NOTE: This disposition is nonprecedential.

United States Court of Appeals for the Federal Circuit

PAUL E. ROBINSON,
Claimant-Appellant

v.

ROBERT WILKIE, SECRETARY OF VETERANS AFFAIRS,
Respondent-Appellee

2020-1969

Appeal from the United States Court of Appeals for Veterans Claims in No. 18-4296, Judge William S. Greenberg.

Decided: January 8, 2021

PAUL E. ROBINSON, Phoenix, AZ, pro se.

SONIA W. MURPHY, Commercial Litigation Branch, Civil Division, United States Department of Justice, Washington, DC, for respondent-appellee. Also represented by JEFFREY B. CLARK, ERIC P. BRUSKIN, ROBERT EDWARD KIRSCHMAN, JR.; MEGHAN ALPHONSO, Y. KEN LEE, Office of General Counsel, United States Department of Veterans Affairs, Washington, DC.

Appendix (H)

Before MOORE, HUGHES, and STOLL, *Circuit Judges*.

PER CURIAM.

Paul E. Robinson appeals a United States Court of Appeals for Veterans Claims (Veterans Court) judgment vacating the Board of Veterans' Appeals (Board) denial of an earlier effective date for his total disability rating based on individual unemployability (TDIU) and remanding for further adjudication. For the reasons discussed below, we *dismiss*.

BACKGROUND

Mr. Robinson served in the United States Army National Guard from October 1976 to January 1982. In August 2009, the Department of Veterans Affairs (VA) granted Mr. Robinson a TDIU effective July 1, 2008. The Board denied his appeal seeking an earlier effective date. On appeal to the Veterans Court, the government conceded that vacatur and remand were warranted because the Board's decision relied on evidence of "sedentary work" prior to July 1, 2008, but the Board failed to explain the meaning of "sedentary work" or how it factored into Mr. Robinson's ability to secure "a substantially gainful occupation." *Robinson v. Wilkie*, No. 18-4296, 2019 WL 5607902, at *1 (Vet. App. Oct. 31, 2019). In a single-judge decision, the Veterans Court remanded "because the necessary discussion of sedentary work constitutes a factual determination that the Board must make in the first instance." *Id.* at *2. A panel of the Veterans Court adopted the single-judge decision. Mr. Robinson appeals.

DISCUSSION

We do not typically review remand orders by the Veterans Court "because they are not final judgments."

Williams v. Principi, 275 F.3d 1361, 1364 (Fed. Cir. 2002). We depart from this rule only if:

> (1) there [has] been a clear and final decision of a legal issue that (a) is separate from the remand proceedings, (b) will directly govern the remand proceedings or, (c) if reversed by this court, would render the remand proceedings unnecessary;
>
> (2) the resolution of the legal issues [] adversely affect[s] the party seeking review; and,
>
> (3) there [is] a substantial risk that the decision would not survive a remand, *i.e.*, that the remand proceeding may moot the issue.

Id.

Mr. Robinson's appeal does not satisfy this standard. There is no clear and final decision of a legal issue, only a remand for expedited readjudication of Mr. Robinson's effective-date arguments. Moreover, the Veterans Court's remand is not adverse to Mr. Robinson because it vacated the Board's denial of Mr. Robinson's desired effective date. Accordingly, we hold we lack jurisdiction over this appeal. *See Jones v. Nicholson*, 431 F.3d 1353, 1359 (Fed. Cir. 2005).

CONCLUSION

Because we lack jurisdiction, we dismiss.

DISMISSED

COSTS

No costs.

NOTE: This order is nonprecedential.

United States Court of Appeals for the Federal Circuit

PAUL E. ROBINSON,
Claimant-Appellant

v.

DENIS MCDONOUGH, SECRETARY OF VETERANS AFFAIRS,
Respondent-Appellee

2020-1969

Appeal from the United States Court of Appeals for Veterans Claims in No. 18-4296, Judge William S. Greenberg.

ON PETITION FOR PANEL REHEARING

Before MOORE, HUGHES, and STOLL, *Circuit Judges*.

PER CURIAM.

ORDER

The court construes Mr. Robinson's "motion for rehearing" as a petition for panel rehearing with incorporated motion for leave to file a non-conforming petition out of time.

Appendix (B)

Upon consideration thereof,

IT IS ORDERED THAT:

(1) The motion for leave to file a non-conforming petition out of time is granted. The petition is accepted for filing.

(2) The petition for panel rehearing is denied on the merits.

(3) The mandate of the court will issue on March 8, 2021.

FOR THE COURT

March 1, 2021
Date

/s/ Peter R. Marksteiner
Peter R. Marksteiner
Clerk of Court

Designated for electronic publication only

UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

No. 18-4296

PAUL E. ROBINSON, APPELLANT,

V.

ROBERT L. WILKIE,
SECRETARY OF VETERANS AFFAIRS, APPELLEE.

Before GREENBERG, *Judge*.

MEMORANDUM DECISION

Note: Pursuant to U.S. Vet. App. R. 30(a), this action may not be cited as precedent.

GREENBERG, *Judge*: Paul E. Robinson served honorably in the U.S. Army National Guard as a 91C (patient care specialist) from October 1976 to January 1982; he served on active duty for training (ACDUTRA) from December 1976 to April 1977 and from May 1978 to August 1979. Record (R.) at 470 (DD Form 214). He appeals pro se a July 6, 2018, Board of Veterans' Appeals decision denying him entitlement to an earlier effective date earlier than July 1, 2008, for a grant of a total disability rating based on individual unemployability (TDIU). R. at 4-19. The appellant argues that the Board has adjudicated his claim in an adversarial manner and points to numerous pieces of evidence that he alleges support this claim. Appellant's Informal Brief at 1-7. He believes that reversal of the decision is warranted because of the alleged unfair adjudication of his claim and his current health condition. Appellant's Informal Brief at 13. The Court will construe the appellant's arguments liberally. *See Calma v. Brown*, 9 Vet.App. 11, 15 (1996) (it is the Court's practice to liberally construe the pleadings of pro se appellants). The Secretary concedes that vacatur and remand are warranted for the Board's decision because the Board erred when it found evidence of sedentary work for the period before July 1, 2008, yet failed to "explain the meaning of 'sedentary work,' or how the concept 'factors into the veteran's overall disability picture and vocational history, and the veteran's ability to secure or follow a substantially gainful occupation.'"

Appendix (C)

Secretary's Brief at 5 (citing *Withers v. Wilkie*, 30 Vet.App. 139, 147 (2018)). For the following reasons the Court will vacate the Board's July 2018 decision and remand the matter for readjudication.

Justice Alito noted in *Henderson v. Shinseki* that our Court's scope of review in this appeal is "similar to that of an Article III court reviewing agency action under the Administrative Procedure Act, 5 U.S.C. § 706." 562 U.S. 428, 432 n.2 (2011); *see* 38 U.S.C. § 7261. The creation of a special court solely for veterans, and other specified relations such as their widows, is consistent with congressional intent as old as the Republic. *See Hayburn's Case*, 2 U.S. (2 Dall.) 409, 410 n., 1 L. Ed. 436 (1792) ("[T]he objects of this act are exceedingly benevolent, and do real honor to the humanity and justice of Congress."). "The Court may hear cases by judges sitting alone or in panels, as determined pursuant to procedures established by the Court." 38 U.S.C. § 7254. Accordingly, the statutory command of Congress that a single judge may issue a binding decision, pursuant to procedures established by the Court, is "unambiguous, unequivocal, and unlimited." *Conroy v. Aniskoff*, 507 U.S. 511, 514 (1993); *see generally Frankel v. Derwinski*, 1 Vet.App. 23, 25-26 (1990).

From the beginning of the Republic, statutory construction concerning congressional promises to veterans has been of great concern. "By the act concerning invalids, passed in June, 1794, vol. 3. p. 112, the secretary at war is ordered to place on the pension list, all persons whose names are contained in a report previously made by him to congress. If he should refuse to do so, would the wounded veteran be without remedy? Is it to be contended that where the law, in precise terms, directs the performance of an act, in which an individual is interested, the law is incapable of securing obedience to its mandate? Is it on account of the character of the person against whom the complaint is made? Is it to be contended that the heads of departments are not amenable to the laws of their country?" *Marbury v. Madison*, 5 U.S. 137, 164, 2 L. Ed. 60, 69 (1803).

