Getting the Train Back on Track: Legal Principles to Guide Extra-Schedular Referrals in U.S. Department of Veterans Affairs Disability Rating Claim Adjudications

Jeffrey D. Parker*

"If your train's on the wrong track, every station you come to is the wrong station."
—*Bernard Malamud*

Introduction

Imagine that you are a frequent rider on a passenger train, traveling the same route and riding the same main rail day after day. On a recent trip, you notice the conductor switch the train from the mainstay rail onto an emergency rail. The emergency rail exists as a backup; to be called upon only in the event the main rail cannot be used. Yet, the main rail is intact, there is no emergency, and the train is now barreling forward at a reckless speed. The conductor assumes the emergency rail will lead to the same destination, without ever having driven a train all the way to its end.

Just as there is a main rail, the U.S. Department of Veterans Affairs (VA) employs a reliable and comprehensive compensation system, known as the VA Rating Schedule, to compensate disabled veterans in nearly all cases.[1]

* Jeffrey Parker is a Veterans Law Judge with the Board of Veterans' Appeals in Washington, D.C., with twenty-four years of VA adjudication experience, who has held 2,000 Board hearings, and decided over 7,000 veterans benefits appeals. Judge Parker has taught various continuing legal education and Veterans Law trainings at the VA and to veterans' representatives. He practiced criminal and administrative law, including Physical Evaluation Board hearings guided by the VA Rating Schedule, as a Lieutenant in the U.S. Navy Judge Advocate Generals Corps during the Persian Gulf era. The views expressed in this Article are the Author's alone and do not necessarily represent the views of the Board, VA, or the U.S. Government.

[1] The Rating Schedule is found at 38 C.F.R., Part IV. The statutory authority enabling the Rating Schedule is 38 U.S.C. § 1155 (2018) ("The Secretary shall adopt and apply a schedule of ratings of reductions in earning capacity from specific injuries or combination of injuries."). Various regulations acknowledge the Rating Schedule. *See, e.g.*, 38 C.F.R. § 3.321(a) ("The 1945 Schedule for Rating Disabilities will be used for evaluating the degree

For the first twenty-five years of jurisprudence, when reviewing administrative decisions issued by the Board of Veterans' Appeals (Board),[2] the United States Court of Appeals for Veterans Claims (Veterans Court)[3] generally recognized that the VA Rating Schedule is adequate to rate almost all veterans' disabilities.[4]

The Veterans Court has recently veered from long-established laws and regulations, and from its own precedents by creating "extra-schedular"[5] disability rating claims. An extra-schedular disability is one that involves an "exceptional" or "unusual"[6] impairment that prevents a veteran from qualifying for compensation under the VA Rating Schedule. Just as a train that turns onto an emergency rail when there is no emergency in sight, recent cases before

---

of disabilities in claims for disability compensation . . . ."); 38 C.F.R. § 4.1 ("This rating schedule is primarily a guide in the evaluation of disability resulting from all types of diseases and injuries encountered as a result of or incident to military service.").

[2] The Board of Veterans Appeals is the highest adjudicative agency within the VA. *See* 38 U.S.C. §§ 7101, 7103 (2018); *Board of Veterans Appeals: What Does the Board Do?*, U.S. Dep't of Veterans Affairs, http://www.bva.va.gov (last visited Apr. 9, 2019) [https://perma.cc/4YSQ-G4KC].

[3] The Veterans Court is an Article I Court, which was established by Congress in the Veterans' Judicial Review Act of 1988, Pub. L. No. 100-687, 102 Stat. 4105 (1988) (codified at 38 U.S.C. §§ 7251–7299 (2018)), and began issuing decisions in 1990. The Veterans Court has limited jurisdiction over the decisions of the Board of Veterans' Appeals. *See* 38 U.S.C. §§ 7252(a)–(b), 7261 (2018). Decisions of the Veterans Court are reviewed by the U.S. Court of Appeals for the Federal Circuit. 38 U.S.C. § 7292 (2018).

[4] 38 C.F.R. § 3.321(a) ("The provisions contained in the rating schedule will represent as far as can practicably be determined, the average impairment in earning capacity in civil occupations resulting from disability.").

[5] *Extra-schedular ratings in unusual cases*—(1) *Disability compensation*. Ratings shall be based, as far as practicable, upon the average impairments of earning capacity with the additional proviso that the Secretary shall from time to time readjust this schedule of ratings in accordance with experience. To accord justice, therefore, to the exceptional case where the schedular evaluations are found to be inadequate, the Director [of] Compensation and Pension Service, upon field station submission, is authorized to approve on the basis of the criteria set forth in this paragraph [(b)] an extra-schedular evaluation commensurate with the average earning capacity impairment due exclusively to the service-connected disability or disabilities. The governing norm in these exceptional cases is: A finding that the case presents such an exceptional or unusual disability picture with such related factors as marked interference with employment or frequent periods of hospitalization as to render impractical the application of the regular schedular standards.

38 C.F.R. § 3.321(b).

[6] 38 C.F.R. § 3.321(b) ("The governing norm in these exceptional cases is a finding that application of the regular schedular standards is impractical because the disability is so exceptional or unusual . . . ").

the Veterans Court, beginning in 2016 with *Yancy v. McDonald*,[7] show the court's active expansion of extra-schedular claims, a move which is creating a duplicative and dual-track VA disability rating system.

This Article opens by providing an explication of the VA Rating Schedule in order to demonstrate its coverage and adequacy. The Article goes on to outline ten accepted veterans law legal principles that have, until recently, guided questions of *extra*-schedular rating referrals under 38 C.F.R. § 3.321(b). The Article then analyzes several precedential decisions according to the guiding principles outlined in the second part of the Article, and points out the logical and practical difficulties created by the ad hoc creation of a dual track rating system.

I. The VA Rating Schedule: Comprehensive and Versatile

"Driving the train doesn't set its course. The real job is laying the track."

—*Ed Catmull*

The VA Rating Schedule is the comprehensive regulatory guide VA adjudicators use to compensate veterans for service-related 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."[8]

Some version of the VA Rating Schedule has been used to rate veterans' disabilities for nearly 100 years. The VA Rating Schedule has been updated[9] over the years to keep pace with medical and scientific advances. The Rating Schedule contains features and mechanisms that make it comprehensive and versatile enough to flexibly and fairly meet the compensation needs of veterans with any disability. Below is a non-exhaustive list of these features and mechanisms, followed by some practical examples.

A. The VA Rating System Accounts for All Body Systems

The VA Rating Schedule accounts for all body systems and body parts, assigning a diagnostic code (DC) to each disability. There are currently 846

---

[7] 27 Vet. App. 484 (2016).

[8] 38 U.S.C. § 1155 (2018).

[9] *See* 38 U.S.C. § 1155 (2018) ("[T]he Secretary shall from time to time readjust this schedule of ratings in accordance with experience."). About two-thirds (517 of 846) of the diagnostic codes currently contained in the VA Rating Schedule have been revised or added since the issuance of the 1945 Rating Schedule. *See* Nat'l Acads. of Scis., A 21st Century System for Evaluating Veterans Disability Benefits 92 (Michael McGeary et al. eds., 2007), https://www.nap.edu/read/11885/chapter/6 [https://perma.cc/2CAB-H374].

diagnostic codes that list symptoms, impairments, or other measures of disability.[10] Disability ratings run from zero percent up to a maximum percent, which is 100 percent for some disabilities, in ten percent increments.[11] The VA revises the Rating Schedule often to comport with developments in medicine and, over the decades since extra-schedular ratings were first promulgated,[12] the VA has added hundreds of new diagnostic codes to keep pace with newly recognized diagnoses and treatments. There is no body system or body part that the 846 diagnostic codes of the VA Rating Schedule do not address.

B. The VA Rating System Provides Many Measures of Disability

The Rating Schedule uses many different measures to capture the severity of a disability and functional impairment that a disability causes. These disability measurements in the Rating Schedule serve as proxies for the average functional impairment that a person with that type of disability would encounter in the work place.[13] Depending on the disability, the Rating Schedule

---

[10] *See* A 21st Century System for Evaluating Veterans Disability Benefits, *supra* note 9, at 92.

[11] *See* 38 U.S.C. § 1155 (2018) (providing ten grades of disability "and no more" up to "total, 100 percent."); 38 C.F.R. § 4.1 ("The percentage ratings represent as far as can practicably be determined the average impairment in earning capacity resulting from such diseases and injuries and their residual conditions in civil occupations.").

[12] *See* VA Rating & Pension Regulation § 1142 (Jan. 25, 1936) ("SPECIAL ACTION WHERE EVALUATIONS UNDER RATING SCHEDULES ARE CONSIDERED INADEQUATE OR EXCESSIVE").

[13] Measures in the Rating Schedule serve as proxies for average functional impairment. *See* Spellers v. Wilkie, 30 Vet. App. 211, 218 (2018) ("All the symptoms for which a cane or walker could serve as a proxy are contemplated by § 4.120 as impairments of motor and sensory function."); McCarroll v. McDonald, 28 Vet. App. 267, 277 (2016) (Kasold, J., concurring) ("These diagnostic codes require only that the Board consider the fact of medication usage, as a proxy for the seriousness of the condition; they do not require that the Board consider any 'ameliorative effect.'").

compensates based on diagnosis,[14] whether the disease is active,[15] subjective and lay reports,[16] clinical measures that are taken by a medical professional,[17]

---

[14] *See, e.g.*, 38 C.F.R. § 4.88b, Diagnostic Code (DC) 6351 (HIV-Related Illness); 38 C.F.R. § 4.97, DC 6510–14 (General Rating Formula for Sinusitis); 38 C.F.R. § 4.97, DC 6834–39 (General Rating Formula for Mycotic Lung Disease); 38 C.F.R. § 4.97, DC 6731 (chronic inactive pulmonary tuberculosis); 38 C.F.R. §4.88b, DC 6304 (malaria); 38 C.F.R. § 4.88b, DC 6309 (rheumatic fever); 38 C.F.R. § 4.114, DC 7324 (distomiasis, intestinal or hepatic); 38 C.F.R. § 4.115b, DC 7528 (malignant neoplasms of the genitourinary system) (2018); 38 C.F.R. §4.114, DC 7345 (chronic liver disease); 38 C.F.R. § 4.114, DC 7354 (hepatitis C); 38 C.F.R. § 4.116, DC 7627 (malignant neoplasms of gynecological system or breast) (2018); 38 C.F.R. § 4.117, DC 7704 (polycythemia vera); 38 C.F.R. § 4.117, DC 7705 (thrombocytopenia, primary, idiopathic or immune); 38 C.F.R. § 4.119, DC 7914 (neoplasm, malignant, any specified part of the endocrine system); 38 C.F.R. § 4.119, DC 7919 (c-cell hyperplasia of the thyroid); 38 C.F.R. § 4.124a, DC 8000 (encephalitis, epidemic, chronic), DC 8002 (new growth of the brain, malignant), DC 8003 (new growth of the brain, benign), DC 8004 (paralysis agitans), DC 8005 (bulbar palsy), DC 8007–09 (embolism of brain vessels), (thrombosis of brain vessels) (hemorrhage of brain vessels), DC 8010 (myelitis), DC 8011 (poliomyelitis, anterior), DC 8012 (hematomyelia), DC 8018 (multiple sclerosis), DC 8019 (meningitis, cerebrospinal, epidemic), DC 8020 (brain abscess), DC 8022 (brain growth, benign, minimum rating), DC 8024 (syringomyelia), DC 8025 (myasthenia gravis).

[15] *See, e.g.*, 38 C.F.R. § 4.117, DC 7703 (leukemia, with active disease or during a treatment phase); 38 C.F.R. § 4.124a, DC 8000 (encephalitis, as active febrile disease).

[16] *See* 38 C.F.R. § 4.87, DC 6260 (tinnitus, recurrent); Charles v. Principi, 16 Vet. App. 370, 374 (2002) (holding that "ringing in the ears is capable of lay observation"); 38 C.F.R. § 4.87a, DC 6275 (smell, complete loss), DC 6276 (taste, complete loss); 38 C.F.R. § 4.124a, DC 8045 (residuals of traumatic brain injury (TBI) ("Subjective symptoms may be the only residual of TBI or may be associated with cognitive impairment or other areas of dysfunction. Evaluate subjective symptoms that are residuals of TBI, whether or not they are part of cognitive impairment, under the subjective symptoms facet in the table . . ."), DC 8046 (cerebral arteriosclerosis) ("Purely subjective complaints such as headache, dizziness, tinnitus, insomnia and irritability, recognized as symptomatic of a properly diagnosed cerebral arteriosclerosis, will be rated [ten] percent or more . . .").

[17] 38 C.F.R. § 4.71s, DCs 5205–70 (specific degrees of measures of ranges of motion of various joints); 38 C.F.R. § 4.71a, DC 5275 (measures leg shortening); 38 C.F.R. § 4.86, DC 6100 (audiometric and speech recognition testing); 38 C.F.R. § 4.104, DCs 7000–20 (cardiovascular disorders measured by metabolic equivalent (MET) test, ejection fraction, left ventricular ejection fraction (LVEF) for cardiovascular fitness); 38 C.F.R. § 4.104, DC 7101 (blood pressure readings); 38 C.F.R. § 4.150, DC 9905 (jaw limitation of motion measures). This includes "signs" objectively observable by a medical professional. *See e.g.*, 38 C.F.R. § 4.114, DC 7354 ("signs and symptoms" of hepatitis C).

specialized clinical tests,[18] the need for treatment or medication,[19] types of treatment,[20] time and wages lost from work,[21] and the amount of time a person is incapacitated or is medically required to rest in bed.[22] The Rating Schedule pays more for a favored limb[23] and pays more for certain combinations of dis-

---

[18] 38 C.F.R. § 4.115a (albuminuria, BUN, uroflowmetry tests); 38 C.F.R. § 4.88b, DC 6351 (T4 cell counts for HIV); 38 C.F.R. § 4.97, DC 6514 (X-rays for sinusitis), DC 6600–04, DC 6825–33, DC 6840–45 (pulmonary function tests, diffusing capacity of the lungs for carbon monoxide (DLCO) tests); 38 C.F.R. § 4.104, DC 7111 and DC 7115 (ankle brachial index by Doppler study); 38 C.F.R. § 4.117, DC 7700 (hemoglobin testing for anemia), DC 7705 (white blood cell platelet count).

[19] 38 C.F.R. § 4.71a, DC 5025 (medication for fibromyalgia); 38 C.F.R. § 4.79, DC 6013 (medication for glaucoma); 38 C.F.R. § 4.88b, DC 6354 (medication that controls chronic fatigue syndrome symptoms); 38 C.F.R. § 4.97, DC 6514 (antibiotics for sinusitis treatment); 38 C.F.R. § 4.104, DC 7101 (hypertension medication); 38 C.F.R. § 4.119, DC 7913 (insulin for diabetes); 38 C.F.R. § 4.117, DC 7716 (aplastic anemia); 38 C.F.R. § 4.119, DC 7903–04 (continuous medication required for control); 38 C.F.R. § 4.115b, DCs 7508, 7510, 7511 (long-term drug therapy for genitourinary disorders); 38 C.F.R. § 4.116, General Rating Formula for Disease, Injury, or Adhesions of Female Reproductive Organs (DC 7610–15, whether symptoms require continuous treatment); 38 C.F.R. § 4.124a, DC 8911, General Rating Formula for Major and Minor Epileptic Seizures, Note 1).

[20] 38 C.F.R. § 4.71a, DC 5297 (rib resection); 38 C.F.R. § 4.56 (history of treatment for muscle injuries); 38 C.F.R. § 4.97, DC 6847 (CPAP machine for sleep apnea, even though the CPAP improves symptoms); 38 C.F.R. § 4.117, DC 7702 (blood platelet or red cell transfusions, bone marrow transplants); 38 C.F.R. § 4.71a, DC 5051–56 (prosthetic implants; 100 percent for a period, then minimum percentage ratings thereafter), DC 5120–73 (amputations, including if for treatment); 38 C.F.R. § 4.104, DC 7018 (pacemaker); 38 C.F.R. § 4.114, DC 7351 (liver transplant), DC 7338 (truss or belt for hernia); 38 C.F.R. § 4.118, DC 7806, 7816 (skin treatments by topical creams, corticosteroids, immunosuppressives).

[21] 38 C.F.R. § 4.124a, DC 8100 (headaches causing severe economic inadaptability); 38 C.F.R. § 4.130 (General Rating Formula for Mental Disorders rates on degrees of "occupational" impairment); 38 C.F.R. § 4.124a (epilepsies note directing adjudicator to develop for effects on employment, social and industrial survey, and consider referral to Director of Compensation for individual unemployability under 38 C.F.R. § 4.16). *See also* Thun v. Peake, 22 Vet. App. 111, 116 (2008) ([I]t is a "faulty proposition that a schedular rating for a service-connected disability is not adequate unless it compensates the veteran *for the actual individualized income* that is not realized but for that disability.") (emphasis in original).

[22] 38 C.F.R. § 4.71a, DC 5243 (intervertebral disc syndrome (IVDS) back rating), DC 5002 (incapacitating periods due to rheumatoid arthritis); 38 C.F.R. § 4.79, DC 6000–09 (incapacitating eye disorders); 38 C.F.R. § 4.97, DC 6514 (sinusitis); 38 C.F.R. § 4.130, DCs 9520 (anorexia); 9521 (bulimia).

