Veteran's service-connected disability. *See Thun v. Peake*, 22 Vet. App. 111, 115 (2008). If there is an exceptional or unusual disability picture, the Board must next consider whether the disability picture exhibits other factors such as marked interference with employment and frequent periods of hospitalization. *Id*. at 115-16. When those two elements are met, the appeal must be referred for consideration of the assignment of an extraschedular rating. Otherwise, the schedular evaluation is adequate, and referral is not required. 38 C.F.R. § 3.321 (b)(1); *Thun*, 22 Vet. App. at 116.

The schedular evaluations in this case are not inadequate. Evaluations in excess of the rating assigned herein are provided for certain manifestations of the service-connected PTSD, but the evidence reflects that those manifestations are not present in this case. From July 31, 1995 to December 17, 2010, the Veteran primarily complains that his PTSD was manifested by a depressed mood, anger, irritability, anxiety, occasional suicidal ideation, social isolation, impaired sleep patterns, fatigue, avoidant behavior, outbursts of anger, nightmares, a strained marital relationship, and difficulty in establishing and maintaining effective work and social relationships. For the period on and after December 17, 2010, the Veteran primarily complains that his PTSD is manifested by short-term memory impairment, concentration difficulties, outbursts of anger, impaired sleep, increasing nightmares, hypervigilant behavior, an exaggerated startle response, obsessional rituals that interfere with routine activities; and difficulty in adapting to stressful situations. These symptoms and the type of resulting functional impairment described by him are contemplated in the rating criteria both prior to November 7, 1996, and the rating criteria set forth under the general formula for rating mental disability on and after November 7, 1996. Moreover, the schedule includes levels of symptomatology more severe than what the Veteran has been shown to have. Without sufficient evidence reflecting that the Veteran's disability picture is so "exceptional or unusual," such that the available schedular evaluation for his service-connected PTSD is somehow inadequate for either period on appeal, referral for a determination of whether the Veteran's disability picture requires the assignment of an extraschedular rating is not warranted. *See Thun v. Peake,* 22 Vet. App. 111, 115-16 (2008); 38 C.F.R. § 3.321 (b)(1) (2016).

As the Board finds that the Veteran's disability picture is contemplated by the rating schedule, the inquiry ends and the Board need not consider whether the disability picture exhibits other related factors such as marked interference with employment and frequent periods of hospitalization.

Further, there are no additional symptoms that have not been attributed to a specific service-connected condition. The Board notes that under *Johnson v. McDonald*, 362 F.3d 1362 (Fed. Cir. 2014), a Veteran may be awarded an extraschedular rating based upon the combined effect of multiple conditions in an exceptional

circumstance where the evaluation of the individual condition fails to capture all the service-connected disabilities experienced. However, in this case, there are no additional service-connected symptoms that have not been attributed to a specific service-connected condition. Accordingly, this is not an exceptional circumstance in which extraschedular consideration may be required to compensate the Veteran for a disability that can be attributed only to the combined effect of multiple conditions.

The Board has also considered whether the issue of entitlement to special monthly compensation (SMC) has been raised within the context of this appeal, but finds that it has not. *See Akles v. Derwinski*, 1 Vet. App. 118, 121 (1991) (noting VA's policy to consider SMC where applicable). In this regard, the Board notes that in *Bradley v. Peake*, the Court determined that a separate TDIU rating predicated on one disability when considered together with another disability separately rated at 60 percent or more could warrant SMC under 38 U.S.C.A. § 1114 (s); 22 Vet. App. 280, 293-94 (2008). Although the Veteran is in receipt of a 70 percent rating for his PTSD and has been awarded a TDIU, the Veteran's award of TDIU is premised on multiple service-connected disabilities that render him unemployable and thus does not constitute a service-connected disability rated as total, which is necessary for an award of SMC under 38 U.S.C.A. § 1114 (s). *See* 38 U.S.C.A. § 1114 (s) (providing for the payment of SMC where a "veteran has a service-connected disability rated as total, and (1) has additional service-connected disability or disabilities independently ratable at 60 percent or more").