The Court is mindful of the appellant's contention that reversal is warranted because of his arguments regarding fair play and his health concerns. However, unfortunately, neither of these things provides a legal basis for reversal. The Court concludes that remand is the appropriate remedy for this matter because the necessary discussion of sedentary work constitutes a factual determination that the Board must make in the first instance. *See Deloach v. Shinseki*, 704 F.3d 1370, 1380 (Fed. Cir. 2013) ("[T]he evaluation and weighing of evidence are factual determinations committed to the discretion of the factfinder—in this case, the Board."). Therefore,

the Court vacates the Board's decision and remands the claim for readjudication. *See Massie v. Shinseki*, 25 Vet.App. 123, 126 (2011). To ensure that the parties' contentions are fully addressed by the Board on remand, the Court orders that the appellant's informal brief and the Secretary's brief be incorporated into the claims file. The Court also notes that, while readjudicating the appropriate effective date for TDIU, the Board must define the phrase "substantially gainful employment" and apply the Court's holding from *Ray v. Wilkie*, 31 Vet.App. 58 (2019). Further, on remand, the appellant may present, and the Board must consider, any additional evidence and arguments. *See Kay v. Principi*, 16 Vet.App. 529, 534 (2002). This matter is to be provided expeditious treatment. *See* 38 U.S.C. § 7112; *see also Hayburn's Case*, 2 U.S. (2 Dall.) at 410, n. ("[M]any unfortunate and meritorious [veterans], whom Congress have justly thought proper objects of immediate relief, may suffer great distress, even by a short delay, and may be utterly ruined, by a long one.").

For the foregoing reasons, the Board's July 6, 2018, decision is VACATED and the matter is REMANDED for readjudication.

DATED: October 31, 2019

Copies to:

Paul E. Robinson

VA General Counsel (027)

Not published
NON-PRECEDENTIAL

UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

No. 18-4296

PAUL E. ROBINSON, APPELLANT,

v.

ROBERT L. WILKIE,
SECRETARY OF VETERANS AFFAIRS, APPELLEE.

Before PIETSCH, GREENEBERG, and ALLEN, *Judges.*

ORDER

Note: Pursuant to U.S. Vet. App. R. 30(a), this action may not be cited as precedent.

On October 31, 2019, the Court issued a memorandum decision that vacated a July 6, 2018, decision of the Board of Appeals for Veterans' Appeals denying entitlement to an effective date earlier than July 1, 2008, for the grant of a total disability rating based on individual unemployability due to service-connected disabilities. On November 21, 2019, the appellant filed a timely motion for panel decision. The motion for a decision by a panel will be granted.

Based on review of the pleadings and the record of proceedings, it is the decision of the panel that the appellant fails to demonstrate that 1) the single-judge memorandum decision overlooked or misunderstood a fact or point of law prejudicial to the outcome of the appeal, 2) there is any conflict with precedential decisions of the Court, or 3) the appeal otherwise raises an issue warranting a precedential decision. U.S. VET. APP. R. 35(e); *see also Frankel v. Derwinski*, 1 Vet.App. 23, 25-26 (1990).

Absent further motion by the parties or order by the Court, judgment will enter on the underlying single-judge decision in accordance with Rules 35 and 36 of the Court's Rules of Practice and Procedure.

Upon consideration of the foregoing, it is

Appendix (D)

ORDERED that the motion for panel decision is granted. It is further

ORDERED that the single-judge decision remains the decision of the Court.

DATED: April 1, 2020 PER CURIAM.

Copies to:

Paul E. Robinson

VA General Counsel (027)

BOARD OF VETERANS' APPEALS

DEPARTMENT OF VETERANS AFFAIRS

IN THE APPEAL OF
PAUL E. ROBINSON
REPRESENTED BY
Adam R. Luck, Attorney

SS [redacted]
Docket No. 08-31 884

DATE: July 6, 2018

ORDER

Entitlement to an effective date earlier than July 1, 2008 for the grant of a total disability rating based on individual unemployability due to the service connected disabilities (TDIU).

FINDING OF FACT

The weight of the evidence preponderates against a finding that prior to July 1, 2008, the Veteran was precluded from securing or following a substantially gainful occupation due to his service-connected disabilities.

CONCLUSION OF LAW

The criteria for an effective date earlier than July 1, 2008 for the grant of a TDIU rating have not been met. 38 U.S.C. §§ 5107, 5110; 38 C.F.R. § 3.400, 4.16.

REASONS AND BASES FOR FINDING AND CONCLUSION

The Veteran served on active duty for training with the Army National Guard from December 1976 to April 1977, and from May 1978 to August 1979.

Attached 4(E)

An August 2009 rating decision granted entitlement to service connection for major depressive disorder with an evaluation of 50 percent, effective February 11, 2008, as well as entitlement to a TDIU, effective July 1, 2008. The Veteran appealed for an earlier effective date for the rating for the psychiatric disorder.

In December 2008, the Veteran testified at an RO hearing. In October 2010, the Veteran testified before the undersigned Veterans Law Judge at a hearing held at the RO. The hearing transcripts are associated with the claims folder.

In April 2013, the Board issued a decision in which it adjudicated several issues on appeal and remanded the issue of entitlement to an effective date earlier than February 11, 2008 for the award of service connection for major depressive disorder to the Agency of Original Jurisdiction (AOJ) for additional development and adjudication.

The Veteran appealed the Board's decision to the U.S. Court of Appeals for Veterans Claims (Court).

In a February 2014 decision, the Board granted the appeal and assigned an effective date of February 28, 2000 for the award of service connection for major depressive disorder.

The AOJ implemented that decision in a March 2014 rating decision and assigned an initial rating of 50 percent for the disability.

In a December 2014 decision, the Court modified the April 2013 Board decision to reflect that under *Rice v Shinseki*, 22 Vet. App.447 (2009) the remand of the effective date for benefits for major depressive disorder included a remand of the effective date for award of the TDIU.

The Court then affirmed the Board's decision, as modified.

Therefore, the Board's April 2013 decision included a remand to the AOJ of the issue of entitlement to an effective date earlier than July 1, 2008 for award of the TDIU.

In May 2015 the Board remanded the appeal for additional development, in light of the modification. In September 2017 the Board sought a medical opinion from the Veterans Health Administration (VHA), which was submitted in December 2017. The Veteran was notified of this opinion by an April 2018 letter and was provided a 60-day time period for response, which was received in May 2018.

Entitlement to an effective date earlier than July 1, 2008 for the grant of a TDIU.

The Veteran seeks an effective date of February 28, 2000 for the award of a TDIU.

With respect to an earlier effective date, a TDIU is a form of increased rating claim, and, therefore, the effective date rules for increased compensation claims apply. *See Norris v. West*, 12 Vet. App. 413, 420 (1999); *Hurd v. West*, 13 Vet. App. 449 (2000). The effective date shall be the later of either the date of receipt of claim, or the date entitlement arose, whichever is later. 38 U.S.C. § 5110 (a); 38 C.F.R. § 3.400(o).

A total disability rating may be assigned, where the schedular rating is less than total, when it is found that the disabled person is unable to secure or follow a substantially gainful occupation as the result of service-connected disabilities. *See* 38 U.S.C. § 1155; 38 C.F.R. §§ 3.340, 3.341, 4.16. Consideration may be given to a Veteran's level of education, special training, and previous work experience in arriving at a conclusion, but not to his age or the impairment caused by any nonservice-connected disabilities. *See* 38 C.F.R. §§ 3.341, 4.16, 4.19.

Unlike the regular disability rating schedule, which is based on the average work-related impairment caused by a disability, "entitlement to a TDIU is based on an individual's particular circumstances." *Rice v. Shinseki*, 22 Vet. App. 447, 452 (2009). Therefore, in adjudicating a TDIU claim, VA must take into account the individual Veteran's education, training, and work history. *Hatlestad v. Derwinski*, 1 Vet. App. 164, 168 (1991) (level of education is a factor in deciding employability); *see Friscia v. Brown*, 7 Vet. App. 294 (1994) (considering Veteran's experience as a pilot, his training in business administration and computer programming, and his history of obtaining and losing 19 jobs in the previous 18 years); *Beaty v. Brown*, 6 Vet. App. 532 (1994) (considering Veteran's

8th grade education and sole occupation as a farmer); *Moore v. Derwinski*, 1 Vet. App. 356 (1991) (considering Veteran's master degree in education and his part-time work as a tutor).