[23] For examples of additional compensation for "favored" or "major" joints or limbs, *see* 38 C.F.R. § 4.71a, DCs 5201–03 (shoulder and arm ratings), DC 5205–13 (elbow and forearm ratings, DC 5214–15 (wrist ratings), DC 5216–23 (finger ankylosis ratings), DCs

abilities.[24] Such medically advanced Rating Schedule measures provide diverse ways to measure actual functional impairment caused by veterans' disabilities.

C. The VA Rating System Allows for Alternative Rating Options

The Rating Schedule for many disabilities or body systems provides alternative rating criteria within a single diagnostic code, from which the VA adjudicator may select the most predominant criteria or the criteria that results in the highest compensation for the veteran. For example, the Rating Schedule allows nerve damage to be rated either based on nerve paralysis (loss of ability to feel or move), on neuritis (nerve inflammation), or on neuralgia (nerve pain).[25] In applying the Rating Schedule criteria, VA adjudicators choose the criteria that yields the highest compensation for the veteran in order to pay compensation benefits up to the legal maximum.[26]

5120–56 (higher percentage ratings for "major" amputated joints). *See also* 38 C.F.R. § 4.69 (guidance to determine dominant hand).

[24] 38 C.F.R. § 4.71a, DC 5104–11.

[25] For other examples, *see* the Rating Schedule at 38 C.F.R. § 4.104, which allows cardiovascular disabilities to be rated based on congestive heart failure *or* clinical METs testing *or* left ventricle ejection fraction/dysfunction *or* cardiac hypertrophy *or* the need for continuous medication; 38 C.F.R. §§ 4.115a (dysfunctions of genitourinary system), and 4.115b (diagnoses of genitourinary system) that allow for ratings based on renal (kidney) dysfunction, voiding dysfunction (urinary leakage or frequency), obstructive voiding, or urinary tract infection—whichever is most favorable to the veteran. See also the elaborate, multi-tiered Rating Schedule criteria for traumatic brain injury (DC 8045) that rates on cognitive impairment and subjective symptoms, emotional and behavioral dysfunction, and physical and neurological dysfunction, and provides for separate physical and psychiatric ratings or one rating under 38 C.F.R. § 4.124a, DC 8045 for all related impairment, whichever method results in higher compensation to the veteran.

[26] The Board has the authority to change the schedular rating criteria used to rate a disability. *See* 38 C.F.R. § 4.21("coordination of rating with impairment of function" is the guiding principle in selecting rating criteria); Butts v. Brown, 5 Vet. App. 532, 539 (1993) (holding that the Board's selection of a diagnostic code should be upheld unless the selection is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law) (citing 38 C.F.R. § 4.21) ("[The] VA and the BVA possess specialized expertise in identifying and assessing the medical nature of a claimed condition, and their application of a particular DC to a particular condition is due greater deference."); 38 C.F.R. § 4.27 (providing that VA adjudicators select diagnostic codes). The selection of a diagnostic code that yields a higher rating fulfills the principle that the VA has a *duty* to maximize a claimant's benefits. The Veterans Court has applied this duty in similar contexts. *See, e.g.*, Bradley v. Peake, 22 Vet. App. 280, 294 (2008) (explaining VA's duty to maximize benefits); Buie v. Shinseki, 24 Vet. App. 242, 243, 247–48, 250–51 (2010) (per curiam) (defending availability of special monthly compensation award where veteran "was already granted entitlement to a total

D. The VA Rating System Focuses on Impairment, Not Just Symptoms

The Rating Schedule measures how a veteran's disability will negatively affect the ability to work [27] and the income stream he is likely to lose on account of his disability.[28] Thus, the Rating Schedule compensates veterans for occupational impairment, [29] which is built into the Rating Schedule's various measures.[30]

The Rating Schedule does not pay veterans on a per-symptom basis; it captures the "effects" or functional impairment symptoms cause.[31] The mere presence of a symptom that is listed in a diagnostic code does not automatically compel the grant of higher compensation. Compensation is paid for functional impairment, while a symptom may or may not be impairing. If, however, a symptom is listed in the Rating Schedule, then its presence there serves as a proxy for functional impairment.

Where symptoms are listed in the Rating Schedule criteria, the frequency, severity, and duration of the symptom will be considered toward a determination as to how much functional impairment the symptom causes.[32] The symptom must be considered in the context of other symptoms and clinical or

---

disability rating based on individual unemployability). AB v. Brown, 6 Vet. App. 35 (1993) (veteran presumed to be seeking highest schedular rating available).

[27] 38 C.F.R. § 4.2 ("Each disability must be considered from the point of view of the veteran working or seeking work.").

[28] *See* 38 C.F.R. § 3.321(a) ("The provisions contained in the rating schedule will represent as far as can practicably be determined, the average impairment in earning capacity in civil occupations resulting from disability.").

[29] 38 C.F.R. § 4.10 (Ratings "are based upon lack of usefulness" of various body parts and systems; the "effects of disability upon the persons' ordinary activity" needs to be fully described).

[30] 38 C.F.R. § 4.1 ("Generally, the degrees of disability specified are considered adequate to compensate for considerable loss of working time from exacerbations or illnesses proportionate to the severity of the several grades of disability.").

[31] Mauerhan v. Principi, 16 Vet. App. 436, 442 (2002) (recognizing that symptoms in the Rating Schedule criteria for rating psychiatric disorders serve as "examples of the type and degree of the symptoms, or their effects, that would justify a particular rating."); Thun v. Peake, 22 Vet. App. 111, 115–16 (2008) (recognizing that the test as to whether the Rating Schedule is adequate is whether the Rating Schedule criteria "reasonably" describe the disability level and symptomatology, as the Rating Schedule is an "approximate" measure of the "average impairment" caused by a specific disability).

[32] *See* Vazquez-Claudio v. Shinseki, 713 F.3d 112, 117 (Fed. Cir. 2013) ("[A] veteran may only qualify for a given disability rating under § 4.130 by demonstrating the particular symptoms associated with that percentage, or others of similar severity, frequency, and duration."). *See also* Bankhead v. Shulkin, 29 Vet. App. 10, 21 (2017) (holding that Board

other measures of disability in the Rating Schedule.[33] The focus of the Rating Schedule is always to compensate an injured veteran to the full extent of his occupational impairment, resulting in maximum compensation to veterans.

E. Examples of Comprehensiveness

One is hard-pressed to even imagine a case in which a functional impairment is not already covered by the existing Rating Schedule measures. This is not to say that, as a matter of law, an extra-schedular disability could *never* arise from these criteria; it is merely to observe that, as a *factual* matter, an extra-schedular fact pattern—some functional impairment that was not contemplated by the same Rating Schedule that regulates these body systems or disabilities in the greatest of detail—will *virtually* never arise in actual veterans cases.

1. Joint (Orthopedic) Disabilities

The Rating Schedule provides specific rating criteria for joint (orthopedic)[34] disabilities and provides several alternative diagnostic codes to choose from. The Rating Schedule includes regulations preceding the diagnostic codes that provide further guidance on rating orthopedic impairment. Joint ratings are also informed by interpretative guidance from VA General Counsel opinions that, for example, bless the practice of granting separate compensation awards for two different impairments of the same knee.[35] Furthermore, joint

---

should consider severity, frequency, and duration of signs and symptoms of mental disorder when determining appropriate rating).

[33] 38 C.F.R. § 4.114, DC 7354 (hepatitis rated on symptoms and "signs"); 38 C.F.R. § 4.115a (obstructed voiding ratings include symptoms of hesitancy, slow or weak stream, or decreased force of stream with specific clinical measures including by uroflowmetry measure); 38 C.F.R. § 4.114, DC 7312 (cirrhosis rates on symptoms such as weakness, anorexia, abdominal pain, and malaise), DC 7314 (cholecystitis rates on gall bladder dyspepsia, confirmed by x-ray, with attacks), DC 7329 (resection of colon rates on symptoms, but also objectively supported examination findings).

[34] For example, the Rating Schedule criteria for rating lumbar spine disabilities specifically provide for ratings based on the presence of painful motion, whether or not such pain radiates; limitations of motion of the spine including due to pain and other orthopedic factors that result in functional impairment. *See* 38 C.F.R. §§ 4.40, 4.45, 4.59; DeLuca v. Brown, 8 Vet. App. 202, 206–07 (1995); Mitchell v. Shinseki, 25 Vet. App. 32, 33–36 (2011) (ratings based upon other clinical findings, such as muscle spasm, guarding, abnormal gait, and abnormal spinal contours, and on the basis of incapacitating episodes).

[35] *See* VAOPGCPREC 23-97 and VAOPGCPREC 9-98 (interpreting that limited or painful motion and instability of a knee may be rated and compensated separately); VAOPGCPREC 9-2004 (knee flexion and knee extension limitations can be compensated separately).

ratings are guided by the Veterans Court's case law,[36] such as a holding that a titled "arthritis" regulation grants to non-arthritic painful joint disabilities the same ten percent compensation as if it were arthritis.[37]

2. Psychological Disorders

The Rating Schedule criteria for psychological disorders[38] are based upon occupational impairment and social impairment. The Rating Schedule criteria

[36] *See* Schafrath v. Derwinski, 1 Vet. App. 589, 592 (1991) (stating that, when 38 C.F.R. §§ 4.40 and 4.45 are read together with schedular rating criteria, functional loss due to pain is recognized); *Deluca*, 8 Vet. App. at 206–07 (stating that functional limitations are applied to the schedular rating criteria to ascertain whether a higher schedular rating can be assigned based on limitation of motion due to pain and during flare-ups, and should be expressed in schedular rating terms of degree of range-of-motion loss); Burton v. Shinseki, 25 Vet. App. 1, 4 (2011) (conducting regulatory interpretation and instructing that majority of 38 C.F.R. § 4.59, which is a schedular consideration rather than an extra-schedular one, "provides guidance for noting, evaluating, and rating joint pain, and that guidance is devoid of any requirement . . . "); Sowers v. McDonald, 27 Vet. App. 472 (2016) (38 C.F.R. § 4.59 is limited by the diagnostic code applicable to the claimant's disability, and is read in conjunction with, and subject to, the relevant diagnostic code); *Mitchell*, 25 Vet. App. at 33–36 (holding that pain alone does not constitute functional impairment under VA regulations, and the rating schedule contains several provisions, such as 38 C.F.R. §§ 4.40, 4.45, 4.59, that address functional loss in the musculoskeletal system as a result of pain and other orthopedic factors when applied to schedular rating criteria). *See also Mitchell*, 25 Vet. App. at 45 n.2; Vogan v. Shinseki, 24 Vet. App. 159, 161 (2010) (if a condition is not listed in VA disability schedule, VA may undertake rating by analogy where disability in question is analogous, in terms of functions affected, anatomical localization, and symptomatology of the ailments). Much of the above analysis also applies to other orthopedic disorders, such as cervical spine, knee, hip, foot, shoulder, elbow, and wrist disorders, and even certain neurological diseases such as radiculopathy.

[37] *Burton*, 25 Vet. App. at 4 (the majority of 38 C.F.R. § 4.59, which is a schedular consideration rather than an extra-schedular consideration, provides guidance for noting, evaluating, and rating joint pain).

[38] The General Rating Formula for Mental Disorders rates upon the extent that mental disorder symptoms result in occupational and social impairment, ranging from no impairment (zero percent disability rating) to total occupational and social impairment (100 percent disability rating). *See* 38 C.F.R. § 4.130. Within each disability rating level are examples of symptoms consistent with the disability rating. For example, a thirty percent disability rating is consistent with symptoms such as depressed mood, anxiety, and suspiciousness. *See id*. As discussed above, however, the severity, frequency, and duration of symptoms may warrant a higher rating. *See* Bankhead v. Shulkin, 29 Vet. App. 10, 21–22 (2017). For instance, a veteran's depression may so severe, frequent, and long-lasting that it more nearly approximates a disturbance of motivation and mood, which is a symptom associated with a fifty percent disability rating. *See* 38 C.F.R. § 4.130. Further, the schedular rating criteria rate by analogy psychiatric symptoms that are "like or similar to" those explicitly listed in the schedular rating

accounts for psychological symptoms that are "like or similar to"[39] other symptoms, self-reported symptoms, and lay, third-party-reported symptoms, as well as objective observations and guidance from a psychiatric manual.[40] Decisional law has also expanded the scope of the Rating Schedule in this area.[41]

---

criteria. *See* Mauerhan v. Principi, 16 Vet. App. 436, 442 (2002). As an example, "agitation," which is not specifically listed in the rating criteria, is defined as excessive, purposeless cognitive and motor activity or restlessness, usually associated with a state of tension or *anxiety*. *See* Dorland's Illustrated Medical Dictionary 40 (32d ed. 2012). As such, by definition, the mental health symptom is like or similar to the schedular symptom of anxiety, which is included in the thirty percent disability rating criteria. Additionally, because the VA is directed to also rate upon the severity, frequency, and duration of mental health symptoms, the mental health symptom of "anger," for example, which is not specifically listed in the rating criteria, could be rated as like or similar to the symptoms of anxiety (thirty percent rating), disturbances of motivation and mood (fifty percent rating), or impaired impulse control (unprovoked irritability with periods of violence) (seventy percent rating) depending on the severity, frequency, and duration of the veteran's anger symptoms.

[39] *Mauerhan*, 16 Vet. App. at 442 (quoting Webster's New World Dictionary to define the Rating Schedule term "such as").

[40] Am. Psychiatric Ass'n, Diagnostic & Statistical Manual of Mental Disorders (5th ed. 2013) (DSM-5) (cited by 38 C.F.R. §§ 4.125; 4.130).

[41] *See, e.g.*, *Mauerhan*, 16 Vet. App. at 443 (describing Rating Schedule for psychiatric disorders at 38 C.F.R. § 4.130 as possessing a "built-in versatility" that allows for rating based on similar symptoms that are not literally in the Rating Schedule).

3. Hearing Loss

The criteria for rating hearing loss,[42] which includes special provisions to rate "[e]xceptional patterns of hearing impairment,"[43] rate based on the loss of ability to hear words and sounds of various frequencies. This dual rating criteria contemplates the universe of relevant sounds and words within the ranges available to an unimpaired person. In addition to hearing loss, the Rating Schedule provides separate ratings and monetary compensation for eleven other ear diseases.[44]

---

[42] The Rating Schedule criteria for hearing loss specifically provide for ratings based on all levels of hearing loss in various contexts, as measured by both Hertz decibel audiometric testing and controlled speech recognition testing. The ability of a hearing-impaired veteran to hear sounds and voices is captured by the audiometric test, which measures different frequencies and captures high frequency hearing loss from sources including voices, music, sirens, and certain high-pitched sounds. The ability of a hearing-impaired veteran to understand people is captured by the speech recognition test measure, which fully contemplates the percentage of conversation comprehension, different word sounds, and words missed in conversations. The Rating Schedule criteria specifically provide for ratings based on all levels of hearing loss, including exceptional hearing patterns, *see* 38 C.F.R. § 4.86, as measured by both audiometric testing and speech recognition testing. *See* Doucette v. Shulkin, 28 Vet. App. 366, 369 (2017) (holding "that the rating criteria for hearing loss contemplate the functional effects of decreased hearing and difficulty understanding speech in an everyday work environment"). The decibel loss and speech discrimination ranges designated for each level of hearing impairment were chosen in relation to clinical findings of the impairment experienced by veterans with certain degrees and types of hearing disability. The regulatory history of 38 C.F.R. §§ 4.85 and 4.86 includes revisions, effective June 10, 1999. *See* 64 Fed. Reg. 25,202 (May 11, 1999). In forming these revisions, the VA sought the assistance of the Veteran's Health Administration (VHA) to develop criteria that contemplated situations in which a veteran's hearing loss was of such a type that speech discrimination tests may not capture the severity of communicative functioning these veterans experienced, or that was otherwise an extreme handicap in the presence of any environmental noise, even with the use of hearing aids. VHA had found, through clinical studies of veterans with hearing loss, that, when certain patterns of impairment are present, a speech discrimination test conducted in a quiet room with the assistance of sound amplification does not always reflect the extent of impairment experienced in the ordinary environment. The decibel threshold requirements for application of Table VIa were based on the findings and recommendations of VHA. The intended effect of the revision was to fairly and accurately assess the hearing disabilities of veterans as reflected in a real-life industrial setting. In sum, the hearing loss rating schedule is intended to measure the universe of possible hearing loss, sound and speech.

[43] 38 C.F.R. § 4.86 (rating based on exceptional patterns of hearing loss that show wide variance from one specific Hertz decibel range to another or where multiple Hertz decibel ranges are high).

[44] 38 C.F.R. § 4.87. A number of symptoms or impairments that might be ear-related, while not specifically considered by the Rating Schedule criteria for hearing loss, have their

The above sections of the Rating Schedule illustrate how intelligently the VA Rating Schedule captures functional impairment to ensure tailored compensation for veterans. The Rating Schedule contains carefully considered and elaborate criteria to rate any and all aspects of veterans' disabilities.

