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This is not Leroy Foster but he had the same job.

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On appeal from the
Department of Veterans Affairs Regional Office in Lincoln, Nebraska

THE ISSUES

1. Entitlement to service connection for degenerative disc disease of the lumbar spine.

2. Entitlement to service connection for peripheral neuropathy

3.. Entitlement to an increased rating for asthma, currently evaluated as 30 percent disabling.

4. Entitlement to an increased rating for bipolar disorder, currently evaluated as 50 percent disabling.

REPRESENTATION

Appellant represented by: The American Legion

WITNESSES AT HEARING ON APPEAL

Appellant, Appellant's Wife, and Appellant's Mother

ATTORNEY FOR THE BOARD

Kristi Barlow, Associate Counsel

INTRODUCTION

The veteran served on active duty from April 1971 to February 1983.

The issue of service connection for a back disorder comes before the Board of Veterans' Appeals (BVA or Board) on

appeal from an April 1990 rating decision of the Department of Veterans Affairs (VA) Regional Office (RO) in Waco, Texas, which found that new and material evidence had not been submitted to reopen the claim of service connection for a back disorder. This matter previously came before the Board three times, most recently in April 1994, when the Board found that new and material evidence had been submitted to reopen the claim and remanded the issue of service connection for a back disorder to the RO for a de novo review. The requested review having been performed, the claim is now returned to the Board for further consideration.

The issue of service connection for peripheral neuropathy, both directly and as secondary to exposure to a herbicidal agent, comes before the Board on appeal from a September 1997 rating decision of the RO in Lincoln, Nebraska, which denied the benefits sought on appeal.

The issue of an increased evaluation for asthma comes before the Board on appeal from a December 1998 rating decision of the RO in Lincoln, Nebraska, which increased the disability evaluation to 30 percent. The veteran contends, however, that additional increase is warranted.

The issue of an increased evaluation for bipolar disorder comes before the Board on appeal from a September 1999 rating decision of the RO in Lincoln, Nebraska, which increased the evaluation to 50 percent. The veteran contends that this disorder too warrants an additional increase in disability evaluation.

The Board notes that in its May 2001 Written Brief Presentation, the veteran's representative requested that a claim for total disability evaluation based on individual unemployability be inferred from the record. In a September 1999 rating decision, however, the RO granted that benefit effective December 14, 1998, the date the veteran filed an application for total disability based on individual unemployability. Therefore, the Board finds that the benefit requested has been granted in full and the issue is not on appeal before it.

The Board also notes that the veteran had been scheduled for

a hearing before a member of the Board in March 2001. That request was withdrawn, but the veteran requested that his appeal be continued.

FINDINGS OF FACT

1. All relevant evidence necessary for an equitable disposition of the veteran's appeal has been obtained by the RO.

2. The veteran sustained a back injury during service as a result of a motor vehicle accident. He has continued to have complaints of lower back pain since that time.

3. The veteran has peripheral neuropathy more likely than not the result of exposure to chemicals during service.

4. The veteran requires daily medication for asthma. He has frequent respiratory infections with no likelihood of improvement.

5. The veteran has occupational and social impairment with reduced reliability and productivity due to disturbances of motivation and mood and difficulty establishing and maintaining effective work relationships as the result of a bipolar disorder.

CONCLUSIONS OF LAW

1. The veteran's back disorder was incurred in active service. 38 U.S.C.A. §§ 1110, 1154 (West 1991); 38 C.F.R. §§ 3.102, 3.303 (2000).

2. The veteran's peripheral neuropathy was incurred in active service. 38 U.S.C.A. §§ 1110, 1154 (West 1991); 38 C.F.R. §§ 3.102, 3.303 (2000).

3. The schedular criteria for a disability evaluation in excess of 30 percent for asthma have not been met. 38 U.S.C.A. §§ 1155, 5017 (West 1991); 38 C.F.R. §§ 4.1-4.16, 4.96, 4.97, Diagnostic Code 6602 (2000).

4. The schedular criteria for a disability evaluation in

excess of 50 percent for bipolar disorder have not been met. 38 U.S.C.A. §§ 1155, 5017 (West 1991); 38 C.F.R. §§ 4.1-4.16, 4.125-4.30, Diagnostic Code 9432 (2000).

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

At the outset of this decision, the Board finds that VA has met its duty to assist the veteran in the development of these claims and duty to notify the veteran of any information and evidence needed to substantiate and complete these claims under the Veterans Claims Assistance Act of 2000, Pub. L. No. 106-475, 114 Stat. 2096 (2000). By virtue of the Statements of the Case and Supplemental Statements of the Case issued during the pendency of the appeal, the veteran and his representative were given notice of the information, medical evidence, or lay evidence necessary to substantiate the veteran's claims. The veteran was afforded VA examinations and the RO made reasonable efforts to obtain relevant records adequately identified by the veteran. In fact, it appears that all evidence identified by the veteran relative to these claims has been obtained and associated with the claims folder. The veteran was also given the opportunity to appear and testify before an RO Hearing Officer to advance any and all arguments in favor of his claims.