To qualify for a total rating for compensation purposes, the evidence must show: (1) a single disability rated as 100 percent disabling; or (2) that the Veteran is unable to secure or follow a substantially gainful occupation as a result of his service-connected disabilities and there is one disability ratable at 60 percent or more, or, if more than one disability, at least one disability ratable at 40 percent or more and a combined disability rating of 70 percent. 38 C.F.R. § 4.16 (a). Disabilities that are not service connected cannot serve as a basis for a total disability rating. 38 C.F.R. §§ 3.341, 4.19.

Even when the percentage requirements under 38 C.F.R. § 4.16 (a) are not satisfied, a total disability evaluation may still be assigned on an extraschedular basis. Indeed, it is the established policy of VA that all Veterans who are unable to secure and follow a substantially gainful occupation by reason of service-connected disabilities shall be rated totally disabled. 38 C.F.R. § 4.16 (b). Therefore, exceptional cases may be submitted to the Director of Compensation and Pension Service for extraschedular consideration when the Veteran is unable to secure and follow a substantially gainful occupation by reason of service connected disability. 38 C.F.R. §§ 3.321 (b), 4.16(b).

The Veteran's major depressive disorder has been rated as 50 percent disabling, effective February 28, 2000. In addition, service connection has been established for gastroesophageal reflux disease (GERD) with recurrent pulmonary aspiration and cough, rated 30 percent disabling, effective March 21, 2000; right patellofemoral syndrome with meniscal tears, status post arthroscopy, rated 10 percent disabling effective February 28, 2000; left patellofemoral syndrome with meniscal tears, status post meniscectomy, rated 10 percent disabling effective February 28, 2000; slight medial-lateral instability, right knee associated with right patellofemoral syndrome with meniscal tears, status post arthroscopy, rated 10 percent disabling, effective October 5, 2010, and; residuals of fractured 6th and 7th right ribs associated with gastroesophageal reflux disease with recurrent pulmonary aspiration and cough, rated as noncompensably disabling, effective February 11, 2008. As such, he meets the schedular criteria for TDIU. 38 C.F.R. § 4.16.

The Veteran's combined disability evaluation during the period on appeal was 70 percent. Additionally, the Board notes that throughout the period on appeal the Veteran has received several periods of a temporary rating of 100 percent for convalescence following knee surgical procedures in 2008. *See* 38 C.F.R. § 4.30. These temporary ratings have not been questioned by the Veteran and are not at issue before the Board at this time.

The question before the Board is whether the Veteran was unemployable prior to July 1, 2008 by reason of his service-connected disabilities, taking into account his educational and occupational background.

The Board finds that the greater weight of the probative evidence is against a finding that the Veteran was unable to secure and follow a substantially gainful occupation by reason of his service-connected disabilities prior to July 1, 2008.

At this juncture, the Board notes that the Veteran's occupational background is unclear. As further detailed below, the Board notes that while he initially stated that he stopped work due to his back injury, he has variously reported being employed in a factory and a nursing facility at that time. He has also reported work in the restaurant industry, as a bus driver and in the clothing industry.

On VA examination in October 2006 the Veteran reported that both his back and knees contributed to his inability to work. He repeated this assertion in a September 2007 VA examination for his GERD.

In an April 2008 VA examination, he asserted that he received Supplemental Security Income (SSI) for both his back and knees, which is partially inconsistent with the evidence of record.

In a May 2009 VA examination, the Veteran asserted that his GERD was incapacitating without further explanation.

In this regard, in a June 2016 VA examination, the Veteran stated that he could not recall how many jobs he had before his Social Security Administration (SSA) determination, nor did he recall how long he worked each position and the circumstances around his departure.

Because the Veteran himself can not recall when he worked, how long he worked, and the if the problem was his service-connected or nonservice connected problems before the SSA determination, remanding this case once again to obtain additional information is not warranted.

Treatment records associated with a workers' compensation claim show that in 1996, the Veteran, who was employed as a nurse, was seen when he developed back pain after lifting a patient. Subsequent treatment records noted onset on low back pain in March 1998. He was temporarily out of work, returning to limited duty some days later. It was noted that his work duties required pushing, pulling, lifting and bending.

Throughout the appeal the Veteran has been in receipt of Social Security disability benefits. The SSA found the Veteran was disabled as a result of back pain due to degenerative disease in the spine, leg pain, myofascial pain syndrome, depression and anxiety.

While SSA decisions regarding unemployability are not controlling for VA, they are relevant and should be weighed and evaluated. *See Collier v. Derwinski*, 1 Vet. App. 413, 417 (1991); *Murincsak v. Derwinski*, 2 Vet. App. 363, 370 (1992).

A March 2000 Residual Functional Capacity Assessment report conducted in connection with the Veteran's application for SSA benefits showed that the Veteran injured his back in March 1998 while he was working on an assembly line in the Master Lock factory. The examiner noted that the Veteran had worked primarily as a licensed nurse practitioner (LPN) over the years, in various facilities. He also worked on call in the nursing pool and at his family's restaurant, before he went to work for Master Lock in January 1998, after an unsuccessful attempt at running his own business (consultant for childhood lead poisoning).

He worked for Master Lock until March 1998 when his back problems forced him to quit this job. Approximately one year later he became a school bus driver for a few months in 1999.

Currently, he complained of severe chronic back pain with spasms that typically radiated down his legs. He also complained of carpel tunnel problems in his right

hand, and wore a brace on this hand. Examination showed that the Veteran was able to frequently lift up to 10 pounds, and could occasionally lift up to 20 pounds. He was able sit and or stand for 6 hours out of an 8 our day. The Veteran's chief complaints were noted to be related to pain and limitations associated with the lumbar spine disability. The examiner noted that the Veteran initially sought mental health treatment in 1993, shortly after the death of his parents. He subsequently began to abuse alcohol and drugs and voluntarily entered treatment for this problem. Mental examination showed that the Veteran was oriented to time, place and person. Memory appeared to be grossly intact. His fund of general knowledge was at an average level. Abstract thinking skills were at an average level, with no indication of any deterioration in this ability. Concentration and attention were adequate. He seemed to have some insight into his current difficulties. The assessment was history of chronic back pain and carpel tunnel syndrome that prevented full time employment since March 1998.

The Veteran was assigned a Global Assessment of Functioning (GAF) of 62. It was determined that the Veteran's capacity for the full range of sedentary work was reduced by additional limitations that narrowed the range of work he could perform, due in part to chronic back and leg pain that required narcotics. Additionally, the Veteran experienced anxiety and depression.

On VA joints examination in January 2005 the Veteran reported having worked in the nursing field until 1998 when he had to stop working due to chronic low-back pain. The examiner noted no impaired ability in the performance of activities of daily living such as eating and hygiene, but the Veteran patient needed alternate knee bending. He also experienced difficulty standing from the tub and while toileting due to knee problems. The Veteran endorsed difficulty walking more than one block as his knees would tighten. He also related knee pain when standing longer than 10 to 15 minutes, or driving longer than two hours. Additionally, when climbing stairs, he reported needing to hold on to the handrail and slowly ascending one step at a time due to knee pain. He presented no limitation with sitting, although he would need to constantly shift due to back pain.

On VA examination in October 2006 the Veteran, who reported having previously as a nurse in various nursing homes, indicated that he was on disability due to his back, although his bilateral knee problem contributed to his overall impairment.

On examination, his gait was normal. He had full range of motion in both knees without significant pain, but with repetition and likely positive McMurray's sign on the right, there was pain with fair endurance on the right and insignificant pain and good endurance on the left without incoordination. X-rays of the knees revealed no abnormalities.

On VA examination in September 2007 to evaluate the Veteran's GERD, the Veteran complained of having dyspepsia within two hours after going to bed, associated with a dry, gagging cough. His symptoms were relieved by sitting up. He denied the use of antacids. He avoided certain foods and large portions of food to control his reflux. The Veteran claimed that his acid reflux in the past interrupted his sleep, leading to fatigue, but he denied any interference with daily activities or work. The Veteran reported that he was last employed for 23 years as a LPN until 1999, when he was forced to quit due to chronic back and leg pain. A September 2007 VA emergency room report noted a history of acid reflux that was relatively well controlled with medication twice daily. His physical exam was normal, with no evidence of anemia. The examiner noted that a recent upper endoscopy done by his GI specialist was normal except doe a finding of reduced lower esophageal sphincter pressure was noted. The report reflects that the Veteran denied any effects on his ability to work related to his GERD.