F. Holistic VA Care

VA disability compensation that is assigned via the Rating Schedule is not the only resource available to veterans to defray the costs of medical treatment or disability accommodations. In addition to disability compensation, there is a host of other programs aimed at restoring injured and impaired veterans, such as VA-exclusive hospitals and medical care (including in some cases treatment for non-service-related disorders), nursing care, caretaker assistance, rehabilitation services, vocational rehabilitation, education programs, employment assistance, special automobile adaptation, specially adapted housing, and special home adaptation grants.[45] There are over 2,200 VA health care and outpatient facilities and 170 VA medical centers that serve more than nine million veterans annually.[46]

It is important to keep in mind that the ancillary programs, care, and assistance the VA provides veterans is intended to, and does, in fact, offset those effects of disability that are not fully remedied by the provision of compensation under the Rating Schedule. These programs address needs that cannot be remedied by compensation alone, including by *extra*-schedular compensation. One should not assume that any service or need not addressed by the VA Rating Schedule must somehow be "extra"-schedular; this would be asking the VA compensation system to address something for which it was never designed to ameliorate.[47]

---

own diagnostic codes and schedular rating criteria, so can be separately service connected, rated, and compensated. These include symptoms of ringing, buzzing, roaring, clicking, hissing, dizziness, vertigo, balance problems, ear pain, earaches, ear pressure, and headaches. *See* 38 C.F.R. § 4.87, DC 6260 (tinnitus), DC 6205 (Meniere's syndrome), DC 6200 (cholesteatoma), DC 6204 (peripheral vestibular disorders), DC 6200 and DC 6201 (otitis media, cholesteatoma, and mastoiditis); 38 C.F.R. § 4.124a, DC 8100 (migraine headaches).

[45] *See* Dep't of Veterans Affairs, Fed. Benefits for Veterans, Dependents & Survivors 8–11, 16–17, 19–20 (2018), https://www.va.gov/opa/publications/benefits_book/2018_Federal_Benefits_for_Veterans.pdf [https://perma.cc/Q6X3-8DVQ].

[46] *Where Do I Get the Care I Need?*, U.S. Dep't of Veterans Affairs, https://www.va.gov/health/findcare.asp (last visited Jan. 13, 2019) [https://perma.cc/693D-ZZHZ].

[47] *See, e.g.*, Bagwell v. Brown, 9 Vet. App. 337, 337–39 (1996) (holding that contentions of pain and suffering, and financial expenses incurred due to a prolonged hospital stay did not trigger referral for extra-schedular rating) (recognizing that awarding compensation for pain and suffering due to the prolonged hospitalization commensurate with actual financial expenses would amount an impermissible "adjust[ment]" of the Rating Schedule in

To summarize, disability compensation under the Rating Schedule is just one of many ways that the VA helps disabled veterans, while extra-schedular disability compensation, which operates outside of the Rating Schedule, is a more specific, less versatile, type of disability compensation. Principled guidance is necessary to help determine when a more specific extra-schedular claim has been raised or proven such that resort to the emergency rail is justified. Fortunately, the principled guidance we seek is enshrined in statutes, regulations, and Veterans Courts' precedents, which are discussed at length, *infra*.

II. Ten Legal Principles for Extra-Schedular Ratings

A. Legal Principle No. 1: "Extra"-Schedular and "Schedular" Ratings Are Mutually Exclusive

"If a train doesn't stop at your station, then it's not your train."

—*Marianne Williamson*

An extra-schedular disability is a disability that is outside of the Rating Schedule. The impairment caused by a service-connected disability either must be rated under the Rating Schedule (if practical)[48] *or* as extra-schedular under 38 C.F.R. § 3.321(b) (if the Rating Schedule is impractical).[49] The Rating Schedule ratings and the extra-schedular ratings provided for in 38 C.F.R. § 3.321(b) are mutually exclusive.[50]

One cannot determine which service-connected disabilities are *extra*-schedular without knowing which disabilities and related functional impairments are schedular, that is, are covered by the VA Rating Schedule. Before an extra-schedular rating determination is made, a VA adjudicator must, as a threshold matter, determine that the entire Rating Schedule is "inadequate"[51] to rate the particular service-connected disability.

---

contravention of the statutory prohibition, found in 38 U.S.C. § 7252(b) (2018), against "review" of the Rating Schedule).

[48] *See* 38 C.F.R. § 3.321(a) (Rating Schedule is based on "the average impairment in earning capacity.").

[49] *See* 38 C.F.R. § 3.321(b)(1) (requiring that the "application of regular schedular standards" is rendered "impractical" by a "disability . . . so exceptional or unusual").

[50] Thun v. Peake, 22 Vet. App. 111, 115 (2008) ("The threshold factor for extraschedular consideration is a finding that the evidence before VA presents such an exceptional disability picture that the available schedular evaluations for that service-connected disability are inadequate"); Sowers v. McDonald, 27 Vet. App. 472, 478 (2016) ("The rating schedule must be deemed inadequate before extraschedular consideration is warranted").

[51] *Thun*, 22 Vet. App. at 115 ("The threshold factor for extraschedular consideration is a finding that the evidence before VA presents such an exceptional disability picture that the available schedular evaluations for that service-connected disability are inadequate.").

The extra-schedular provision of 38 C.F.R. § 3.321(b) exists as a safety net for the handful of disabled veterans whose impairment is so "exceptional or unusual" that the otherwise encyclopedic VA Rating Schedule, with its labyrinth of provisions, omits coverage. This extra rail is thus properly activated only when the main track is broken, closed or has yet to be built.

B. Legal Principle No. 2: The VA Rating Schedule Maximizes Benefits to Veterans

> "When a train goes through a tunnel and it gets dark, you don't throw away the ticket and jump off. You sit still and trust the engineer."
>
> —*Corrie ten Boom*

The VA Rating Schedule has multiple mechanisms designed to maximize benefits to veterans.[52] These mechanisms, by law and by policy, operate to give a veteran-claimant the higher payment whenever possible. The following sub-section explores some of the benefit-maximizing mechanisms inherent to the VA Rating Schedule.

1. Doubt is Resolved in the Veteran's Favor

Where there is a balance of positive and negative evidence, reasonable doubt is resolved[53] to grant the veteran service connection or a higher rating, which is a classification that, in turn, pays higher compensation.[54] For example, if a

---

[52] *See* A.B. v. Brown, 6 Vet. App. 35, 38 (1993) (presuming every veteran seeks the highest compensation); Bradley v. Peake, 22 Vet. App. 280 (2008); Buie v. Shinseki, 24 Vet. App. 242, 250 (2010) (recognizing possibility that special monthly compensation award may still be available even in cases where veteran has already received a 100 percent rating); Copeland v. McDonald, 27 Vet. App. 333, 338 (2015) ("[T]he [VA] Secretary has, through various regulations, created procedural mechanisms to account for all symptoms and effects arising from service-connected conditions.").

[53] 38 U.S.C. § 5107(b) (2018) ("When there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter, the Secretary shall give the benefit of the doubt to the claimant.").

[54] 38 C.F.R. § 3.102 ("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."). *See, e.g.*, specific Rating Schedule provisions based on the same legal standard, including 38 C.F.R. § 4.3 ("[R]easonable doubt . . . regarding the degree of disability . . . will be resolved in favor of the claimant."); 38 C.F.R. § 4.7 ("Where there is a question as to which of two evaluations shall be applied, the higher evaluation will be assigned."). In *Pierce v. Principi*, 18 Vet. App. 440, 445 (2004), the Veterans Court reviewed various regulations that interpret the Rating Schedule and are intended to maximize benefits, describing "the application of and interplay" between 38 C.F.R. §§ 4.3, 4.7 and 4.21, which, taken together, stand for the proposition that "all elements specified in a disability grade need not necessarily be found" to get the higher rating, and the Rating Schedule criteria.

veteran's joint impairment falls exactly midway between the degrees required for a ten percent rating and the degrees required for a twenty percent rating, the VA adjudicator can round up to grant the twenty percent rating, a decision which, in turn, grants the veteran more compensation.

While the general principle of resolving reasonable doubt[55] in a veteran's favor on larger questions, such as ultimate rating percentage, is widely acknowledged and discussed by the courts, reasonable doubt can be resolved favorably[56] for a veteran on a number of lesser factual questions that, once posed, serve as the factual predicates a veteran may need to establish in order to prevail on the ultimate disability claim questions.[57]

The reasonable doubt legal standard is a generous legal standard that, to this writer's knowledge, is found nowhere else in American jurisprudence. A veteran can support a rating claim with evidence only strong enough to raise a question as to whether a benefit should be granted.[58] As an aside, even before resolving reasonable doubt to the merits of the rating claim to grant higher

---

[55] 38 C.F.R. § 3.102 ("When . . . a reasonable doubt arises regarding . . . the degree of disability . . . such doubt will be resolved in favor of the claimant.").

[56] 38 U.S.C. § 5107(b) (2018) ("When there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter, the Secretary shall give the benefit of the doubt to the claimant."); 38 C.F.R. § 3.102 ("or any other point, such doubt will be resolved in favor of the claimant.").

[57] For example, in 38 C.F.R. § 4.71a, DC 5276, there could be conflicting evidence on the question of whether built-up shoe or arch support relieves foot symptoms; this one finding does not guarantee a higher rating, as severity of the foot disability is also to be considered, but whether foot symptoms are relieved is one of the criteria that would move the disability picture very close to the next higher rating. Another example is where there is evidence that a CPAP has been prescribed by a doctor but the veteran testifies that he rarely uses it, creating evidence both for and against a finding that the sleep apnea "requires use of" such breathing assistance (38 C.F.R. § 4.97, DC 6847). This principle applies even in "successive" rating criteria where a disability must meet all the lower requirements before getting a higher rating. When the rating criteria are successive, "to establish a given disability rating, all the rating criteria for that and for lower ratings must be met." Petermann v. Wilkie, 30 Vet. App. 150, 153 (2018). For example, under 38 C.F.R. § 4.119, DC 7913, the rating criteria for diabetes mellitus, a ten percent rating is warranted when the diabetes is manageable by restricted diet alone, a twenty percent rating is warranted when restricted diet plus insulin or an oral hypoglycemic agent is necessary, a forty percent rating is warranted when insulin, restricted diet, and regulation of activities is necessary, and so on with increasing severity until all the criteria for a 100 percent total disability rating are met.

[58] 38 U.S.C. § 5107(b) (2018) ("When there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter, the Secretary shall give the benefit of the doubt to the claimant."); 38 C.F.R. § 3.102 ("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."). *See* Gilbert

disability compensation, the VA has already liberally construed for the veteran whether there is a rating claim,[59] has told the veteran what is needed for a higher rating,[60] has construed legal arguments for the veteran, has helped develop evidence to support the rating,[61] and has made favorable inferences from the evidence for the veteran.[62]

2. Undifferentiated Symptoms

In the event that a veteran's service-related disability gets worse, his compensation will scale up to account for the deterioration, even if the causes of the worsening are not service-related.[63] As a practical matter, though not as

---

v. Derwinski, 1 Vet. App. 49, 54 (1990) (veteran need only demonstrate an "approximate balance of positive and negative evidence" in order to prevail.).

[59] Once a claim is received, the VA must review the claim, supporting documents, and oral testimony in a liberal manner to identify and adjudicate all reasonably raised claims. *See* EF v. Derwinski, 1 Vet. App. 324, 326 (1991); Collier v. Derwinski, 2 Vet. App. 247, 251 (1992) (holding that, although appellant had not filed form requesting individual unemployability, an informal claim was raised because appellant had repeatedly stated he was unable to work due to service-connected disability); Akles v. Derwinski, 1 Vet. App. 118, 121 (1991) (holding that VA was obliged to infer a claim for special monthly compensation where it "may be applicable and the veteran does not place his eligibility at issue"); Suttman v. Brown, 5 Vet. App. 127, 132 (1993) (stating that where a review "reasonably reveals that the claimant is seeking a particular benefit, [the Board] is required to adjudicate the issue").

[60] 38 U.S.C. § 5103(a)(1) (2018) ("The Secretary shall provide to the claimant . . . notice of any information, and any medical or lay evidence, not previously provided to the Secretary that is necessary to substantiate the claim."); 38 CFR § 3.159(b) (defining types of evidence VA must notify veteran is needed to substantiated a claim); Vazquez-Flores v. Shinseki, 580 F.3d 1270, 1273–74 (Fed. Cir. 2009) (specifying type of notice VA must give veteran in a claim for increased rating).

[61] 38 U.S.C. § 5103A (2018) ("The Secretary shall make reasonable efforts to assist a claimant in obtaining evidence necessary to substantiate the claimant's claim for a benefit" that include requesting documents and providing medical examinations and medical opinions); 38 C.F.R. 3.159(c) (detailing types of evidence VA must help veteran obtain or develop); Norris v. W., 12 Vet. App. 413, 417 (1999) (holding that VA failed to assist by requesting medical records and records of hospitalization for veteran seeking increased disability rating); Golz v. Shinseki, 590 F.3d 1317 (Fed. Cir. 2010) (holding that VA has obligation to secure Social Security records if there exists reasonable possibility that records would help substantiate claim).

[62] Shockley v. West, 11 Vet. App. 208, 214 (1998) (stating that VA is required to apply all relevant law in adjudicating claim even though not raised by the appellant).

[63] The exclusion from compensation of disability that is caused by non-service-related disorder is generally only applied at the time secondary service connection is granted under 38 C.F.R. § 3.310, when the service-connected disability is determined to have worsened (though not caused) the non-service-related disorder; afterwards, there is no similar mechanism to exclude from compensation worsening of service-connected disability due to

a matter of law,[64] the VA pays the veteran compensation for all the undifferentiated non-service-related impairments that worsen the service-connected disability.[65] For example, if a veteran's back injury is service-connected, all subsequent back pain will be considered service-connected, even if the additional back pain is actually due to age, lack of exercise, or obesity. By not discounting for non-service-related factors that worsen the service-connected disability, the VA uses the Rating Schedule to maximize compensation for the service-connected disability.

3. By Analogy

Where a disability is not specifically listed by name or diagnosis in the VA Rating Schedule, the Rating Schedule provides a mechanism to capture and compensate for the functional impairment caused by the disability. Under 38 C.F.R. § 4.20, unlisted disabilities can be rated by analogy to a disability with similar functional impairment, anatomical location, and symptoms.[66] For example, a veteran's non-migraine headaches could be rated as analogous to migraine headaches.[67]

4. Similar Symptoms

The VA Rating Schedule provides the means to recognize, rate and compensate for functional impairment even when such impairment is not specifically set forth in the text of the Rating Schedule. The "built-in versatility"[68] of

---

non-service-related factors. In virtually all cases of subsequent worsening of the service-connected disability for any reason, it is too factually and medically difficult to differentiate such non-service-related causes that worsened the disability. For example, where a veteran is service-connected for diabetes caused by herbicide exposure (presumed), all worsening of the diabetes and its complications will be considered service related and compensated, even if the later worsening is actually due to non-service-related factors of obesity, smoking, age, sedentary lifestyle, and poor nutrition.

[64] 38 C.F.R. § 4.14 ("Avoidance of Pyramiding . . . the use of manifestations not resulting from service-connected disease or injury in establishing the service-connected evaluation, and the evaluation of the same manifestation under different diagnoses are to be avoided.").

[65] Mittleider v. West, 11 Vet. App.181, 182 (1998) (holding that undifferentiated symptoms are rated as symptoms of the service-connected disability).

[66] 38 C.F.R. § 4.20 ("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."). 38 C.F.R. § 4.27 ("When an unlisted disease, injury, or residual condition is encountered, requiring rating by analogy, the diagnostic code number will be 'built up'" by showing both the underlying disability and the disability to which it is rated by analogy).

[67] *See* 38 C.F.R. § 4.124a, DC 8100 (migraine).

[68] *See* Mauerhan v. Principi, 16 Vet. App. 436, 443 (2002) (recognizing the Rating Schedule for psychiatric disorders at 38 C.F.R. § 4.130 has a "built-in versatility" that allows

the Rating Schedule enables adjudicators to award compensation for symptoms that are not mentioned by name in the Rating Schedule but are similar enough to a symptom or functional impairment recognized by the Rating Schedule.[69]

For example, when rating orthopedic disabilities, the rating criteria specifically include painful motion.[70] The inclusion, by symptomatology, of painful motion contemplates a range of activity restrictions that, while not literally listed in the Rating Schedule, are caused by joint pains, such as difficulty bending, lifting, sitting for prolonged periods, standing for prolonged periods, walking for prolonged periods, dressing oneself, exercising, mowing the lawn, working overhead, and climbing stairs or ladders.[71]

As another example of how the Rating Schedule criteria contemplate impairment not literally listed, thereby reducing any purported need for resort to the extra-schedular rating system, the hearing loss rating criteria provide for compensation ratings based on all levels of hearing loss in various contexts, as measured by both audiometric testing and speech recognition testing.[72] The hearing loss Rating Schedule criteria contemplate the following impairments that are not literally listed in the Rating Schedule criteria:

---

for rating based on similar symptoms that are not literally in the Rating Schedule).

[69] *Mauerhan*, 16 Vet. App. at 442 (schedular rating criteria rate by analogy psychiatric symptoms that are "like or similar to" those explicitly listed in the schedular rating criteria for rating mental disorder ratings at 38 C.F.R. § 4.130). Other examples, include: 38 C.F.R. § 4.114, DC 7345 ("such as" symptoms listed to rate chronic liver disease), DC 7354 ("such as" symptoms listed to rate hepatitis); 38 C.F.R. § 4.88b, DC 6314 ("such as" symptoms listed to rate beriberi heart disease).

[70] *See, e.g.*, 38 C.F.R. § 4.40 (stating that functional loss may be due to factors that include pain, recognizing that "a part which becomes painful on use must be regarded as seriously disabled"); 38 C.F.R. § 4.45 (directing that, in rating joint disabilities, pain on movement will be considered); 38 C.F.R. § 4.59 (directing that painful motion is an important factor of arthritis disability).