Entitlement to a TDIU for the period prior to March 16, 2009

Awards of TDIU are governed, in part, by 38 C.F.R. § 4.16 (a) (2016). Under that regulation, total disability ratings for compensation can be assigned, where the schedular rating is less than total, when the disabled person is, in the judgment of the rating agency, unable to secure or follow a substantially gainful occupation as a result of service-connected disabilities: provided that, if there is only one such disability, the disability must be ratable at 60 percent or more, and that, if there are two or more disabilities, there shall be at least one disability ratable at 40 percent or

more, and sufficient additional disability to bring the combined rating to 70 percent or more. *See also* 38 C.F.R. §§ 3.340, 3.341 (2016).

Furthermore, it is the policy of VA that all veterans who are unable to secure and follow a substantially gainful occupation by reason of service connected disability shall be rated totally disabled. 38 C.F.R. § 4.16 (b). Thus, if a veteran fails to meet the applicable percentage standards enunciated in 38 C.F.R. § 4.16 (a), an extra-schedular rating is for consideration where the veteran is unemployable due to service connected disability. 38 C.F.R. § 4.16 (b); *see also Fanning v. Brown*, 4 Vet. App. 225 (1993). Neither nonservice-connected disabilities nor advancing age may be considered in the determination. 38 C.F.R. §§ 3.341, 4.19; *Van Hoose v. Brown*, 4 Vet. App. 361, 363 (1993). Thus, the Board may not consider the effects of the Veteran's nonservice-connected disabilities on his ability to function.

When all of the evidence is assembled, VA is responsible for determining whether the evidence supports the claim or is in relative equipoise, with the appellant prevailing in either event, or whether a fair preponderance of the evidence is against the claim, in which case the claim is denied. *Gilbert v. Derwinski*, 1 Vet. App. 49, 55 (1990).

The Veteran’s service-connected for PTSD, is evaluated as 50 percent disabling for the period prior to December 17, 2010, and 70 percent disabling on and after December 17, 2010. The Veteran is also service-connected for his coronary artery disease, which is evaluated as 30 percent disabling, effective March 16, 2009 (as determined herein). In addition, the Veteran is service-connected for residual surgical scar, status post coronary artery bypass graft, which has been evaluated as noncompensably disabling, effective March 16, 2009.

By way of the December 2014 rating decision, the RO granted the Veteran’s claim for entitlement to a TDIU, effective from August 31, 2010, the date the Veteran initially had a combined rating of 70 percent. *See* 38 C.F.R. § 4.16(a). However, given that the Veteran has been assigned earlier effective dates for the grants of service connection for his CAD, status post CABG, and residual surgical scar, status post CABG, herein, the Board finds that the 70 percent combined rating

would also have been effective from that earlier effective date (March 16, 2009) as well. As such, the percentage requirement for TDIU, under subsection (a) of section 4.16 was met March 16, 2009. In his August 2016 Appellant Brief, the Veteran sought entitlement for a TDIU for the period prior to the effective date assigned. For the period prior to March 16, 2009, the Veteran was only service-connected for his PTSD which was evaluated as 50 percent disabling. Thus, for the period prior to March 16, 2009, the Veteran does not meet the schedular requirements for a total disability rating based on individual unemployability due to service-connected disabilities under 38 C.F.R. § 4.16(a).

With regard to whether the Veteran is entitled to TDIU pursuant to 38 C.F.R. § 4.16 (b) for the period prior to March 16, 2009, the Board has no authority to award TDIU under § 4.16(b) in the first instance. Rather, the rating board must submit to the Director, Compensation and Pension Service for extraschedular consideration all cases of Veterans who are unemployable by reason of service-connected disabilities, but who fail to meet the percentage standards set forth in § 4.16(a). *Bowling v. Principi*, 15 Vet. App. 1, 10 (2001). If the Director denies the extraschedular TDIU, the Board has jurisdiction to grant or deny the appeal, or remand for additional development and the Director's decision is the same as the RO's as far as the Board's jurisdiction and standard of review. *Wages v. McDonald*, 27 Vet. App. 233, 238 (2015) ("In short, the Director's decision is no different than an RO's decision in terms of its effect on the Board's statutory jurisdiction and the Board's standard of review").

