FL 1-25
JUL 1992(RS)

U. S. DEPARTMENT OF VETERANS AFFAIRS
Regional Office
11000 Wilshire Boulevard
Los Angeles, CA 90024

MAY 2 6 1994

344

Lemuel C. Bray
P. O. Box 86965
Terminal Annex
Los Angeles, CA 90086

C [redacted]
Bray, Lemuel C.

Dear Mr. Bray:

You have filed what the law calls a "Notice of Disagreement" with our action on your claim, the first step in appealing to the Board of Veterans' Appeals. This letter and enclosures give you very important information. Please read them carefully.

By law we are required to send you the enclosed "Statement of the Case" so that you can make the best possible argument to the Board of Veterans' Appeals as to why you think our ruling should be changed. This is not a decision on your appeal but an explanation of what was done here.

Your argument or "Substantive Appeal" should be set out on the enclosed VA Form 9, Appeal to Board of Veterans' Appeals. If there is anything you do not understand about the instructions on the form, we will gladly explain. The important things are to say, in your own words, what benefit you want, what facts in the statement you disagree with, and any error you believe we made in applying the law.

When the form is returned to us, your case will be sent to the Board of Veterans' Appeals in Washington, D.C., for a decision. The Board of Veterans Appeals will base its decision on an independent review of the entire record.

Before your case is sent to the Board of Veterans' Appeals, you may have a hearing before regional office personnel. To request a hearing before regional office personnel, notify us and we will arrange a time and place for the hearing. VA will furnish the hearing room, provide hearing officials and prepare a transcript of the hearing which will be placed in your claims folder. VA cannot pay any other expenses of a hearing. Regional office personnel will decide, based on the testimony and other evidence, whether your claim is successfully reopened and whether it can be granted.

C[redacted]
Bray, Lemuel

If you have completed your appeal by filing a "Substantive Appeal" and your claim remains denied, the transcript of the hearing would be included in the record sent to the Board of Veterans' Appeals. As noted on the enclosed VA Form 9, you may also request a hearing before the Board of Veterans' Appeals. You are entitled to have a hearing before both regional office personnel and the Board of Veterans' Appeals. DO NOT DELAY FILING YOUR "SUBSTANTIVE APPEAL" IF YOU REQUEST A HEARING BEFORE REGIONAL OFFICE PERSONNEL.

An accredited representative of a recognized service organization may represent you without charge. An agent or attorney, such as a legal aid attorney or one in private practice, may also represent you. VA cannot pay fees of agents or attorneys. After the first final decision of the Board of Veterans' Appeals in your claim, an attorney or accredited agent may charge you a fee under certain circumstances for representing you before the Department of Veterans Affairs, including the Board of Veterans' Appeals, or the United States Court of Veterans' Appeals. For more information refer to 38 U.S.C. 5904. If an attorney or accredited agent represents you before the Department, a copy of any fee agreement between you and the attorney or accredited agent must be filed at the following address: Counsel to the Chairman (1C3), Board of Veterans' Appeals, 810 Vermont Avenue, N.W., Washington, D.C., 20420.

If we do not hear from you in 60 days, we will assume you do not intend to complete your appeal and we will close our record. See Item 3 of the Instructions in VA Form 9, Appeal to Board of Veterans' Appeals, if you require more time. (38 U.S.C. § 7105(d)(3), 7105A(b))

Sincerely,

GERALD T. MANAR
Adjudication Officer

Enclosure: VA Form 9

FL 1-25a,
MAY1990(R)

U. S. Department of Veterans Affairs

VA Regional Office

Los Angeles, CA 90024

Date: MAY 26 1994

Bray, Lemuel C.

[redacted]

STATEMENT OF THE CASE

IN THE APPEAL
OF

Lemuel C. Bray

FROM THE DECISION OF THE
U. S. DEPARTMENT OF VETERANS AFFAIRS

NOTICE TO APPELLANT:

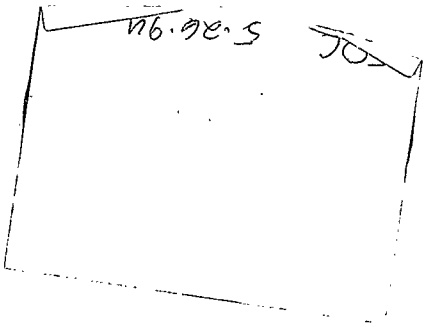
This is not a decision on the appeal you have initiated. It is a "Statement of the Case" which the law requires us to furnish to help you in completing your appeal.