I. Background

The veteran's service records reveal that he served as a fuel specialist during the Vietnam Conflict while stationed in Guam. While in service, he presented for treatment on a number of occasions with complaints of skin problems and eye irritation due to exposure to jet fuel. Service medical records also show that the veteran was involved in a motor vehicle accident in August 1976, and was diagnosed as having cervical and lumbar strain. He reported having complaints of lower back pain several times during the remaining six years of active service.

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Post-service treatment records show that the veteran presented for treatment for severe back pain in May 1985 and related having a history of lower back pain with no recent trauma. He continued to have periodic treatment for lower

back pain and in September 1993 underwent decompressive lumbar laminectomy with foraminotomy. In November 1994, the veteran's neurosurgeon stated that it was difficult to say whether the veteran's symptoms prior to surgical intervention were directly related to the motor vehicle accident during service because his problems were degenerative in nature, but that he believed that based upon the veteran's continued complaints of lower back pain since that time that the veteran's degenerative disc disease of lumbar spine was a continuous problem since service.

During the course of the veteran's appeal regarding his back disorder, he underwent several VA examinations. In July 1992, clinical testing showed a herniated disc at the L4-L5 level and degenerative disc disease and degenerative joint disease of the lumbar spine were diagnosed. In June 1993, a VA examiner opined that the veteran's degenerative spinal disease would have occurred regardless of the lumbar strain experienced in service because the veteran was overweight and had an endomorph body style. In summary, the examiner opined that the veteran had an ongoing degenerative process which was not connected to his active service.

The veteran has a history of treatment for gout in his lower extremities. He relates that he has experienced a "pins and needle" sensation in his feet since service, more specifically, since his exposure to jet fuel and herbicidal agents when performing the duties as a fuel specialist. These complaints were treated as symptoms of gout.

In February 1997, the veteran underwent VA examination and was found to have peripheral neuropathy possibly due to exposure to Agent Orange as well as other chemicals. The examiner opined that the etiology of the veteran's peripheral neuropathy was possibly toxic as opposed to metabolic and ordered a work-up to determine if the veteran had diabetes. In April 1997, the VA examiner received the results of the diabetes work-up and opined that the veteran's peripheral neuropathy was more likely than not caused by a toxic mechanism rather than a metabolic neuropathy as diabetes mellitus had been ruled out. In August 1997, another addendum was added to the VA examination following magnetic resonance imaging of the veteran's lumbosacral spine.

Specifically, the examiner opined that the veteran's degenerative disc disease of the lumbosacral spine had no bearing on the diagnosis of peripheral neuropathy.

The veteran is followed by a private physician for asthma. His symptoms are controlled with the use of several medications on a daily basis and, as such, the results of pulmonary function studies are within normal limits. The veteran's treating physician has reported on several occasions that the veteran will be on medication for asthma indefinitely as there is no likelihood of improvement. The veteran also suffers from frequent respiratory infections which involve constitutional symptoms.

The veteran is also treated for a bipolar disorder, which was previously diagnosed as dysthymia. He complains of depression due to his physical limitations and an inability to maintain employment relationships. The veteran's psychiatric disorder causes disturbances of motivation and mood. Although the record is somewhat contradictory on the issue of whether the veteran takes medication on a regular basis for a psychiatric disorder, his treating psychiatrist reported in January 2000 that the veteran's symptoms were controlled with medication. The physician also opined that the veteran's psychiatric disorder was incurable in the foreseeable future.

II. Degenerative Disc Disease of the Lumbar Spine

Service connection for VA compensation purposes will be granted for a disability resulting from disease or personal injury incurred in the line of duty or for aggravation of a preexisting injury in the active military, naval or air service. See 38 U.S.C.A. § 1110; 38 C.F.R. § 3.303(a). When a veteran seeks service connection for a disability, due consideration shall be given to the supporting evidence in light of the places, types, and circumstances of service, as evidenced by service records, the official history of each organization in which the veteran served, the veteran's military records, and all pertinent medical and lay evidence. See 38 U.S.C.A. § 1154; 38 C.F.R. § 3.303(a). The mere fact of an in-service injury is not enough; there

must be evidence of a chronic disability resulting from that injury. If there is no evidence of a chronic condition during service, or an applicable presumptive period, then a showing of continuity of symptomatology after service is required to support the claim. See 38 C.F.R. § 3.303(b). Evidence of a chronic condition must be medical, unless it relates to a condition to which lay observation is competent. See Savage v. Gober, 10 Vet. App. 488, 495-498 (1997). If service connection is to be established by continuity of symptomatology, there must be medical evidence that relates a current condition to that symptomatology. Id.