[71] *See* 38 C.F.R. § 4.40 (listing factors including pain that hinder normal working movements of the joints, including impairment of excursion, strength, speed, coordination, and endurance); 38 C.F.R. § 4.45 (directing that, in rating joint disabilities, pain on movement is one factor of disability that can cause reductions in normal excursion of joint movements in different planes); 38 C.F.R. § 4.59 (directing that painful motion is an important factor of arthritis disability of the respective joint being rated, and indicates findings and indicia such as facial expression, wincing, muscle spasm, crepitation, and pain on flexion and weight bearing that indicate a painful joint); 38 C.F.R. § 4.71 (using plates that show normal ranges of motion of all major joints as a base to measure limitations of joint motion).

[72] *See* 38 C.F.R. § 3.385 (reflecting audiometric and speech recognition measures used to establish the presence of hearing loss disability); 38 C.F.R. § 4.85(a) (providing that examinations for hearing impairment for VA purposes must include a controlled speech discrimination test and a puretone audiometry test); 38 C.F.R. § 4.85(h) (providing tables

difficulty understanding instructions, understanding conversations in a noisy room or with background noise, hearing sirens, using the telephone, locating where sounds originate, and hearing soft voices, as well as the need to use hearing aids, the need to turn up the television or radio volume, and the need to ask others to repeat themselves.

For a third example, psychiatric symptoms that are not literally listed in the Rating Schedule are fully encompassed as "like or similar to" Rating Schedule criteria.[73]

5. Unproven Rating Elements

The VA Rating Schedule anticipates "atypical instances" where the evidence of disability or impairment fails to show that the veteran meets the Rating Schedule criteria.[74] In such cases, the VA may waive some of the Rating Schedule criteria in order to justify a grant of the higher rating option and payment of higher-end compensation to the veteran.[75] For example, if a knee disability is painful and locks, but there is no effusion, notwithstanding the

---

converting puretone threshold average scores and speech discrimination scores into Roman numerals used to calculate the rating percentage).

[73] *See* The General Rating Formula for Mental Disorders at 38 C.F.R. § 4.130 rates upon differing levels of occupational and social impairment, with the type and severity of symptoms as illustrative only. Examples include anhedonia, which is literally not in the Rating Schedule but is like or similar to Rating Schedule criteria of depressed mood (thirty percent rating) or disturbances of motivation and mood (fifty percent rating); and homicidal ideation, which is like or similar to Rating Schedule criteria of disturbances of motivation and mood (fifty percent rating), impaired impulse control (seventy percent rating), or persistent danger of hurting self or others (100 percent rating). Other examples of symptoms that are not literally listed in the Rating Schedule criteria, but that are contemplated by the comprehensive Rating Schedule criteria include, intrusive thoughts, which are like or similar to Rating Schedule criteria of impaired judgment (fifty percent rating), obsessional rituals which interfere with routine activities (seventy percent rating), or deficiency in thinking (seventy percent rating), recklessness, which is like or similar to Rating Schedule criteria of impaired impulse control (seventy percent rating), and social isolation, which is like or similar to Rating Schedule criteria of disturbances of motivation and mood (fifty percent rating), difficulty establishing and maintaining effective work and social relationships (fifty percent rating), or inability to establish and maintain effective relationships (seventy percent Rating).

[74] 38 C.F.R. § 4.21 ("In view of the number of atypical instances it is not expected, especially with the more fully described grades of disabilities, that all cases will show all the findings specified. Findings sufficiently characteristic to identify the disease and the disability therefrom, and above all, coordination of rating with impairment of function will, however, be expected in all instances.").

[75] *See id.* ("[I]t is not expected . . . that all cases will show all the findings specified.").

Rating Schedule lists all three criteria, the VA may find the presence of only two of the three requirements is enough to pay compensation.[76]

6. 100 % Compensation for Surgery, Recovery, and for Set Periods of Time

The VA Rating Schedule pays 100% compensation for extended hospital stays during surgery[77] and for the recuperation and convalescence period after surgery, which can be extended for up to a year if there are persistent complications.[78]

The VA Rating Schedule pays 100% compensation for the period, often six months or one year, following certain treatments or surgeries,[79] regardless of whether a veteran recuperates earlier or even returns to full-time work. For certain procedures such as joint replacements, for example, the Rating Schedule pays a minimum amount of compensation after the joint replacement, regardless of the actual level of functional impairment,[80] and compensation can be increased beyond the minimum level if there are severe complications or more severe functional impairment. The Rating Schedule also provides minimum ratings for certain disabilities,[81] which can always receive a higher rating for actual functional impairments that are worse than the minimum.

7. Regulations Guide to Higher Ratings

Regulations that precede the current VA Rating Schedule's diagnostic codes provide guidance and explain how to rate disabilities.[82] These regulations work "in tandem"[83] with the diagnostic codes, by providing guidance that

---

[76] *See* 38 C.F.R. § 4.71a, DC 5258 (twenty percent rating requires frequent episodes of locking, pain, and effusion into the joint).

[77] 38 C.F.R. § 4.29 (providing a 100 percent "temporary total" rating "without regard to other provisions of the rating schedule when it is established that a service-connected disability has required hospital treatment in a [VA] or an approved hospital for a period in excess of 21 days").

[78] 38 C.F.R. § 4.30.

[79] *See, e.g.*, 38 C.F.R. § 4.71a, DC 5051–56 (100 percent for one year following major joint replacements); 38 C.F.R. § 4.115b DC 7531 (100 percent for one year following kidney transplant).

[80] *See, e.g.*, 38 C.F.R. §4.71a, DC 5051–56 (providing a minimum twenty percent or thirty percent for major joints).

[81] *See, e.g.*, 38 C.F.R. § 4.115b , DC 7531 (minimum thirty percent for kidney transplant), DC 7532 (minimum twenty percent for renal tubular disorders); 38 C.F.R. § 4.124a, DC 8000–12, 8018–25 (minimum rating percentage for organic diseases of the central nervous system).

[82] Southall-Norman v. McDonald, 28 Vet. App. 346, 351 (2016).

[83] *See* Petitti v. McDonald, 27 Vet. App. 415, 424 (2015) (recognizing and applying "regulations that precede the rating schedule" that "explain how to arrive at proper evaluations

often results in higher compensation for disabled veterans. For example, the regulations before promulgation of the current joint (orthopedic) rating criteria direct that a painful joint must receive a minimum rating of ten percent even if the joint does not show loss of motion otherwise sufficient to justify ten percent compensation.[84] These regulations result in higher compensation for periods when a disability is at its worst,[85] even though this means paying the higher amount of compensation to the veteran for those intermittent periods when the symptoms have waned or the relevant disorder is dormant or relatively inactive.[86]

8. Separate Compensation Payments for Separate Problems

The Rating Schedule fully and separately compensates veterans in situations where a single disability triggers separate functional impairments. For example, if knee arthritis later causes the knee to become unstable, the VA will recognize and pay separate compensation for two disabilities—arthritis and instability—both of which affect the same knee.[87]

In many cases, the Rating Schedule itself anticipates future complications or progressions of certain disabilities, and provides separate and distinct disability recognition and separate ratings (separate compensation) for those complications without requiring a veteran to prove the complication is related

---

under the" diagnostic codes") (citing DeLuca v. Brown, 8 Vet. App. 202, 204–08 (1995)) (citing Schafrath v. Derwinski, 1 Vet. App. 589, 599–93 (1991)). *See* Pierce v. Principi, 18 Vet. App. 440, 445 (2004) (noting the "application of and interplay" between these regulations and the Rating Schedule criteria).

[84] *See* 38 C.F.R. §§ 4.40, 4.45, 4.59, as interpreted by *DeLuca*, 8 Vet. App. at 204–08 (pain is capable of causing additional limitation of motion beyond what is clinically measured); Burton v. Shinseki, 25 Vet. App. 1, 4 (2011) (38 C.F.R. § 4.59 makes available a ten percent rating for joint pain of all major joints, not just arthritic joints.); *Petitti*, 27 Vet. App. at 424 (holding that painful motion of joint was limited motion as required for ten percent rating) (applying 38 C.F.R. § 4.59 and Rating Schedule criteria).

[85] *See* Sharp v. Shulkin, 29 Vet. App. 26, 34–36 (2017) (holding that VA must elicit information regarding the severity, frequency, duration, or functional loss manifestations during flare-ups and must attempt to compensate for limitations during flare-ups); *DeLuca*, 8 Vet App. 202 (requiring a medical opinion as to whether there would be additional limitation of motion during pain/flare-ups of pain).

[86] For other examples of such preamble regulatory guidance, *see* 38 C.F.R. § 4.69 (recognizing that a favored hand receives higher compensation under various diagnostic codes); 38 C.F.R. § 4.88a (directing minimum fifty percent rating for new onset of chronic fatigue syndrome).

[87] *See* VAOPGCPREC 23-97, VAOPGCPREC 9-98 (finding that that rating of knee limitation of motion due to pain and separate rating for knee instability was not pyramiding). *See also* VAOPGCPREC 9-2004 (finding that separate ratings may be provided for both limitation of extension and limitation of flexion of the same joint).

to the service-connected disability. For example, when objective neurological symptoms, such as peripheral neuropathy, manifest in a veteran who suffers from a lower back disability, separate compensation is paid for the neurological disorder, on top of the compensation that he is already paid for his back injury.[88]

9. Built-In Safeguards Against Reductions in Compensation

In some cases, the Rating Schedule operates to protect a veteran's compensation so that, even if the veterans' disability improves, the amount of compensation cannot be reduced.[89] VA rating regulations provide rigorous due process[90] and require a strong evidentiary showing of material improvement[91] before a rating (monetary compensation) can be reduced.

10. Disorders that Do Not Affect Work

Notwithstanding the premise that disability is based on average occupational impairment, the Rating Schedule even provides compensation for a few disorders that are not typically occupationally impairing,[92] like erectile dysfunction,[93] in addition to some gynecological disorders, such as atrophied ovaries.[94]

11. "Special" Monthly Compensation

The Rating Schedule has an entire scheme dedicated to ensuring payouts to deserving veterans of "special" monthly compensation,[95] over and above the regular compensation amounts for "special" functional limitations. These "special" functional limitations include, but are not limited to, loss, or loss of

---

[88] *See* 38 C.F.R. § 4.71a, General Rating Formula for Diseases and Injuries of the Spine, Note 1 ("Evaluate any associated objective neurologic abnormalities . . . separately, under an appropriate diagnostic code.").

[89] *See* 38 C.F.R. § 3.951 ("[A] disability which has been continuously rated at or above any evaluation of disability for 20 or more years for compensation purposes . . . will not be reduced.").

[90] 38 C.F.R. § 3.105(e) (outlining due process to reduce a disability rating).

[91] 38 C.F.R. § 3.344(a) (requiring full and complete examinations, and prohibiting reduction on the basis of a single examination, and cautions for when diagnoses change, and requires that that "the improvement will be maintained under the ordinary conditions of life."). *See* Brown v. Brown, 5 Vet. App. 413, 416, 419–420, 422 (1993) .

[92] *See, e.g.*, 38 C.F.R. § 4.79, DC 6023 (loss of eyebrows); 38 C.F.R. § 4.97, DC 6504 (disfigurement of the nose); 38 C.F.R. § 4.118, DC 7823 (vitiligo; loss of skin pigmentation), DC 7831 (alopecia; loss of hair); 38 C.F.R. § 4.118 (some skin disfigurement characteristics).

[93] 38 C.F.R. § 4.115b, DC 7522 (penile deformity), DC 7523 (atrophy of testicles).

[94] 38 C.F.R. § 4.116, DC 7620 (twenty percent rating and special monthly compensation provided for atrophy of both ovaries).

[95] *See* 38 U.S.C. § 1114 (2018); 38 C.F.R. § 3.350.

use, of limbs, vision, reproductive organs, or speech; the need for assistance of another person; or if a veteran is bedridden.[96] Special monthly compensation under this section of the Rating Schedule is intended to provide compensation coverage for those rare and unique impairments which result from combinations of certain disabilities and which otherwise may escape coverage by other sections of the Rating Schedule.[97]

12. Compensation for Subjective Symptoms

In many cases, a veteran's own lay-verified symptoms or impairments, some of which are subjective and diagnostically unverifiable, are sufficient as a basis for the payment of compensation under the Rating Schedule. For example, a ten percent rating is provided for reported ringing in the ears (tinnitus), where the only underlying evidence required for such a rating is the provision of consistent lay statements.[98]

13. Conclusion: Nearly All Conceivable Impairments Are Compensated Under the VA Rating System Without Resort or Reference to the Extra-Schedular Rating System

The comprehensive Rating Schedule successfully provides criteria to rate every type of disability. The Rating Schedule has a variety of measures to score the symptoms and functional impairment, and has a host of legal mechanisms to recognize virtually all types of functional impairment. It will indeed be the unique and rare case when the entire Rating Schedule could not adequately compensate a veteran for an identified impairment.

C. Legal Principle No. 3: Extra-Schedular Claims Must Be Raised

An extra-schedular rating claim can and must be raised before the VA by the evidence of record, by a veteran,[99] or representative, or by the Board.[100] When

---

[96] *See* 38 U.S.C. § 1114 (2018); 38 C.F.R. § 3.350; 38 C.F.R. § 3.352 (criteria for determining need for aid and attendance or for being bedridden); 38 C.F.R. § 3.383 (special compensation for paired organs and extremities).

[97] Such combinations include loss of use of both legs or feet, both arms or hands, one hand and one foot, both eyes, or three extremities. *See* 38 U.S.C. § 1114 (2018); 38 C.F.R. § 3.350.

[98] 38 C.F.R. § 4.87, DC 6260; Charles v. Principi, 16 Vet. App. 370, 374 (2002) (holding that "ringing in the ears is capable of lay observation.").

[99] *See* Bd. of Veterans' Appels, Op. Counsel, Prec. 6-96 (Aug. 16, 1996).

[100] *See* Colayong v. West, 12 Vet. App. 524, 536 (1999) (holding that the Board must consider referral for extra-schedular consideration "[w]here there is evidence in the record that shows exceptional or unusual circumstances or where the veteran has asserted that a schedular rating is inadequate"); *Thun*, 22 Vet. App. at 115 ("When either a claimant or the evidence of record suggests that a schedular rating may be inadequate, the Board must specifically adjudicate the issue of whether referral for an extraschedular rating is warranted.");

a rating claim is appealed from the Board to the Veterans Court, the issue of extra-schedular rating must be specifically raised before the Court.[101] Unless and until an extra-schedular issue is alleged (even without proof) or is raised by the record, no extra-schedular referral question has, in fact, been raised.[102]

At the Veterans Court level, the burden is on the party asking for an exception from the VA Rating Schedule to make a two-part pleading: first, that application of the VA Rating Schedule is inadequate or impractical in his or her case, and, second, that there is an exceptional or unusual impairment at issue.[103] A party is generally precluded from raising arguments or issues before the Veterans Court that were not raised below before the Board.[104]

Smallwood v. Brown, 10 Vet. App. 93, 98 (1997) (holding that the Board must address "the issue of whether an extra-schedular rating is warranted [when it] is reasonably raised by the Board's own factual findings").

[101] *See* Dingess v. Nicholson, 19 Vet. App. 473, 499 (2006) (holding that if 38 C.F.R. § 3.321(b) was not sought by veteran nor reasonably raised by facts found by Board, then Board was not required to discuss whether referral was warranted); Cromer v. Nicholson, 19 Vet. App. 215, 217 (2005) ("[I]ssues not raised on appeal are considered abandoned"); *Yancy v. McDonald*, 27 Vet. 484, 494 (2016) (stating "that the Board is required to address whether referral for extraschedular consideration is warranted . . . only when the issue is argued by the claimant or reasonably raised by the record"); *See* Doucette v. Shulkin, 28 Vet. App. 366, 372 (2017) (holding that either the veteran must protest assignment of a schedular rating as inadequate or the evidence must present exceptional or unusual circumstances) ("[T]he appellant did not assert below that his scheduler rating was inadequate, and he does not now otherwise identify any evidence of record which reveals that his hearing loss presents an exceptional or unusual disability picture. Accordingly, the Court holds that the Board was not obligated to discuss extraschedular referral in this case.").

[102] *See* 38 C.F.R. § 3.102 ("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. . . . . [not] pure speculation or remote possibility"); 38 C.F.R. § 4.20 ("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 rating assigned to organic diseases and injuries be assigned by analogy to conditions of functional origin.").

[103] *See* 38 C.F.R. § 3.321(b).

[104] *See* Pederson v. McDonald, 27 Vet. App. 276, 283–84 (2015) (en banc) (discussing the court's power to decline to address an issue over which it has jurisdiction when raised for the first time on appeal). *See also* Maggitt v. West, 202 F.3d 1370, 1377 (Fed. Cir. 2000) ("while the Veterans Court may hear legal arguments raised for the first time with regard to a claim that is properly before the court, it is not compelled to do so in every instance."); Carbino v. West, 168 F.3d 32, 34 (Fed. Cir. 1999) ("An improper or late presentation of an issue or argument under the court's rules need not be considered and, in fact, ordinarily should not be considered.").