A VA mental disorders examination report in April 2008 recorded a history of alcohol and drug abuse, along with grieving, until 1998.

By December of 1997 the Veteran had a history of five episodes of treatment for alcohol and other drug abuse, with corresponding diagnoses and a diagnosis of narcissistic personality disorder. In 1998 the Veteran was treated for grief following the death of his mother. He reported having worked as a nurse from 1979 to 1997 when he had to stop because of his back and knees. He related irritability due to his knee pain. Reportedly, he was in school until the 12th grade and then earned his GED and LPN degrees. In October 2007 the Veteran produced a positive screen for depression.

The examiner assigned a GAF score of 65 and opined that the Veteran exhibited depression signs and symptoms that were transient or mild, which decreased work

efficiency and ability to perform occupational tasks only during periods of significant stress.

The examiner further noted that the Veteran attributed his unemployability to his physical problems, specifically his back and knees, as opposed to his mental health problems. In any event, the examiner found that at that time, the Veteran's mild depression was at most productive of mild vocational limitations, including mild occasional depressed mood, low energy, motivation and drive.

On VA spine examination in April 2008, the Veteran related an occupational history that included restaurant work and work in the clothing field. He had been a LPN since 1981. He worked in a nursing home until 1998 due to back problems.

On VA bones examination in April 2008 the Veteran reported having worked for Master Lock in 1998 when he experienced onset of low back pain. During the following two years the Veteran underwent treatment with multiple evaluation for his back, all which failed to disclose any gait asymmetry. The examiner noted that prior to onset of back pain, there was no mention of significant physical limitations due to his knees. Examination revealed normal extension of the knees with flexion limited by five degrees, bilaterally. There was no significant gait abnormality. The medical records indicated he was doing physical activities such as playing basketball up to that point.

The Veteran underwent a VA examination in April 2008 to evaluate his respiratory symptoms associated with a fractured rib secondary to GERD. The examiner noted recurrent pulmonary aspiration with cough and associated rib fracture with GERD. The examiner noted onset of chronic coughing in 2007 along with a history of smoking. Pulmonary function studies were normal.

On VA mental health disorders examination in May 2009, the examiner noted that the Veteran appeared to be significantly more depressed and angry than when he was last examined a year earlier. The examiner found that the Veteran's level of functioning had decreased and the depression continued to be exacerbated by his physical impairments and the perception that no one cared.

On physical examination in May 2009, the examiner found that the Veteran's restrictions on his ability to perform activities of daily living appeared to be volitional and driven mainly by his psychological status. The examiner opined that the Veteran's lumbar spine and lower extremity complaints, regardless of service-connection, did not limit the Veteran occupationally. Additionally, the Veteran was not on medications that would limit his ability to seek employment. The examiner concluded that the Veteran was therefore, from a physical standpoint, fit to perform work activities.

A VA psychiatric opinion was obtained in July 2015 to address the Veteran's employability prior to July 1, 2008. Following a review of the claims file, the examiner determined that from 2000 to 2008 there was a lack of evidence to substantiate a finding that his psychiatric symptoms were productive of any substantial impairment. In this regard, during that time frame there was minimal evidence of mental health treatment that could shed light on his functioning. The available records documented depression and posttraumatic stress disorder, along with complaints of frustration over his medical problems. However, there was no information about his functional status. The examiner found that the lack of mental health intakes, psychological assessments, clinical treatment notes, psychiatric summaries, or psychiatric hospitalization summaries, from 2000 to 2008, failed to provide sufficient information regarding his occupational functioning. The examiner concluded that there was no evidence during the period in question that the Veteran's depression was productive of significant functional impairment that would have rendered the Veteran totally and permanently unemployable.

A VA examiner in July 2015 indicated that other than surgical treatment for the knees in 2008, the record failed to disclose episodes of significant impairment related to his service connected physical disabilities. The examiner concluded that the Veteran's service connected GERD would not impair his ability to work in a sedentary capacity. While the Veteran's service-connected fractured ribs were productive of some lifting restrictions, the condition did not impair his ability to perform sedentary work. Similarly, while the Veteran's bilateral knee disorders restricted the Veteran's ability to do any prolonged walking or standing, there was no impediment to working in a sedentary capacity.

In July 2016 a VA examiner reviewed the claims file and noted the Veteran's complaints of difficulty getting along with others and occasional absenteeism due to stomach problems or physical pain. The examiner noted that treatment records between 2000 and 2008 generally did not show treatment for mental health problems and clinical treatment notes did not include treatment with antidepressants as part of the Veteran's medication regimen, until after October 2007 when the Veteran had a positive screening test for depression. Accordingly, the examiner opined that it was not at least as likely as not that between February 2000 and July 2008 the Veteran was totally disabled due to depression.

Evidence supporting functional impairment between February 2000 and July 2008 showed that when confronted with stress the Veteran may experience some depression. Otherwise, review of the documents covering the above timeframe did not reveal sufficient evidence to support a finding that the Veteran's depressive disorder clinically significantly affected his ability to adapt to change, maintain a regular work schedule, concentrate, reason, work without being impaired by substance abuse, work without being incapacitated by emotional and mental issues, or work without being distracted by problems provoked by interpersonal interactions, nor did it affect his ability to be reliable and productive, and secure a job, maintain a job, or complete a job.

In contrast, in a September 2016 private vocational assessment report, following an interview with the Veteran, a vocational rehabilitation specialist noted the Veteran's reports of self-isolation and difficulty dealing with co-workers and supervisors during the period on appeal. The vocational rehabilitation specialist also noted the Veteran's complaints of flash backs with episodes of rage and aggression since 2000. The Veteran reported limitations associated with his service-connected bilateral knee disorder and GERD, including the need to take frequent bathroom breaks and elevate his legs when seated, as well as inability stand more than 10 to 15 minutes, or walk more than one block.

Reportedly, since 2000, his psychiatric disorder was productive of sleep disturbance, irritability, poor concentration, hypervigilance, and increased startle response. The vocational rehabilitation specialist indicated that the Veteran's back and knee disorders resulted in an unnatural altered gait that impaired his ability to

sit or stand. His highest level of education achieved was 10th grade, although he attained GED and LPN degrees.

The vocational rehabilitation specialist noted that the Veteran's work as a LPN was heavily physically demanding and although this was skilled labor, the skills did not transfer to less physically demanding jobs due to the lack of advanced education. His physical limitations reduced the Veteran's employment prospects to sedentary work, as all other jobs required prolonged standing or walking, and sedentary nursing jobs required a Bachelor or Master's degrees. The vocational rehabilitation specialist further found that due to his service-connected conditions, the Veteran would have trouble completing any entry level unskilled work. Additionally, his difficulties dealing with people and anger outbursts, along with absenteeism, would interfere with his ability to work unskilled jobs, and there were no unskilled jobs that could be performed in isolation. As such, it was more likely than not that the Veteran was unable to maintain substantial gainful employment between February 2000 and July 2008 because his service-connected disabilities resulted in an inability to attend basic work functions.

Finally, in December 2017 a VHA medical expert reviewed the claims file and concluded that from 2000 through 2008, the Veteran's service-connected disabilities did not render him unable to secure or follow a substantially gainful occupation. Concerning the Veteran's psychiatric disorder, the VHA physician noted that during this period the records reflected GAF scores ranging between 53 and 65, corresponding no more than mild to moderate symptoms. During this period the Veteran's GERD was productive of restrictions including no heavy lifting and repeated bending. The Veteran was also advised to avoid holding his breath with lifting or constriction of the abdomen. His knees were also productive of restrictions, including no kneeling, crawling and squatting, as well as limitations climbing stairs, lifting more than 20 pounds, or standing or walking longer than 15 minutes at a time. The VHA physician concluded that these restrictions were consistent with sedentary work, as were his psychiatric symptoms. As a LPN, the Veteran had transferable skills. There were many sedentary jobs in health clinics, hospitals, nursing homes, and in the insurance industry for a LPN, such as working with medical records, billing, coding, and compliance departments.