In determining employability for VA purposes, consideration is given to the level of education, special training, and work experience, but not to age or nonservice-connected disabilities. 38 C.F.R. §§ 3.341, 4.16(a), 4.19; *see also Faust v. West*, 13 Vet. App. 342 (2000). The question is whether the Veteran is capable of performing the physical and mental acts required by employment. *Van Hoose v. Brown*, 4 Vet. App. 361, 363 (1993) (citing 38 C.F.R. §§ 4.1 , 4.15, 4.16(a)). The Veteran does not have to be 100 percent unemployable in order to be entitled to a TDIU. *Roberson v. Principi*, 251 F.3d 1378, 1385 (Fed. Cir. 2001). When there is an approximate balance of positive and negative evidence as to any issue, all reasonable doubt will be resolved in favor of the claimant. 38 U.S.C.A. § 5107.

"Substantially gainful employment" is that employment "which is ordinarily followed by the nondisabled to earn their livelihood with earnings common to the particular occupation in the community where the veteran resides." *Moore v. Derwinski*, 1 Vet. App. 356, 358 (1991). As further provided by 38 C.F.R. § 4.16 (a), "marginal employment shall not be considered substantially gainful employment."

The Veteran has reported that he worked at an automobile body shop alongside his brothers following his military service, and began his own automotive business sometime in 1979. He was self-employed for at least eighteen years before filing his claim for service connection for PTSD in July 1995. According to the Veteran, he stopped working that same year, and ultimately sold his business soon thereafter. The Veteran contends that he was unable to maintain his business as a result of his PTSD and symptoms arising therefrom. The Veteran further contends that his PTSD prevented him from seeking, gaining, and maintaining meaningful, gainful employment following his retirement in 1995.

Based on a review of the claims file, the Board finds that the preponderance of the evidence is against a finding that, for the period prior to March 16, 2009, the Veteran's service-connected psychiatric disorder alone precluded his participating in all forms of regular substantially gainful employment; therefore referral for extraschedular consideration is not warranted.

A historical overview of the Veteran's claim has been provided above, and a few facts not discussed at length above have been summarized herein. At the May 1995 VA Agent Orange (AO) examination, it was noted that the Veteran had been prompted to undergo an AO examination due to medical problems he had been experiencing. The Veteran specifically complained of gastrointestinal problems, and explained that he had been hospitalized at the WBAMC the previous year for internal gastrointestinal bleeding, and after undergoing an evaluation and medical testing, he had been diagnosed with having gastric ulcers. At the time of this evaluation, when asked about any readjustment difficulties he faced following his return from Vietnam, the Veteran reported to experience occasional nightmares, and

past thoughts of suicide which he described as fleeting in nature. The Veteran described himself as a hyper individual who used to drink to calm his nerves. With regard to his employment, the Veteran indicated that he owned his own automotive business, and he did not report any difficulties performing his occupational duties as a result of any readjustment problems following service. At the November 1995 VA treatment visit, the Veteran asserted that he owned his own automotive business and felt proud of doing his job well. At the time of the February 1996 VA psychiatric examination, the Veteran indicated that he was still working and had one employee working for him.

At the February 1996 VA examination conducted in connection to any potential residuals of dioxin exposure, the Veteran listed all of his medical problems, and explained that he had been admitted to WBAMC in September 1994 with severe epigastric abdominal pain associated with gastrointestinal bleeding. After undergoing an endoscopy, he was diagnosed with a bleeding gastric ulcer, and hospitalized for several days, during which time, he received intensive medical treatment for his gastric ulcer. The Veteran also reported to have degenerative arthritis in both shoulders, which began sometime in 1985. In addition, the Veteran reported the onset of pain in his lower back sometime in 1995, and after undergoing physical examination of the spine, he was diagnosed with possible degenerative arthritis involving the lumbar spine. In addition, the Veteran reported the onset of pain in his knees and feet sometime in 1995, and stated that he had been diagnosed with possible degenerative arthritis in these joints as well.

In his December 2010 application for a TDIU, the Veteran asserted that he last worked on a full-time basis in January 1996, and he became too disabled to work in February 1997. According to the Veteran, his PTSD prevented him from securing or following any substantially gainful employment. When asked whether he had tried to obtain any other employment since becoming too disabled to work, the Veteran indicated that he had not. The Veteran also indicated that he had not received any additional education or training since becoming too disabled to work.