Please read the forwarding letter carefully, as well as the instructions on the enclosed appeal form. These explain your appeal rights and tell you what you must do to complete your appeal.

ISSUE:

1. Entitlement to increased evaluation for mixed organic personality syndrome, currently evaluated at 30 percent disabling.
2. Entitlement to service connection for depression.
3. Entitlement to service connection for seizure condition
4. Entitlement to service connection for cervical and lumbar disc disease.
5. Entitlement to a total rating under the provisions of 38 CFR 4.29 based on hospitalization for a service connected disability.
6. Entitlement to increased evaluation for left wrist condition, currently evaluated at a noncompensable level.

Contentions: The veteran claims depression and seizure conditions secondary to service-connected facial fractures or mixed organic personality syndrome. He further claims service connection for cervical and lumbar disc disease secondary to a seizure condition.



BRAY, Lemuel C.
C[redacted]

SUMMARY OF EVIDENCE AND ADJUDICATIVE ACTIONS:

Military Service: February 20, 1964 to July 19, 1974, honorable.

Date of Birth: May 16, 1945.

Post-service Summary:

Service connection was established at noncompensable evaluations for residuals of a fractured left malar and left zygoma and fractured left wrist by original rating decision of February 25, 1976. Rating decision of May 14, 1987 established service connection at a 30 percent evaluation for mixed organic personality syndrome, an evaluation later upheld by the Board of Veterans Appeals on October 17, 1990.

December 10, 1990

Claim for increase was received.

January 22, 1992

A rating board reviewed the evidence, including service medical records for the period of service April 5, 1961 to July 19, 1974, examination results of August 21, 1991 to October 18, 1991 and outpatient treatment records of March 19, 1982 to January 25, 1991 from the Los Angeles VA Outpatient Clinic.

During service, X-rays indicated an old compression fracture of the left wrist and an old depressed fracture to the left inferior orbital rim. Orthopedic examination showed range of motion within normal limits for the left wrist, and muscle strength was 5/5 bilaterally. On neurological examination, the pupils were equal and reactive to light and accomodation. Extra occular movements were intact. There was some decrease of sensation to pinprick on V1, expecially in the area where the veteran had previous surgery on the left side, compared to the right side. V2 and V3 were intact, and the face was symmetrical. The tongue was midline, and positive cornea and gag reflex were noted.

The veteran had present complaints of intermittent episodes of drowsiness, and inability to keep his head up. He said he constantly falls asleep during the day and that episodes range from 2 or 3 times up to 10 times per day. He falls asleep for about five seconds for up to 10 minutes or an hour. He denied any bowel or bladder incontinence, subsequent headaches, or anyone seeing him jerking. The veteran reported his left leg jerked for several minutes during one episode, during which he was awake. The episodes reportedly happen at anytime during the day, morning, or night.

BRAY, Lemuel C.
C[redacted]

Although he had been having hearing problems for several years, he denied any episodes of double vision, blurred vision, slurred speech, problems with breathing or snoring, difficulty swollowing or smelling, weakness on the right or left side, numbness or tingling sensation on any of the extremities, sleep paralysis, sleep attacks, cataplexy, or any hynagogic hallucinations. He said that, in a few episodes, he had lost balance and fell with no loss of consciousness. He stated that he never loses consciousness and that he does not have any tongue biting, blood in his mouth, or any aching all over. Mr. Bray started using chlorohydrate, after which the episodes improved, and there were no other complaints.

The veteran admitted to having several car accidents due to these episodes of falling asleep and inability to perform driving. On neurological examination, the gait was adequate for heel, toe, and tandem walking. Romberg was negative, and there was no trunk or limb ataxia. Cranial nerves 1 through 12 were intact and visual fields were intact. Motor examination was 5/5 on the upper extremity with good bulk and good tone. There was no fasciculation or involuntary movements. Cerebellar function was good for rapid alternating movements. There was no ataxia and no past-pointing. Reflexes were slightly increased but symmetrical, with no Babinski.

