DEPARTMENT OF VETERANS AFFAIRS
DEPARTMENT OF VETERANS AFFAIRS
VA Regional Office

April 9, 2020

In Reply Refer To:

Dear Mr.

You have filed a Notice of Disagreement with our action. This is the first step in appealing to the Board of Veterans' Appeals (BVA). This letter and enclosures contain very important information concerning your appeal.

Statement of the Case

We have enclosed a Statement of the Case, a summary of the law and evidence concerning your claim. This summary will help you to make the best argument to the BVA on why you think our decision should be changed.

What You Need To Do

To complete your appeal, you must file a formal appeal. We have enclosed VA Form 9, Appeal to the Board of Veterans' Appeals, which you may use to complete your appeal. We will gladly explain the form if you have questions. Your appeal should address:

- the benefit you want
- the facts in the Statement of the Case with which you disagree; and
- the errors that you believe we made in applying the law.

On August 23, 2017, the President signed into law the Veterans Appeals Improvement and Modernization Act of 2017 (Appeals Modernization Act), creating a modernized review system for claims and appeals. The modernized appeals system took effect on February19, 2019, and provides streamlined choices for seeking review of your VA claim decision. You are eligible to opt-in to this new process based on your receipt of this Statement of the Case or Supplemental Statement of the Case. If you continue to disagree with our decision, please refer to the enclosed fact sheet for a more thorough explanation of your decision review options and submission deadlines should you decide to opt-in. If you wish to remain in the legacy process, please follow the instructions above regarding actions required to request further review of your appeal.

When You Need To Do It

You must file your appeal with this office within 60 days from the date of this letter or within the remainder, if any, of the one-year period from the date of the letter notifying you of the action that you have appealed. **If we do not hear from you within this period, we will close your case.** If you need more time to file your appeal, you should request more time before the time limit for filing your appeal expires. See item 5 of the instructions in VA Form 9, Appeal to Board of Veterans' Appeals.

Hearings

You may have a hearing before we send your case to the BVA. If you tell us that you want a hearing, we will arrange a time and a place for the hearing. VA will provide the hearing room, the hearing official, and a transcript of the hearing for the record. VA cannot pay any other expenses of the hearing. You may **also** have a hearing before the BVA, as noted on the enclosed VA Form 9, Appeal to the Board of Veterans' Appeals. **Do not delay filing your appeal if you request a hearing. Your request for a hearing does not extend the time to file your appeal.**

Representation

If you do not have a representative, it is not too late to choose one. An accredited representative of a recognized service organization may represent you in your claim for VA benefits without charge. An accredited attorney or an accredited agent may also represent you before VA, and may charge you a fee for services performed after the filing of a notice of disagreement. In certain cases, VA will pay your accredited agent or attorney directly from your past due benefits. For more information on the accreditation process and fee agreements (including filing requirements), you and/or your representative should review 38 U.S.C. § 5904 and 38 C.F.R. § 14.636 and VA's website at http://www.va.gov/ogc/accreditation.asp. You can find the necessary power of attorney forms on this website, or if you ask us, we can send you the forms. You can also find the names of accredited attorneys, agents and service organization representatives on this website.

What We Will Do

After we receive your appeal, we will send your case to the BVA in Washington, DC for a decision. The BVA will base its decision on an independent review of the entire record, including the transcript of the hearing, if you have a hearing.

Sincerely yours,

Regional Office Director

Regional Office Director

Enclosure(s): VA Form 9
AMA Fact Sheet

CC: SOUTH DAKOTA DEPARTMENT OF VETERANS AFFAIRS

ISSUE:

1. Entitlement to an earlier effective date for sleep apnea.
2. Entitlement to an evaluation in excess of 10 percent for left knee anterior cruciate ligament rupture with tearing of the medial meniscus with osteoarthritis.
3. Entitlement to an evaluation in excess of 10 percent for complex tear of the right knee medial and lateral meniscus, popliteal cyst, and osteoarthritis.

EVIDENCE:

- Rating decision dated November 5, 2018
- Notification letter dated November 7, 2018
- Service treatment and personnel records for the veteran's period of service dated from June11, 1975, to May 22, 1979 and from March 10, 1988, to February 29, 2000
- VA Form 21-0966, Intent To File A Claim For Compensation and/or Pension, or Survivors Pension and/or DIC, received December 29, 2017
- VA Form 21-526EZ Application for Disability Compensation and Related Compensation Benefits, received June 15, 2018, with attached statements, medical evidence, and lay statements
- VAMC (Veterans Affairs Medical Center) treatment records, Richmond, from May 7, 2018through July 5, 2018
- VA letter concerning your claim, dated July 27, 2018
- Medical evidence, lay statement, and medical articles received on July 30, 2018
- Lay statements received August 2, 2018
- VA contract examination, dated August 4, 2018
- Medical evidence received from Tricare on August 22, 2018
- VA Form 21-4138, Statement in Support of Claim, received August 29, 2018, with attached statement and lay statement
- VA letter concerning your claim, dated August 30, 2018
- VA contract examination, dated October 10, 2018
- VA contract examination, dated October 30, 2018
- Rating Decision, dated February 15, 2001
- VA contract examination, dated May 8, 2000
- Rating Decision, dated September 2, 2008
- Report from Mary Washington Hospital dated August 22, 2007
- Reports from Stafford Primary Care Associates dated July 19, 2007 to December 27, 2007
- Outpatient treatment records, VAMC Richmond, dated May 7, 2018 through December 11, 2018
- MRI Report, Medical Imaging at Lee's Hill, dated November 17, 2014

- Medical opinions, Craig N. Bash, dated January 12, 2018
- MRI Report, Medical Imaging at Lee's Hill, dated November 17, 2014
- Medical opinions, Craig N. Bash, dated January 12, 2018
- MRI report dated April 12, 2016
- Radiology reports dated March 25, 2016 through May 24, 2019
- Sworn Statement dated February 1, 2019
- VA Form 21-0958, Notice of Disagreement, received June 10, 2019
- Private treatment records, Mary Washington Medical Group, dated February 7, 2019
- Treatment note, Denvia Johnson, dated April 17, 2018
- Treatment note, Marshall Rennie, dated May 16, 2019
- Sworn statements dated June 3, 2019
- VA contract examination, Neck Condition, dated November 30, 2018
- VA Form 21-0958, Notice of Disagreement, received June 10, 2019
- Disability Benefits Questionnaire, Knee Conditions, dated May 21, 2019
- VA Form 21-0820, Report of Contact, dated July 24, 2019
- VA Form 21-0820, Report of Contact, dated October 24, 2019
- DRO Process Explanation Letter, dated October 25, 2019
- Outpatient treatment notes, Ft. Belvoir, dated December 20, 2017 through October 11, 2019
- VA contract examination, Neck Conditions, conducted by LHI, Logistics Health Incorporated, dated November 30, 2018
- Rating Decision, dated January 10, 2019
- Rating decision dated September 2, 2008

ADJUDICATIVE ACTIONS:

06-15-2018 Claim received.

11-05-2018 Claim considered based on all the evidence of record.

11-07-2018 Claimant notified of decision.

06-10-2019 Notice of Disagreement received.

06-10-2019 De Novo Review election received from appellant.