Based on a review of the medical findings the Board finds that there are other nonservice-connected disabilities that impacted the Veteran's employability for the

period prior to March 16, 2009. The record predominantly reflects that the Veteran voluntarily chose to retire soon after undergoing treatment for his gastric ulcers, and not as a result of his impaired psychiatric condition. During the earlier VA treatment visits dated in 1995 and 1996 the Veteran did not even report any difficulties conducting his occupational duties as a result of his psychiatric condition. As noted above, the Veteran is not service-connected for his gastric ulcer, and other than his statements alone, there is no evidence in the record to show that his PTSD, or symptoms associated thereto, led to his stomach ulcer. The Board acknowledges that the Veteran is receiving SSA disability benefits, in part, as a result of his PTSD. However, he is also receiving SSA disability benefits due to his degenerative arthritis, so any impairment with regard to his ability to work, for SSA purposes, is not solely related to his PTSD.

Moreover, as discussed in the previous section, review of the VA and non-VA treatment records did not show the Veteran's psychiatric symptoms to be so severe as to render him unemployable for the period prior to March 16, 2009. As discussed above, the Veteran was consistently described as pleasant and well-behaved with a euthymic mood. The Board acknowledges that he underwent inpatient treatment for his PTSD on three separate occasions between January 1997 and October 2000. The record reflects that the Veteran voluntarily chose to admit himself to help alleviate his PTSD symptoms, and also, as a way to help improve his marital relationship. Review of his hospital records reflects an improvement in the Veteran's psychiatric condition following treatment, which included group and individual therapy and medication. The Veteran has maintained a good relationship with his children, and although he attributed his lack of friends to his PTSD symptoms, the hospital records themselves reflected that he got along well with the patients and staff at the VA hospital. As noted above, during his hospitalization from August to October 1997, it was noted that the Veteran interacted well with the staff and peers, and socialized with the other veterans. These records also reflect that he participated well in the PTSD program and behaved properly in the unit. Also, during his hospitalization from August to October 2000, the Veteran was described as friendly and cooperative towards the staff, and it was noted that he interacted well with others.

The evidence does not reflect that the Veteran sought mental health treatment for his PTSD following his last hospitalization in 2000, until 2008, and his treatment records dated from 2008 to 2010 reflect that his psychiatric symptoms were, at most, moderate in severity. He was consistently described as cooperative in nature, and as someone who displayed good reliability of answers, adequate concentration, and an adequate attention span. He was also assigned GAF scores ranging from 62-65, which denotes more mild symptoms, and based on the characteristics he exhibited, his symptoms were simply not shown to be of such severity that they impaired his ability to obtain or maintain employment for the period prior to March 29, 2010. While Dr. T., in the May 2016 report, determined that the Veteran's service-connected PTSD prevented him from securing and maintaining substantially gainful employment as of 1995 when he stopped working as a self-employed automotive business owner, the Board finds that this conclusion is not consistent with the objective medical findings. Indeed, a few sections in her report are contradicted by the objective medical findings. Although she asserted that the Veteran was working for his brother from 1990 to 1995, and was ultimately fired in 1995, at the time of the February 1996 VA psychiatric examination, the Veteran still described himself as self-employed and there is no indication that he had been fired the previous year. Also, in his December 2010 Application for a TDIU, the Veteran stated that he became too disabled to work in 1997, not 1995.

Furthermore, evidence referenced by Dr. T. did not support the determination that the Veteran was unemployable as a result of his PTSD. As noted above, at the January 2011 VA examination (the report of which was referenced by Dr. T.), it was noted that the Veteran's functional status had been within normal limits in areas such as employment and social interaction, and it was further noted that his inability to work was more likely due to his physical strength and endurance and only minimally attributed to his PTSD. As previously discussed, the Veteran had continued working steadily post-service, and had been self-employed for at least 18 years at the time of his retirement in 1997. It was not until he developed and received treatment for a bleeding ulcer in 1994, and received possible diagnoses of degenerative arthritis in his lower back, knees and feet, that he decided to retire. If the Veteran's PTSD symptoms were so severe as to render him unable to obtain and maintain employment since July 1995, then it must be purely coincidental that he

developed a gastric ulcer and degenerative arthritis in his feet, knees, and lower back right around the same time of his retirement as well.