The electrocardiogram in September 1990 was within normal limits. A Holter monitor on October 26, 1990 showed predominant occasional premature ventricular contractions, and in June 1990, an abnormal electroencephalogram showed lateralized theta burst on post-hyperventilation phase and lateralization to the left midtemporal area. Beta activities were seen and continued. No spike or sharp waves were noted. In March 1986, the electroencephalogram was within normal limits, and the examiner's impression was primary excessive drowsiness. These episodes happen when the veteran is doing some skillful tasks or accounting, and will last when he is doing something relaxing. The episodes did not appear to be organic in nature: they appeared to be more functional since they could happen while performing skilled tasks. If the episodes involved a sleep disorder, then they would happen anytime during the day, regardless of activity. Nor were the episodes likely to be seizures.

On mental status examination, Mr. Bray was alert, friendly, oriented and cooperative, appearing to be above average in intelligence. His memory appeared to be adequate, and he was able to subtract sevens without difficulty. There was no evidence of strangeness in behavior or thought. However, due to his spells, he would not be able to hold employment. The diagnosis was mixed organic personality syndrome due to head trauma. A review of the outpatient treatment reports showed that they were cumulative in nature and reflective of the current examination.

The Rating Board determined that an increased evaluation for the veteran's left facial fracture, and fracture of the left wrist was not in order, as the current examination showed only minimal disability. An increased evaluation for mixed organic personality syndrome was not in order, as the findings on the current examination were similar to findings already of record, and did not objectively demonstrate more than definite social and industrial impairment.

BRAY, Lemuel C.
C[redacted]

February 27, 1992

Request for increase and temporary total evaluation was received, based on hospitalization for seizure condition. The veteran also claimed service connection for herniated lumbar and cervical disks sustained in an automobile accident in September 1990, alleged as a result of a seizure while driving.

July 31, 1992

A rating board reviewed additional evidence, including inpatient treatment records for hospitalization from August 12, 1991 to January 15, 1992, hospital summary of February 18, 1992 to February 24, 1992 and treatment records to April 1, 1992 from the West Los Angeles VA Medical Center.

All neurological tests had failed to reveal a true seizure condition, showing essentially negative findings. The veteran apparently had pseudo-seizures. He had been kicked in the head by a horse at 14 years of age. The veteran had claimed cervical and lumbar disc disease due to an automobile accident in September 1990, which he reported was the result of a seizure while driving. This was not objectively supported by the evidence. The veteran had been seen immediately following the accident, with no complaints or findings for spinal problems. An admission of August 12, 1991 to January 15, 1992 involved a work-up regarding seizures and related depression, for which the veteran was put on Prozac. There was no evidence of chronic depression, or that the depression was related to the veteran's service-connected conditions. The admission of February 18, 1992 was for similar reasons and included back problems.

The Rating Board determined that service connection was not established for pseudo-seizures, as all tests were normal and a true seizure condition had not been diagnosed. Accordingly, a temporary total evaluation under 38 CFR 4.29 (Paragraph 29 benefits) was not in order, as the veteran had not been hospitalized for a service-connected disability in excess of 21 days. Service connection was denied for cervical and lumbar disc disease as not shown due to a service-connected condition by the evidence of record. Nor was a depressive neurosis due to a service-connected condition shown.

August 31, 1992

Date of Hearing Officer's decision. The Hearing Officer considered personal hearing testimony from June 11, 1992, hospital reports of August 12, 1991 to January 15, 1992 and February 18, 1992 to February 24, 1992 and outpatient treatment report of April 1, 1992 from the West Los Angeles VA Medical Center.

The veteran testified that his left thumb was fixed with a metal insert and had been so since 1969. He had very slight motion of the thumb and claimed an error was made in not recognizing this fact by the original rating decision which had granted service connection. The veteran is naturally right-handed. He stated that he also has tendonitis and uses a splint. The condition reportedly does not bother him too much.