10-25-2019 Appeal Election Letter sent to the appellant.

04-09-2020 De Novo Review performed based on all the evidence of record.

04-09-2020 The veteran was furnished a Statement of the Case outlining actions taken on the claim.

PERTINENT LAWS; REGULATIONS; RATING SCHEDULE PROVISIONS:

Unless otherwise indicated, the symbol "§" denotes a section from title 38 of the Code of Federal Regulations, Pensions, Bonuses and Veterans' Relief. Title 38 contains the regulations of the Department of Veterans Affairs which govern entitlement to all veteran benefits.

§3.102 (New) Reasonable doubt.

It is the defined and consistently applied policy of the Department of Veterans Affairs to administer the law under a broad interpretation, consistent, however, with the facts shown in every case. When, after careful consideration of all procurable and assembled data, a reasonable doubt arises regarding service origin, the degree of disability, or any other point, such doubt will be resolved in favor of the claimant. By reasonable doubt is meant one which exists because of an approximate balance of positive and negative evidence which does not satisfactorily prove or disprove the claim. It is a substantial doubt and one within the range of probability as distinguished from pure speculation or remote possibility. It is not a means of reconciling actual conflict or a contradiction in the evidence. Mere suspicion or doubt as to the truth of any statements submitted, as distinguished from impeachment or contradiction by evidence or known facts, is not justifiable basis for denying the application of the reasonable doubt doctrine if the entire complete record otherwise warrants invoking this doctrine. The reasonable doubt doctrine is also applicable even in the absence of official records, particularly if the basic incident allegedly arose under combat, or similarly strenuous conditions, and is consistent with the probable results of such known hardships. (Authority: 38 U.S.C. 501(a))

§3.103 Procedural due process and appellate rights.

(a) Statement of policy. Every claimant has the right to written notice of the decision made on his or her claim, the right to a hearing, and the right of representation. Proceedings before VA are ex parte in nature, and it is the obligation of VA to assist a claimant in developing the facts pertinent to the claim and to render a decision which grants every benefit that can be supported in law while protecting the interests of the Government. The provisions of this section apply to all claims for benefits and relief, and decisions thereon, within the purview of this part 3.

(b) The right to notice:

(1) General. Claimants and their representatives are entitled to notice of any decision made by VA affecting the payment of benefits or the granting of relief. Such notice shall clearly set forth the

decision made, any applicable effective date, the reason(s) for the decision, the right to a hearing on any issue involved in the claim, the right of representation and the right, as well as the necessary procedures and time limits, to initiate an appeal of the decision.

(2) Advance notice and opportunity for hearing. Except as otherwise provided in paragraph (b)(3) of this section, no award of compensation, pension or dependency and indemnity compensation shall be terminated, reduced or otherwise adversely affected unless the beneficiary has been notified of such adverse action and has been provided a period of 60 days in which to submit evidence for the purpose of showing that the adverse action should not be taken.

(3) Exceptions. In lieu of advance notice and opportunity for a hearing, VA will send a written notice to the beneficiary or his or her fiduciary at the same time it takes an adverse action under the following circumstances:

(i) An adverse action based solely on factual and unambiguous information or statements as to income, net worth, or dependency or marital status that the beneficiary or his or her fiduciary provided to VA in writing or orally (under the procedures set forth in Sec. 3.217(b)), with knowledge or notice that such information would be used to calculate benefit amounts.

(ii) An adverse action based upon the beneficiary's or fiduciary's failure to return a required eligibility verification report.

(iii) Evidence reasonably indicates that a beneficiary is deceased. However, in the event that VA has received a death certificate, a terminal hospital report verifying the death of a beneficiary or a claim for VA burial benefits, no notice of termination (contemporaneous or otherwise) will be required.

(iv) An adverse action based upon a written and signed statement provided by the beneficiary to VA renouncing VA benefits (see §3.106 on renouncement).

(v) An adverse action based upon a written statement provided to VA by a veteran indicating that he or she has returned to active service, the nature of that service, and the date of reentry into service, with the knowledge or notice that receipt of active service pay precludes concurrent receipt of VA compensation or pension (see §3.654 regarding active service pay).

(vi) An adverse action based upon a garnishment order issued under 42 U.S.C. 659(a). (Authority: 38 U.S.C. 501(a))

(4) Restoration of benefits. VA will restore retroactively benefits that were reduced, terminated, or otherwise adversely affected based on oral information or statements if within 30 days of the date on which VA issues the notification of adverse action the beneficiary or his or her fiduciary

asserts that the adverse action was based upon information or statements that were inaccurate or upon information that was not provided by the beneficiary or his or her fiduciary. This will not preclude VA from taking subsequent action that adversely affects benefits.

(c) The right to a hearing.

(1) Upon request, a claimant is entitled to a hearing at any time on any issue involved in a claim within the purview of part 3 of this chapter, subject to the limitations described in §20.1304 of this chapter with respect to hearings in claims which have been certified to the Board of Veterans Appeals for appellate review. VA will provide the place of hearing in the VA office having original jurisdiction over the claim or at the VA office nearest the claimant's home having adjudicative functions or, subject to available resources and solely at the option of VA, at any other VA facility or federal building at which suitable hearing facilities are available. VA will provide one or more employees who have original determinative authority of such issues to conduct the hearing and be responsible for establishment and preservation of the hearing record. Hearings in connection with proposed adverse actions and appeals shall be held before one or more VA employees having original determinative authority who did not participate in the proposed action or the decision being appealed. All expenses incurred by the claimant in connection with the hearing are the responsibility of the claimant.

(2) The purpose of a hearing is to permit the claimant to introduce into the record, in person, any available evidence which he or she considers material and any arguments or contentions with respect to the facts and applicable law which he or she may consider pertinent. All testimony will be under oath or affirmation. The claimant is entitled to produce witnesses, but the claimant and witnesses are expected to be present. The Veterans Benefits Administration will not normally schedule a hearing for the sole purpose of receiving argument from a representative. It is the responsibility of the VA employee or employees conducting the hearings to explain fully the issues and suggest the submission of evidence which the claimant may have overlooked and which would be of advantage to the claimant's position. To assure clarity and completeness of the hearing record, questions which are directed to the claimant and to witnesses are to be framed to explore fully the basis for claimed entitlement rather than with an intent to refute evidence or to discredit testimony. In cases in which the nature, origin, or degree of disability is in issue, the claimant may request visual examination by a physician designated by VA and the physician's observations will be read into the record. (Authority: 38 U.S.C. 501(a))

(d) Submission of evidence. Any evidence whether documentary, testimonial, or in other form, offered by the claimant in support of a claim and any issue a claimant may raise and any contention or argument a claimant may offer with respect thereto are to be included in the records.

(e) The right to representation. Subject to the provisions of §§14.626 through 14.637 of this title, claimants are entitled to representation of their choice at every stage in the prosecution of a claim.