The Board finds the opinion of the VA examiners and VHA physician to be highly persuasive and probative in finding that the evidence does not support a conclusion that from 2000 through 2008, the Veteran's service-connected disabilities did not render him unable to secure or follow a substantially gainful occupation. The findings of the VA examiners and VHA physician were based on a review of the evidence, which did not substantiate a finding of entitlement to a TDIU prior to July 1, 2008. The examiners and VHA physician considered the complete record and the Veteran's contentions, and provided an explanation as to why the evidence does not support a finding that the Veteran's service-connected disabilities rendered him unemployable prior to July 1, 2008. The Board finds these opinions highly probative. *See Nieves-Rodriguez v. Peake*, 22 Vet. App. 295, 302-04 (2008) (holding that it is the factually accurate, fully articulated, sound reasoning for the conclusion that contributes to the probative value of a medical opinion).

Conversely, the Board finds the September 2016 private vocational assessment report appears to rely on the self-reporting of the Veteran regarding his own limitations between February 2000 and July 2008, and a new recollection regarding his previous work experiences, which, as noted above, has significantly varied throughout the appeal (the Veteran himself has noted problems recalling such facts).

While the Veteran admitted to difficulty with alcohol and drugs, the full extent or etiology of this addiction does not appear to be considered by the vocational expert, nor does the vocational expert appear to fully appreciate the impact of the Veteran's non-service connected back disability on his employability, which, at least initially, was singled out as the cause of the Veteran's unemployment in 1998. The Board must note that the Veteran's back problems are indicated within the record a great deal in this case.

Additionally, the vocational rehabilitation specialist determined that the Veteran would have likely had trouble completing all basic requirements for unskilled, sedentary labor from February 2000 to July 2008. The opinion suggests that there is no work for a LNP that does not require moderate to heavy physical labor, and that although LPN is skilled labor, these skills do not transfer to any sedentary employment in the nursing field absent at least a Bachelor's degree. It is hard to imagine that there are no sedentary jobs in the vast healthcare field that a LNP

could not perform absent a Bachelor's degree (if we do not consider the Veteran's nonservice connected problems, as we are required to do in this case).

Moreover, to the extent the vocational rehabilitation specialist found the Veteran unsuitable for any entry level unskilled labor due to the service-connected disabilities, the vocational rehabilitation specialist's assessment of the severity of the Veteran's depressive disorder, GERD and bilateral knee disorders, prior to July 1, 2008, is not supported by the contemporaneous clinical evidence of record. While some of the symptoms and limiting factors associated with the service-connected disabilities as noted in the private vocational assessment report are also recorded in the contemporaneous treatment records, many are not, and those that are, certainly do not reflect the same level of impairment or frequency suggested by the vocational rehabilitation specialist in support of the opinion.

Although the evidence of record indicates that the Veteran did not work from February 2000 to July 2008, and his service connected disabilities were productive of some occupational limitations during this period, the preponderance of the evidence is against finding that his service-connected disabilities rendered him unemployable prior to July 1, 2008. Moreover, the VHA and multiple VA examination opinion reports as outlined above, fail to show that the Veteran's *service-connected disabilities* either singularly or jointly, precluded the Veteran from gainful employment from February 2000 to July 2008. The Veteran's private and VA treatment records do not contradict the medical opinions of the VHA physician and VA examiners described above. In fact, the medical evidence which served as the basis for the grant of TDIU was dated after that date. Treatment notes and examination reports documented an increase in the Veteran's psychiatric symptoms in 2009. A VA examiner in May 2009 noted that the Veteran appeared to be significantly more depressed and angry since he was last examined a year earlier. Similarly, treatment records after July 1, 2008 recorded much lower GAF scores, including a GAF score of 40, indicative of serious symptoms.

In this regard, it is important for the Veteran to understand that there is now a highly significant amount of highly probative medical evidence that provide evidence against this claim that the Board simply cannot ignore.

While the Veteran is competent to report symptoms he experiences, an opinion as to the limitations on gainful employment due to his service-connected disabilities is beyond his medical expertise. *Jandreau v. Nicholson*, 492 F.3d 1372, 1377 (Fed. Cir. 2007). Thus, any such lay statements regarding him being unable to work are not competent or sufficient.

The Veteran's statements have been carefully considered (in fact, without consideration of the problems the Veteran has cited, there would be little objective medical basis for the 60 and 70 percent combined disability ratings from February 2000 through July 2008). The Board observes that the assigned disability ratings recognize that the impairment due to his service-connected disabilities makes it difficult to obtain and keep employment (that the Veteran had problems from February 2000 through July 2008 is not in dispute – it is only the degree of the problem). However, the ultimate question in determining entitlement to a TDIU is whether the Veteran is capable of performing the physical and mental acts required by employment, not whether he can find employment. *See Van Hoose*, 4 Vet. App. at 363. If the Veteran did not have problems with his service-connected disabilities, including his psychiatric disorder, there would be no basis for the combined disability ratings assigned from February 2000 through July 2008 (which, it is important for the Veteran to understand, will cause him many problems and in several cases, were granted on the basis of giving the Veteran the benefit of the doubt, notwithstanding other evidence which did not support his claims).

In this case, the weight of the evidence is against a finding that from February 2000 through July 2008 the Veteran was unable to obtain and maintain substantially gainful employment *solely* as a result of his service-connected disabilities, either singularly or jointly.

In conclusion, the preponderance of evidence does not document that the Veteran's service-connected disabilities prevented him from securing or following a substantially gainful occupation prior to July 1, 2008. As such, there is no reasonable doubt to be resolved, and the claim must be denied. 38 U.S.C. § 5107 (b); *see also Gilbert, supra.*

IN THE APPEAL OF
PAUL E. ROBINSON

SS [redacted]
Docket No. 08-31 884

JOHN J. CROWLEY
Veterans Law Judge
Board of Veterans' Appeals

ATTORNEY FOR THE BOARD — T. Azizi-Barcelo, Counsel

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).

Designated for electronic publication only

UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS

No. 13-2403

PAUL E. ROBINSON, APPELLANT,

V.

ROBERT A. MCDONALD,
SECRETARY OF VETERANS AFFAIRS, APPELLEE.

Before KASOLD, *Chief Judge*.

MEMORANDUM DECISION

Note: Pursuant to U.S. Vet. App. R. 30(a), this action may not be cited as precedent.

KASOLD, *Chief Judge*: Veteran Paul E. Robinson appeals pro se that part of an April 16, 2013, decision of the Board of Veterans' Appeals (Board) that denied (1) benefits for a lumbar spine disability, because it was not related to service or a service-connected disability, (2) a disability rating in excess of 30% for gastroesophageal reflux disease (GERD), effective March 2000, and (3) disability ratings in excess of 10% for right-knee patellofemoral syndrome, effective February 2000, 10% for left-knee patellofemoral syndrome, effective February 2000, and 10% for right-knee instability, effective September 2011.[1] Mr. Robinson argues that the Board erred in its determinations, and that the Board failed to address the issue of an earlier effective date for his total disability rating based on individual unemployability (TDIU). The Secretary disputes this argument. Single-judge disposition is appropriate. *Frankel v. Derwinski*, 1 Vet.App. 23, 25-26 (1990). For the reasons stated below, that part of the Board decision on appeal will be modified and, as modified, affirmed.

[1] The Board also remanded the issue of the appropriate effective date for Mr. Robinson's 50% disability rating for major depressive disorder. That issue is not on appeal. *See Adams v. West*, 13 Vet.App. 453, 454 (2000) (Court lacks jurisdiction over a remanded claim).

After Dix (F)

I. Lumbar Spine Disability

In support of his argument regarding his lumbar spine disability, Mr. Robinson (1) lists record citations that, he asserts, establish that his current condition began in service, and (2) cites treatise evidence that discusses the kinetic chain between knee disabilities and the spine. As to direct service connection, the Board noted one instance of back treatment in service, followed by no back complaints for more than 15 years, and then back complaints from various injuries at Mr. Robinson's postservice occupation. The Board further noted the view of a May 2009 VA medical examiner that Mr. Robinson's back condition was not the result of military service. As to secondary service connection, the Board noted the treatise evidence and Mr. Robinson's view that his service-connected knee disability led to an altered gait and ultimately a back condition, but the Board ultimately relied on the views of the May 2009 VA medical examiner, as well as an April 2008 VA examiner, that Mr. Robinson's knee disability did not cause or permanently aggravate his back condition. The Board found these two medical opinions adequate to decide the claim and more probative than the general treatise information and Mr. Robinson's lay assertions regarding medically complex etiology.

