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"Top 10" Court Cases for Advocates

Forget David Letterman! Here's a "top 10" list of Court of Appeals for Veterans Claims (CAVC) and Court of Appeals for the Federal Circuit cases for advocates. The upcoming 20th anniversary of the Veterans Court presents an opportune time to reflect on judicial decisions that have affected thousands of veterans, dependents, and survivors and shaped many lives for years to come. We chose these ten cases because they have had a wide impact, beyond the immediate resolution of a dispute between the veteran and the VA. These cases set precedent and provide examples of how particular statutes, regulations and VA Manual provisions apply to real-life cases, allowing entitlement to benefits that the VA and the BVA (Board of Veterans' Appeals) denied.

We tried to choose cases relating to a variety of issues, including service connection, the duty to assist; the impact of lay evidence, evaluation of disability, post-traumatic stress disorder (PTSD), and total disability based on individual unemployability (TDIU). The primary criterion we considered was whether the case had (or should have) a great impact at VA regional offices (ROs)—the level where hundreds of thousands of claims are quickly and often erroneously denied. Therefore, we did not include cases whose main impact has been at the Court and the Board—those cases may be discussed in a later article. Also, cases that are no longer good law, such as *Karnas v. Derwinski,* 1 Vet. App. 308 (1991), are not included.

This list is obviously not exhaustive. Many significant cases were not able to be included in our "top 10" list, such as *Stegall v. West,* 11 Vet. App. 268, 271 (1998) (a veteran whose case is remanded by the Board or Court has the right to have VA comply with the remand order); *Fugere v. Derwinski,* 1 Vet. App. 103, 107 (1990) (a VA manual provision that ordered VA to take prescribed action on certain cases was a substantive VA rule); and *Wagner v. Principi*, 370 F.3d 1089 (Fed. Cir. 2004) (to rebut the presumption of sound condition the VA must show clear and unmistakable evidence of both a preexisting condition and a lack of in-service aggravation). We may discuss "runner-up" cases in a future issue.

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Use this article as a reference tool to become more familiar with the leading cases in veterans law and how to use them. They should help you maneuver through the VA claims adjudication process and obtain benefits as quickly as possible.

VA Can't Base Denial on its Own Medical Judgment

Colvin v. Derwinski, 1 Vet. App. 171 (1991)

Colvin stands for a now deeply embedded and fundamental principle of veterans law—the VA may use only independent medical evidence to support its benefits decisions. The VA may not use the medical opinion or judgment of the VA rater or BVA Veterans Law Judge to support a decision.

For many years prior to *Colvin,* VA decisions were based on the findings of VA physicians who were part of the decision-making process. A doctor employed by VA would not only provide the medical opinion that would be used to decide the claim, he or she would participate in deciding whether to grant or deny benefits. This practice of having VA doctors play a decision-making role was ended by *Colvin*.

The Court held that:

> If the medical evidence of record is insufficient, or, in the opinion of the BVA, of doubtful weight or credibility, the BVA is always free to supplement the record by seeking an advisory opinion, ordering a medical examination or citing recognized medical treatises in its decisions that clearly support its ultimate conclusions . . . . This procedure ensures that all medical evidence contrary to the veteran's claim will be made known to him and be part of the record before this Court.

Colvin, 1 Vet.App. at 175.

But advocates must watch out . . . even though the formal procedure of having a VA doctor play a decision-making role stopped after Colvin, VA raters and BVA Veterans Law Judges persist in relying on their own medical judgments to decide claims. For example, the VA and BVA may often make a determination that an

in-service injury was "acute, without chronic residual disability." However, the degree of injury and whether any disabilities resulted from the injury are medical assessments that the VA and the Board are not competent to make unless there is independent medical evidence to support that conclusion. This means that in many cases the VA's determination that an in-service injury was acute and did not result in chronic disability may violate Colvin.

Another common problem is that the VA may dismiss favorable medical evidence of record without citing to medical evidence in the record or medical literature to support its rejection. A good rule of thumb based on *Colvin* is that if there is a VA-made medical conclusion—not directly based on a medical examination report, advisory opinion, or medical literature—the conclusion may be erroneous because the VA has no independent medical support for its findings. Decisions containing unsupported medical conclusions should be appealed.

Low Threshold for Who Receives VA Exam and Opinion

McLendon v. Nicholson, 20 Vet. App. 79 (2006)

McLendon answered one of the most difficult questions plaguing veterans and advocates since passage of the Veterans Claims Assistance Act (VCAA) of 2000: when is a veteran/claimant entitled to a VA medical exam or opinion as part of the duty to assist? This question is crucial to many veterans. It is preferable, of course, for veterans to obtain their own private exams and opinions to support their claims. However, doing so would impose a huge financial burden on veterans who do not have private health care coverage or who cannot otherwise obtain their own supportive medical evidence.