(f) Notification of decisions. The claimant or beneficiary and his or her representative will be notified in writing of decisions affecting the payment of benefits or granting relief. All notifications will advise the claimant of the reason for the decision; the date the decision will be effective; the right to a hearing subject to paragraph (c) of this section; the right to initiate an appeal by filing a Notice of Disagreement which will entitle the individual to a Statement of the Case for assistance in perfecting an appeal; and the periods in which an appeal must be initiated and perfected (See part 20 of this chapter, on appeals). Further, any notice that VA has denied a benefit sought will include a summary of the evidence considered. (Authority: 38 U.S.C. 501, 1115, 1506, 5104.)

§3.104 (05/2001) Finality of decisions.

(a) A decision of a duly constituted rating agency or other agency of original jurisdiction shall be final and binding on all field offices of the Department of Veterans Affairs as to conclusions based on the evidence on file at the time VA issues written notification in accordance with 38 U.S.C. 5104. A final and binding agency decision shall not be subject to revision on the same factual basis except by duly constituted appellate authorities or except as provided in §3.105 and §3.2600 of this part.

(b) Current determinations of line of duty, character of discharge, relationship, dependency, domestic relations questions, homicide, and findings of fact of death or presumptions of death made in accordance with existing instructions, and by application of the same criteria and based on the same facts, by either an Adjudication activity or an Insurance activity are binding one upon the other in the absence of clear and unmistakable error.

[29 FR 1462, Jan. 29, 1964, as amended at 29 FR 7547, June 12, 1964; 56 FR 65846, Dec. 19, 1991; 66 FR 21874, May 2, 2001]

§3.105(b) Revision of decisions (Difference of opinion).

Whenever an adjudicative agency is of the opinion that a revision or an amendment of a previous decision is warranted, a difference of opinion being involved rather than a clear and unmistakable error, the proposed revision will be recommended to Central Office. However, a decision may be revised under §3.2600 without being recommended to Central Office.

§3.109 Time limit.

(a) Notice of time limit for filing evidence.

(1) If a claimant's application is incomplete, the claimant will be notified of the evidence necessary to complete the application. If the evidence is not received within 1 year from the date of such notification, pension, compensation, or dependency and indemnity compensation may not be paid by reason of that application (38 U.S.C. 5103(a)). Information concerning the whereabouts of a person who has filed claim is not considered evidence.

(2) The provisions of this paragraph are applicable to original applications, formal or informal, and to applications for increased benefits by reason of increased disability, age, or the existence of a dependent and to applications for reopening or resumption of payments. If substantiating evidence is required with respect to the veracity of a witness or the authenticity of documentary evidence timely filed, there will be allowed for the submission of such evidence 1 year from the date of the request therefor. However, any evidence to enlarge the proofs and evidence originally submitted is not so included.

(b) Extension of time limit. Time limits within which claimants or beneficiaries are required to act to perfect a claim or challenge an adverse VA decision may be extended for good cause shown. Where an extension is requested after expiration of a time limit, the action required of the claimant or beneficiary must be taken concurrent with or prior to the filing of a request for extension of the time limit, and good cause must be shown as to why the required action could not have been taken during the original time period and could not have been taken sooner than it was. Denials of time limit extensions are separately appealable issues. (Authority: 38 U.S.C. 501(a))

§3.110 Computation of time limit.

(a) In computing the time limit for any action required of a claimant or beneficiary, including the filing of claims or evidence requested by VA, the first day of the specified period will be excluded and the last day included. This rule is applicable in cases in which the time limit expires on a workday. Where the time limit would expire on a Saturday, Sunday, or holiday, the next succeeding workday will be included in the computation.

(b) "The first day of the specified period" referred to in paragraph (a) of this section shall be the date of mailing of notification to the claimant or beneficiary of the action required and the time limit therefor. The date of the letter of notification shall be considered the date of mailing for purposes of computing time limits. As to appeals, see §§20.302 and 20.305 of this chapter. (Authority: 38 U.S.C. 501(a))

§3.155 Informal claims.

(a) Any communication or action, indicating an intent to apply for one or more benefits under the laws administered by the Department of Veterans Affairs, from a claimant, his or her duly authorized representative, a Member of Congress, or some person acting as next friend of a

claimant who is not sui juris may be considered an informal claim. Such informal claim must identify the benefit sought. Upon receipt of an informal claim, if a formal claim has not been filed, an application form will be forwarded to the claimant for execution. If received within 1 year from the date it was sent to the claimant, it will be considered filed as of the date of receipt of the informal claim.

(b) A communication received from a service organization, an attorney, or agent may not be accepted as an informal claim if a power of attorney was not executed at the time the communication was written.

(c) When a claim has been filed which meets the requirements of §3.151 or §3.152, an informal request for increase or reopening will be accepted as a claim.

§3.156 (10-06) New and Material Evidence.

(a) General. A claimant may reopen a finally adjudicated claim by submitting new and material evidence. New evidence means existing evidence not previously submitted to agency decisionmakers. Material evidence means existing evidence that, by itself or when considered with previous evidence of record, relates to an unestablished fact necessary to substantiate the claim. New and material evidence can be neither cumulative nor redundant of the evidence of record at the time of the last prior final denial of the claim sought to be reopened, and must raise a reasonable possibility of substantiating the claim.
(Authority: 38 U.S.C. 501, 5103A(f), 5108)
(b) Pending claim. New and material evidence received prior to the expiration of the appeal period, or prior to the appellate decision if a timely appeal has been filed (including evidence received prior to an appellate decision and referred to the agency of original jurisdiction by the Board of Veterans Appeals without consideration in that decision in accordance with the provisions of 20.1304(b)(1) of this chapter), will be considered as having been filed in connection with the claim which was pending at the beginning of the appeal period.
(Authority: 38 U.S.C. 501)
(c) Service department records. (1) Notwithstanding any other section in this part, at any time after VA issues a decision on a claim, if VA receives or associates with the claims file relevant official service department records that existed and had not been associated with the claims file when VA first decided the claim, VA will reconsider the claim, notwithstanding paragraph (a) of this section. Such records include, but are not limited to:
(i) Service records that are related to a claimed in-service event, injury, or disease, regardless of whether such records mention the veteran by name, as long as the other requirements of paragraph (c) of this section are met;
(ii) Additional service records forwarded by the Department of Defense or the service department to VA any time after VA's original request for service records; and

(iii) Declassified records that could not have been obtained because the records were classified when VA decided the claim.
(2) Paragraph (c)(1) of this section does not apply to records that VA could not have obtained when it decided the claim because the records did not exist when VA decided the claim, or because the claimant failed to provide sufficient information for VA to identify and obtain the records from the respective service department, the Joint Services Records Research Center, or from any other official source.
(3) An award made based all or in part on the records identified by paragraph (c)(1) of this section is effective on the date entitlement arose or the date VA received the previously decided claim, whichever is later, or such other date as may be authorized by the provisions of this part applicable to the previously decided claim.
(4) A retroactive evaluation of disability resulting from disease or injury subsequently service connected on the basis of the new evidence from the service department must be supported adequately by medical evidence. Where such records clearly support the assignment of a specific rating over a part or the entire period of time involved, a retroactive evaluation will be assigned accordingly, except as it may be affected by the filing date of the original claim.

§3.159 (New) Department of Veterans Affairs assistance in developing claims.