The ultimate question here is whether the Veteran was capable of performing the physical and mental acts required by gainful employment prior to March 29, 2010. *Van Hoose, supra*. The Board finds that with the exception of his periods of inpatient hospitalization from January 1997 to February 1997, August 1997 to October 1997, and August 2000 to October 2000, the record is absent any indication that the Veteran's service-connected PTSD, alone, precluded his ability to obtain or maintain substantially gainful employment for the period prior to March 29, 2010. The Board acknowledges that the evidence certainly shows that the Veteran's service-connected PTSD impacted his employment. Indeed, the Veteran reported that he attempted to return to his place of employment a few times but could not tolerate being around others. While the Board sympathizes with the difficulties the Veteran faced interacting with others at his employment, and acknowledges that this impact on the Veteran's employment is significant, it is contemplated in the 50 percent disability rating he was assigned during the period on appeal. While the Veteran's service-connected PTSD may have impacted negatively upon his employability, this disability, alone, did preclude his participation in substantially gainful occupation.

After considering the probative value of the evidence in this case, the Board finds that the evidence against the Veteran's claim for a TDIU for the period prior to March 16, 2009 to be more probative than the evidence in favor of the claim. Although the Veteran's service-connected disability no doubt resulted in a degree of functional impairment, as acknowledged by the 50 percent disability rating, the probative evidence of record does not show that the service connected PTSD, alone, prevented all substantially gainful employment for the period prior to March 29, 2010. The record reflects that the Veteran experienced a myriad of health problems that contributed to his decision to retire in 1997, and subsequent inability to work. The Board notes that the Veteran is competent to attest to factual matters of which he has first-hand knowledge, including problems he has encountered at work as a result of his service-connected disability. *See Washington v. Nicholson*, 19 Vet. App. 362, 368 (2005). Moreover, the Federal Circuit has held that lay evidence is

one type of evidence that must be considered, and that competent lay evidence can be sufficient in and of itself. *Buchanan v. Nicholson*, 451 Vet. App. 1331, 1335 (Fed. Cir. 2006). Nevertheless, the Board must still weigh the lay statements of record against the objective evidence of record. *See Layno v. Brown*, 6 Vet. App. 465 (1994). The Board has considered the Veteran's contentions but gives greater probative weight to the VA medical records, which provide a clinical description of the symptoms and treatment of the Veteran's PTSD throughout the years prior to March 29, 2010, as well as the Veteran's reported history and opinions, of which the Board finds is more probative than the Veteran's general lay statements. *Acevedo v. Shinseki*, 25 Vet. App. 286, 294 (2012) (medical reports must be read as a whole and in the context of the evidence of record).

Absent the minimum percentage requirements for basic eligibility for TDIU pursuant to 38 C.F.R. § 4.16 (a) being met, and given the evidence (summarized above) which does not show impairment due to service-connected disability which would preclude a less stressful and more solitary type of employment for the period prior to March 16, 2009, the Board concludes that referral of this matter for extraschedular consideration is not indicated.

The preponderance of the evidence is against this claim for entitlement to TDIU for the period prior to March 16, 2009. Therefore, there is no reasonable doubt to be resolved. The appeal for this matter must be denied. 38 U.S.C.A. § 5107 (b), 38 C.F.R. § 4.3.

Entitlement to a TDIU for the period from March 16, 2009 through August 30, 2010

As discussed above, the Veteran’s service-connected for PTSD, is evaluated as 50 percent disabling for the period prior to December 17, 2010, and 70 percent disabling on and after December 17, 2010. The Veteran is also service-connected for his coronary artery disease, which is evaluated as 30 percent disabling, effective March 16, 2009 (as determined herein). In addition, the Veteran is service-connected for residual surgical scar, status post coronary artery bypass graft, which has been evaluated as noncompensably disabling, effective March 16, 2009. By

way of the December 2014 rating decision, the RO granted the Veteran's claim for entitlement to a TDIU, effective from August 31, 2010, the date the Veteran initially had a combined rating of 70 percent. *See* 38 C.F.R. § 4.16(a). However, given that the Veteran has been assigned earlier effective dates for the grants of service connection for his CAD, status post CABG, and residual surgical scar, status post CABG, herein, the Board finds that the 70 percent combined rating would also have been effective from that earlier effective date (March 16, 2009) as well. *See* 38 C.F.R. § 4.25 (2016). As such, for the period from March 16, 2009, the Veteran meets the percentage requirements for a total disability evaluation under 38 C.F.R. § 4.16(a).