The Hearing Officer deferred on a decision pending the receipt of a hospital report from the West Los Angeles VA Medical Center, which was pending at the time of the hearing. That report, from August 12, 1991 to January 15, 1992 had now been made available for review. The Hearing Officer also noted that there was a hospital report from the West Los Angeles VA Medical Center of February 18, 1992 to February 24, 1992, and an outpatient report of April 1, 1992 of record at the time of the hearing. None of these records showed treatment for the veteran's service-connected left wrist condition. There were no significant findings concerning the wrist.

The veteran's testimony, as well as arguments from his representative, were considered along with a review of the documentary evidence of record. It was determined that an increased rating for the veteran's service-connected left wrist condition remained denied. Objective medical findings failed to meet the criteria for a compensable evaluation. As a result, the decision that was on appeal was upheld.

March 8, 1993

Notice of disagreement was received, regarding evaluation of traumatic brain disease based on depression and the denial of service connection for depression, a seizure condition and secondary spinal condition. The veteran also disagreed with the denial of a temporary total evaluation based on hospitalization from August 1991 to January 1992.

October 26, 1993 to November 16, 1993

Dates of various documents received by certified mail. The various documents appear to present some form of civil complaint by the veteran against the Secretary of the Department of Veterans Affairs before the United Stated District Court, 9th Circuit Appeals Court, and Supreme Court. The specific cause of action and the substantive reason for the submission of the documents to the Regional Office is unclear.

BRAY, Lemuel C.
C[redacted]

PERTINENT LAWS, REGULATIONS, RATING SCHEDULE PROVISIONS:

38 U.S.C. 5107(a)(b)

(a) Except when otherwise provided by the Secretary in accordance with the provisions of this title, a person who submits a claim for benefits under a law administered by the Secretary shall have the burden of submitting evidence sufficient to justify a belief by a fair and impartial individual that the claim is well grounded. The Secretary shall assist such a claimant in developing the facts pertinent to the claim. Such assistance shall include requesting information as described in section 5106 of this title.

(b) When, after consideration of all evidence and material of record in a case before the department with respect to benefits under laws administered by the Secretary, there is an approximate balance of positive and negative evidence regarding the merits of an issue material to the determination of the matter, the benefit of the doubt in resolving each issue shall be given to the claimant. Nothing in this subsection shall be construed as shifting from the claimant to the Secretary the burden specified in subsection (a) of this section.

38 U.S.C. 1110. Basic Entitlement

For disability resulting from personal injury suffered or disease contracted in line of duty, or for aggravation of a preexisting injury suffered or disease contracted in line of duty, in the active military, naval, or air service, during a period of war, the United States will pay to any veteran thus disabled and who was discharged or released under conditions other than dishonorable from the period of service in which said injury or disease was incurred, or preexisting injury or disease was aggravated, compensation as provided in this subchapter, but no compensation shall be paid if the disability is a result of the person's own willful misconduct or abuse of alcohol or drugs.

38 U.S.C. 1155. Authority for schedule for rating disabilities.

The Secretary shall adopt and apply a schedule of ratings of reductions in earning capacity from specific injuries or combination of injuries. The ratings shall be based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations. The schedule shall be constructed so as to provide ten grades of disability and no more, upon which payments of compensation shall be based, namely, 10 percent, 20 percent, 30 percent, 40 percent, 50 percent, 60 percent, 70 percent, 80 percent, 90 percent, and total, 100 percent. The Secretary shall from time to time readjust this schedule of ratings in accordance with experience. However, in no event shall such a readjustment in the rating schedule cause a veteran's disability rating in effect on the effective date of the readjustment to be reduced unless an improvement in the veteran's disability is shown to have occurred.

BRAY, Lemuel C.
C[redacted]

38 CFR 3.303 Principles relating to service connection.

(a) General. Service connection connotes many factors but basically it means that the facts, shown by evidence, establish that a particular injury or disease resulting in disability was incurred coincident with service in the Armed Forces, or if preexisting such service, was aggravated therein. This may be accomplished by affirmatively showing inception or aggravation during service or through the application of statutory presumptions. Each disabling condition shown by a veteran's service records, or for which he seeks a service connection must be considered on the basis of the places, types and circumstances of his service as shown by service records, the official history of each organization in which he served, his medical records and all pertinent medical and lay evidence. Determinations as to service connection will be based on review of the entire evidence of record, with due consideration to the policy of the Department of Veterans Affairs to administer the law under a broad and liberal interpretation consistent with the facts in each individual case.