(a) Definitions. For purposes of this section, the following definitions apply:

(1) Competent medical evidence means evidence provided by a person who is qualified through education, training, or experience to offer medical diagnoses, statements, or opinions. Competent medical evidence may also mean statements conveying sound medical principles found in medical treatises. It would also include statements contained in authoritative writings such as medical and scientific articles and research reports or analyses.

(2) Competent lay evidence means any evidence not requiring that the proponent have specialized education, training, or experience. Lay evidence is competent if it is provided by a person who has knowledge of facts or circumstances and conveys matters that can be observed and described by a lay person.

(3) Substantially complete application means an application containing the claimant's name; his or her relationship to the veteran, if applicable; sufficient service information for VA to verify the claimed service, if applicable; the benefit claimed and any medical condition(s) on which it is based; the claimant's signature; and in claims for nonservice-connected disability or death pension and parents' dependency and indemnity compensation, a statement of income.

(4) For purposes of paragraph (c)(4)(i) of this section, event means one or more incidents associated with places, types, and circumstances of service giving rise to disability.

(5) Information means non-evidentiary facts, such as the claimant's Social Security number or address; the name and military unit of a person who served with the veteran; or the name and address of a medical care provider who may have evidence pertinent to the claim.

(b) VA's duty to notify claimants of necessary information or evidence.

(1) When VA receives a complete or substantially complete application for benefits, it will notify the claimant of any information and medical or lay evidence that is necessary to substantiate the claim. VA will inform the claimant which information and evidence, if any, that the claimant is to provide to VA and which information and evidence, if any, that VA will attempt to obtain on behalf of the claimant. VA will also request that the claimant provide any evidence in the claimant's possession that pertains to the claim. If VA does not receive the necessary information and evidence requested from the claimant within one year of the date of the notice, VA cannot pay or provide any benefits based on that application. If the claimant has not responded to the request within 30 days, VA may decide the claim prior to the expiration of the one-year period based on all the information and evidence contained in the file, including information and evidence it has obtained on behalf of the claimant and any VA medical examinations or medical opinions. If VA does so, however, and the claimant subsequently provides the information and evidence within one year of the date of the request, VA must readjudicate the claim. (Authority: 38 U.S.C. 5103)

(2) If VA receives an incomplete application for benefits, it will notify the claimant of the information necessary to complete the application and will defer assistance until the claimant submits this information. (Authority: 38 U.S.C. 5102(b), 5103A(3))

(c) VA's duty to assist claimants in obtaining evidence. Upon receipt of a substantially complete application for benefits, VA will make reasonable efforts to help a claimant obtain evidence necessary to substantiate the claim. In addition, VA will give the assistance described in paragraphs (c)(1), (c)(2), and (c)(3) to an individual attempting to reopen a finally decided claim. VA will not pay any fees charged by a custodian to provide records requested.

(1) Obtaining records not in the custody of a Federal department or agency. VA will make reasonable efforts to obtain relevant records not in the custody of a Federal department or agency, to include records from State or local governments, private medical care providers, current or former employers, and other non-Federal governmental sources. Such reasonable efforts will generally consist of an initial request for the records and, if the records are not received, at least one follow-up request. A follow-up request is not required if a response to the initial request indicates that the records sought do not exist or that a follow-up request for the records would be futile. If VA receives information showing that subsequent requests to this or another custodian could result in obtaining the records sought, then reasonable efforts will include an initial request

and, if the records are not received, at least one follow-up request to the new source or an additional request to the original source.

(i) The claimant must cooperate fully with VA's reasonable efforts to obtain relevant records from non-Federal agency or department custodians. The claimant must provide enough information to identify and locate the existing records, including the person, company, agency, or other custodian holding the records; the approximate time frame covered by the records; and, in the case of medical treatment records, the condition for which treatment was provided.

(ii) If necessary, the claimant must authorize the release of existing records in a form acceptable to the person, company, agency, or other custodian holding the records. (Authority: 38 U.S.C. 5103A(b))

(2) Obtaining records in the custody of a Federal department or agency. VA will make as many requests as are necessary to obtain relevant records from a Federal department or agency. These records include but are not limited to military records, including service medical records; medical and other records from VA medical facilities; records from non-VA facilities providing examination or treatment at VA expense; and records from other Federal agencies, such as the Social Security Administration. VA will end its efforts to obtain records from a Federal department or agency only if VA concludes that the records sought do not exist or that further efforts to obtain those records would be futile. Cases in which VA may conclude that no further efforts are required include those in which the Federal department or agency advises VA that the requested records do not exist or the custodian does not have them.

(i) The claimant must cooperate fully with VA's reasonable efforts to obtain relevant records from Federal agency or department custodians. If requested by VA, the claimant must provide enough information to identify and locate the existing records, including the custodian or agency holding the records; the approximate time frame covered by the records; and, in the case of medical treatment records, the condition for which treatment was provided. In the case of records requested to corroborate a claimed stressful event in service, the claimant must provide information sufficient for the records custodian to conduct a search of the corroborative records.

(ii) If necessary, the claimant must authorize the release of existing records in a form acceptable to the custodian or agency holding the records. (Authority: 38 U.S.C. 5103A(b))

(3) Obtaining records in compensation claims. In a claim for disability compensation, VA will make efforts to obtain the claimant's service medical records, if relevant to the claim; other relevant records pertaining to the claimant's active military, naval or air service that are held or maintained by a governmental entity; VA medical records or records of examination or treatment at non-VA facilities authorized by VA; and any other relevant records held by any Federal department or agency. The claimant must provide enough information to identify and locate the

existing records including the custodian or agency holding the records; the approximate time frame covered by the records; and, in the case of medical treatment records, the condition for which treatment was provided. (Authority: 38 U.S.C. 5103A(c))

(4) Providing medical examinations or obtaining medical opinions.

(i) In a claim for disability compensation, VA will provide a medical examination or obtain a medical opinion based upon a review of the evidence of record if VA determines it is necessary to decide the claim. A medical examination or medical opinion is necessary if the information and evidence of record does not contain sufficient competent medical evidence to decide the claim, but:

(A) Contains competent lay or medical evidence of a current diagnosed disability or persistent or recurrent symptoms of disability;

(B) Establishes that the veteran suffered an event, injury or disease in service, or has a disease or symptoms of a disease listed in §3.309, §3.313, §3.316, and §3.317 manifesting during an applicable presumptive period provided the claimant has the required service or triggering event to qualify for that presumption; and

(C) Indicates that the claimed disability or symptoms may be associated with the established event, injury, or disease in service or with another service-connected disability.

(ii) Paragraph (4)(i)(C) could be satisfied by competent evidence showing post-service treatment for a condition, or other possible association with military service.

(iii) Paragraph (c)(4) applies to a claim to reopen a finally adjudicated claim only if new and material evidence is presented or secured. (Authority: 38 U.S.C. 5103A(d))

(d) Circumstances where VA will refrain from or discontinue providing assistance. VA will refrain from providing assistance in obtaining evidence for a claim if the substantially complete application for benefits indicates that there is no reasonable possibility that any assistance VA would provide to the claimant would substantiate the claim. VA will discontinue providing assistance in obtaining evidence for a claim if the evidence obtained indicates that there is no reasonable possibility that further assistance would substantiate the claim. Circumstances in which VA will refrain from or discontinue providing assistance in obtaining evidence include, but are not limited to:

(1) The claimant's ineligibility for the benefit sought because of lack of qualifying service, lack of veteran status, or other lack of legal eligibility;

(2) Claims that are inherently incredible or clearly lack merit; and

(3) An application requesting a benefit to which the claimant is not entitled as a matter of law. (Authority: 38 U.S.C. 5103A(a)(2))

(e) Duty to notify claimant of inability to obtain records.