The Veterans Court may not raise extra-schedular issues *sua sponte*.[105] The Veterans Court is limited to the facts found[106] by the Board and the Board's determination as to whether, based on those facts, an extra-schedular claim has been properly raised.[107]

D. Legal Principle No. 4: Identify What Is So "Exceptional or Unusual" About the Disability or Impairment such that Resort to the Extra-Schedular Rating System Is Justified

Some impairment that is *not* contemplated by the Rating Schedule must be identified. As stated in legal principle no. 1, *supra*, identifying what is *not* contemplated by the Rating Schedule requires knowledge as to what impairment *is* covered by the Rating Schedule, as the Rating Schedule must be exhausted in order to justify classification of an impairment that is "extra" to or outside of the Rating Schedule. Any analysis of extra-schedular referral questions triggers the essential threshold question: Is there a unique functional impairment in this case that is *not* compensated for by the Rating Schedule?

As indicated in legal principle no. 3, *supra*, raising an extra-schedular issue requires some identification by either the veteran or the evidence of record of the unique impairment as part of the two-part pleading or evidentiary showing in the record that the VA Rating Schedule is inadequate in its provision for the claimed disability or impairment.[108]

The burden of raising an extra-schedular rating issue (by anyone, including a veteran, the evidence, the VA, the Board, or even the Veterans Court during Board referral review)[109] should include the burden to specifically identify the

---

[105] *See* Sanchez-Benitez v. Principi, 259 F.3d 1356, 1363 (Fed. Cir. 2001) (holding that Veterans Court erred when "on its own, [it] found that there was nothing in the record to suggest that Mr. Sanchez-Benitez's case was 'exceptional or unusual.'").

[106] *See* Kuppamala v. McDonald, 27 Vet. App. 447, 454 (2015) ("extraschedular consideration is not a question of opinion or discretion, but one of fact . . . . Clearly, this is a fact-driven analysis assessing a veteran's unique disability picture and whether that picture results in an average impairment in earning capacity significant enough to warrant an extra-schedular rating.").

[107] *See., e.g.*, Dingess v. Nicholson, 19 Vet. App. 473, 499 (2006) (recognizing the proper standard of review for extra-schedular claims).

[108] *See* 38 C.F.R. § 3.321(b) (2018); Fisher v. Principi, 4 Vet. App. 57, 59(1993) ("As this [c]ourt interprets 38 C.F.R. §§ 3.321 and 4.16 (b), the rating schedule will apply unless there are "exceptional or unusual" factors which would render application of the schedule impractical."); *Thun*, 22 Vet. App. at 115 ("The threshold factor for extraschedular consideration is a finding that the evidence before VA presents such an exceptional disability picture that the available schedular evaluations for that service-connected disability are inadequate.").

[109] *See* Dingess v. Nicholson, 19 Vet. App. 473, 499 (2006) ("[T]his [c]ourt's review is limited to the facts found by the Board and to a determination of whether, based on those

unique functional impairment that will serve as the claimant's ticket to the extra rail. The *unique functional impairment*, not just a symptom, must be identified.[110] Symptoms listed in the Rating Schedule are not, by definition, extra-schedular, but are proxies for impairment for some disabilities; therefore, identification of a single symptom does not necessarily identify an exceptional or unusual disability that is so uniquely functionally impairing as to raise an extra-schedular issue. If, in a given case, the Veterans Court cannot identify the extra-schedular impairment, a claim for referral of extra-schedular rating in fact has not been raised.

In cases where an extra-schedular impairment is not identifiable, the Veterans Court is to review the Board's decision on referral under the clearly erroneous standard of review.[111] In the absence of evidence of "exceptional or unusual circumstances," the Board's non-referral of an extra-schedular question under 38 C.F.R. § 3.321 for adjudication is harmless error.[112]

facts, a claim for 38 C.F.R. § 3.321(b)(1) extraschedular consideration was reasonably raised and should have been discussed.").

[110] As stated in legal principle no. 1, *supra*, the impairment must be exceptional or unusual; an impairment listed in the Rating Schedule, *ipso facto*, has been contemplated to be a typical symptom or impairment or measure of impairment of the service-connected disability being rated, and so is, by definition, *not extra*-schedular.

[111] 38 U.S.C. § 7261(a)(4) (2018) ("In any action brought under this chapter, the Court of Appeals for Veterans Claims, to the extent necessary to its decision and when presented, shall . . . in the case of a finding of material fact adverse to the claimant made in reaching a decision in a case before the Department with respect to benefits under laws administered by the Secretary, hold unlawful and set aside or reverse such finding if the finding is clearly erroneous."). *See* Thun, 22 Vet. App. at 115; Johnston v. Brown, 10 Vet. App. 80, 84 (1997); Cromley v. Brown, 7 Vet. App. 376, 378 (1995) (citing Gilbert v. Derwinski, 1 Vet. App. 49, 53 (1990)).

[112] *See* 38 U.S.C. § 7261(b)(2) (2018) (The Court of Appeals for Veterans Claims shall "take due account of the rule of prejudicial error."). *See also* Fisher v. Principi, 4 Vet. App. 57, 59 (1993) ("[I]n the absence of exceptional or unusual circumstances, the failure to deal with [a different type of extra-schedular rating under 38 C.F.R. § 4.16(b) that has the same referral standard as 38 C.F.R. 3.321 (2018)] would at the most be harmless error."); Bagwell v. Brown, 9 Vet. App. 337, 339 (1996) (holding no prejudice to appellant resulted from Board's non-referral where factors not capable of raising extra-schedular referral were identified); Shipwash v. Brown, 8 Vet. App. 218, 227 (1995) (finding no exceptional or unusual circumstances that would have required Board to discuss possibility of extra-schedular referral); *Thun*, 22 Vet. App. at 115 (holding that where the assertions are not capable of raising extra-schedular referral, there is no harm in the Board's denial of referral).

E. Legal Principle No. 5: Secondary Service Connection Requires a Claim and Adjudication

Secondary service connection is available when a service-connected disability causes or worsens a primary disability that the Rating Schedule has not already recognized as a complication or byproduct of some other, already recognized service-connected disability.[113] VA regulation specifically provides that a secondary disability will be recognized as a distinct disability, assigned a separate diagnostic code, and will be entitled to separate monetary compensation.[114] Secondary service connection claims are common and are much easier for a veteran to establish than an extra-schedular rating.

A claim for secondary service connection may be raised by the veteran at any time during his or her lifetime.[115] Such secondary service connection claims are also liberally implied by the VA and raised for a veteran when the evidence suggests a secondary relationship. For example, if the pain and range of motion limitations that have resulted from a service-connected back injury

---

[113] 38 C.F.R. § 3.310(a)–(b) ("disability which is proximately due to or the result of a service-connected disease or injury shall be service connected. . . . Any increase in severity of a nonservice-connected disease or injury that is proximately due to or the result of a service-connected disease or injury, and not due to the natural progress of the nonservice-connected disease, will be service connected."). *See* Libertine v. Brown, 9 Vet. App. 521, 522 (1996) (recognizing that if "a service-connected disability causes another disability to occur, the appropriate course is to grant secondary service connection and . . . rate the disabilities separately"). *See also* Allen v. Brown, 7 Vet. App. 439 (1995) (holding that secondary service connection is available where the service-connected disability aggravates a non-service-related disorder). In order to establish service connection for a claimed secondary disorder, there must be medical evidence of a current disability, evidence of a service-connected disability, and medical evidence of a nexus between the service-connected disability and the current disability. *See* Wallin v. West, 11 Vet. App. 509, 512 (1998); Reiber v. Brown, 7 Vet. App. 513, 516–17 (1995).

[114] 38 C.F.R. § 3.310(a)–(b) ("[D]isability which is proximately due to or the result of a service-connected disease or injury shall be service connected. . . . Any increase in severity of a nonservice-connected disease or injury that is proximately due to or the result of a service-connected disease or injury, and not due to the natural progress of the nonservice-connected disease, will be service connected."). *See* Libertine v. Brown*,* 9 Vet. App. 521, 522 (1996) (recognizing that if "a service-connected disability causes another disability to occur, the appropriate course is to grant secondary service connection and . . . rate the disabilities separately,").

[115] There is no statute of limitations for filing compensation claims, either for original claims for service connection (asking for the disability to be recognized as related to service) or for increased ratings (higher compensation) for disabilities that are already found by the VA to be service-connected. A veteran can raise a claim at any time, even decades after service, and can endlessly file new claims and submit new evidence in pursuit of a benefit.

(an orthopedic disorder) are so persistent and severe that they cause depression, secondary service connection and separate compensation is available for the related and diagnosed depressive disorder (a psychological disorder).[116]

In this way, the availability of a secondary service connection designation serves a function similar to that of the extra-schedular ratings, namely, to compensate for functional impairments that exist as a consequence of some recognized primary disability.[117] The former does so, however, first by explicitly granting service connection for the secondary disability and then consulting the Rating Schedule to separately rate and compensate the secondary disability. Because the Rating Schedule covers every body system and every body part, the numerous avenues to recognition and compensation under the Rating Schedule criteria are available for purposes of classifying and grading the secondary impairment. To the extent the comprehensive Rating Schedule is available to rate such secondary complications and impairments, an extra-schedular rating is precluded.

F. Legal Principle No. 6: Only Doctors Are Qualified to Diagnose the Causes of Medical Conditions (Colvin Rule)

The Veterans Court has held that the Board may not substitute its own medical judgment on questions of medical causation, but must rely on the medical evidence found in the record.[118] Such assertion of medical relationship in the absence of medical evidence showing the relationship would involve speculation.[119] There is a large body of the Veterans Court's case law, spearheaded by *Colvin*, that discourages speculation about medical relationships.[120]

---

[116] Psychological disorders are separately ratable under the General Rating Formula for Mental Disorders at 38 C.F.R. § 4.130.

[117] The secondary service connection regulation at 38 C.F.R. § 3.310 already anticipates certain complications as secondary to the primary disability without further proof. For example, cardiovascular disease is held to be the proximate result of the service-connected amputation or amputations, and Parkinsonism, seizures, dementias, depression, and diseases of hormone deficiency are held to be the proximate result of service-connected TBI.

[118] *See* Colvin v. Derwinski, 1 Vet. App. 171, 175 (1991) (holding that the Board is not competent to supplement the record "with its own unsubstantiated medical conclusions").

[119] *See* 38 C.F.R. § 3.102 ("[P]ure speculation and remote possibility" are not to be used in determining "the degree of disability, or any other point."); 38 C.F.R. § 4.20 ("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 rating assigned to organic diseases and injuries be assigned by analogy to conditions of functional origin.").

[120] *See* Tirpak v. Derwinski, 2 Vet. App. 609, 611 (1992) (physician's comment couched in terms of "may or may not" was held to be speculative); Stegman v. Derwinski, 3 Vet. App. 228, 230 (1992) (favorable evidence which does little more than suggest possibility of causation is insufficient to establish service connection); Obert v. Brown, 5 Vet. App. 30,

The Veterans Court, which is not a fact-finder,[121] is likewise not permitted to rely on its own medical knowledge to diagnose or find medical causation for purposes of rating. Medical relationships and secondary relationships are medical and factual questions reserved for the VA fact-finders.

G. Legal Principle No. 7: The VA Cannot Pay Twice for the Same Disability)

VA regulation prohibits paying a veteran twice for the same disability.[122] The underlying legal concept is that an agency can only pay disability compensation benefits authorized by Congress.[123]

As applied to extra-schedular ratings, the regulatory prohibition against double dipping means that symptoms or impairment already related to a service-connected disability cannot also be compensated again as extra-schedular. Symptoms related by medical evidence to a non-service-related disorder

---

33 (1993) (physician's statement that the Veteran "may" have had pertinent symptoms also implied "may or may not," and was deemed speculative); Morris v. West, 13 Vet. App. 94, 97 (1999) (diagnosis that appellant was "possibly" suffering from a disability was deemed speculative); Bloom v. West, 12 Vet. App. 185, 186–87 (1999) (treating physician's opinion that service "could have" precipitated disability found too speculative).

[121] *See* 38 U.S.C. § 7261(c) (2018) ("In no event shall findings of fact made by the Secretary or the Board of Veterans' Appeals be subject to trial *de novo* by the Court."); Hensley v. West, 212 F.3d 1255, 1263–64 (Fed. Cir. 2000) (holding that the Veterans Court should have remanded case to the Board rather than "dissecting the factual record in minute detail") ("'[I]n no event shall findings of fact made by the Secretary or Board of Veterans Appeals be subject to trial *de novo* by the Court [of Appeals for Veterans Claims].' The statutory provisions are consistent with the general rule that appellate tribunals are not appropriate for a for initial fact finding.") (alteration in original) (citing 38 U.S.C. § 7261(c) (1998)).

[122] 38 C.F.R. § 4.14, which announces the prohibition against double dipping, reads:

> Avoidance of Pyramiding. The evaluation of the same disability under various diagnoses is to be avoided. Disability from injuries to the muscles, nerves, and joints of an extremity may overlap to a great extent, so that special rules are included in the appropriate bodily system for their evaluation. Dyspnea, tachycardia, nervousness, fatigability, etc., may result from many causes; some may be service connected, others, not. Both the use of manifestations not resulting from service-connected disease or injury in establishing the service-connected evaluation, and the evaluation of the same manifestation under different diagnoses are to be avoided."

See also Esteban v. Brown, 6 Vet. App. 259, 261–62 (1994); Lyles v. Shulkin, 29 Vet. App. 107 (2017) (holding that 38 C.F.R. § 4.14 prohibits compensating a veteran twice for the same symptoms or functional impairment).

[123] *See* McTighe v. Brown, 7 Vet. App. 29, 30 (1994); Smith v. Derwinski, 2 Vet. App. 429, 432–33 (1992) (citing Office of Pers. Mgmt. v. Richmond, 496 U.S. 414, 426 (1990)) ("No equities, no matter how compelling, can create a right to payment out of the United States Treasury which has not been provided for by Congress.")).

cannot be used to find extra-schedular impairment because this would be using a non-service-related disorder as a basis for service-related compensation. If a symptom that is not yet in the Rating Schedule causes the same functional impairment as an identified symptom that is presently found in the Rating Schedule, recognition of the excluded symptom by way of extra-schedular rating would compensate the same functional impairment twice.[124]

H. Legal Principle No. 8: Stare Decisis

Stare decisis, the doctrine establishing that a court is bound by precedent, applies to prior precedential decisions.[125] Precedents of the Veterans Court are binding unless overturned by the Veterans Court *en banc* or the Federal Circuit. Veterans Court decisions, precedential or not,[126] have an outsized influence on the state of veterans law because the court's case law is the lens

---

[124] While the anti-pyramiding regulatory provisions, strictly speaking, are binding only on VA adjudicators acting as fact-finders, rather than on the Veterans Court, the Veterans Court should be guided by these principles so as not to itself pyramid compensation by finding or creating extra-schedular issues that overlap with schedular ratings, or cause the VA to pyramid by having to comply with court orders to adjudicate the same symptoms or impairment both as Rating Schedule criteria and as extra-schedular criteria. The Veterans Court should not suggest a hypothetical grant of extra-schedular benefits to VA adjudicators that is contrary to the anti-pyramiding provision. Double compensation for the same functional impairment goes well beyond the overarching rule to maximize benefits. The rule against pyramiding should also restrain the Veterans Court from engaging in fact-finding regarding the existence of extra-schedular benefits in actual cases; any pyramiding of benefits created by a Veterans Court decision that also raised an extra-schedular issue means the Veterans Court found facts that the Board did not, likely running afoul of 38 U.S.C. § 7261(c) (2018) ("In no event shall findings of fact made by the Secretary or the Board of Veterans' Appeals be subject to trial *de novo* by the Court.").

[125]

> Adherence to precedent does not mean simply refusing to overrule past decisions—it means taking them seriously as starting points for analysis in future cases. . . . [I]t reflects a need to give credence to the reasoning in earlier opinions. The willingness of judges to defer in this way to their predecessors—and their expectation of similar deference from their successors—transforms the Court from an ever-changing collection of individual judges to an institution capable of building a continuing body of law rather than merely a succession of one-time rulings.

Daniel A. Farber, *The Rule of Law and the Law of Precedents*, 90 Minn. L. Rev. 1173, 1183 (2005).

[126] To the extent that they are clear, individual Veterans Court judge memorandum decisions, which carry no precedential value, become the law of the case for the particular case before the court, and, cumulatively, affect many Board decisions and establish "trends" in veterans law. Board Veterans Law Judges and all VA adjudicators will reflexively respect and fully implement a Veterans Court decision to the extent it is discernable.

through which even primary legal authority is viewed by the Board and VA adjudicators.[127]

I. Legal Principle No. 9: The VA Rating Schedule Cannot Be "Reviewed"

"You can't let nobody run your train."

—*LeBron James*

Congress specifically prohibited the Veterans Court from reviewing the VA Rating Schedule: "The [Veterans] Court may not review the schedule of ratings for disabilities . . . or any act of the Secretary in adopting or revising that schedule."[128]

The Veterans Court is to review a Board decision rather than the underlying Rating Schedule. The Veterans Court is prohibited from finding facts in a case, even if it disagrees with the way the Board weighed the evidence to determine the level of compensation.[129]

The Veterans Court is to review Board findings of fact under the "clearly erroneous"[130] standard of review.[131] In its review of Board decisions, the Veterans Court is required to consider whether any legal errors are present in Board decisions and, if found, whether those errors are prejudicial.[132]

---

[127] The view of the Veterans Court with respect to the Board is provided in Jeffrey Parker, *Two Perspectives on Legal Authority Within the Department of Veterans Affairs Adjudication*, 1 VETERANS L. REV. 208, 216 (2009).

