BOARD OF VETERANS' APPEALS

FOR THE SECRETARY OF VETERANS AFFAIRS

IN THE APPEAL OF [redacted]

Docket No. [redacted] 11-12 911

Represented by
Disabled American Veterans

DATE: April 22, 2021

ORDER

Service connection for transient ischemic attacks (TIA) with seizure-like activity, but no actual seizure disorder, is granted.

An increased rating of 20 percent for low back pain with mild degenerative changes, effective December 29, 2009, is granted.

An increased rating for the low back disability in excess of 10 percent prior to December 29, 2009, in excess of 20 percent effective from December 29, 2009, and in excess of 40 percent since August 21, 2015, is denied.

An increased rating for left lower extremity radiculopathy, rated as 10 percent disabling prior to August 27, 2013, and 20 percent disabling thereafter, is denied.

An increased rating for right lower extremity radiculopathy, rated as 10 percent disabling prior to August 27, 2013, and 20 percent disabling thereafter, is denied.

REMANDED

Service connection for chronic arthritis of the joints (other than the cervical spine and great toes), to include left and right knee arthritis and associated right knee instability, is remanded.

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Service connection for a bilateral great (big) toe disability, to include arthritis, hallux valgus, and hallux rigidus, is remanded.

FINDINGS OF FACT

1. The Veteran has diagnosed transient ischemic attacks (TIA) with seizure-like activity, but no actual seizure disorder, that was caused by his service-connected hypertension, which is in turn associated with his service-connected diabetes.

2. Throughout the appeal period, there has been no ankylosis or neurologic impairment associated with the Veteran's low back disability other than his already service-connected bilateral lower extremity radiculopathy or neuropathy; and he had IVDS, but no incapacitating episodes with prescribed rest and treatment.

3. Prior to December 29, 2009, the Veteran's low back disability manifested by pain and painful motion with limitation of thoracolumbar spine forward flexion to greater than 60 degrees and combined motion to greater than 120 degrees, with no muscle spasm or guarding that resulted in abnormal gait or spinal curvature

4. From December 29, 2009, through August 20, 2015, the Veteran's low back disability manifested by pain and painful motion with limitation of thoracolumbar spine forward flexion to greater than 30 degrees, but not greater than 60 degrees, when considering the effects of flareups and repeated use over time.

5. Since August 21, 2015, the Veteran's low back disability manifested by pain and painful motion, with forward flexion of the thoracolumbar spine to 30 degrees or less, when considering the effects of flareups and repeated use over time.

6. Prior to August 27, 2013, the Veteran's bilateral lower extremity radiculopathies manifested by no more than mild incomplete paralysis of the sciatic nerve.

7. Since August 27, 2013, the Veteran's bilateral lower extremity radiculopathies have manifested by no more than moderate incomplete paralysis of the sciatic nerve.

CONCLUSIONS OF LAW

1. The criteria for service connection for transient ischemic attacks (TIA) with seizure-like activity, but no actual seizure disorder, are met. 38 U.S.C. §§ 1110, 1131, 5107; 38 C.F.R. §§ 3.102, 3.310.

2. The criteria for an increased rating for low back pain with mild degenerative changes of 20 percent, effective December 29, 2009, are met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 3.400, 4.1, 4.3, 4.7, 4.10, 4.40, 4.45, 4.59, 4.71a, Diagnostic Codes 5237, 5242, & 5243.

3. The criteria for an increased rating for low back pain with mild degenerative changes in excess of 10 percent prior to December 29, 2009, in excess of 20 percent from December 29, 2009 to August 20, 2015, and in excess of 40 percent since August 21, 2015, are not met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 3.400, 4.1, 4.3, 4.7, 4.10, 4.40, 4.45, 4.59, 4.71a, Diagnostic Codes 5237, 5242, & 5243.

4. The criteria for an increased rating for left lower extremity radiculopathy, rated as 10 percent disabling prior to August 27, 2013, and 20 percent disabling thereafter, are not met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 3.400, 4.1, 4.3, 4.7, 4.10, 4.123, 4.124, 4.124a, Diagnostic Code 8520.

5. The criteria for an increased rating for right lower extremity radiculopathy, rated as 10 percent disabling prior to August 27, 2013, and 20 percent disabling thereafter, are not met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 3.400, 4.1, 4.3, 4.7, 4.10, 4.123, 4.124, 4.124a, Diagnostic Code 8520.

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

The Veteran served on active duty from August 1969 to August 1999.

This matter is before the Board of Veterans' Appeals (Board) on appeal from rating decisions issued in April 2009, which denied service connection for a bilateral big toe condition; and in July 2011 (with notice to the Veteran in August 2011), which denied service connection for chronic arthritis, service connection for ischemic

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strokes and seizures, and increased ratings for the low back disability and associated right and left lower extremity sciatic nerve disabilities. Rating decisions in October 2013 and November 2015 granted partial increases for the low back and bilateral lower extremity neurologic disabilities, as reflected in the issues above.