Based on the record of proceedings (ROP), the Board's weighing of the evidence and ultimate denial of service connection are plausible and not clearly erroneous. *See Owens v. Brown*, 7 Vet.App. 429, 433 (1995) (reviewing Board's weight assignments and its denial of service connection under the "clearly erroneous" standard); *Gilbert v. Derwinski*, 1 Vet.App. 49, 52 (1990) ("'A finding is "clearly erroneous" when . . . the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed.'" (quoting *United States v. U.S. Gypsum Co.*, 333 U.S. 364, 395 (1948))).

II. GERD

In support of his argument regarding GERD, Mr. Robinson contends that he has peptic ulcer disease, but he cites no medical diagnosis of such a disease in the record, and he fails to demonstrate that he has the medical knowledge and training to self-diagnose this disease or that the Board erred in not specifically labeling his condition as peptic ulcer disease. *See Hilkert v. West*, 12 Vet.App. 145, 151 (1999) (en banc) (appellant bears burden of demonstrating error on appeal); Record (R.) at 22 (Board noting Mr. Robinson's work as a nurse, but that he had not submitted proof

of requisite training or experience regarding gastrointestinal conditions); *see also Jandreau v. Nicholson*, 492 F.3d 1372, 1377 (Fed. Cir. 2007) (layperson cannot establish a medical diagnosis of a condition unless the condition is simple, rather than complex, the person is reporting a contemporaneous medical diagnosis, or the description of symptoms is later supported by the diagnosis of a medical professional).

Also in support of his GERD argument, Mr. Robinson cites record treatise information that ulcers can be caused by H. pylori,[2] and he reasons that an October 2011 examination report was inadequate for Board decision because the examiner stated that there is no association between GERD and H. pylori. The Board, however, noted the medical articles on GERD submitted by Mr. Robinson, but it viewed the examiner's statement as a finding that there was no association between GERD and H. pylori *in Mr. Robinson's case*, and gave greater weight to the examiner's opinion than it gave to the speculative treatises. *See Sacks v. West*, 11 Vet.App. 314, 317 (1998) (treatise information discussing what *can* cause a certain disability is speculative); *Herlehy v. Brown*, 4 Vet.App. 122, 123 (1993) (noting that medical opinions directed at specific patients generally are more probative than medical treatises). Based on the ROP, the Board assignment of weight to the October 2011 examination report and treatises is plausible and not clearly erroneous. *See Owens* and *Gilbert*, both *supra*.

Moreover, reading the Board's statement as a whole, as it should be read, *see Janssen v. Principi*, 15 Vet.App. 370, 379 (2001) (per curiam), the Board's analysis as to why a higher disability rating was unwarranted was predicated on Mr. Robinson's symptoms, not the examiner's finding regarding H. pylori. As noted by the Board, a 60% disability rating under 38 C.F.R. § 4.114, Diagnostic Code (DC) 7346 requires "[s]ymptoms of pain, vomiting, material weight loss and hematemesis or melena with moderate anemia; or other symptom combinations productive of severe impairment of health." Although Mr. Robinson argues that the record contains evidence of a respiratory condition due to GERD, gastric problems, and anemia, he cites laboratory reports that do not reflect, to a lay person, any of these problems (R. at 1344 and 1597), and he fails to cite any record evidence substantiating his lay view of these reports. Moreover, the Board found that medical

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[2] "H. pylori" is "a species that causes gastritis and pyloric ulcers and is also associated with stomach cancer." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 829 (32d ed. 2012).

reports reflected no anemia, no *material* weight loss (as he lost less than 10% of his body weight), no hematemesis or melena, that the bowel-movement issue was unrelated to GERD, and that no identifiable respiratory system was due to GERD. Mr. Robinson fails to demonstrate that the Board clearly erred in these findings. *See Hilkert* and *Gilbert*, both *supra*.

Also, although the Board noted Mr. Robinson's complaints of nausea, vomiting, bloating, regurgitation, weight loss, and difficulty controlling bowel movements, the Board found a 60% disability rating unwarranted, because the medical evidence reflected that Mr. Robinson's GERD (1) was relatively well controlled, (2) rarely impacted his employability or basic functioning, and (3) infrequently caused episodes of epigastric distress. Based on the ROP, the Board's disability rating assignment for his gastrointestinal condition is plausible and not clearly erroneous. *See Johnston v. Brown*, 10 Vet.App. 80, 84 (1997) (Board's decision regarding the degree of disability under the rating schedule is reviewed under the "clearly erroneous" standard); *Gilbert, supra*.

III. Knee Disabilities

In support of his argument regarding his knee disabilities, Mr. Robinson notes that he had surgery in 2008 to remove his meniscus and he contends that (1) his claim should have been characterized as seeking benefits for a meniscus tear, rather than patellofemoral syndrome, (2) a 2005 VA examination report was inaccurate in finding no signs or symptoms of a meniscus tear, and an MRI should have been performed, (3) VA examiners in general failed to review records prior to 2007, (4) the Board erred in not assigning greater weight to medical treatise information showing how meniscus problems can lead to instability, and (5) additional disability ratings of 20% under 38 C.F.R. § 4.71a, DC 5258, and 10% under 38 C.F.R. § 4.71a, DC 5261, are warranted.

As to Mr. Robinson's first contention, the record medical evidence reflects diagnoses of patellofemoral syndrome in the knees, and Mr. Robinson acknowledges that his meniscus was removed in 2008, and that his claim involves the disability rating for the periods before *and* after the removal of his meniscus. Overall, the Board discussed Mr. Robinson's meniscus tear and subsequent removal throughout its analysis, addressed the potential application of many knee-related DCs to his

symptomatology, and did not limit its discussion based on the characterization of his condition. In sum, Mr. Robinson fails to demonstrate Board error. *See Hilkert, supra.*

As to the second contention, even assuming the 2005 VA examiner erred when he reported no symptoms of meniscus tear at the time of the 2005 examination, the Board did not dispute that Mr. Robinson had a meniscus tear prior to his 2008 surgery. The record also reflects that an MRI was provided and, particularly because disability ratings are predicated primarily on symptomatology, Mr. Robinson fails to demonstrate that another MRI was necessary for the Board to have sufficient medical evidence to render a decision on his claim. *See Hilkert, supra*; *see also McLendon v. Nicholson*, 20 Vet.App. 79, 84 (2006) (Secretary need not provide additional medical evidence if there is sufficient medical evidence to decide the claim).

As to Mr. Robinson's third contention, a review of the Board decision reflects that the Board relied on VA examination reports from May 2009 and October 2011. The May 2009 examiner noted that the claims file was available, and the October 2011 examiner stated that he reviewed Mr. Robinson's claims file and service records. In sum, Mr. Robinson fails to demonstrate that these examiners failed to review pre-2007 records or that the medical reports relied on by the Board were inadequate for decision. *See Hilkert, supra*; *see also Sickels v. Shinseki*, 643 F.3d 1362, 1366 (Fed. Cir. 2011) (applying the presumption of regularity – which provides that, "in the absence of clear evidence to the contrary, the court will presume that public officers have properly discharged their official duties" – to VA medical examiners).

As to Mr. Robinson's fourth contention, the Board acknowledged the submitted treatise information and noted that VA examinations were performed to explore whether such general information applied to Mr. Robinson's case. The Board explained that the resultant VA examinations reflected only slight knee instability, and only in his right knee. Mr. Robinson fails to demonstrate Board error in assigning more weight to the personal VA examinations than general treatise information. *See Hilkert* and *Herlehy*, both *supra.*

As to the fifth contention, the Board addressed Mr. Robinson's argument that a 20% disability rating under DC 5258 (dislocated semilunar cartilage) was warranted – in addition to his other disability ratings – for the period prior to his meniscus removal. The Board noted that DC 5258 requires dislocated cartilage "with frequent episodes of 'locking,' pain, and effusion into the joint,"

and acknowledged Mr. Robinson's painful meniscus tear prior to its removal, but found that the tear resulted in only some episodes of locking and no effusion, such that a 20% disability rating under DC 5258 was not warranted. Based on the ROP, that finding is plausible and not clearly erroneous. *See Johnston* and *Gilbert*, both *supra*. In addition, although Mr. Robinson argues that a 10% disability rating under DC 5261 (limitation of leg extension) is warranted (in addition to his other disability ratings), the Board found that Mr. Robinson primarily demonstrated full extension throughout the appeal period. Based on the ROP, that finding also is plausible and not clearly erroneous. *See Gilbert, supra.*

IV. TDIU

Mr. Robinson's final argument is that the Board failed to address the issue, raised by Mr. Robinson in a January 2013 submission to the Board, of an earlier effective date for his TDIU. The Secretary argues that this issue was not properly on appeal, as an effective date for TDIU was assigned in an August 2009 rating decision, and the ROP does not reflect any disagreement with that TDIU effective-date determination submitted within one year of August 2009. TDIU, however, can be considered part and parcel of an underlying claim for benefits, *see Rice v. Shinseki,* 22 Vet.App. 447 (2009), and a review of the August 2009 rating decision reflects that the grant of TDIU and the effective date assigned for TDIU were based primarily on the 50% disability rating and February 2008 effective date assigned for his major depressive disorder. *See* R. at 1018-22.