The remaining question, therefore, is whether the Veteran's service-connected disabilities rendered him unable to secure or follow a substantially gainful occupation during this time frame. As discussed above, the Veteran underwent a CABG procedure at WBAMC in December 2008, and the operative report reflects that his preoperative and postoperative diagnoses were coronary artery disease and angina pectoris. Subsequent VA treatment records reflect that the Veteran was seen for follow-up treatment, and continued undergoing post-operative cardiac rehabilitation to help improve his condition. At the August 2010 VA examination, when asked about the effect of his PTSD on his occupational and social functioning, the examiner determined that the Veteran's psychiatric disorder resulted in deficiencies in his judgment, thinking, work, family relationships and his mood. At the January 2011 VA examination, the examiner, a VA psychiatrist, determined that the Veteran's inability to work was more likely due to his physical strength and endurance and only minimally attributed to his PTSD. This is consistent with the Veteran's reported complaints of fatigue at the July 2012 VA examination in connection to his heart condition. During this examination, the Veteran stated that his heart condition had worsened since its onset, and he cannot do anything as he always feels tired, especially after completing yardwork or painting something in his house. On physical examination, the Veteran's metabolic equivalents (METS) level on the interview-based METS test was shown to be greater than 5 to 7 METS, and consistent with activities such as walking one flight of stairs, golfing, mowing the lawn, and doing heavy yard work. The Veteran also reported to experience dyspnea, dizziness and fatigue at this indicated METS level. In light of these

medical findings above, the Board resolves reasonable doubt in favor of the Veteran, and finds that for the period from March 16, 2009, the evidence of record indicates that the Veteran is unable to obtain and/or maintain substantially gainful employment due to the combined effects of his PTSD and heart disability.

Based on the above analysis, the Board concludes that a grant of TDIU is warranted under 38 C.F.R. § 4.16(a) (2016) for the period from March 16, 2009 through August 30, 2010. The benefit sought on appeal is accordingly granted for that period.

ORDER

An effective date of March 16, 2009, but no earlier, for entitlement to service connection for CAD status post CABG is granted.

An effective date of March 16, 2009, but no earlier, for entitlement to service connection for residual surgical scar, status post CABG as secondary to the service-connected CAD status post CABG is granted.

Entitlement to a TDIU is granted for the period from March 16, 2009 through August 30, 2010, subject to the laws and regulations governing the award of monetary benefits.

Entitlement to a TDIU for the period prior to March 16, 2009, is denied.

Entitlement to an initial disability rating in excess of 50 percent for PTSD, for the period prior to December 17, 2010, is denied.

Entitlement to an initial disability rating in excess of 70 percent for PTSD, for the period on and after December 17, 2010 is denied.

Entitlement to a temporary total evaluation under 38 C.F.R. § 4.29 for psychiatric hospitalization from January 9, 1997 to February 7, 1997, is granted.

Entitlement to a temporary total evaluation under 38 C.F.R. § 4.29 for psychiatric hospitalization from August 20, 1997 to October 29, 2997, is granted.

Entitlement to a temporary total evaluation under 38 C.F.R. § 4.29 for psychiatric hospitalization from August 7, 2000 to October 20, 2000, is granted.

REMAND

The Veteran contends that his service-connected CAD, and residual surgical scar, status post coronary artery bypass graft are more disabling than currently evaluated. After a review of the claims folder, the Board finds that a remand of the Veteran's rating claims is required to allow for further development of the record.