In September 2014, the Veteran testified at a personal hearing at his local Regional Office (RO), or Travel Board hearing, before the undersigned Veterans Law Judge. The Board sent the Veteran a letter in October 2020 indicating that he could request a virtual tele-hearing instead of waiting for a Travel Board hearing. However, there is no pending hearing request, and the transcript of his prior hearing is of record.

The Board remanded these matters for additional development in June 2015 and April 2017. In August 2018, the Board issued a decision that denied service connection for chronic arthritis and remanded the remaining issues. The August 2018 Board decision also found that the issue of entitlement to an increased rating for diabetes was no longer in appellate status based on an award in a November 2017 rating decision and the Veteran's limitation of his appeal for that issue.

The Veteran appealed to the U.S. Court of Appeals for Veterans Claims (Court). In a June 2019 Order, pursuant to a Joint Motion for Remand by the parties, the Court vacated and remanded the Board's 2018 decision as to the denial of service connection for chronic arthritis. As noted in the 2015 Board remand, a claim for cervical spine (neck) arthritis was already separately denied and is not on appeal, and the Veteran clarified during his 2014 Board hearing that his claimed arthritis was primarily in the knees and feet, specifically the two big toes, as shown in x-rays. Similarly, the June 2019 Joint Motion found that the 2018 Board denial did not adequately address the claimed chronic arthritis in the knees and feet. In January 2020, the Board remanded the issue of chronic arthritis, primarily limited to the knees and feet or toes, for further development pursuant to the Joint Motion.

The case now returns to the Board for further consideration of all issues after development pursuant to the 2018 and 2020 (post-Joint Motion) Board remands. The Veteran's representative provided arguments in August 2020 and March 2021.

As explained below, another remand is necessary for the knee and toe issues.

The Board's decision herein is a full grant of issue on appeal for service connection for seizure or stroke. Otherwise, there is no argument or indication of any error as to the duty to notify, to include during the Board hearing. Moreover, the Veteran has shown actual knowledge of the required elements for the claims and had ample opportunity to participate in the adjudication. *See* 38 U.S.C. §§ 5102, 5103, 5103A; 38 C.F.R. § 3.159; *Scott v. McDonald*, 789 F.3d 1375 (Fed. Cir. 2015).

As to the duty to assist, the Veteran's service treatment and personnel records, VA treatment records from multiple facilities and other identified post-service treatment facilities have been obtained and considered. The Veteran was provided updated VA examination for his increased rating claims, and there is no argument or indication that these examinations do not reflect the current severity or are otherwise inadequate. A further remand for another VA examination or medical evidence would not have a reasonable possibility of assisting in substantiating the claims on appeal. *See* 38 C.F.R. § 3.159. Therefore, the prior remand directives were at least substantially complied with, and a decision may be issued at this time.

Service Connection

Service connection will be granted for disability resulting from disease or injury incurred in or aggravated by active service, even if the condition was first diagnosed after service. 38 U.S.C. §§ 1110, 1131; 38 C.F.R. §§ 3.303, 3.304.

Generally, the three-element test for service connection requires: (1) a current disability; (2) in-service incurrence or aggravation of a disease or injury; and (3) a causal relationship between the current disability and the in-service disease or injury. *Shedden v. Principi*, 381 F.3d 1163, 1166-67 (Fed. Cir. 2004). Presumptions also apply for certain conditions, which are discussed below as relevant.

Secondary service connection will be granted if the evidence demonstrates that a current disability is proximately due to or the result of, or is aggravated beyond its natural progression, by service-connected disability. 38 C.F.R. § 3.310. Such aggravation need not be permanent. *See Ward v. Wilkie*, 31 Vet. App. 233 (2019).

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In adjudicating the merits of such claims, reasonable doubt that exists because of an approximate balance of positive and negative evidence concerning any point will be resolved in favor of the claimant. 38 U.S.C. § 5107(b); 38 C.F.R. § 3.102.

1. Service connection for ischemic strokes and seizures

In his July 2009 claim, the Veteran asserted that he has a disorder manifested by strokes or seizures as secondary to his treatment with peginterferon and ribavirin for his service-connected hepatitis C from 1999 to 2006. He stated that in May 2009 he had a temporary loss of balance, loss of control of his right-sided extremities, and loss of speech, and a CT scan showed a history of micro-strokes.

In his August 2011 notice of disagreement, the Veteran also asserted that his stroke or seizure condition is secondary to his service-connected diabetes.

In a September 2014 statement, the Veteran's wife described episodes of his strokes or seizures when he would collapse and lose consciousness and control.

During his October 2014 Board hearing, the Veteran testified that he had been experiencing micro-strokes. He stated that his doctor told him in 2012 when he was first admitted to the emergency room that he had Jacksonian-type seizures and that they could be related to his diabetes. He was treated again in 2013 and 2014.