The ROP reflects that Mr. Robinson has been unemployed since 1999. In the context of this case, the effective date assigned for Mr. Robinson's disability rating for his major depressive disorder is inextricably intertwined with the effective date for his TDIU. *See Tyrues v. Shinseki*, 23 Vet.App. 166, 178-79 (2009) (remand generally appropriate when matter on appeal is inextricably intertwined with matters being adjudicated below), *modified on other grounds by* 26 Vet.App. 31 (2012); *Henderson v. West*, 12 Vet.App. 11, 20 (1998) ("[W]here a decision on one issue would have a significant impact upon another . . . , the two claims are inextricably intertwined." (internal quotation marks omitted)). Thus, Mr. Robinson's timely Notice of Disagreement with the August 2009 rating decision as to the effective date for his disability rating for major depressive disorder encompassed the effective date for TDIU. When the Board remanded the issue of the effective date for major

depressive disorder, it should have included a remand of the effective date for TDIU. To clarify this, the Board decision on appeal will be modified to reflect the proper scope of the remanded matter.

V. Conclusion

Accordingly, that part of the April 16, 2013, Board decision on appeal is MODIFIED to reflect that the remand of the effective date for benefits for major depressive disorder includes a remand of the effective date for TDIU and, as modified, the Board decision is AFFIRMED.

DATED: December 31, 2014

Copies to:

Paul E. Robinson

VA General Counsel (027)

PTSD: National Center for PTSD

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Treatment of Co-Occurring PTSD and Substance Use Disorder in VA

Key Points

- Posttraumatic stress disorder (PTSD) and substance use disorder (SUD) often co-occur among Veterans seeking Veterans Affairs (VA) care.
- Patients with PTSD and SUD can tolerate and benefit from evidence-based trauma-focused PTSD treatment such as Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT).
- Per VA policy, patients with PTSD and SUD should be offered evidence-based treatment for both disorders. Having one should not be a barrier to receiving treatment for the other.
- Shared decision making about treatment for co-occurring PTSD and SUD using a patient-centered collaborative approach that incorporates measurement based care (MBC) is recommended.

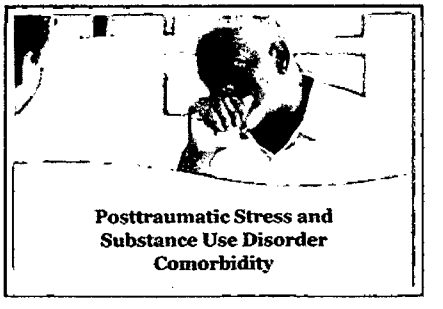
Prevalence and Characteristics

PTSD and SUD often co-occur. According to one national epidemiologic study, 46.4% of individuals with lifetime PTSD also met criteria for SUD (1). In another national epidemiologic study, 27.9% of women and 51.9% of men with lifetime PTSD also had SUD (2). Women with PTSD were 2.48 times more likely to meet criteria for alcohol abuse or dependence and 4.46 times more likely to meet criteria for drug abuse or dependence than women without PTSD. Men were 2.06 and 2.97 times more likely, respectively (2). There are few comparable population prevalence estimates among Veterans. A substantial majority of Veterans with PTSD have met criteria for comorbid substance use at some point. The National Vietnam Veterans Readjustment Study, conducted in the 1980s, found 74% of Vietnam Veterans with PTSD had comorbid SUD (3). Whether these findings generalize to other cohorts is unknown.

CONTINUING EDUCATION COURSE

Posttraumatic Stress and Substance Use Disorder Comorbidity

This course describes the correlates of co-occurring PTSD and SUD, treatment research and VA/DoD Clinical Practice Guideline recommendations.



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Posttraumatic Stress Disorder and Co-Occurring Substance Use Disorders: Advances in Assessment and Treatment

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Abstract

Posttraumatic stress disorder (PTSD) and substance use disorders (SUDs) are prevalent and frequently co-occur. Comorbid PTSD/SUD is associated with a more complex and costly clinical course when compared with either disorder alone, including increased chronic physical health problems, poorer social functioning, higher rates of suicide attempts, more legal problems, increased risk of violence, worse treatment adherence, and less improvement during treatment. In response, psychosocial treatment options have increased substantially over the past decade and integrated approaches – treatments that address symptoms of both PTSD and SUD concurrently –are fast becoming the preferred model for treatment. This paper reviews the prevalence, etiology and assessment practices as well as advances in the behavioral and pharmacologic treatment of comorbid PTSD and SUDs.

Keywords: PTSD, posttraumatic stress disorder, trauma, substance use disorders, addiction, integrated treatment

Overview of PTSD and Substance Use Disorders

Posttraumatic stress disorder (PTSD) is an anxiety disorder that may develop subsequent to exposure to a traumatic event (experienced or witnessed). Traumatic events are defined as events that involve actual or threatened death, serious injury, or threat to the physical integrity of oneself or others, and are responded to with intense fear, helplessness or horror (American Psychiatric Association, 2000). Diagnosis of PTSD requires that the traumatic event (Criterion A) is followed by at least one month of the following three distinct symptom clusters; intrusive recollection or reexperiencing (Criterion B), avoidance or emotional numbing (Criterion C), and hyperarousal (Criterion D). With respect to substance use disorders (SUDs), the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV) provides diagnostic criteria for two forms of SUDs – substance abuse and substance dependence. Substance abuse is characterized by a maladaptive pattern of use leading to clinically significant impairment or distress. Maladaptive use is described as the recurrence of at least one of the following:

use in physically hazardous situations, substance-related legal problems, failure to fulfill major role obligations, or social/interpersonal problems related to use. Substance dependence is also a maladaptive pattern of use that is characterized by three or more of the following: (1) tolerance of the substance; (2) withdrawal symptoms when the substance is reduced or ceased; (3) using more than was planned or for a longer period than was planned; (4) unsuccessful efforts to reduce or control use; (5) significant time spent obtaining, using, or recovering from use; (6) interference with important social, occupational, or recreational activities; and (7) continued use despite knowledge of its cause or exacerbation of a physical or psychological problem(s).

Comorbidity of PTSD and SUDs is prevalent across a diverse range of populations and settings. In addition, comorbid PTSD/SUD is associated with a more complex and costly clinical course when compared with either disorder alone, including increased chronic physical health problems, poorer social functioning, higher rates of suicide attempts, more legal problems, increased risk of violence, worse treatment adherence, and less improvement during treatment (Back et al., 2000; Driessen et al., 2008; Norman, Tate, Anderson, & Brown, 2007; Ouimette, Brown, & Najavits, 1998; Ouimette, Goodwin, & Brown, 2006; Tarrier, 2004; Tate, Norman, McQuiad, & Brown, 2007; Young, Rosen, & Finney, 2005). The current paper (1) reviews the epidemiology and etiology of comorbid PTSD/SUD; (2) highlights commonly used self-report, clinician-administered, and biological assessments for PTSD and SUDs; and (3) discusses advances in evidence-based psychotherapeutic and pharmacologic treatment options for patients presenting with comorbid PTSD/SUD.