The Veteran was provided VA examinations in connection with his service-connected heart and skin disorders in July 2012. During his examination, he provided his military and medical history and recalled undergoing a CABG procedure in December 2008, and receiving extensive cardiac rehabilitation following this procedure. The Veteran described his condition as worsening since its onset, and stated that he cannot do anything as he always feels tired, especially after completing yardwork or painting something in his house. Report of a February 2011 chest x-ray reflects an impression of post coronary bypass surgery. While these results are negative for acute infiltrate, they do reveal "[p]rominent anterior eventration [in the] right diaphragm." Based on her evaluation of the Veteran, the VA examiner diagnosed the Veteran with having atherosclerotic cardiovascular disease, coronary artery disease and stable angina. When asked whether continuous medication is required for control of the Veteran's heart condition, the examiner marked yes, and noted that metoprolol tartrate tablets are indicated in the long-term treatment of angina pectoris. The examiner observed that the Veteran had undergone a triple bypass procedure and heart catheterization procedure in December 2008 for his coronary artery disease. The examiner also noted that the Veteran had been hospitalized in December 2008 for obstructive

coronary artery disease, at which time he had undergone a right femoral angiography and was discharged in stable condition.

On physical examination, the Veteran's heart rhythm was shown to be regular, and his heart sounds were shown to be normal. The Veteran also underwent an echocardiogram (EKG) in July 2012, the results of which were shown to be normal. Results of a gated exercise cardiac perfusion study revealed "normal uptake in all segments of the left ventricle in both distress and rest images." The ventricular ejection fraction was 64 percent, and the left ventricular wall motion showed septal dyskinesis. The examiner described these results as normal with normal left ventricular function, and negative for evidence of exercise induced cardiac perfusion defect. The Veteran's METS level on the most recent interview-based METS test was shown to be greater than 5 to 7 METS, and consistent with activities such as walking one flight of stairs, golfing, moving the lawn, and doing heavy yard work. The Veteran reported to experience dyspnea, dizziness and fatigue at this indicated METS level. When asked whether the METS level limitation was due solely to the heart condition, the examiner marked no and further indicated that 30 percent of the METS level limitation was due solely to the heart condition. When asked whether the Veteran had any other non-cardiac medical condition that limited his METS level, the examiner marked yes, and attributed the limited METs level to obesity and nephrolithiasis. The examiner also noted that the Veteran had scars as a result of the CABG procedure he underwent in December 2008. When asked whether any of the scars were painful and/or unstable, or if the total area of all related scars were greater than 39 square centimeters, the examiner indicated that it was not.

In the August 2016 Appellant's Informal Brief, the Veteran, through his attorney, asserted that his service-connected heart and scar disabilities had worsened since his last VA examination. As it has been close to five years since the Veteran has been provided a VA examination concerning these conditions and given that he has asserted a worsening of both conditions, a remand is necessary to ensure that the record contains evidence of the current severity of the Veteran's service-connected right knee and left hip disabilities. 38 U.S.C.A. § 5103A (West 2014); 38 C.F.R.

§ 3.159 (2016); *Green v. Derwinski*, 1 Vet. App. 121 (1991); *Caffrey v. Brown*, 6 Vet. App. 377 (1994).

Also, as this claim is being remanded for additional development, the AOJ should also attempt to retrieve any outstanding medical records pertaining to treatment provided for the Veteran's service-connected CAD, and residual surgical scar, status post CABG.

Accordingly, the case is REMANDED for the following action:

> 1. Make arrangements to obtain the Veteran's complete VA treatment record dated since May 2012.
>
> 2. Thereafter, schedule the Veteran for an appropriate VA examination to assess the current severity of his CAD status post CABG. The electronic claims file, including a complete copy of this remand, must be made available to and reviewed by the examiner. The examination should include any diagnostic testing or evaluation deemed necessary.
>
> The examiner must identify all present symptoms and manifestations attributable to the Veteran's service-connected CAD status post CABG, in accordance with the rating criteria specified at 38 C.F.R. § 4.104, Diagnostic Code (DCs) 7005 (2016), as appropriate. The examiner should provide, to the greatest extent possible, comprehensive information that addresses all components of the applicable rating criteria - to include an assessment of exercise capacity in terms of METs (metabolic equivalent); left ventricular function; any evidence of congestive heart failure; and any associated symptoms including dyspnea, fatigue, angina, dizziness, or syncope, and its frequency. It is preferable that the appropriate

Disability Benefits Questionnaire (DBQ) be used for this purpose.