[128] 38 U.S.C. § 7252(b) (2018). *See* Wingard v. McDonald, 779 F.3d 1354, 1356–57 (Fed. Cir. 2015) (discussing the inability of the Veterans Court to review the schedule of ratings for disabilities); Copeland v. McDonald, 27 Vet. App. 333, 338 (2015); Prokarym v. McDonald, 27 Vet. App. 307, 311–12 (2015); Bagwell v. Brown, 9 Vet. App. 337, 338 (1996) (recognizing that awarding compensation for pain and suffering due to prolonged hospitalization amounts to impermissible "adjusting" of the Rating Schedule in contravention of the statutory prohibition, found in 38 U.S.C. § 7252(b), against "review" of the Rating Schedule).

[129] *See* 38 U.S.C. § 7261(c) (2018) ("In no event shall findings of fact made by the Secretary or the Board of Veterans' Appeals be subject to trial *de novo* by the Court.").

[130] *See* McCarroll v. McDonald, 28 Vet. App. 267, 275 (2016) (holding that the Board's determination regarding the proper disability rating to assign is a factual finding subject to clear error review); Roberts v. Shinseki, 23 Vet. App. 416, 423–24 (2010) (holding that a factual finding must be affirmed when there is a plausible basis in the record to support it and the reasons for it have been sufficiently explained in the Board's decision).

[131] 38 U.S.C. § 7261(a)(4) (2018) ("[I]n the case of a finding of material fact adverse to the claimant . . . [the Veterans Court may] hold unlawful and set aside or reverse such finding if the finding is clearly erroneous.").

[132] *See* 38 U.S.C. § 7261(b)(2) (2018) (providing that the Veterans Court "shall take due account of the rule of prejudicial error.").

The Veterans Court insists its VA oversight has never run afoul of the prohibition against "review" of the Rating Schedule, notwithstanding the court's own internal debate about what constitutes review of the Rating Schedule.[133] The case law generated by the Veterans Court, however, extensively interrogates VA Rating Schedule criteria,[134] including the interpretation and application of specific diagnostic codes.[135]

---

[133] The dissent in *Copeland* provides one example of an attempt at explaining why Veterans Court holdings, which deal with the substantive content of Rating Schedule criteria, do not run afoul of the prohibition against "review" of the Rating Schedule. *See* Copeland v. McDonald, 27 Vet. App. 333, 340 (2015) (Greenberg, J., dissenting) ("we cannot, as a matter of law, question, but can only interpret, the Rating Schedule). Judge Greenberg's explanation in dissent is offered just after he accused the majority panel of coming "dangerously close" to violating the statutory prohibition of 38 U.S.C. § 7252 against reviewing the Rating Schedule. *See id.*

[134] *See, e.g.*, Williams v. Wilkie, 30 Vet. App. 134, 138 (2018) (quoting DORLAND'S ILLUSTRATED MEDICAL DICTIONARY) (defining the Rating Schedule term "deformity"); Correia v. McDonald, 28 Vet. App. 158, 165 n.4 (2016) (quoting DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 429 (32d ed. 2012) to define the Rating Schedule term "crepitation"); Johnson v. McDonald, 27 Vet. App. 497 (2016), *rev'd*, Johnson v. Shulkin, 862 F.3d 1351 (Fed. Cir. 2017), *remanded to* Johnson v. Shulkin, No. 14-2778, 2018 U.S. App. Vet. Claims LEXIS 101 (Jan. 31, 2018) (finding "systemic therapy" includes both oral and topical application when not otherwise expressly limited in the rating schedule); Jones v. Shinseki, 26 Vet. App. 56, 62 (2012) (finding Secretary's failure to include effects of medication as a consideration of diagnostic code when it has included such effects in other diagnostic codes should be viewed as deliberate); Mauerhan v. Principi, 16 Vet. App. 436, 442 (2002) (quoting WEBSTER'S NEW WORLD DICTIONARY) (to define the Rating Schedule term "such as"); Drosky v. Brown, 10 Vet. App. 251, 255 (1997) (finding that inclusion of the word "or" in the rating criteria provides an independent basis, rather than an additional requirement, for the assignment of a specific disability rating); Roby v. Wilkie, No. 17-528, 2019 U.S. Vet. Claims LEXIS 439, at *11 (Mar. 19, 2019) (defining "permitting," "passage," and "liquids" in terms of DC 7203).

[135] *See, e.g.*, Bankhead v. Shulkin, 29 Vet. App. 10, 20 (2017) (evaluating General Rating Formula for Mental Disorders and noting that the seventy percent criteria for "suicidal ideation" did not include descriptors, modifiers, or indicators, such as, "active," "passive," "intent," and/or "plan"); Johnson v. McDonald, 27 Vet. App. 497, 502 (2016) (DC 7806 lists corticosteroid use as a systemic therapy without distinguishing between types of application such as oral or topical); *Copeland*, 27 Vet. App. at 336 (holding that diagnostic code 5284 (foot injuries, other) is not "applicable to all foot conditions as a catch-all" code for rating purposes) (internal quotation marks omitted); Hudgens v. Gibson, 26 Vet. App. 558 (2014), *rev'd*, Hudgens v. McDonald, 823 F.3d 630 (Fed. Cir. 2016), *remanded to* Hudgens v. McDonald, No. 13-0370, 2016 U.S. App. Vet. Claims LEXIS 1374, at * 1–2 (Sept. 13, 2016) (finding DC 5055 applied only to total knee replacements and not to partial knee replacements); Tatum v. Shinseki, 26 Vet. App. 443, 447–48 (2014) (concluding, after consulting MERRIAM WEBSTER'S COLLEGIATE DICTIONARY 1223 (10th ed. 1999), that the term

J. Legal Principle No. 10: Final VA Decisions Must Be Respected

When a claim that presses a finding of service connection for a disability has been adjudicated by the VA and denied, that decision is legally "final."[136] A final decision denying service connection means that, as a matter of law, compensation may not be paid for the disability and/or for any related, subsequent symptoms and impairments, since an injury that has been adjudicated as unrelated to service could never produce secondary injuries or impairments that qualify as service-connected. The final VA decision that a disability, and its consequential impairments, are unrelated to service or to a service-connected disability means that the same disability and symptoms cannot be classified as extra-schedular, as this would be a *de facto* recognition that the disability is secondary to the service-connected disability, thereby undermining the finality of the applicable VA decision.[137] Even though once the claim is denied, the VA decision becomes final, a veteran may any time initiate a new claim for compensation for the same disorder so long as the new claim is supported by new evidence. Unless and until this new claim is successful, the prior decision remains final.

Most of the ten legal principles above are not specific to extra-schedular claims. Each principle, however, provides legal guidance or outright constrains reliance on extra-schedular claims or appeals. The balance of this Article will analyze Veterans Court precedents according to the ten principles.

"cessation," as it's used in 38 C.F.R. § 4.115b, DC 7528 (2013), contemplates "the cessation of treatment for the cancer itself, as opposed to treatment for residuals secondary to the cancer"); Pierce v. Principi, 18 Vet. App. 440, 445 (2004) (discussing DC 8100) (noting that "the Secretary's counsel conceded at oral argument that 'productive of' could be read as having either the meaning of 'producing' or 'capable of producing.'").

[136] Rating actions from which an appeal is not perfected become final one year after the decision. 38 U.S.C. § 7105; 38 C.F.R. § 20.1103. *See also* Cook v. Principi, 318 F.3d 1334 (Fed. Cir. 2002) (("If a veteran fails to appeal from an RO decision concerning a claim, the decision becomes 'final,' and 'the claim will not thereafter be reopened or allowed, except as may otherwise be provided by regulations not inconsistent with this title.'") (quoting 38 U.S.C. § 7105(c)); Sims v. Shinseki, 578 F.3d 1332 (2009). Board decisions are final when issued. *See* 38 U.S.C. § 7104 (2018); 38 C.F.R. § 20.1100.

[137] *See, e.g.*, McEachin v. Shinseki, No. 13-0172, 2014 U.S. App. Vet. Claims LEXIS 332 (Vet. App. Mar. 6, 2014). In *McEachin*, a Veterans Court judge who failed to recognize a prior final VA denial of service connection for disability, seemed to suggest that disorders of tinnitus, ear pain, and headaches, for which VA had already denied service connection, should be considered under extra-schedular analysis for the hearing loss issue.

III. Early Extra-Schedular Precedent, 1990-2016

In seventeen precedential decisions[138] from the inception of the Veterans

[138] *See* Moyer v. Derwinski, 2 Vet. App. 289, 293–94 (1992) (remanding for development by Board of reasons and bases supporting determination of applicability of extra-schedular ratings where Board had not correctly applied Rating Schedule criteria in first instance); Roberts v. Derwinski, 2 Vet. App. 387 (1992) (vacating Board decision that had failed to address extra-schedular impairment in pension case, even though extra-schedular rating system is not applicable to pension cases); Fisher v. Principi, 4 Vet. App. 57, 60 (1993) (stating several guiding principles applicable to extra-schedular referral questions, but doing so in context of claim to which extra-schedular rating under 38 C.F.R. § 3.321(b) is inapplicable); Kellar v. Brown*,* 6 Vet. App. 157, 160–61 (1994) (remanding with instruction to Board to develop requisite reasons and bases with respect to extra-schedular issue, where veteran-appellant had vocally asserted an extra-schedular claim before Board, evidence supporting service-connection between back disability and impaired employment existed, and medical records and physician's letter portrayed appellant as totally disabled); Ardison v. Brown*,* 6 Vet. App. 405, 409 (1994) (finding Board's reasoning in support of an extra-schedular referral decision to be conclusory) (remanding extra-schedular claim where the record seemed to show that the veteran's feet flared-up occasionally, that he had to remove his shoes about half the time to keep his foot disorder from worsening, and that this condition required extended periods away from work and impaired employment); Shipwash v. Brown, 8 Vet. App. 218, 227 (1995) (finding harmless error in Board's failure to state whether it had considered extra-schedular referral where "exceptional or unusual" circumstances to require the Board to discuss extra-schedular referral were not raised); Floyd v. Brown, 9 Vet. App. 88 (1996) (holding that Board should not have granted extra-schedular rating in the first instance, but that such action in veteran's favor amounted to harmless error); Bagwell v. Brown, 9 Vet. App. 337, 339 (1996) (holding that averments of pain, suffering, financial expenses, incurred due to a prolonged hospital stay, did not trigger referral for extra-schedular rating); Johnston v. Brown, 10 Vet. App. 80 (1997) (vacating the Board's one line denial of claim for extra-schedular rating) (remanding decision to deny because decision was both a first instance denial of extra-schedular rating and because Board's published reasoning was conclusory, but doing so in context of case where the identified non-service-related disability could not, as a matter of law, have constituted extra-schedular disability); Smallwood v. Brown, 10 Vet. App. 93, 98 (1997) (holding that, where Board's factual development revealed symptom (drainage and odor emanating from the foot) not listed among orthopedic Rating Schedule criteria for rating foot disabilities, Board erred by not entertaining referral of claim to appropriate VA official for consideration as extra-schedular under 38 C.F.R. § 3.321(b)); Colayong v. West, 12 Vet. App. 524, 536 (1999) (vacating and remanding Board decision refusing to refer disability for extra-schedular consideration, notwithstanding fact that a claim to extra-schedular rating had never been raised); Sanchez-Benitez, 13 Vet. App. 282, 286–87 (1999) (finding no "exceptional or unusual" circumstances present to require extra-schedular referral), *but see* Sanchez-Benitez v. Principi, 259 F.3d 1356, 1362 (Fed. Cir. 2001) (holding that Veterans Court should not, *sua sponte*, make extra-schedular referral finding if Board had refused to do so below); Dingess v. Nicholson, 19 Vet. App. 473, 498–99 (2006)

Court until 2016, the Veterans Court developed little legal guidance as to its extra-schedular referral review. The first twenty-five years of Veterans Court extra-schedular decisional law reveal only a handful of cases in which some plausible extra-schedular impairment was identified. Other precedents from this same period identify some general impairment or occupational impairment sufficient to remand the case back to the Board for further fact finding or reasons and bases on the extra-schedular question. Still other precedents ostensibly identified as a potential extra-schedular issue did not identify impairment that, as a matter of law, could qualify as extra-schedular disability.

While the early precedents stayed primarily on the main rail, sometimes questioning whether a turn onto the extra rail would be proper, these cases also left the extra-schedular ratings issue open to be defined later on.

A. Cases of Plausible Extra-Schedular Impairment

In a few of its earlier precedents, the Veterans Court identified plausible *extra*-schedular impairment outside of the Rating Schedule criteria for the disability at issue. For example, in *Ardison v. Brown*,[139] the identified potential extra-schedular impairment from the service-connected athlete's foot included having to remove shoes to keep the foot disorder from worsening, and extended time away from work and impaired employment during

(finding that veteran-appellant had not raised an extra-schedular claim before Board, and that Board was not obligated to raise, *sua sponte*, the claim on the veteran's behalf, where even "a liberal reading of" the evidence did not either raise an extra-schedular claim for the Board to pursue or demonstrate the veteran's intent to seek extra-schedular rating); Thun v. Peake, 22 Vet. App. 111 (2008) (upholding Board's refusal to refer for extra-schedular consideration) (finding that a veteran's assertion of loss of earning capacity did not, without more, meet the threshold extra-schedular requirement that demands a showing that the Rating Schedule is inadequate)); Anderson v. Shinseki, 22 Vet. App. 423, 427 (2009) (reiterating *Thun* three-step analysis) (holding that any extra-schedular referral analysis by VA is conducted for limited purpose of determining whether *referral* for extra-schedular consideration is warranted) (remanding case to Board for adequate statement of reasons and bases, although relying on symptoms fully contemplated by the Rating Schedule measures for hearing loss to do so); Kuppamala v. McDonald, 27 Vet. App. 447 (2015) (remanding to Board to provide reasons and bases and to discuss where symptoms—including weight loss, loss of appetite, disturbed sleep, fatigue, memory and concentration problems, and low back and leg pain—fit in the overall disability picture); Sowers v. McDonald, 27 Vet. App. 472 (2016) (vacating Board's decision to deny extra-schedular rating and remanding extra-schedular question to Board because of intervening Federal Circuit decision, subsequently changed by VA rule, that allowed for a combination of disabilities to create extra-schedular impairment where, individually, each disability could not qualify).

[139] 6 Vet. App. 405, 409 (1994).

flare-ups. The Veterans Court found the Board's extra-schedular referral was conclusory and it remanded the issue.

In *Shipwash v. Brown*,[140] where the service-connected disability was to the little finger, the potentially extra-schedular impairment was framed as an inability to "throw a football, use a typewriter efficiently, run his hand through his hair, put his hand in his pocket," loss of employment, and likely harm to career prospects.[141] The Veterans Court found that a showing of exceptional or unusual circumstances were wanting and, thus, that the facts of the claimed impairment did not compel extra-schedular referral.[142]

In *Smallwood v. Brown*,[143] where the service-connected disability was a lasting orthopedic foot injury, the potential extra-schedular impairment identified was framed as the foul smelling drainage of the foot. The Veterans Court found the Board erred by not referring the case for extra-schedular rating.

In *Kuppamala v. McDonald*,[144] where the service-connected disability was a bowel disorder, the potential extra-schedular symptoms included weight loss, loss of appetite, and fatigue. The Veterans Court remanded the case to the Board to develop the record further as to where the symptoms listed above fit in the overall picture of compensable, extra-schedular disability.

B. Impairment Determined Not to Be Extra-Schedular

In precedents holding that the Board's rationale denying an extra-schedular referral were inadequate, neither the evidence nor the Court identified actual *extra*-schedular impairment. The failure to identify the precise extra-schedular impairment in this line of cases is attributable to the general, generic language used to frame the impairment before schedular rating.

---

[140] 8 Vet. App. 218, 227 (1995).

[141] *Id.* at 222.

[142] *Id.* at 227 ("[T]he BVA must address referral . . . only where circumstances are presented which the Director of VA's Compensation and Pension Service might consider exceptional or unusual. In this case, there was no evidence of "an exceptional or unusual disability picture with such related factors as marked interference with employment or frequent periods of hospitalization as to render impractical the application of the regular schedular standards," and thus the Board was not required to discuss [referral under 38 C.F.R. § 3.321(b)(1)].").

[143] 10 Vet. App. 93, 98 (1997).

[144] 27 Vet. App. 447 (2015) There is no similar plausible suggestion that other court-identified symptoms of disturbed sleep, memory and concentration problems, and low back and leg pain could have any relationship to the service-connected bowel disability.

In *Kellar v. Brown*,[145] (back disability) there was some general evidence of interference with employment. In *Moyer v. Derwinski*,[146] (hand and arm injury) the severe and complex nature of disabilities triggered further explanation by the Board, and in *Bagwell v. Brown*,[147] (blindness in one eye) there was an employer letter mentioning denial of employment due to disability without specifically addressing any one disability at issue.