(1) If VA makes reasonable efforts to obtain relevant non-Federal records but is unable to obtain them, or after continued efforts to obtain Federal records concludes that it is reasonably certain they do not exist or further efforts to obtain them would be futile, VA will provide the claimant with oral or written notice of that fact. VA will make a record of any oral notice conveyed to the claimant. For non-Federal records requests, VA may provide the notice at the same time it makes its final attempt to obtain the relevant records. In either case, the notice must contain the following information:

(i) The identity of the records VA was unable to obtain;

(ii) An explanation of the efforts VA made to obtain the records;

(iii) A description of any further action VA will take regarding the claim, including, but not limited to, notice that VA will decide the claim based on the evidence of record unless the claimant submits the records VA was unable to obtain; and

(iv) A notice that the claimant is ultimately responsible for providing the evidence.

(2) If VA becomes aware of the existence of relevant records before deciding the claim, VA will notify the claimant of the records and request that the claimant provide a release for the records. If the claimant does not provide any necessary release of the relevant records that VA is unable to obtain, VA will request that the claimant obtain the records and provide them to VA. (Authority: 38 U.S.C. 5103A(b)(2))

(f) For the purpose of the notice requirements in paragraphs (b) and (e) of this section, notice to the claimant means notice to the claimant or his or her fiduciary, if any, as well as to his or her representative, if any. (Authority: 38 U.S.C. 5102(b), 5103(a))

§3.2600 Review of benefit claims decisions.

(a) A claimant who has filed a timely Notice of Disagreement with a decision of an agency of original jurisdiction on a benefit claim has a right to a review of that decision under this section. The review will be conducted by an Adjudication Officer, Veterans Service Center Manager, or

Decision Review Officer, at VA's discretion. An individual who did not participate in the decision being reviewed will conduct this review. Only a decision that has not yet become final (by appellate decision or failure to timely appeal) may be reviewed. Review under this section will encompass only decisions with which the claimant has expressed disagreement in the Notice of Disagreement. The reviewer will consider all evidence of record and applicable law, and will give no deference to the decision being reviewed.

(b) Unless the claimant has requested review under this section with his or her Notice of Disagreement, VA will, upon receipt of the Notice of Disagreement, notify the claimant in writing of his or her right to a review under this section. To obtain such a review, the claimant must request it not later than 60 days after the date VA mails the notice. This 60-day time limit may not be extended. If the claimant fails to request review under this section not later than 60 days after the date VA mails the notice, VA will proceed with the traditional appellate process by issuing a Statement of the Case. A claimant may not have more than one review under this section of the same decision.

(c) The reviewer may conduct whatever development he or she considers necessary to resolve any disagreements in the Notice of Disagreement, consistent with applicable law. This may include an attempt to obtain additional evidence or the holding of an informal conference with the claimant. Upon the request of the claimant, the reviewer will conduct a hearing under §3.103(c).

(d) The reviewer may grant a benefit sought in the claim notwithstanding §3.105(b), but, except as provided in paragraph (e) of this section, may not revise the decision in a manner that is less advantageous to the claimant than the decision under review. A review decision made under this section will include a summary of the evidence, a citation to pertinent laws, a discussion of how those laws affect the decision, and a summary of the reasons for the decision.

(e) Notwithstanding any other provisions of this section, the reviewer may reverse or revise (even if disadvantageous to the claimant) prior decisions of an agency of original jurisdiction (including the decision being reviewed or any prior decision that has become final due to failure to timely appeal) on the grounds of clear and unmistakable error (see §3.105(a)).

(f) Review under this section does not limit the appeal rights of a claimant. Unless a claimant withdraws his or her Notice of Disagreement as a result of this review process, VA will proceed with the traditional appellate process by issuing a Statement of the Case.

(g) This section applies to all claims in which a Notice of Disagreement is filed on or after June 1, 2001. (Authority: 38 U.S.C. 5109A and 7105(d))

§3.326 (New) Examinations.

For purposes of this section, the term examination includes periods of hospital observation when required by VA.

(a) Where there is a claim for disability compensation or pension but medical evidence accompanying the claim is not adequate for rating purposes, a Department of Veterans Affairs examination will be authorized. This paragraph applies to original and reopened claims as well as claims for increase submitted by a veteran, surviving spouse, parent, or child. Individuals for whom an examination has been scheduled are required to report for the examination.

(b) Provided that it is otherwise adequate for rating purposes, any hospital report, or any examination report, from any government or private institution may be accepted for rating a claim without further examination. However, monetary benefits to a former prisoner of war will not be denied unless the claimant has been offered a complete physical examination conducted at a Department of Veterans Affairs hospital or outpatient clinic.

(c) Provided that it is otherwise adequate for rating purposes, a statement from a private physician may be accepted for rating a claim without further examination. (Authority: 38 U.S.C. 5107(a))

§3.327 Reexaminations.

(a) General. Reexaminations, including periods of hospital observation, will be requested whenever VA determines there is a need to verify either the continued existence or the current severity of a disability. Generally, reexaminations will be required if it is likely that a disability has improved, or if evidence indicates there has been a material change in a disability or that the current rating may be incorrect. Individuals for whom reexaminations have been authorized and scheduled are required to report for such reexaminations. Paragraphs (b) and (c) of this section provide general guidelines for requesting reexaminations, but shall not be construed as limiting VA's authority to request reexaminations, or periods of hospital observation, at any time in order to ensure that a disability is accurately rated. (Authority: 38 U.S.C. 501(a))

(b) Compensation cases:

(1) Scheduling reexaminations. Assignment of a prestabilization rating requires reexamination within the second 6 months period following separation from service. Following initial Department of Veterans Affairs examination, or any scheduled future or other examination, reexamination, if in order, will be scheduled within not less than 2 years nor more than 5 years within the judgment of the rating board, unless another time period is elsewhere specified.

(2) No periodic future examinations will be requested. In service-connected cases, no periodic reexamination will be scheduled:

(i) When the disability is established as static;

(ii) When the findings and symptoms are shown by examinations scheduled in paragraph (b)(2)(i) of this section or other examinations and hospital reports to have persisted without material improvement for a period of 5 years or more;

(iii) Where the disability from disease is permanent in character and of such nature that there is no likelihood of improvement;

(iv) In cases of veterans over 55 years of age, except under unusual circumstances;

(v) When the rating is a prescribed scheduled minimum rating; or

(vi) Where a combined disability evaluation would not be affected if the future examination should result in reduced evaluation for one or more conditions.

(c) Pension cases. In nonservice-connected cases in which the permanent total disability has been confirmed by reexamination or by the history of the case, or with obviously static disabilities, further reexaminations will not generally be requested. In other cases further examination will not be requested routinely and will be accomplished only if considered necessary based upon the particular facts of the individual case. In the cases of veterans over 55 years of age, reexamination will be requested only under unusual circumstances.