It is the defined and consistently applied policy of VA 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. See 38 C.F.R. § 3.102.

The evidence of record shows that the veteran injured his back in a motor vehicle accident during service and made several complaints of lower back pain subsequent thereto while still on active duty. The veteran has asserted that he was prescribed pain medication during service and did not seek medical treatment each time he experienced back pain as he had the medication on hand to treat the pain. The same holds true for the veteran's post-service treatment; he was treated periodically for complaints of lower back pain and prescribed medication to be taken on an as needed basis.

The veteran's treating neurosurgeon opined that the veteran's degenerative spinal disease was continuous from service, but a VA examiner opined that the veteran's spinal disease would have occurred notwithstanding the accident in service. Although the VA examiner's opinion has been given full

consideration, the Board notes that it does not address the fact that the veteran did, in fact, have an accident in service. Merely saying that a degenerative condition would have happened anyway does not dismiss the fact that the veteran injured his back in service. Therefore, resolving all reasonable doubt in favor of the veteran pursuant to 38 C.F.R. § 3.102 as it appears that it is as least as likely as not that the veteran's current back disorder is a result of his inservice accident, the Board finds that the veteran's degenerative disc disease of the lumbar spine was incurred in service and service connection is hereby granted.

III. Peripheral Neuropathy

As stated above, service connection for VA compensation purposes will be granted for a disability resulting from disease or personal injury incurred in the line of duty or for aggravation of a preexisting injury in the active military, naval or air service. See 38 U.S.C.A. § 1110; 38 C.F.R. § 3.303(a). When a veteran seeks service connection for a disability, due consideration shall be given to the supporting evidence in light of the places, types, and circumstances of service, as evidenced by service records, the official history of each organization in which the veteran served, the veteran's military records, and all pertinent medical and lay evidence. See 38 U.S.C.A. § 1154; 38 C.F.R. § 3.303(a).

The evidence of record shows that the veteran has peripheral neuropathy of a toxic etiology as opposed to metabolic. He is treated with medication for tingling in his hands and feet and relates no history of exposure to toxins other than while serving as a fuel specialist in service. The only medical opinion of record regarding the cause of the veterans' peripheral neuropathy is that it is more likely than not a toxic mechanism and could be due to exposure to Agent Orange as well as other chemicals. There is no medical evidence of record to suggest that the veteran's peripheral neuropathy is from anything other than exposure to chemicals.

Given the evidence as outline above and resolving all reasonable doubt in favor of the veteran pursuant to

38 C.F.R. § 3.102, the Board finds that the veteran's peripheral neuropathy is the result of exposure to chemicals while in service. Therefore, service connection is granted on a direct basis under 38 C.F.R. § 3.303(a). Because there is no evidence other than the veteran's assertions regarding the exposure to herbicidal agents during service, the Board cannot find service connection on a secondary basis; however, this issue is moot as service connection is hereby granted on a direct basis.

IV. Asthma

Disability evaluations are determined by the application of the schedule of ratings which is based on average impairment of earning capacity. See 38 U.S.C.A. § 1155. Separate diagnostic codes identify the various disabilities. Where entitlement to compensation has been established and an increase in the disability rating is at issue, the present level of disability is of primary concern. See Francisco v. Brown, 7 Vet. App. 55, 58 (1994). Consideration must also be given to a longitudinal picture of the veteran's disability to determine if the assignment of separate ratings for separate periods of time, a practice known as "staged" ratings, is warranted. See Fenderson v. West, 12 Vet. App. 119 (1999).

38 C.F.R. § 4.97, Diagnostic Code 6602, sets out the criteria for evaluating bronchial asthma. A 30 percent evaluation is assigned when there is evidence of FEV-1 scores of fifty-six to seventy percent predicted, FEV-1/FVC scores of fifty-six to seventy percent, daily inhalational or oral bronchodilator therapy, or inhalational anti-inflammatory medication; a 60 percent evaluation is assigned when there is evidence of FEV-1 scores of forty to fifty-five percent predicted, FEV-1/FVC scores of forty to fifty-five percent, at least monthly visits to a physician for required care of exacerbations, or intermittent (at least three per year) courses of systemic (oral or parenteral) corticosteroids; and, a 100 percent evaluation is assigned when there is evidence of FEV-1 scores less than forty percent predicted, FEV-1/FVC scores less than forty percent, more than one attack per week with episodes of respiratory failure, or requirement of daily use of systemic (oral or

parenteral) high dose corticosteroids or immune-suppressive medications.