Epidemiology and Etiology of PTSD and SUDs

Several large-scale epidemiological surveys conducted among the general population over the past two decades have demonstrated the high co-occurrence of PTSD and SUDs. The National Comorbidity Survey (NCS; $N = 5,877$), which assessed the prevalence and co-occurrence of a range of psychiatric disorders using the Diagnostic and Statistical Manual, Third Edition-Revised (DSM-III-R) revised diagnostic criteria, provided one of the earliest national estimates of the scope of the problem among the general U.S. population (Kessler, Sonega, Bromet, Hughes, & Neslon, 1995). NCS data indicated a 7.8% lifetime prevalence of PTSD and a 26.6% lifetime prevalence of SUDs; individuals with PTSD were 2 to 4 times more likely than individuals without PTSD to meet criteria for an SUD. The National Comorbidity Survey – Replication ($N = 9,282$; Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005) conducted approximately ten years later using DSM-IV diagnostic criteria (American Psychiatric Association, 2000), documented similar estimates of lifetime PTSD (6.4%) and lifetime SUDs (35.3%). More recently, data from the 2010 National Epidemiologic Survey on Alcohol and Related Conditions ($N = 34,653$) estimated a lifetime PTSD prevalence of 6.4% (Pietrzak, Goldstein, Southwick, & Grant, 2011). Among individuals with PTSD, nearly half (46.4%) also met criteria for an SUD and more than one-in-five (22.3%) met criteria for substance dependence. Similarly, international data from the Australian National Survey of Mental Health and Well-Being ($N = 10,641$) found that over one-third (34.4%) of individuals meeting criteria for PTSD also met criteria for at least one SUD, most commonly alcohol use disorders (Mills, Teeson, Ross, Peters, 2006).

Among treatment-seeking populations, high rates of comorbid PTSD and SUDs also have been consistently observed. Patients with PTSD have been shown to be up to 14 times more likely than patients without PTSD to have an SUD (Chilcoat & Menard, 2003; Ford, Russo, & Mallon, 2007). Conversely, among patients seeking treatment for SUDs, lifetime PTSD rates range between 30% and over 60% (Back et al., 2000; Brady, Back, & Coffey, 2004; Dansky, Brady, & Roberts, 1994; Jacobsen, Southwick, & Kosten, 2001; Stewart, Conrod, Samoluk, Pihl, Dongier, 2000; Triffleman, Marmar, Delucchi, & Ronfeldt, 1995). The variation in estimates observed across the aforementioned studies is likely attributable to differences in the types of clinics sampled, variant patient populations and measurement techniques employed.

Finally, research on Veteran populations demonstrates that, in comparison to the general population, Veterans are at increased risk for developing both PTSD and SUDs, and that severity of combat exposure is directly linked to risk for development and chronicity of PTSD symptoms (Hoge et al., 2004; Kang, Natelson, Mahan, Lee, & Murphy, 2003). A recent study assessed army Veterans three to four months post-deployment from Iraq and found a 27% prevalence rate for alcohol misuse, as well as a significant association between severity of combat exposure and alcohol misuse, such that those with higher severity of combat exposure had a 93% higher odds of screening positive for alcohol misuse (Santiago et al., 2010). Prevalence rates for SUDs among Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans have been estimated at 21%, and approximately 15% to 20% of OEF/OIF military troops meet criteria for PTSD post-deployment (Bray & Houranni, 2007; Hoge, et al., 2004; Seal, Berthenhal, Miner, Sen, & Marmar, 2007; Thomas et al., 2010). Research also documents high rates of comorbid PTSD/SUD among Veterans (Centers for Disease Control and Prevention, 1988; Shipherd, Stafford, & Tanner, 2005). A recent study (Petrakis, Rosenheck, & Desai, 2011) using national administrative data from the Department of Veterans Affairs indicated that, among Veterans who had served in Vietnam era or later, almost half (41.4%) with an SUD were dually diagnosed with PTSD.

Etiology and Order of Onset

Several theories have been posited to explain the functional association between PTSD and SUDs. The *self-medication theory* (Khantzian, 1985, 1990, 1997; Reed, Anthony, & Breslau, 2007), perhaps the most prominent theory, postulates that substance use serves as an attempt to alleviate PTSD symptoms. In support of this theory, one study (Saladin, Brady, Dansky, & Kilpatrick, 1995) found that hyperarousal and avoidance symptoms were more prominent among individuals with comorbid PTSD/SUD, as compared to those with PTSD alone. Further, among individauls with comorbid PTSD/SUD, alcohol dependence was more strongly associated with hyperarousal cluster (Criterion D) symptoms than cocaine dependence. Therefore, an individual's drug of choice, either central nervous system depressant or stimulant, in comorbid PTSD/SUD cases may reflect an attempt to alleviate a particular cluster of symptoms. Experimental findings among individuals with comorbid PTSD/SUD demonstrate a consistent increase in substance craving in response to presentation of personalized trauma cues (Coffey et al., 2002). Furthermore, increase in craving is predicted by severity of PTSD symptoms (Saladin et al., 2003), and trauma-cue elicited craving is reduced following trauma-focused imaginal exposure (Coffey, Stasiewicz, Hughes, & Brimo, 2006). Adding to this complex relationship, withdrawal from substances may closely mimic some symptoms of PTSD (e.g., sleep disturbance, difficulty concentrating, feelings of detachment, irritability) and contribute to a reinforcing cycle of self-medication that fosters the development of an SUD. Although the direction of the causal relationship between comorbid PTSD and SUDs is likely to vary from one individual to another, in the majority of cases the development of PTSD precedes the development of the SUD, providing temporal support for the self-medication hypothesis (Back, Brady, Sonne, & Verduin, 2006; Back, Jackson, Sonne, & Brady, 2005; Chilcoat & Breslau, 1998; Compton, Cottler, Phelps, Abdallah, & Sptiznagel, 2000; Jacobsen, Southwick, & Kosten, 2001; Stewart & Conrod, 2003). More recently, Ouimette and colleagues (2010) followed 35 outpatients with comorbid PTSD and SUDs and tracked weekly fluctuations in symptoms over a 26-week period in order to examine dynamic interactions between symptoms of PTSD and SUDs. Overall, the findings support the self-medication hypothesis and suggest that PTSD and SUD symptoms co-vary concurrently and over time, such that increases in PTSD symptoms are associated with increases in symptoms of substance dependence. Several studies investigating patients' perceptions of the interrelationship of their PTSD and SUD symptoms also provide support for the self-medication hypothesis (Back, Brady, Jaanimagi & Jackson, 2006; Brown, Stout, & Gannon-Rowley, 1989).

DEPARTMENT OF VETERANS AFFAIRS
Appeals Management Center
1722 Eye Street N. W.
Washington, D. C. 20241

PAUL E. ROBINSON

VA File Number
[redacted]0997

Represented By:
DISABLED AMERICAN VETERANS

Rating Decision
March 06, 2014

INTRODUCTION

The records reflect that you are a veteran of the Peacetime. You served in the Army from December 5, 1976 to April 8, 1977 and from August 16, 1978 to August 3, 1979. The Board of Veterans Appeals made their decision on your appeal on February 7, 2014. We have implemented their decision based on the evidence listed below.

DECISION

Entitlement to an earlier effective date for service connection of major depressive disorder is granted because a clear and unmistakable error was made; therefore, a 50 percent evaluation is assigned effective February 28, 2000. A 50 percent evaluation is assigned from February 28, 2000.

EVIDENCE

- Board of Veteran's Appeals (BVA) decision dated February 7, 2014
- Your claims folder was reviewed in its entirety

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REASONS FOR DECISION

Whether the effective date of compensation for major depressive disorder was a clear and unmistakable error.

Board of Veterans' Appeals (BVA) decision of February 7, 2014 granted entitlement to an earlier effective date for service connection for major depressive disorder. Please refer to that decision document for the complete reasons and bases for the grant to entitlement to service connection for major depressive disorder. The evaluation assigned is 50 percent with an effective date of February 28, 2000. The effective date is based on the date your original claim was received.

Clear and unmistakable errors are errors that are undebatable, so that it can be said that reasonable minds could only conclude that the previous decision was fatally flawed at the time it was made. A determination that there was clear and unmistakable error must be based on the record and the law that existed at the time of the prior decision. Once a determination is made that there was a clear and unmistakable error in a prior decision that would change the outcome, then that decision must be revised to conform to what the decision should have been.

A 50 percent evaluation is assigned from February 28, 2000. This evaluation is not based on evaluation criteria in the rating schedule. The reason this non-schedular evaluation is assigned is because the Board of Veterans' Appeals (BVA) has granted it.

This decision represents a Board of Veterans' Appeals grant that is considered to be a full and final determination of this issue on appeal.

REFERENCES:

Title 38 of the Code of Federal Regulations, Pensions, Bonuses and Veterans' Relief contains the regulations of the Department of Veterans Affairs which govern entitlement to all veteran benefits. For additional information regarding applicable laws and regulations, please consult your local library, or visit us at our web site, www.va.gov.

M21-1MR, Part I,
5C.13.f.

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