Resolving reasonable doubt in the Veteran's favor, the Board finds that he has diagnosed transient ischemic attacks (TIA) with seizure-like activity, but no actual seizure disorder. Additionally, this current disability was caused by his service-connected hypertension, which is in turn associated with his diabetes. Therefore, the criteria for a grant of secondary service connection are met. 38 C.F.R. § 3.310.

Specifically, VA examinations and medical opinions were provided in June 2011, August 2013, August 2015, and September 2019, which addressed the Veteran's current diagnosis and his assertions as to secondary service connection.

As to a current disability, there is conflicting evidence as to whether the Veteran has a seizure disorder. However, the most probative evidence, including the 2019 VA examination, reflects a diagnosis of TIA and no actual seizure disorder.

A June 2009 CT scan of the head showed multiple small nonacute infarcts in the bilateral parietal deep white matter and is also chronic ischemia in the white matter. A September 2009 MRI of the brain showed chronic microvascular ischemic changes as small chronic lacunar infarcts in the bilateral basal ganglia.

Treatment records in April 2012 and April 2013 noted diagnoses of syncopal episode. A May 2012 record gave a diagnosis of seizure disorder, partial simple; multiple seizures; new onset focal seizure (Jacksonian type). A May 2012 CT scan of the head showed senescent changes and chronic small vessel ischemic disease.

Emergency department records on February 21, 2014, noted that the Veteran complained of a single syncopal episode with abrupt onset, in that the Veteran felt faint and lost consciousness and collapsed. Although the record stated that there was "generalized seizure activity observed (for 2 minutes)," the rest of the record clarifies that this meant observation by the Veteran's wife, not a medical provider. The record noted that the event was not witnessed, it occurred just prior to arrival and he had recovered at the scene, and he felt normal currently. The Veteran's wife heard him fall and came into the room, where she saw him laying against the tub shaking his arms and legs and moaning, which continued for about two minutes. He was unresponsive and confused, and was oriented again after about 20 minutes. The Veteran reported having similar symptoms once previously, but during triage his wife reported that he had multiple similar episodes in the past. Also, during triage, the Veteran also reported that his blood pressure today at VA was over 200 systolic. The provider noted that an EKG showed no acute ischemia, and a CT scan of the head showed no acute disease. Upon consultation with a neurologist, the provider diagnosed a seizure, noting a concern for new onset seizure in an older patient and that an MRI and electroencephalogram (EEG) would be obtained.

A February 21, 2014, record by a neurologist for an ER consult to rule out seizures noted an assessment of transient alteration of awareness. The Veteran described the recent episodes and reported prior similar episodes occurring about once a year that were witnessed by his wife. The provider noted a history of TIA in 2009 that presented as bilateral shakiness, "seizures" [quotes used in the record], slurring speech, and blurred vision, syncope episodes, hypertension poorly controlled, and diabetes mellitus since 2006. The neurologist gave a diagnosis of transient alteration of awareness in a patient with hypertension, diabetes mellitus,

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obstructive sleep apnea, and history of TIA with episodes of loss of consciousness preceded by lightheadedness followed by a brief post-ictal period. The differential at that time consisted of convulsive syncope versus complex partial seizures. A prior MRI showed TIA with evidence of chronic microvascular ischemic disease and lacunar infarcts. The neurologist stated that the Veteran had significant stroke vascular risk factors and spells could be potentially a manifestation of TIA, and he should be admitted for further workup including MRI for TIA and an EEG.

A February 21, 2014, EEG report later that day stated that no focal or generalized epileptiform activity observed. The impression was that the results were a normal awake and asleep EEG for age, with no definite epileptiform activity seen.

In October 2014, the Veteran's primary care provider summarized that he had received emergency treatment for diabetic-related problems. He noted treatment in May 2012, April 2013, and February 2014 for syncope and seizure, syncope, and collapse, and localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures without mention of intractable epilepsy.

The June 2011 and September 2019 examiners determined that the Veteran had diagnoses of transient ischemic attacks (TIA) or chronic microvascular ischemic changes with small chronic lacunar infarcts in the bilateral basal ganglia, as shown by a September 2009 MRI, not an actual seizure disorder or seizure activity.

During the 2011 VA examination, the Veteran reported attacks two to three times per week with dizziness, weakness of the arms and legs and the right side of the body, very slight tremors of both hands, stiffness in the arms, being unable to walk, blurred vision, and swelling of the tongue. The examiner noted a history of TIA or cerebrovascular attack (CVA) in 1996, 2003, 2009, and 2010, with hospitalizations then and at other times, and that they occur periodically. The examiner stated that the Veteran was experiencing TIA with no lasting residuals, not a seizure disorder.

During the August 2013 VA examination, the Veteran reported that he was first diagnosed with mini-strokes or TIA when he had a CT scan for neck and head pain. He reported symptoms of TIA of intermittent blurred vision, neck pain, swollen tongue with slurring, and headache. He could not recall the last episode, but he reported having ER treatment for episodes of syncope, most recently in March.