(b) Chronicity and continuity. With chronic disease shown as such in service (or within the presumptive period under Sec. 3.307) so as to permit a finding of service connection, subsequent manifestations of the same chronic disease at any later date, however remote, are service connected, unless clearly attributable to intercurrent causes. This rule does not mean that any manifestation of joint pain, any abnormality of heart action or heart sounds, any urinary findings of casts, or any cough, in service will permit service connection of arthritis, disease of the heart, nephritis, or pulmonary disease, first shown as a clearcut clinical entity, at some later date. For the showing of chronic disease in service there is required a combination of manifestations sufficient to identify the disease entity, and sufficient observation to establish chronicity at the time, as distinguished from merely isolated findings or a diagnosis including the word, Chronic. When the disease identity is established (leprosy, tuberculosis, multiple sclerosis, etc.), there is no requirement of evidentiary showing of continuity. Continuity of symptomatology is required only where the condition noted during service (or in the presumptive period) is not, in fact, shown to be chronic or where the diagnosis of chronicity may be legitimately questioned. When the fact of chronicity in service is not adequately supported, then a showing of continuity after discharge is required to support the claim.

(c) Preservice disabilities noted in service. There are medical principles so universally recognized as to constitute fact (clear and unmistakable proof), and when in accordance with these principles existence of a disability prior to service is established, no additional or confirmatory evidence is necessary. Consequently with notation or discovery during service of such residual conditions (scars; fibrosis of the lungs; atrophies following disease of the central or peripheral nervous system; healed fractures; absent, displaced or resected parts of organs; supernumerary parts; congenital malformations or hemorrhoidal tags or tabs, etc.) with no evidence of the pertinent antecedent active disease or injury during service the conclusion must be that they preexisted service. Similarly, a manifestation of lesions or symptoms of chronic disease from date of enlistment, or so close thereto that the disease could not have originated in so short a period will establish preservice existence thereof.

BRAY, Lemuel C.
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Conditions of an infectious nature are to be considered with regard to the circumstances of the infection and if manifested in less than the respective incubation periods after reporting for duty, they will be held to have preexisted service. In the field of mental disorders, personality disorders which are characterized by developmental defects or pathological trends in the personality structure manifested by a lifelong pattern of action or behavior, chronic psychoneurosis of long duration or other psychiatric symptomatology shown to have existed prior to service with the same manifestations during service, which were the basis of the service diagnosis, will be accepted as showing preservice origin. Congenital or developmental defects, refractive error of the eye, personality disorders and mental deficiency as such are not diseases or injuries within the meaning of applicable legislation.

(d) Postservice initial diagnosis of disease. Service connection may be granted for any disease diagnosed after discharge, when all the evidence, including that pertinent to service, establishes that the disease was incurred in service. Presumptive periods are not intended to limit service connection to diseases so diagnosed when the evidence warrants direct service connection. The presumptive provisions of the statute and Department of Veterans Affairs regulations implementing them are intended as liberalizations applicable when the evidence would not warrant service connection without their aid.

38 CFR 3.309 Disease subject to presumptive service connection.

(a) Chronic diseases. The following diseases shall be granted service connection although not otherwise established as incurred in service if manifested to a compensable degree within the applicable time limits under Sec 3.307 following service in a period of war or following peacetime service on or after January 1, 1947, provided the rebuttable presumption provisions of Sec. 3.307 are also satisfied.

Anemia, primary.
Arteriosclerosis.
Arthritis.
Atrophy, Progressive muscular.
Brain hemorrhage.
Brain thrombosis.
Bronchiectasis.
Calculi of the kidney, bladder, or gallbladder.
Cardiovascular-renal disease, including hypertension. (This term applies to combination involvement of the type of arteriosclerosis, nephritis, and organic heart disease, and since hypertension is an early symptom long preceding the development of those diseases in their more obvious forms, a disabling hypertension within the 1-year period will be given the same benefit of service connection as any of the chronic diseases listed.)
Cirrhosis of the liver.
Coccidioidomycosis.
Diabetes mellitus.