C. Impairment Is Improperly Classified as Extra-Schedular as a Matter of Law

In other early precedents, the impairment identified as extra-schedular could not have been extra-schedular as a matter of law. For example, in *Johnston v. Brown*,[148] the identified impairment was due to a *non-service-related*

---

[145] 6 Vet. App. 156 (1994). In *Kellar*, the veteran-appellant had, "[o]n numerous occasions, . . . sought extraschedular consideration of his claim for increase" and proffered "statements . . . that his back condition . . . interfered with his employment . . . as well as a physician's letter and VA progress notes indicating that [the] appellant [wa]s totally disabled." *Id.* at 161. The Veterans Court remanded the claim after holding that that the Board failed to make the required findings of fact in supports of its "reasons or bases for [the] decision that referral [of the extra-schedular claim] . . . under 38 C.F.R. § 3.321 (1993) was not warranted." *Id.* The Veterans Court in *Kellar* recognized the ability of the Rating Schedule to encompass the symptom of pain and to provide a separate rating for neurological manifestations from the service-connected back disability. *Id.* at 160–61. *See* Roberts v. Derwinski, 2 Vet. App. 387 (1992) (where the Court similarly found a 38 C.F.R. § 3.321(b) extra-schedular claim by relying on evidence that instead raised a 38 U.S.C. § 1521(claim for pension)).

[146] 2 Vet. App. 289 (1992). The evidence in *Moyer* showed three different impairments, all ratable under the Rating Schedule. *Id.* at 289. Because the Board had prior misapplied the Rating Schedule, the veteran was already receiving a special monthly compensation package that recognized complete loss of use of the (right) hand, in addition to compensation for the separately rated service-connected disability to his hand and for an arm injury affecting bones, muscles, and nerves. *Id.* at 293. The Veterans Court found that the context of the case suggested that further "analysis"—both schedular *and* extra-schedular—was needed. *Id.* at 293–94. The case was remanded to the Board with instructions to provide such an explanation of the Board's rejection of the veteran's 38 C.F.R. § 3.321(b)(1) claim for extra-schedular rating, in the face of appellant's evidence. *Id*. The Veterans Court did not speculate as to what the extra-schedular disability might be.

[147] 9 Vet. App. 337, 339 (1996). The impairment claimed in *Bagwell* was the general denial of employment due in part to the service-connected disability at issue.

[148] In *Johnston v. Brown*, 10 Vet. App. 80 (1997), the purported extra-schedular impairment stemmed from a non-service-connected and post-service back injury that caused the veteran to be paralyzed below the waist and wheelchair-bound. Amid its own internal debate on this question, the Veterans Court held that the Board should have addressed the effects of the non-service-connected disability and the ensuing fact of being wheelchair-bound due

disability sustained *after* discharge. In *Roberts v. Derwinski*[149] and *Colayong v west*,[150] the impairment was total (100 percent),[151] whereas an extra-schedular rating can attach to one, and only one, disability that is *not* totally disabling.[152] In *Anderson v. Shinseki*,[153] the identified hearing-related symptoms—inability to participate in conversation with friends, inability to answer or use a telephone without the aid of someone on another line, and inability to understand the dialogue of speakers, newscasters, and actors on the radio, television, at church, and at the theater—while not literally in the hearing loss Rating Schedule, were captured by the Rating Schedule's audiometric and speech recognition test measures for hearing loss.[154]

D. Early Precedents Produce Minimal Guidance

The early case law in the area of VA disability rating and compensation failed to produce legal guideposts that could be deployed to constrain Veterans Courts that found themselves presiding over extra-schedular referral decisions. Moreover, these early cases neglected to set any standard requiring the referring court to formulate a precise definition of the *extra*-schedular impairment before proceeding to the question of referral outside of the conventional system. Leaving extra-schedular ratings to be defined in some way other than in relation to the Rating Schedule left room for future reasoning by the Veterans Court that symptoms not literally itemized in the Rating Schedule might be eligible for extra-schedular consideration.

IV. Contemporary Extra-Schedular Precedent, 2016-2019

> "Somehow they knew this train led to nowhere, but they were wondering what it would be like to ride on it."
>
> —*Long Black Train, Josh Turner*

to the *non-service-related* injury on the veteran's service-connected disabilities (wrist and chest pain to get out of the wheelchair and chest pain when using crutches). *See id*. at 85.

[149] 2 Vet. App. 387, 390–91 (1992) (indicating that potential extra-schedular impairment was total rating for pension).

[150] 12 Vet App. 524, 536 (1999) (indicating that potential extra-schedular impairment was total rating for compensation).

[151] *Compare* 38 C.F.R. § 4.16 (total ratings for compensation, which are based on *all* service-connected disabilities, rather than just one disability), *with* 38 C.F.R. § 4.17 (total ratings for pension, which include non-service-connected disabilities).

[152] 82 Fed. Reg. 57,830 (Dec. 7, 2017) (clarifying that extra-schedular ratings apply to only one disability, not a combination of disabilities).

[153] 22 Vet. App. 423, 427 (2009).

[154] *See* 38 C.F.R. § 3.385.

In a series of recent and self-referential precedents beginning in 2016, the Veterans Court discovered a new frontier of extra-schedular rating possibilities that were untethered from the comprehensive and tested language and byzantine structure of the VA Rating Schedule, its own pronouncements, and many of the categorically binding legal principles outlined, *supra*. Without strong precedent to remind the court of the policies undergirding its time-honored reliance on the main rail, and of the inherent hazards of resort to the extra rail in cases once considered commonplace, a new generation of conductors, without consideration, began regularly turning the trains onto the extra track.

A. In Yancy, the Veterans Court Strays Off Course

In *Yancy v. McDonald*,[155] the Veterans Court ever so slightly turned the train onto the extra rail when it held that a veteran's discomfort with prolonged standing or sitting—symptoms which are easily ratable under the Rating Schedule—somehow warranted referral for *extra*-schedular consideration. The identified service-connected disabilities, for which the veteran was already receiving compensation under the main-rail Rating Schedule, were, respectively, a bilateral foot disability, left and right knee instability, other left and right knee disabilities, hemorrhoids, eardrum rupture, varicoceles, and umbilical hernia.[156]

The Court in *Yancy* vacated the Board's nonreferral decision and remanded with instructions to the Board to address whether the veteran's myriad disabilities, when considered in the aggregate, effectively combined to produce

[155] 27 Vet. App. 484, 494 (2016) (vacating Board's finding that referral for extra-schedular consideration was unwarranted because Rating Schedule is adequate to rate particular veteran's disabilities).

[156] In *Yancy*, the foot disability of pes planus was rated at thirty percent under 38 C.F.R. § 4.71a, DC 5276, which includes severe symptomatology such as objective evidence of marked deformity (including pronation and abduction), pain on manipulation and use accentuated, an indication of swelling on use, and characteristic callosities. The right knee instability and left knee instability were each rated as ten percent under 38 C.F.R. § 4.71a, DC 5257, which is for slight instability of the knee. There was a separate knee rating for left knee medical meniscectomy rated under 38 C.F.R. § 4.71a, DC 5003 for painful limitation of motion. There was a separate knee rating for right knee retropatellar irritation, which was rated under 38 C.F.R. § 4.71a, DC 5260 for painful limitation of flexion. The hemorrhoids were rated at ten percent under 38 C.F.R. § 4.114, DC 7336, which is for large or thrombotic external or internal hemorrhoids that are irreducible, with excessive redundant tissue, and evidencing frequent recurrences. The service-connected disabilities also included a right eardrum rupture, small bilateral varicoceles, and an umbilical hernia.

a novel, unrecognized disability.[157] The Board had already made this finding in the negative.[158] The *Yancy* court was unclear as to which service-connected disabilities it relied upon to find there might be interaction between disabilities sufficient to cause extra-schedular impairment. The court's analysis was necessarily limited to the foot disability because that was the only rating issue on appeal, yet the Veterans Court, inexplicably, addressed the veteran's inability to sit for prolonged periods,[159] which was, and is, an impairment that is contemplated by the Rating Schedule. The other identified impairment—the inability to stand for prolonged periods—was, and is, contemplated by the Rating Schedule for the other service-connected painful foot and knee disabilities[160] for which the veteran had already separately been compensated.

Its reliance on Rating Schedule criteria (inability to sit or stand for prolonged periods caused by the service-connected foot, knee, and hemorrhoid disabilities, for which the veteran was already receiving compensation) to support its extra-schedular finding renders the rationale and holding produced by the *Yancy* court inconsistent with legal principle no. 1, *supra*, which

---

[157] Johnson v. McDonald, 762 F.3d 1362 (Fed. Cir. 2014) (holding that extra-schedular ratings do not only apply to standalone disabilities, but a combination of two or more disabilities could be used to find an extra-schedular rating claim had been raised); see 82 Fed. Reg. 57,830 (Dec. 8, 2017) (clarifying that extra-schedular ratings apply to only one disability at a time, not to a combination or synergy of disabilities); *supra* note 146.

[158] *Yancy*, 27 Vet. App. at 487–88.

[159] *See id*. at 484.

[160] Interference with standing is considered as part of the schedular rating criteria under 38 C.F.R. § 4.45, which contemplates "[i]nstability of station" and "interference with . . . standing and weight-bearing." Interference with sitting is also considered as part of the schedular rating criteria under 38 C.F.R. § 4.45. To the extent that prolonged standing and sitting cause incidental knee pain, such pain is considered as part of the Rating Schedule criteria, to include as due to orthopedic factors such as weakness (standing), incoordination (standing), and fatigability (standing and sitting), which are incorporated into the schedular rating criteria as applied to the particular diagnostic code. *See* DeLuca v. Brown, 8 Vet. App. 202 (1995); 38 C.F.R. §§ 4.40, 4.45, 4.59. *See* Schafrath v. Derwinski, 1 Vet. App. 589 (1991) (read together with schedular rating criteria, 38 C.F.R. §§ 4.40, 4.45 recognize functional loss due to pain); Burton v. Shinseki, 25 Vet. App. 1, 4 (2011) (the majority of 38 C.F.R. § 4.59, which is a schedular consideration rather than an extra-schedular consideration, provides guidance for noting, evaluating, and rating joint pain); Sowers v. McDonald, 27 Vet. App. 472 (2016) (38 C.F.R. § 4.59 is limited by the diagnostic code applicable to the claimant's disability, and is read in conjunction with, and subject to, the relevant diagnostic code); Mitchell v. Shinseki, 25 Vet. App. 32, 33–36 (2011) (pain alone does not constitute functional impairment under VA regulations, and the rating schedule contains several provisions, such as 38 C.F.R. §§ 4.40, 4.45, 4.59, that address functional loss in the musculoskeletal system as a result of pain and other orthopedic factors when applied to schedular rating criteria).

indicates that schedular and extra-schedular ratings are mutually exclusive. Consequently, the command of legal principle no. 4, *supra*, which instructs reviewing courts to identify "exceptional or unusual" extra-schedular impairment *before* consulting, and exhausting, the main-rail Rating Schedule, was likewise not satisfied by the decision in *Yancy*.

Because the impairment purportedly identified by the Veterans Court in *Yancy* is caused by the synergy of several different service-connected disabilities for which the veteran was already receiving full compensation, *Yancy* suggests approval for double payment on account of a single impairment as an extra-schedular disability. This result contravenes legal principle no. 7, *supra*, which disallows double dipping.[161]

B. In Doucette, the Veterans Court Marks a Path onto the Extra Rail

"Who stole that train off the track? / Whoever took it better come and put it back / I heard that engine whistle blow / It should have been here long ago"

—*Marshall Crenshaw*

In *Doucette v. Shulkin*,[162] the Veterans Court tracked the main rail, but its *dicta* wedged an opening for future trains to easily traverse in order to access the extra rail. The *Doucette* court reviewed the comprehensive nature of the hearing loss Rating Schedule criteria and held that the audiometric measures in the Rating Schedule were adequate to rate all of the veteran's hearing loss complaints ("difficulty . . .distinguishing sounds in a crowded environment, locating the source of sounds, understanding conversational speech, hearing the television, and using the telephone").[163] The court noted that these prototypical impairments "are precisely the effects . . . [the VA Rating Schedule] . . . [is] designed to measure."[164] The Board was not obligated to discuss extra-

[161] *See* 38 C.F.R. § 4.14; Esteban v. Brown, 6 Vet. App. 259, 261–62 (1994); Lyles v. Shulkin, 29 Vet. App. 107 (2017) (holding that 38 C.F.R. § 4.14 prohibits the double compensation of a veteran for the same symptoms or functional impairment); *see* McTighe v. Brown, 7 Vet. App. 29, 30 (1994); Smith v. Derwinski, 2 Vet. App. 429, 432–33 (1992) ("No equities, no matter how compelling, can create a right to payment out of the United States Treasury which has not been provided for by Congress.")).

[162] 28 Vet. App. 366 (2016).

[163] *Id.* at 371–72.

[164] *Id.* at 369. The Rating Schedule requires audiometric decibel testing and controlled speech recognition testing to measure hearing loss. *See* 38 C.F.R. § 3.385. *See also* Lendenmann v. Principi, 3 Vet. App. 345, 349 (1992) ("mechanical application of audiometric testing results to a rating table"); Bruce v. West, 11 Vet. App. 405, 409 (1998) (citing *Lendenmann*); *cf.* Hensley v. Brown, 5 Vet. App. 155, 158 (1993) ("Entitlement to service connection for impaired hearing is subject to the . . . requirements of 38 C.F.R. § 3.385, the

schedular referral because neither the veteran nor the evidence had actually raised an extra-schedular rating issue.[165]

Had the Veterans Court stopped at its actual holding in *Doucette*, the case would have been unremarkable.[166] Instead, the Veterans Court, in *dicta*,[167] suggested that in other cases certain symptoms, such as ear pain, dizziness, recurrent loss of balance, and social isolation, would require Board explanation as to whether the Rating Schedule for hearing loss contemplated those functional effects. The creation of this unfounded and tacit association between the hypothetical list of disorders and future hearing loss cases has had the unfortunate effect of precedent.[168]

The court's assumed connection between the listed symptoms (ear pain, dizziness, recurrent loss of balance, and social isolation) and hearing loss is inconsistent with several legal principles. Contrary to legal principle no. 3, which states that extra-schedular claims must be raised by the evidence, the veteran, or the Board, the Veterans Court in *Doucette* simply presumes its list of disorders is related to hearing loss.

"stated purpose" of which "was 'to establish criteria for . . . determining the levels at which hearing loss becomes disabling' and to establish 'a department-wide rule for making determinations regarding service connection for impaired hearing.'") (citing Ledford v. Derwinski, 3 Vet. App. 87, 89 (1992)).

[165] *See Doucette*, 28 Vet. App. at 372 ("[D]ifficulty hearing or understanding speech . . . is contemplated by the schedular rating criteria for hearing loss. . . . These functional effects [of hearing loss] . . . did not reasonably raise the issue of whether referral for extraschedular consideration was warranted, the appellant did not assert below that his scheduler rating was inadequate, and he does not now otherwise identify any evidence of record which reveals that his hearing loss presents an exceptional or unusual disability picture. Accordingly, the Court holds that the Board was not obligated to discuss extraschedular referral in this case.").

[166] *See* King v. Shulkin, No. 16-2959, 2018 WL 1212422, at *2–3 (Vet. App. Mar. 8, 2018) (en banc) (Toth, J., dissenting) (per curiam) ("[M]uch of our extraschedular jurisprudence has developed around advisory comments that had no bearing on the resolution or facts of any case.").

[167] The *King* court was so sensitive to having its *dicta* labeled as such in *Doucette*, that it attempted, retroactively, to rebrand the offending passage. *See* King v. Shulkin, 29 Vet. App. 174, 18 (2017) ("The Secretary's contention about *Doucette* is clearly wrong. To the extent that the Secretary challenges that portion of *Doucette* stating that there is a class of functional effects that are outside the rating schedule as '*dicta*,' we affirmatively hold now that it was not. The notion that there is a class of functional effects existing outside the rating schedule was integral to the Court's holding there.").

[168] In *Rossy*, *v. Shulkin*, 29 Vet. App. 142 (2017), which similarly involved a hearing loss rating issue, the Veterans Court noted that the majority holding in *Doucette* had left "open the possibility that extraschedular consideration for hearing loss might be warranted by *other* symptoms or functional affects."

The assumption of the Veterans Court in *Doucette* that these disorders are easily related to service-connected hearing loss skates past the requirement that a VA legal adjudication is necessary to establish secondary service connection.[169] The court's assumption that other disorders were related to the hearing loss cannot be squared with legal principle no. 5, *supra*, which instructs that a finding of secondary service connection first requires both a claim and an adjudication. The aforenamed symptoms are actually separate and distinct disorders that would *never* be rated as part of a service-connected hearing loss because they simply, empirically are not hearing loss symptoms or impairment. Once secondary service connection is adjudicated in a case like *Doucette*, however, the Rating Schedule then separately recognizes and compensates each of these non-hearing-related disorders under different diagnostic codes in the Rating Schedule.[170]

Furthermore, the *Doucette* court violated legal principle no. 4 when it neglected to identify any *extra*-schedular impairment involved in the case. The court-listed impairments—ear pain, dizziness, recurrent loss of balance, and social isolation—are individually ratable disabilities under the Rating Schedule. By definition, therefore, these disabilities are not sufficiently "exceptional" or "unusual" impairments to justify referral beyond the Rating Schedule.

The assumption by the court in *Doucette* that these disorders might somehow be related to service-connected hearing loss involves medical speculation by the Veterans Court, which is a move that is incompatible with the *Colvin* rule, *supra*. For example, while ear pain resides in the same general anatomic location as does hearing loss, there are many causes of ear pain other than hearing loss. While dizziness and recurrent loss of balance may affect the inner ear fluid equilibrium, the court's jump from one part of the ear to another and from one function (hearing) to another (balance) requires medical opinion to bridge the gap. Social isolation is a psychological symptom or impairment that, to establish, would require opinion from a psychological expert to causally relate the symptom or impairment, here, social isolation, and hearing loss, and to rule out all of life's other traumatic causes.