§3.400 General.

Except as otherwise provided, the effective date of an evaluation and award of pension, compensation or dependency and indemnity compensation based on an original claim, a claim reopened after final disallowance, or a claim for increase will be the date of receipt of the claim or the date entitlement arose, whichever is the later. (Authority: 38 U.S.C. 5110(a))

(2) Disability compensation:

(i) Direct service connection (§3.4(b)). Day following separation from active service or date entitlement arose if claim is received within 1 year after separation from service; otherwise, date of receipt of claim, or date entitlement arose, whichever is later. Separation from service means separation under conditions other than dishonorable from continuous active service which extended from the date the disability was incurred or aggravated.

(o) Increases (38 U.S.C. 5110(a) and 5110(b)(2), Pub. L. 94-71, 89 Stat. 395; §§3.109, 3.156, 3.157):

(1) General. Except as provided in paragraph (o)(2) of this section and §3.401(b), date of receipt of claim or date entitlement arose, whichever is later. A retroactive increase or additional benefit will not be awarded after basic entitlement has been terminated, such as by severance of service connection.

(2) Disability compensation. Earliest date as of which it is factually ascertainable that an increase in disability had occurred if claim is received within 1 year from such date otherwise, date of receipt of claim.

§4.1 Essentials of evaluative rating

This rating schedule is primarily a guide in the evaluation of disability resulting from all types of diseases and injuries encountered as a result of or incident to military service. The percentage ratings represent as far as can practicably be determined the average impairment in earning capacity resulting from such diseases and injuries and their residual conditions in civil occupations. Generally, the degrees of disability specified are considered adequate to compensate for considerable loss of working time from exacerbations or illnesses proportionate to the severity of the several grades of disability. For the application of this schedule, accurate and fully descriptive medical examinations are required, with emphasis upon the limitation of activity imposed by the disabling condition. Over a period of many years, a veteran's disability claim may require reratings in accordance with changes in laws, medical knowledge and his or her physical or mental condition. It is thus essential, both in the examination and in the evaluation of disability, that each disability be viewed in relation to its history.

§4.2 Interpretation of examination reports

Different examiners, at different times, will not describe the same disability in the same language. Features of the disability which must have persisted unchanged may be overlooked or a change for the better or worse may not be accurately appreciated or described. It is the responsibility of the rating specialist to interpret reports of examination in the light of the whole recorded history, reconciling the various reports into a consistent picture so that the current rating may accurately reflect the elements of disability present. Each disability must be considered from the point of view of the veteran working or seeking work. If a diagnosis is not supported by the findings on the examination report or if the report does not contain sufficient detail, it is incumbent upon the rating board to return the report as inadequate for evaluation purposes.

§4.3 Resolution of reasonable doubt

It is the defined and consistently applied policy of the Department of Veterans Affairs to administer the law under a broad interpretation, consistent, however, with the facts shown in every case. When after careful consideration of all procurable and assembled data, a reasonable doubt arises regarding the degree of disability such doubt will be resolved in favor of the claimant. See §3.102 of this chapter.

§4.6 Evaluation of evidence

The element of the weight to be accorded the character of the veteran's service is but one factor entering into the considerations of the rating boards in arriving at determinations of the evaluation of disability. Every element in any way affecting the probative value to be assigned to the evidence in each individual claim must be thoroughly and conscientiously studied by each member of the rating board in the light of the established policies of the Department of Veterans Affairs to the end that decisions will be equitable and just as contemplated by the requirements of the law.

§4.7 Higher of two evaluations.

Where there is a question as to which of two evaluations shall be applied, the higher evaluation will be assigned if the disability picture more nearly approximates the criteria required for that rating. Otherwise, the lower rating will be assigned.

§4.10 Functional impairment

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. Whether the upper or lower extremities, the back or abdominal wall, the eyes or ears, or the cardiovascular, digestive, or other system, or psyche are affected, evaluations are based upon lack of usefulness, of these parts or systems, especially in self-support. This imposes upon the medical examiner the responsibility of furnishing, in addition to the etiological, anatomical, pathological, laboratory and prognostic data required for ordinary medical classification, full description of the effects of disability upon the person's ordinary activity. In this connection, it will be remembered that a person may be too disabled to engage in employment although he or she is up and about and fairly comfortable at home or upon limited activity.

§4.40 Function loss

Disability of the musculoskeletal system is primarily the inability, due to damage or infection in parts of the system, to perform the normal working movements of the body with normal

excursion, strength, speed, coordination and endurance. It is essential that the examination on which ratings are based adequately portray the anatomical damage, and the functional loss, with respect to all these elements. The functional loss may be due to absence of part, or all, of the necessary bones, joints and muscles, or associated structures, or to deformity, adhesions, defective innervation, or other pathology, or it may be due to pain, supported by adequate pathology and evidenced by the visible behavior of the claimant undertaking the motion. Weakness is as important as limitation of motion, and a part which becomes painful on use must be regarded as seriously disabled. A little used part of the musculoskeletal system may be expected to show evidence of disuse, either through atrophy, the condition of the skin, absence of normal callosity or the like.

§4.45 The joins

As regards the joints the factors of disability reside in reductions of their normal excursion of movements in different planes. Inquiry will be directed to these considerations:

(a) Less movement than normal (due to ankylosis, limitation or blocking, adhesions, tendon-tie-up, contracted scars, etc.).

(b) More movement than normal (from flail joint, resections, nonunion of fracture, relaxation of ligaments, etc.).

(c) Weakened movement (due to muscle injury, disease or injury of peripheral nerves, divided or lengthened tendons, etc.).

(d) Excess fatigability.

(e) Incoordination, impaired ability to execute skilled movements smoothly.

(f) Pain on movement, swelling, deformity or atrophy of disuse. Instability of station, disturbance of locomotion, interference with sitting, standing and weight-bearing are related considerations. For the purpose of rating disability from arthritis, the shoulder, elbow, wrist, hip, knee, and ankle are considered major joints; multiple involvements of the interphalangeal, metacarpal and carpal joints of the upper extremities, the interphalangeal, metatarsal and tarsal joints of the lower extremities, the cervical vertebrae, the dorsal vertebrae, and the lumbar vertebrae, are considered groups of minor joints, ratable on a parity with major joints. The lumbosacral articulation and both sacroiliac joints are considered to be a group of minor joints, ratable on disturbance of lumbar spine functions.

§4.59 Painful motion

With any form of arthritis, painful motion is an important factor of disability, the facial expression, wincing, etc., on pressure or manipulation, should be carefully noted and definitely related to affected joints. Muscle spasm will greatly assist the identification. Sciatic neuritis is not uncommonly caused by arthritis of the spine. The intent of the schedule is to recognize painful motion with joint or periarticular pathology as productive of disability. It is the intention to recognize actually painful, unstable, or malaligned joints, due to healed injury, as entitled to at least the minimum compensable rating for the joint. Crepitation either in the soft tissues such as the tendons or ligaments, or crepitation within the joint structures should be noted carefully as points of contact which are diseased. Flexion elicits such manifestations. The joints involved should be tested for pain on both active and passive motion, in weight-bearing and nonweight-bearing and, if possible, with the range of the opposite undamaged joint

§4.20 Analogous ratings

When an unlisted condition is encountered it will be permissible to rate under a closely related disease or injury in which not only the functions affected, but the anatomical localization and symptomatology are closely analogous. Conjectural analogies will be avoided, as will the use of analogous ratings for conditions of doubtful diagnosis, or for those not fully supported by clinical and laboratory findings. Nor will ratings assigned to organic diseases and injuries be assigned by analogy to conditions of functional origin.