BRAY, Lemuel C.
C[redacted]

Encephalitis lethargica residuals.
Endocarditis. (This term covers all forms of valvular heart disease.)
Endocrinopathies.
Epilepsies.
Hansen's disease.
Hodgkin's disease.
Leukemia.
Lupus erythematosus, systemic.
Myasthenia gravis.
Myelitis.
Myocarditis.
Nephritis.
Other organic diseases of the nervous system.
Osteitis deformans (Paget's disease)
Osteomalacia.
Palsy, bulbar.
Paralysis agitans.
Psychoses.
Purpura idiopathic, hemorrhagic.
Raynaud's disease.
Sarcoidosis.
Scleroderma.
Sclerosis, amyotrophic lateral.
Sclerosis, multiple.
Syringomyelia.
Thromboangiitis obliterans (Buerger's disease).
Tuberculosis, active.
Tumors, malignant, or of the brain or spinal cord or peripheral nerves.
Ulcers, peptic (gastric or duodenal) (A proper diagnosis of gastric or duodenal ulcer (peptic ulcer) is to be considered established if it represents a medically sound interpretation of sufficient clinical findings warranting such diagnosis and provides an adequate basis for a differential diagnosis from other conditions with like symptomatology; in short, where the preponderance of evidence indicates gastric or duodenal ulcer (peptic ulcer). Whenever possible, of course, laboratory findings should be used in corroboration of the clinical data.)

38 CFR 3.310(a) Proximate results, secondary conditions.

General. Disability which is proximately due to or the result of a service-connected disease or injury shall be service connected. When service connection is thus established for a secondary condition, the secondary condition shall be considered a part of the original condition.

BRAY, Lemuel C.
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38 CFR 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.

38 CFR 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.

38 CFR 4.29 Ratings for service-connected disabilities requiring hospital treatment or observation.

A total disability rating (100 percent) will be assigned without regard to other provisions of the rating schedule when it is established that a service-connected disability has required hospital treatment in a Department of Veterans Affairs or an approved hospital for a period in excess of 21 days or hospital observation at Department of Veterans Affairs expense for a service-connected disability for a period in excess of 21 days.

(a) Subject to the provisions of paragraphs (d), (e), and (f) of this section this increased rating will be effective the first day of continuous hospitalization and will be terminated effective the last day of the month of hospital discharge (regular discharge or release to non-bed care) or effective the last day of the month of termination of treatment or observation for the service-connected disability. A temporary release which is approved by an attending Department of Veterans Affairs physician as part of the treatment plan will not be considered an absence.

BRAY, Lemuel C.
C[redacted]

(1) An authorized absence in excess of 4 days which begins during the first 21 days of hospitalization will be regarded as the equivalent of hospital discharge effective the first day of such authorized absence. An authorized absence of 4 days or less which results in a total of more than 8 days of authorized absence during the first 21 days of hospitalization will be regarded as the equivalent of hospital discharge effective the ninth day of authorized absence.

(2) Following a period of hospitalization in excess of 21 days, an authorized absence in excess of 14 days or a third consecutive authorized absence of 14 days will be regarded as the equivalent of hospital discharge and will interrupt hospitalization effective on the last day of the month in which either the authorized absence in excess of 14 days or the third 14 day period begins, except where there is a finding that convalescence is required as provided in paragraph (e) or (f) of this section. The termination of these total ratings will not be subject to Sec. 3.105(e) of this chapter.

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

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

(d) On these total ratings Department of Veterans Affairs regulations governing effective dates for increased benefits will control.

(e) The total hospital rating if convalescence is required may be continued for periods of 1, 2, or 3 months in addition to the period provided in paragraph (a) of this section.

(f) Extension of periods of 1, 2, or 3 months beyond the initial 3 months may be made upon approval of the Adjudication Officer.

(g) Meritorious claims of veterans who are discharged from the hospital with less than the required number of days but need post-hospital care and a prolonged period of convalescence will be referred to the Director, Compensation and Pension Service, under Sec. 3.321(b)(1) of this chapter.