McLendon reiterated that under the VCAA a VA exam and/or opinion is required if there is:

1. competent evidence of a current disability or persistent or recurrent symptoms of a disability;
1. evidence establishing that an event, injury, or disease occurred in service or establishing certain diseases manifesting during an applicable presumptive period; and
1. an indication that the disability or persistent or recurrent symptoms of a disability may be associated with service or with another service-connected disability; but
1. insufficient competent medical evidence on file for VA to decide the claim.

As to the "may be associated" requirement, *McLendon* made clear that this is a *low threshold*. For example, the "may be associated" requirement may be met if there is favorable medical linkage evidence not strong enough to support a grant of benefits or if there is lay evidence of continuity of symptoms. Those methods are not exclusive; there are other means to meet the "may be associated" requirement.

Although *McLendon* clarified that the threshold is *low*, the VA often refuses to provide claimants with exams and opinions or fails to give an exam and opinion without explaining why the veteran doesn't meet the requirements. In fact, *McLendon* errors are a primary reason for many Veterans Court remands—the cases are sent back for VA to either provide an exam or opinion or to explain why none is required.

If a VA exam and opinion has not been scheduled where warranted, *McLendon* provides a good hook for an advocate. If the VA concludes that no exam or opinion is required where one appears warranted, and the veteran is unable to privately generate such evidence, the case should be appealed.

Stop VA From Wrongly Rejecting Lay Evidence

Buchanan v. Nicholson, 451 F.3d 1331 (Fed. Cir. 2006)

Buchanan highlights the importance of lay evidence in adjudicating claims. For advocates, the main value of *Buchanan* is that it held that no medical evidence is required to corroborate or support lay statements.

In *Buchanan*, the Board rejected a favorable medical opinion that the veteran had a psychiatric disability manifest within a year following discharge. The Board rejected the medical opinion because it was based on a

buddy statement and statements of family members who described the veteran's behavior since service. The Board found the lay statements cited by the medical opinion not credible without contemporaneous medical records.

The Federal Circuit held that contemporaneous medical records are not necessary to make lay statements credible (believable). Lay statements may be believable even without medical evidence showing that the veteran experienced certain symptoms. (However, the Board may consider the lack of contemporaneous medical records and weigh that fact against lay evidence.)

Buchanan is especially helpful to advocates in several particular situations. Sometimes the VA denies service connection because service medical records fail to show complaints of or treatment for a claimed condition, even where there is lay evidence supporting the veteran's contentions. Under *Buchanan,* VA cannot reject that lay evidence as not believable unless it is contradicted by the record or otherwise shown to be incredible. *Buchanan* may also be used where the veteran has submitted lay evidence of continuity of symptoms to bridge an evidentiary gap between active service and the diagnosis of current disability. Again, VA may not reject that lay evidence as not believable simply because there are no records of treatment in the years during which the veteran is claiming to have had symptoms.

Buchanan may also be helpful is when there is disagreement as to whether VA owes the veteran a medical exam and opinion. The RO or BVA may deny a VA exam, stating that the there is no evidence indicating that a current disability may be related to service or to a service-connected disability. *See* the discussion of *McLendon* above. However, if there is lay evidence of continuity of symptoms VA is not free to reject this evidence and advocates should argue that VA exam and opinion is warranted.

Make VA Perform a Thorough Exam

Green (Victor) v. Derwinski,
1 Vet. App. 121 (1991)

VA Compensation & Pension (C&P) exams are not models of perfection. There are many complaints that the exams are superficial, the exam reports raise more questions than they resolve, and the doctor or physician's assistant is unwilling to spend sufficient time with the veteran. Deficient as many exams still are, there is no doubt that *Green* has improved the situation.

In *Green,* the veteran was diagnosed with poliomyelitis in service and claimed service connection for left leg residuals. In the C&P exam report, the doctor stated that "[t]here are some elements on the neurologic examination that are somewhat questionable and not entirely compatible with the diagnosis of polio." He suggested that further review might clarify diagnostic doubt and that additional diagnostic studies might be helpful. The examiner did not indicate whether the veteran's current left leg disability was related to the inservice poliomyelitis. On that record, the VA and the Board denied service connection for residuals. The Board stated that the VA exam did not demonstrate chronic residuals of polio.

The Court found the VA exam and the BVA decision seriously deficient. *Green* held that the duty to assist requires "the conduct of a thorough and contemporaneous medical examination, one which takes into account the records of prior medical treatment, so that the evaluation of the claimed disability will be a fully informed one." *Green,* 1 Vet.App. at 124.

The court has relied on *Green* in numerous situations because it provides a solid basis for veterans to obtain a (hopefully) better exam. Thousands of veterans have successfully argued that their VA exam and/or opinion is not adequate, contemporaneous (current), does not contain sufficient detail, does not address relevant facts and medical science, does not address symptoms listed in the diagnostic code, did not occur during an active stage, etc. This has forced VA to provide better exams.

Make it Hard for VA to Attack a PTSD Diagnosis (& other Helpful PTSD Rules)

Cohen v. Brown, 10 Vet. App. 128 (1997)

Cohen is without doubt the most important PTSD case decided by the CAVC. It created *multiple* favorable rules that advocates can use to help veterans establish service connection for PTSD.