§4.71a (5260) Schedule of ratings-musculoskeletal system

5260 Leg, limitation of flexion of:

Flexion limited to 15° 30
Flexion limited to 30° 20
Flexion limited to 45° 10
Flexion limited to 60° 0

§4.71a (5003) Schedule of ratings-musculoskeletal system

5003 Arthritis, degenerative (hypertrophic or osteoarthritis):

Degenerative arthritis established by X-ray findings will be rated on the basis of limitation of motion under the appropriate diagnostic codes for the specific joint or joints involved (DC 5200 etc.). When however, the limitation of motion of the specific joint or joints involved is noncompensable under the appropriate diagnostic codes, a rating of 10 pct is for application for each such major joint or group of minor joints affected by limitation of motion, to be combined,

not added under diagnostic code 5003. Limitation of motion must be objectively confirmed by findings such as swelling, muscle spasm, or satisfactory evidence of painful motion. In the absence of limitation of motion, rate as below:

With X-ray evidence of involvement of 2 or more major joints
or 2 or more minor joint groups, with occasional incapacitating exacerbations 20
With X-ray evidence of involvement of 2 or more major joints
or 2 or more minor joint groups 10

Note (1): The 20 pct and 10 pct ratings based on X-ray findings, above, will not be combined with ratings based on limitation of motion.

Note(2): The 20 pct and 10 pct ratings based on X-ray findings, above, will not be utilized in rating conditions listed under diagnostic code 5013 to 5024, inclusive.

§4.97 (6847) Schedule of ratings-respiratory system

6847 Sleep Apnea Syndromes (Obstructive, Central, Mixed)

Chronic respiratory failure with carbon dioxide
retention or cor pulmonale, or; requires tracheostomy 100

Requires use of breathing assistance device
such as continuous airway pressure (CPAP) machine 50

Persistent day-time hypersomnolence30

Asymptomatic but with documented sleep disorder breathing 0

§19.32 Closing of appeal for failure to respond to Statement of the Case.

The agency of original jurisdiction may close the appeal without notice to an appellant or his or her representative for failure to respond to a Statement of the Case within the period allowed. However, if a Substantive Appeal is subsequently received within the 1-year appeal period (60-day appeal period for simultaneously contested claims), the appeal will be considered to be reactivated. (Authority: 38 U.S.C. 7105(d)(3))

§20.1100 Rule 1100. Finality of decisions of the Board.

(a) General. All decisions of the Board are by majority decision and will be stamped with the date of mailing on the face of the decision. Unless the Chairman of the Board orders reconsideration, and with the exception of matters listed in paragraph (b) of this section, all Board decisions are final on the date stamped on the face of the decision. With the exception of matters listed in paragraph (b) of this section, the decision rendered by the reconsideration Section in an appeal in which the Chairman has ordered reconsideration is final.

(b) Exceptions. Final Board decisions are not subject to review except as provided in 38 U.S.C. 1975 and 1984 and 38 U.S.C. chapters 37 and 72. A remand is in the nature of a preliminary order and does not constitute a final decision of the Board. (Authority: 38 U.S.C. 511(a), 7103, 7104(a))

§20.1104 Rule 1104 Finality of determinations of the agency of original jurisdiction affirmed on appeal.

When a determination of the agency of original jurisdiction is affirmed by the Board of Veterans' Appeals, such determination is subsumed by the final appellate decision. (Authority: 38 U.S.C. 7104(a))

§20.204 Rule 204. (03/03) Withdrawal of Appeal.

(a) When and by whom filed. Only an appellant, or an appellant's authorized representative, may withdraw an appeal. An appeal may be withdrawn as to any or all issues involved in the appeal.

(b) Filing.

(1) Form and content. Except for appeals withdrawn on the record at a hearing, appeal withdrawals must be in writing. They must include the name of the veteran, the name of the claimant or appellant if other than the veteran (e.g., a veteran's survivor, a guardian, or a fiduciary appointed to receive VA benefits on an individual's behalf), the applicable Department of Veterans Affairs file number, and a statement that the appeal is withdrawn. If the appeal involves multiple issues, the withdrawal must specify that the appeal is withdrawn in its entirety, or list the issue(s) withdrawn from the appeal.

(2) Where to file. Appeal withdrawals should be filed with the agency of original jurisdiction until the appellant or representative filing the withdrawal receives notice that the appeal has been transferred to the Board. Thereafter, file the withdrawal at the following address: Director, Management and Administration (014), Board of Veterans' Appeals, 810 Vermont Avenue, NW., Washington, DC 20420.

(3) When effective. Until the appeal is transferred to the Board, an appeal withdrawal is effective when received by the agency of original jurisdiction. Thereafter, it is not effective until received by the Board. A withdrawal received by the Board after the Board issues a final decision under Rule 1100(a) (§20.1100(a) of this part) will not be effective.

(c) Effect of filing. Withdrawal of an appeal will be deemed a withdrawal of the Notice of Disagreement and, if filed, the Substantive Appeal, as to all issues to which the withdrawal applies. Withdrawal does not preclude filing a new Notice of Disagreement and, after a Statement of the Case is issued, a new Substantive Appeal, as to any issue withdrawn, provided such filings would be timely under these rules if the appeal withdrawn had never been filed. (Authority: 38 U.S.C. 7105(b) and (d))

§20.302 Rule 302. (07/08) Time limit for filing...

(a) Notice of Disagreement. Except in the case of simultaneously contested claims, a claimant,or his or her representative, must file a Notice of Disagreement with a determination by the agency of original jurisdiction within one year from the date that that agency mails notice of the determination to him or her. Otherwise, that determination will become final. The date of mailing the letter of notification of the determination will be presumed to be the same as the date of that letter for purposes of determining whether an appeal has been timely filed. (Authority: 38 U.S.C. 7105(b)(1))

(b) Substantive Appeal.

(1) General. Except in the case of simultaneously contested claims, a Substantive Appeal must be filed within 60 days from the date that the agency of original jurisdiction mails the Statement of the Case to the appellant, or within the remainder of the 1-year period from the date of mailing of the notification of the determination being appealed, whichever period ends later. The date of mailing of the Statement of the Case will be presumed to be the same as the date of the Statement of the Case and the date of mailing the letter of notification of the determination will be presumed to be the same as the date of that letter for purposes of determining whether an appeal has been timely filed.

(2) Special rule in certain cases where additional evidence is submitted. Except in the case of simultaneously contested claims, if (i) a claimant submits additional evidence within 1 year of the date of mailing of the notification of the determination being appealed, and (ii) that evidence requires, in accordance with §19.31 of this title, that the claimant be furnished a Supplemental Statement of the Case, then the time to submit a Substantive Appeal shall end not sooner than 60 days after such Supplemental Statement of the Case is mailed to the appellant, even if the 60-day

period extends beyond the expiration of the 1-year appeal period. (Authority: 38 U.S.C. 7105 (b)(1), (d)(3).)