The examiner must provide a comprehensive report including complete rationales for all opinions and conclusions reached, citing the objective medical findings leading to the conclusions.

4. Then, the AOJ shall arrange a scar examination of the residual surgical scar, status post CABG, associated with CAD status post CABG, with the appropriate examiner. The examiner is asked to identify and assess all symptomatology of the residual surgical scar, status post CABG, to include any limitation of function and loss of sensation. In addition to conducting regular testing, the examiner should identify and numerate any and all scars associated with this disability, and opine as to whether such scars are linear, superficial, deep, painful, unstable, and/or exhibit any other disabling effects. It is preferable that the appropriate Disability Benefits Questionnaire (DBQ) be used for this purpose.

The examiner must provide a comprehensive report including complete rationales for all opinions and conclusions reached, citing the objective medical findings leading to the conclusions.

4. After completing the above, and any other development as may be indicated by any response received as a consequence of the actions taken in the preceding paragraphs, the Veteran's claims should be readjudicated based on the entirety of the evidence. If the claims remain denied, the Veteran and his representative should be

issued a supplemental statement of the case. An appropriate period of time should be allowed for response.

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

These claims must be afforded expeditious treatment. The law requires that all claims that are remanded by the Board or by the Court for additional development or other appropriate action must be handled in an expeditious manner. *See* 38 U.S.C.A. §§ 5109B, 7112 (West 2014).

_____

JAMES G. REINHART
Veterans Law Judge, Board of Veterans' Appeals

Department of Veterans Affairs

YOUR RIGHTS TO APPEAL OUR DECISION

The attached decision by the Board of Veterans' Appeals (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. Your local VA office will implement the Board'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. Please note that if you file a Notice of Appeal with the Court and a motion with the Board at the same time, this may delay your appeal at the Court because of jurisdictional conflicts. If you file a Notice of Appeal with the Court ***before*** you file a motion with the Board, the Board will not be able to consider your motion without the Court's permission or until your appeal at the Court is resolved.

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 have another 120 days from the date the Board 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.* Please note that the 120-day time limit to file a Notice of Appeal with the Court does not include a period of active duty. If your active military service materially affects your ability to file a Notice of Appeal (e.g., due to a combat deployment), you may also be entitled to an additional 90 days after active duty service terminates before the 120-day appeal period (or remainder of the appeal period) begins to run.

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 Board to reconsider any part of this decision by writing a letter to the Board clearly explaining why you believe that the Board 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 your letter be as specific as possible. A general statement of dissatisfaction with the Board decision or some other aspect of the VA claims adjudication process will not suffice. If the Board 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:

Litigation Support Branch
Board of Veterans' Appeals
P.O. Box 27063
Washington, DC 20038

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 Board to vacate any part of this decision by writing a letter to the Board stating why you believe you were denied due process of law during your appeal. *See* 38 C.F.R. 20.904. 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 on the previous page for the Litigation Support Branch, 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 on the previous page for the Litigation Support Branch, 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 Board, 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 the VA, you can get information on how to do so at the Court's website at: http://www.uscourts.cavc.gov. The Court's website provides a state-by-state listing of persons admitted to practice before the Court who have indicated their availability to the represent appellants. You may also request this information by writing directly to the Court. Information about free representation through the Veterans Consortium Pro Bono Program is also available at the Court's website, or at: http://www.vetsprobono.org, mail@vetsprobono.org, or (855) 446-9678.

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: If you hire an attorney or agent to represent you, a copy of any fee agreement must be sent to VA. The fee agreement must clearly specify if VA is to pay the attorney or agent directly out of past-due benefits. See 38 C.F.R. 14.636(g)(2). If the fee agreement provides for the direct payment of fees out of past-due benefits, a copy of the direct-pay fee agreement must be filed with the agency of original jurisdiction within 30 days of its execution. A copy of any fee agreement that is not a direct-pay fee agreement must be filed with the Office of the General Counsel within 30 days of its execution by mailing the copy to the following address: Office of the General Counsel (022D), Department of Veterans Affairs, 810 Vermont Avenue, NW, Washington, DC 20420. See 38 C.F.R. 14.636(g)(3).

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).