BRAY, Lemuel C.
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38 CFR 4.31 A no-percent ratings.

In every instance where the schedule does not provide a zero percent evaluation for a diagnostic code, a zero percent evaluation shall be assigned when the requirements for a compensable evaluation are not met.

38 CFR 4.40 Functional 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.

38 CFR 4.45 The joints.

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.

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(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.

BRAY, Lemuel C.
[redacted]

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.

38 CFR 4.125 General considerations.

The field of mental disorders represents the greatest possible variety of etiology, chronicity and disabling effects, and requires differential consideration in these respects. These sections under mental disorders are concerned with the rating of psychiatric conditions, specifically psychotic and psychoneurotic disorders and psychological factors affecting physical conditions as well as organic mental disorders. Advances in modern psychiatry during and since World War II have been rapid and profound and have extended to the entire medical profession a better understanding of and deeper insight into the etiological factors, psychodynamics, and psychopathological changes which occur in mental disease and emotional disturbances. The psychiatric nomenclature employed is based upon the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM- III), American Psychiatric Association. This nomenclature has been adopted by the Veterans Health Services and Research Administration of the Department of Veterans Affairs. It limits itself to the classification of disturbances of mental functioning. To comply with the fundamental requirements for rating psychiatric conditions, it is imperative that rating personnel familiarize themselves thoroughly with this manual (American Psychiatric Association Manual, 1980 Edition) which will be hereinafter referred to as the APA manual.

38 CFR 4.130 Evaluation of psychiatric disability.

The severity of disability is based upon actual symptomatology, as it affects social and industrial adaptability. Two of the most important determinants of disability are time lost from gainful work and decrease in work efficiency. The rating board must not underevaluate the emotionally sick veteran with a good work record, nor must it overevaluate his or her condition On the basis of a poor work record not supported by the psychiatric disability picture. It is for this reason that great emphasis is placed upon the full report of the examiner, descriptive of actual symptomatology. The record of the history and complaints is only preliminary to the examination. The objective findings and the examiner's analysis of the symptomatology are the essentials. The examiner's classification of the disease as "mild," "moderate," or "severe" is not determinative of the degree of disability, but the report and the analysis of the symptomatology and the full consideration of the whole history by the rating agency will be. In evaluating disability from psychotic disorders it is necessary to consider, in addition to present symptomatology or its absence, the frequency, severity, and duration of previous psychotic periods, and the veteran's capacity for adjustment during periods of remission.

BRAY, Lemuel C.
C[redacted]

Repeated psychotic periods, without long remissions, may be expected to have a sustained effect upon employability until elapsed time in good remission and with good capacity for adjustment establishes the contrary. Ratings are to be assigned which represent the impairment of social and industrial adaptability based on all of the evidence of record. (See Sec. 4.16 regarding the issue of individual unemployability based on mental disorder.) Evidence of material improvement in psychotic disorders disclosed by field examination or social survey should be utilized in determinations of competency, but the fact will be borne in mind that a person who has regained competency may still be unemployable, depending upon the level of his or her disability as shown by recent examinations and other evidence of record. (Authority: 38 U.S.C. 501(a); 38 U.S.C. 1155)

38 CFR 4.124a; DC 8045 Brain disease due to trauma:

Purely neurological disabilities, such as hemiplegia, epileptiform seizures, facial nerve paralysis, etc., following trauma to the brain, are rated under the diagnostic codes specifically dealing with such disabilities.

Purely subjective complaints such as headaches, dizziness, insomnia, etc., recognized as symptomatic of brain trauma will be rated 10% and no more under diagnostic code 9304. This 10% rating will not be combined with any other rating for a disability due to brain trauma. Ratings in excess of 10% for brain disease due to trauma under DC 9304 are not assignable in the absence of a diagnosis of non-psychotic organic brain syndrome with brain trauma.

38 CFR 4.132 Psychoneurotic disorders.

Note (4). When two diagnoses, one organic and the other psychological or psychoneurotic, are presented covering the organic and psychiatric aspects of a single disability entity, only one percentage evaluation will be assigned under the appropriate diagnostic code determined by the rating board to represent the major degree of disability. When the diagnosis of the same basic disability is changed from an organic one to one in the psychological or psychoneurotic categories, the condition will be rated under the new diagnosis.