(c) Response to Supplemental Statement of the Case. Where a Supplemental Statement of the Case is furnished, a period of 30 days from the date of mailing of the Supplemental Statement of the Case will be allowed for response. The date of mailing of the Supplemental Statement of the Case will be presumed to be the same as the date of the Supplemental Statement of the Case for purposes of determining whether a response has been timely filed. Provided a Substantive Appeal has been timely filed in accordance with paragraph (b) of this section, the response to a Supplemental Statement of the Case is optional and is not required for the perfection of an appeal. (Authority: 38 U.S.C. 7105(d)(3))

§20.305 Rule 305. Computation of time limit for filing.

(a) Acceptance of postmark date. When these Rules require that any written document be filed within a specified period of time, a response postmarked prior to expiration of the applicable time limit will be accepted as having been timely filed. In the event that the postmark is not of record, the postmark date will be presumed to be five days prior to the date of receipt of the document by the Department of Veterans Affairs. In calculating this 5-day period, Saturdays, Sundays and legal holidays will be excluded.

(b) Computation of time limit. In computing the time limit for filing a written document, the first day of the specified period will be excluded and the last day included. Where the time limit would expire on a Saturday, Sunday, or legal holiday, the next succeeding workday will be included in the computation. (Authority: 38 U.S.C. 7105)

38 USC Section 5107 (03/02) Claimant responsibility; benefit of the doubt

(a) CLAIMANT RESPONSIBILITY- Except as otherwise provided by law, a claimant has the responsibility to present and support a claim for benefits under laws administered by the Secretary.

(b) BENEFIT OF THE DOUBT- The Secretary shall consider all information and lay and medical evidence of record in a case before the Secretary with respect to benefits under laws administered by the Secretary. When there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter, the Secretary shall give the benefit of the doubt to the claimant.

VA, in determining all claims for benefits that have been reasonably raised by the filings and evidence, has applied the benefit-of-the-doubt and liberally and sympathetically reviewed all submissions in writing from the Veteran as well as all evidence of record.

DECISION:

1. Entitlement to an earlier effective date for sleep apnea is denied.
2. Entitlement to an evaluation in excess of 10 percent for left knee anterior cruciate ligament rupture with tearing of the medial meniscus with osteoarthritis is denied.
3. Entitlement to an evaluation in excess of 10 percent for complex tear of the right knee medial and lateral meniscus, popliteal cyst, and osteoarthritis is denied.

REASONS AND BASES:

1. Entitlement to an earlier effective date for sleep apnea.

Rating decision dated November 5, 2018, granted entitlement to sleep apnea effective December 29, 2017, the date we received your intent to file. You were previously denied service connection for this condition in rating decision dated September 2, 2008. That decision was final from one year after date of notification.

As we received your request to reconsider this issue more than one year following the date of notification, we cannot go earlier than the date of intent to file. The issue is considered final, and no continuous prosecution was present. Although you reported misunderstanding the appeals process and time lines, this is not a valid reason to grant entitlement to an earlier date.

Since our last review, we have not received any etiological evidence showing an earlier effective date is warranted. As such, your request is denied.

2. Entitlement to an evaluation in excess of 10 percent for left knee anterior cruciate ligament rupture with tearing of the medial meniscus with osteoarthritis.

Rating decision dated November 5, 2018, continued a 10 percent evaluation for your left knee. Please note: on your Notice of Disagreement, you requested a separate evaluation for instability of the knee. This issue was addressed on rating decision dated April 9, 2020. You also requested a separate evaluation of patellofemoral syndrome. This issue was not previously addressed, and there is no evidence of a current diagnosis of PFS. Additionally, this diagnosis alone would not be subject to a separate rating, as objective range of motion and stability testing are also used in the

evaluation for this condition. If you would like to file a separate claim for consideration for this condition, please submit a formal application.

Rating dated November 2018, assigned a 10 percent evaluation based on:

• Painful motion of the knee (38 CFR §4.59 allows consideration of functional loss due to painful motion to be rated to at least the minimum compensable rating for a particular joint. Since you demonstrate painful motion of the knee, the minimum compensable evaluation of 10 percent is assigned)

Additional symptom(s) include: • X-ray evidence of degenerative arthritis

The provisions of 38 CFR §4.40 and §4.45 concerning functional loss due to pain, fatigue, weakness, or lack of endurance, incoordination, and flare-ups, as cited in DeLuca v. Brown and Mitchell v. Shinseki, have been considered and applied under 38 CFR §4.59.

A higher evaluation of 20 percent evaluation is not warranted unless x-ray evidence shows arthritis with involvement of two or more major joints or two or more minor joint groups with occasional incapacitating exacerbations; or, recurrent subluxation or lateral instability of the knee that is moderate; or, flexion limited to 30 degrees; or, extension limited to 15 degrees; or, for dislocated semilunar cartilage with frequent episodes of "locking," pain, and effusion into the joint.

Although we received additional medical reports from Dr. Nash and your physical therapist, there is no evidence showing a higher evaluation based on range of motion testing is warranted. As we have received not etiological evidence showing an increased evaluation is warranted, your 10 percent evaluation is confirmed.

3. Entitlement to an evaluation in excess of 10 percent for complex tear of the right knee medial and lateral meniscus, popliteal cyst, and osteoarthritis.

Rating decision dated November 5, 2018, continued a 10 percent evaluation for your right knee. Please note: on your Notice of Disagreement, you requested a separate evaluation for instability of the knee. This issue was addressed on rating decision dated April 9, 2020. You also requested a separate evaluation of patellofemoral syndrome. This issue was not previously addressed, and there is no evidence of a current diagnosis of PFS. Additionally, this diagnosis alone would not be subject to a separate rating, as objective range of motion and stability testing are also used in the Rating dated November 2018, assigned a 10 percent evaluation based on:

• Painful motion of the knee (38 CFR §4.59 allows consideration of functional loss due to painful motion to be rated to at least the minimum compensable rating for a particular joint. Since you demonstrate painful motion of the knee, the minimum compensable evaluation of 10 percent is assigned)

Additional symptom(s) include: • X-ray evidence of degenerative arthritis

The provisions of 38 CFR §4.40 and §4.45 concerning functional loss due to pain, fatigue, weakness, or lack of endurance, incoordination, and flare-ups, as cited in DeLuca v. Brown and Mitchell v. Shinseki, have been considered and applied under 38 CFR §4.59.

A 20 percent evaluation is not warranted unless x-ray evidence shows arthritis with involvement of two or more major joints or two or more minor joint groups with occasional incapacitating exacerbations; or, recurrent subluxation or lateral instability of the knee that is moderate; or, flexion limited to 30 degrees; or, extension limited to 15 degrees; or, for dislocated semilunar cartilage with frequent episodes of "locking," pain, and effusion into the joint.

Although we received additional medical reports from Dr. Nash and your physical therapist, there is no evidence showing a higher evaluation based on range of motion testing is warranted. As we have received not etiological evidence showing an increased evaluation is warranted, your 10 percent evaluation is confirmed.