The evidence of record reveals that the veteran has periodic asthmatic attacks, but his symptoms are well controlled with daily medications. The pulmonary function scores are all within normal limits due to the control of symptoms. The veteran has occasional respiratory infections, but no episodes of respiratory failure. While the veteran is seen on a regular basis by his treating physician, he does not require monthly visits to control exacerbation of symptoms.

Given the evidence as outlined above, the Board finds that the veteran's asthma more closely resembles the criteria for a 30 percent evaluation under Diagnostic Code 6602. Specifically, he requires daily inhalational therapy. The criteria for a 60 percent evaluation are not met because the veteran does not require monthly care for exacerbations or intermittent courses of systemic corticosteroids. As such, the Board finds that the 30 percent evaluation currently assigned for asthma is accurate and the appeal for a higher evaluation must be denied.

The potential application of other various provisions of Title 38 of the Code of Federal Regulations has been considered, whether or not they were raised by the veteran, as required by the holding of the Court in Schafrath v. Derwinski, 589, 593 (1991). As a result, however, the Board finds that the evaluation assigned in this decision adequately reflects the clinically established impairment experienced by the veteran.

V. Bipolar Disorder

As stated above, disability evaluations are determined by the application of the schedule of ratings which is based on average impairment of earning capacity. See 38 U.S.C.A. § 1155. Separate diagnostic codes identify the various disabilities. Where entitlement to compensation has been established and an increase in the disability rating is at issue, the present level of disability is of primary concern. See Francisco v. Brown, 7 Vet. App. 55, 58 (1994). Consideration must also be given to a longitudinal picture of

the veteran's disability to determine if the assignment of separate ratings for separate periods of time, a practice known as "staged" ratings, is warranted. See Fenderson v. West, 12 Vet. App. 119 (1999).

38 C.F.R. § 4.130, Diagnostic Code 9432 requires the use of criteria set forth in Diagnostic Code 9440 for the evaluation of a bipolar disorder. A 50 percent disability evaluation is assigned when there is evidence of occupational and social impairment with reduced reliability and productivity due to such symptoms as flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short- and long-term memory (e.g., retention of only highly learned material, forgetting to complete tasks); impaired judgment; impaired abstract thinking; disturbances of motivation and mood; difficulty in establishing and maintaining effective work and social relationships. A 70 percent disability evaluation is assigned when there is evidence of occupational and social impairment with deficiencies in most areas, such as work, school, family relations, judgment, thinking, or mood due to such symptoms as suicidal ideation; obsessional rituals which interfere with routine activities; speech intermittently illogical, obscure, or irrelevant; near-continuous panic or depression affecting the ability to function independently, appropriately, and effectively; impaired impulse control (such as unprovoked irritability with periods of violence); spatial disorientation; neglect of personal appearance and hygiene; difficulty in adapting to stressful circumstances (including work or a worklike setting); inability to establish and maintain effective relationships.

The evidence of record reveals that the veteran is married and lives with his wife. There has been no contention that the veteran has any difficulty maintaining his social relationships. His appearance at each VA examination has been noted as neat and there is no contention that the veteran has difficulty maintaining his personal appearance and hygiene. The veteran's treating psychiatrist reported that the veteran's symptoms are controlled with medication and there is no suggestion in the record that the veteran has suicidal ideation, obsessional rituals, illogical, obscure

and/or irrelevant speech, or spatial disorientation. Although the veteran experiences periods of depression and panic which disturb his motivation and mood, there is no evidence that either affect his ability to live independently.

Given the evidence as outlined above, the Board finds that the veteran's bipolar disorder more closely resembles the criteria for a 50 percent evaluation under Diagnostic Code 9432. Specifically, the veteran experiences disturbances in his motivation and mood and, as a result, has difficulty maintaining effective work relationships. The criteria for a 70 percent evaluation are not met because the veteran is not shown to be deficient in most areas of his life. As such, the Board finds that the 50 percent evaluation currently assigned for bipolar disorder is accurate and the appeal for a higher evaluation must be denied.

The potential application of other various provisions of Title 38 of the Code of Federal Regulations has been considered, whether or not they were raised by the veteran, as required by the holding of the Court in Schafrath v. Derwinski, 589, 593 (1991). As a result, the Board finds that the evaluation assigned in this decision for bipolar disorder adequately reflects the clinically established impairment experienced by the veteran.

ORDER

Service connection for degenerative disc disease of the lumbar spine is granted.

Service connection for peripheral neuropathy is granted.

A disability evaluation in excess of 30 percent for asthma is denied.

A disability evaluation in excess of 50 percent for bipolar disorder is denied.

John E. Ormond, Jr.
Member, Board of Veterans' Appeals