38 CFR 4.132; DC 9304 Dementia associated with brain trauma:

Dementia, associated with brain trauma, is rated under the general rating formula for organic mental disorders.

The basic syndrome of organic mental disorder may be the only mental disturbance present or it may appear with related "psychotic" manifestations. An organic mental disorder with or without such qualifying phrase will be rated according to the general rating formula for organic mental disorders, assigning a rating which reflects the entire psychiatric picture. An organic mental disorder, as defined in the American Psychiatric Association manual, is characterized solely by psychiatric manifestations. However, neurological or other manifestations of etiology common to the mental disorder may be present, and if present, are to be rated separately as distinct entities under the neurological or other appropriate system and combined with the rating for the mental disorder.

General Rating Formula for Organic Mental Disorders: Impairment of intellectual functions, orientation, memory and judgment, and lability and shallowness of affect of such extent, severity, depth, and persistence as to produce total social and industrial inadaptability is rated 100%. Less than 100%, in symptom combinations productive of: Severe impairment of socail and industrial adaptability is 70%; considerable impairment of social and industrial adaptability is 50%; definite impairment of social and industrial adaptability is 30%; mild impairment of social and industrial adaptability is 10%; no impairment of social and industrial adaptability is 0%.

38 CFR 4.71a; DC 5215 Wrist, limitation of motion of:

Limitation of motion of wrist with palmar flexion limited in line with forearm or with dorsiflexion less than 15 degrees, is rated 10% (major and minor).

DECISION:

1. Entitlement is not established to an increased evaluation for mixed organized personality syndrome.
2. Service connection is not established for depression.
3. Service connection is not established for a seizure condition.
4. Service connection is not established for cervical and lumbar disc disease.
5. Entitlement to a total rating under the provisions of 38 CFR 4.29 is not established.
6. Entitlement to an increased evaluation for left wrist condition is not established.

REASONS FOR DECISION:

1. In determining evaluations for disability from mental disorders, consideration is given to abnormalities of conduct, judgement and emotional reactions which produce impairment of earning capacity. Social inadaptability is evaluated only as it affects industrial adaptability. An examiner's classification of the disease as mild, moderate or severe, is not determinative of the degree of disability, but such report and analysis of the symptomatology will be given full consideration. The evidence does not show symptomatology characteristic of mixed organic personality syndrome producing considerable social and industrial inadaptability to warrant a 50 percent evaluation.

BRAY, Lemuel C.
C[redacted]

2 and 3. The evidence does not show a diagnosis for a chronic depressive neurosis or a true seizure condition. Since there are no official records of either condition being noted, claimed, treated or diagnosed during service or at time of discharge, and there is no evidence of manifestations of a seizure condition to a compensable degree by approved method during the one-year regulatory period following military discharge, there is no basis for the granting of primary service connection. Nor does the evidence objectively show a probative medical relationship between symptoms for the claimed seizure condition or depressive neurosis and the veteran's service-connected facial fractures or mixed organic personality syndrome. In the absence of such evidence, there is no foundation to grant service connection on a secondary basis.

4. Fundamentally, service connection for a seizure condition must be established in order to consider secondary service connection for cervical and lumbar disc disease, a requisite which has not been met. Further, the evidence does not objectively show cervical and lumbar disc disease incidental to an automobile accident in September 1990, nor does it show that any form of seizure condition caused the accident.

5. The veteran was hospitalized from August 1991 to January 1992 primarily for evaluation of a seizure disorder. A true seizure disorder was not found, and the veteran is not otherwise service-connected for a seizure/pseudo-seizure condition. As the veteran was not hospitalized in excess of 21 days primarily for treatment of a service-connected condition, entitlement to a total evaluation under the provisions of 38 CFR 3.29 is not established.

6. A compensable (10 percent) evaluation for residuals of the veteran's left wrist fracture would minimally require limitation of motion with palmar flexion limited in line with the forearm or dorsiflexion less than 15 degrees. As the objective evidence does not show such functional limitations, entitlement to an increased evaluation is not established.

Page 19.

BRAY, Lemuel C.
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