---

[169] *See* 38 C.F.R. § 3.310(a), (b) (providing secondary service connection for related disorders caused or worsened by the service-connected disability) ("When service connection is . . . established for a secondary condition, the secondary condition shall be considered a part of the original condition.").

[170] Ear pain (analogous to 38 C.F.R. § 4.87, DC 6211, perforated tympanic membrane); dizziness or recurrent loss of balance or vertigo (38 C.F.R. § 4.87, DC 6204 eripheral vestibular disorder or DC 6205 Meniere's); social isolation due to difficulties communicating (38 C.F.R. § 4.130, General Formula for Rating Mental Disorders).

The *Doucette* majority purported to invite the VA Secretary to revise the hearing loss Rating Schedule, hoping to accomplish by persuasion what it could not do as a matter of law: to add the list of court-identified, separately ratable "symptoms" (ear pain, dizziness, recurrent loss of balance, and social isolation) to the hearing loss Rating Schedule. The court's invitation acknowledges the fact that adding these symptoms to the hearing loss Rating Schedule criteria requires revision by the court of the hearing loss Rating Schedule criteria. This result is prohibited by legal principle no. 9, *supra*.

C. In Rossy, the Veterans Court Keeps to the Main Rail

> "Nighttime in the switching yard / Get it out on the mainline / Listen to the rhythm of the train go by / Listen to the train whistle whine"
>
> —*Nighttime in the Switching Yard, Warren Zevon*

In *Rossy v. Shulkin*,[171] the Veterans Court applied the precedent of the majority holding in *Doucette*, *supra*, to uphold the Board's finding that referral for extra-schedular rating was unwarranted because the veteran's hearing loss was "adequately contemplated by" the Rating Schedule criteria. The court noted the veteran's assertions—he had complained of not being able to hear his spouse or conversations in noisy or crowded places—before concluding that these hearing-related complaints were "squarely within the type of symptoms and functional effects contemplated and compensated by VA's schedular rating criteria."[172]

Rossy addressed the hearing loss rating issue before the Veterans Court and did not speculate as to what other disorders *might* be related to hearing loss. *Rossy* seemed to require that other impairments must first be "associated with" the hearing loss disability.[173]

Rossy stands outs as an exemplar of the type and extent of review required for Board extra-schedular referral decisions. The *Rossy* court did not presume other impairments to be a part of the hearing loss disability, but, consistent with legal principle no. 5, that secondary service connection requires a claim

---

[171] *Rossy v. Shulkin,* 29 Vet. App. 142 (2017).

[172] As outlined above, the VA Rating Schedule criteria for hearing loss include audiometric testing and speech recognition testing, and include ratings based on exceptional hearing patterns.

[173] *See* 38 C.F.R. § 3.310 (providing secondary service connection for related disorders caused or worsened by the service-connected disability). *See also* legal principle no. 5, that secondary service connection must be established and is the mechanism to recognize such suggested secondary relationship of other specific disorders to the hearing loss.

and adjudication, seemed to require that there be an association between such other impairments and the service-connected hearing loss disability.[174]

D. In King, Travelers Can Select a Track

"And the old men sit round the cracker barrels / The children hum their Christmas carols / The train tracks all run parallel / But they'll all meet up one day"

—*He Forgot That It Was Sunday, John Prine*

In *King v. Shulkin*,[175] the majority purported to hold, as a "matter of law,"[176] that the Rating Schedule criteria are "irrelevant" to an extra-schedular analysis.[177] This holding prevents any conductor from even looking down the main rail to determine its fitness for travel when deciding which rail to ride on.

If the legal principles, *supra*, had been observed, the *King* case could have ended with a routine remand to the Board for further development of the Board's rationale explaining how, in this veteran's case, the comprehensive Rating Schedule criteria for hearing loss—the audiometric and speech recognition measures—fully compensate this veteran for his actual hearing loss disability.[178]

In *King*, no extra-schedular impairment was ever alleged, and there was no attempt by the court to identify any such extra-schedular impairment. Legal principle no. 3, *supra* requires an extra-schedular claim to be raised by someone other than the Veterans Court, namely, by the evidence, the veteran, or the Board.

Yet *King* purports to be a matter-of-law holding that raises new possibilities for extra-schedular claims, even though the pronouncement that Rating

---

[174] See Rossy, 29 Vet. App. at 144 (referencing that Doucette only left open the "possibility that extraschedular consideration for hearing loss might be warranted by other symptoms or functional effects associated with" a service-connected hearing loss disability).

[175] 29 Vet. App. 174 (2017).

[176] King, 29 Vet. App. 176, 181, 183 (stating that its "interpretation of the law is a general principle" that applies to all disabilities, such that Board reliance on the presence of higher schedular rating criteria in extra-schedular referral analysis was "incorrect as a matter of law").

[177] King at 176, 181 (purporting to "hold" that "the availability of a higher schedular rating is irrelevant in" and "plays no role in" an extra-schedular analysis).

[178] *See* Bankhead v. Shulkin, 29 Vet. App. 10, 18, 20 (2017) (remanding for development by Board of adequate reasons and bases underlying decision where Board had not adequately discussed symptoms in the higher rating criteria) ("Use of the term 'such symptom as' in [38 C.F.R.] § 4.130 indicates that the list of symptoms that follows is non-exhaustive, meaning that VA is not required to find presence of all, most, or even some of the enumerated symptoms to assign a particular evaluation.").

Schedule criteria are "irrelevant" to extra-schedular analysis was stated in *dicta179* and derived from its own flawed hypothetical illustration as follows:

> [A]ssume that a veteran has a disability that awards compensation at a 30% rating for veterans with symptoms "a" and "b." Assume also that this disability is awarded a 50% rating for veterans with symptoms "a," "b," "x," and "z." Now presume a veteran is before the Board who is rated at 30% and has sufficient medical evidence exhibiting symptoms "a," "b," and "x" but not "z." Under the Board's logic, no matter how significantly that veteran's earning ability were impaired, the Board would be permitted to grant the veteran only a 30% rating and deny referral for extraschedular consideration because, as it found here, the rating criteria "provided for higher ratings for more severe symptoms." Such a finding, however, would leave the veteran entirely uncompensated for symptom "x" with no recourse to extraschedular consideration because symptom "x" is contemplated by a higher schedular rating. This example is precisely the situation § 3.321(b)(1) was created to address.[180]

This hypothetical is faulty when applied in the VA disability compensation context. Where one of two higher Rating Schedule criteria is met, as the hypothetical proposes, the higher rating percentage would be *granted* under the Rating Schedule by the VA adjudicator. Consistent with legal principle no. 2, *supra*, VA adjudicators know well how to maximize benefits for veterans by resolving reasonable doubt in those cases where not every criterion that is eligible to be met under the higher rating is met in order to grant the higher compensation provided for under the Rating Schedule. A VA adjudicator will simply resolve reasonable doubt regarding the degree of disability[181] in a veteran's favor in order to justify the decision to award the higher schedular rating, by locating a schedular symptom sufficient to show impairment that nearly approximates the higher rating.[182] The VA does not require all possible criteria for a higher rating to be met. A regulation that is applicable to all disabilities explicitly allows the VA adjudicator to grant the higher schedular compensation when only some of the higher Rating Schedule

---

[179] *See Petermann v. Wilkie*, 30 Vet. App. 150, 157 (2018) (Toth, J., dissenting) ("The hypothetical discussion in *King* . . . remains *dicta* . . ."). *See also id*. at 154 n.3 (The majority agreed that the hypothetical in *King* was *dicta* in the strict sense because "it did not describe the precise facts in *King*," but then found the question to be academic because the fact pattern in *Petermann* "present[ed] that exact situation" as contemplated by the *King* hypothetical.).

[180] *King*, 29 Vet. App. at 182.

[181] 38 C.F.R. § 4.3 (reasonable doubt is resolved in favor of a claimant).

[182] 38 C.F.R. § 4.7 (The higher possible rating applies "if the disability picture more nearly approximates the criteria required for that rating."). *See* Bankhead v. Shulkin, 29 Vet. App. 10, 23 (2017) (holding that a symptom in the higher schedular rating criteria needs to be discussed and an explanation offered as to why the higher rating was not selected).

criteria are met.[183] *King* did not mention or cite any of these pro-veteran Rating Schedule provisions.[184]

The implication in *King* that the Rating Schedule is inadequate for rating all functional impairments and, therefore, is not worthy to be even *one* of several factors at play in an extra-schedular rating referral, is diametrically opposed to the tenet found in legal principle no. 2, *supra*, which states that the VA Rating Schedule is designed to maximize benefits to veterans. The so-called "irrelevant" Rating Schedule criteria declared not eligible for consideration under *King* includes the Rating Schedule's unique provisions designed to recognize and rate "exceptional" patterns of hearing loss.[185]

The statement of the *King* majority that "the availability of a higher schedular rating is irrelevant in an extraschedular analysis" is a departure from of the weight of prior decisional law[186] and is inconsistent with legal principle no. 8, *supra*. The *King* hypothetical, *supra*, ignores the Veterans Court's own precedents which echo the requirement of the extra-schedular regulation that the Rating Schedule criteria be consulted first, and then exhausted, before resort to the extra-schedular rating system is appropriate.[187]

The *King* court's statement in *dicta*,[188] that higher Rating Schedule criteria may never be considered in extra-schedular referral questions, has the effect of eliminating consideration of the Rating Schedule criteria to determine what may be *extra*-schedular, that is, the critical threshold question regarding whether impairment is *not* contemplated by the Rating Schedule. Without consideration of the impairments and disabilities covered by the

[183] 38 C.F.R. § 4.21 (all the elements specified in a disability grade need not necessarily be found to get the higher rating).

[184] The regulations that would allow a VA adjudicator to recognize and compensate a single, if functionally impairing, symptom are: 38 C.F.R. § 4.3 (reasonable doubt resolved in favor of claimant), 38 C.F.R. § 4.7 (The higher possible rating applies "if the disability picture more nearly approximates the criteria for that rating."), and 38 C.F.R. § 4.21 (all elements specified in a disability grade need not necessarily be found to obtain higher rating).

[185] 38 C.F.R. § 4.86 ("EXCEPTIONAL PATTERNS OF HEARING IMPAIRMENT").

[186] For the *King* court, the precedents it reviewed began with *Thun v. Peake* in 2009 and, after a footnote nod to *Anderson v. Shinseki*, it jumped to the 2017 *dicta* in *Doucette*.

[187] *See* 38 C.F.R. § 3.321(b) (finding that the "regular schedular standards" must be rendered "impractical" by an "exceptional or unusual disability picture"); Thun v. Peake, 22 Vet. App. 111, 115 (2008) ("The threshold factor for extraschedular consideration is a finding that the evidence before VA presents such an exceptional disability picture that the available schedular evaluations for that service-connected disability are inadequate"); Sowers v. McDonald, 27 Vet. App. 472, 478 ("The rating schedule must be deemed inadequate before extraschedular consideration is warranted."). *See* legal principle no. 1, *supra* (schedular and extra-schedular ratings are mutually exclusive).

[188] For information on this footnote, please contact the article's author.

Rating Schedule, legal principle no. 1, *supra*, is violated. The statement of the *King* court in *dicta* also raises the question whether *King's* prohibition against looking at rating schedule criteria at all is a "review" of the Rating Schedule criteria contrary to legal principle no. 9, *supra*.

The immediate consequence of removing consultation of the Rating Schedule from the equation aimed at determining if a functional impairment is extra-schedular is to create a number of ostensibly extra-schedular ratings that are, in fact, identical to schedular ratings. An uncompensated symptom expressly covered by the Rating Schedule is, thus, converted to an extra-schedular symptom. There is nothing unique or exceptional about a symptom that was deliberately, and by regulation, anticipated to be part of a disability. The act of severing a single symptom from the Rating Schedule does not change its character.

King effectively turns off the default switch to the main rail and recommends both rails equally to the conductor and the traveler.[189] King radically expands the extra-schedular universe of claims by creating the very real likelihood that many disabilities that were fully contemplated by the Rating Schedule will now receive a parallel and contradictory treatment as an extra-schedular claim.[190] Compensation for the very same symptoms or impairment listed in the Rating Schedule creates several practical future complications, one of which is paying twice for the same symptom or impairment (contrary to legal principle no. 7, supra, against double dipping) when the disability

[189] *See King*, 29 Vet. App. at 178 (referring to "traditional schedular analysis" as the more traveled road, but possibly adequate to encapsulate a veteran's disability picture, and extra-schedular analyses as the less traveled road that may be taken when there is sufficient evidence of record). A veteran may now identify one uncompensated symptom and claim it as an extra-schedular rating, an issue that then may be pursued throughout VA and to the Veterans Court. The dissent in *Doucette* would achieve the same end by completely eviscerating the hearing loss Rating Schedule criteria, saying that the hearing loss rating criteria did not measure anything, and labeling it "nonexistent criteria" so as to leave *extra*-schedular as the *only* path to travel. The dissent in *Rossy* would open the second path by simply raising extra-schedular rating where neither claimant nor evidence had done so and then sending any claimant the Veterans Court chooses down the path that the court selects for them.

[190] This is necessarily the case because *King* effectively removed, as a matter of law, any requirement that a claimant or the evidence show or even suggest any "exceptional" or unusual or unique impairment that is not contemplated by the Rating Schedule. Because the extra-schedular impairment can now be the very *same impairment that is explicitly listed in the Rating Schedule*, *King* radically reinterprets 38 C.F.R. § 3.321(b) to remove the requirement to identify exceptional or unusual impairment that is not in the Rating Schedule (legal principle no. 4, *supra*). Any disability can *de facto* be exceptional or unusual because the Rating Schedule measure by which to discern what is exceptional or unusual has been rendered irrelevant.

worsens and the single "symptom" in the Rating Schedule for which extra-schedular compensation has been paid is no longer distinct from the rest of the higher Rating Schedule criteria. King marks a radical departure from the early case law; starting in King, the Veterans Court has chartered a new route. The decision to veer off course and the declaration that the main rail (Rating Schedule) is broken in some places so that all future trains are prohibited from looking farther down the main rail to see if it is functioning cannot be challenged (as "a matter of law").

E. In Petermann, the Veterans Court Erects Barriers to Block Access to the Main Rail

> "I tried to save us / But little did I know / You are a speeding train off track / With little time to go"
>
> —*Ending in Tragedy, New Found Glory*

In *Petermann v. Wilkie*,[191] by declaring a specific type of Rating Schedule criteria ("successive" ratings for diabetes) to be irrelevant to extra-schedular claims, the Veterans Court placed barricades on the main rail, thereby making passage more difficult and making the extra rail appear the better alternative.

In *Petermann*, the veteran had diabetes rated at forty percent disabling. His ailment resulted in hypoglycemic reactions and recurrent hospital treatment, among other complications.[192] The Veterans Court in *Petermann* reports there was evidence in the case of hypoglycemic reactions and required hospital treatment at least once per year, on average, and that this evidence is relevant to the higher Rating Schedule criteria under the diagnostic code for rating diabetes mellitus of sixty percent.[193] If the facts are as the Veterans Court represents, and the veteran was already rated forty percent, the court had two unused remedies in *Petermann.*

One remedy was for the Veterans Court simply to remand the case to the Board for adequate reasons and bases on the *schedular* rating of diabetes (i.e., to explain why a sixty percent *schedular* rating is not warranted). Another remedy was to reverse the Board decision and grant the higher sixty percent *schedular* rating (under DC 7913, sixty percent is for one or two hospitalizations per year) by finding clear error in the Board decision's failure to apply the Rating Schedule mechanisms[194] and, as a result, denying the sixty percent rating under the Rating Schedule.

---

[191] 30 Vet. App. 150 (2018).

[192] *Id.* at 155.

[193] *Id.*

[194] At the time the rating mechanisms of 38 C.F.R. §§ 4.3, 4.7, 4.21 were available because the Veterans Court had not yet restricted the use of 38 C.F.R. §§ 4.7 and 4.21 in successive rating claims, something it would later do in *Johnson (Willie) v. Wilkie*, 30 Vet.

Petermann converted a basic schedular rating case into an extra-schedular rating case by applying the *King* hypothetical to successive ratings, bestowing upon it legal legitimacy.[195][196] *Petermann* thus inherits all the faulty logic of the *King* court, including the notion that the Rating Schedule is unable to recognize and compensate[197] actual functional impairment that might accompany a single symptom[198] in the higher Rating Schedule criteria,[199] a perception that is contrary to legal principle no. 2, *supra*. As *Petermann* also effectively *removes* Rating Schedule criteria from extra-schedular referral consideration in the successive rating context, doing so likewise raises the question of whether this is a "review" of the Rating Schedule criteria contrary to legal principle no. 9, *supra*.

Earlier Veterans Court decisions required a finding that the Rating Schedule is inadequate, along with an attempt to identify unique or exceptional impairment, before referral outside the Ratings Schedule could be justified.[200] In

App. 245 (2018). In *Petermann*, the Board could have granted the sixty percent rating based on the number of hospitalizations, and it appears from the remand that *Petermann* also met the rest of the criteria for a sixty percent rating since he was in receipt of noncompensable rating for complication of diabetic nephropathy.

[195] *See Petermann*, 30 Vet. App. at 152 n.3, declaring that the court's holding (which was simply application of *King's* hypothetical to successive ratings) would render "academic" the troubling questions of whether *King's* purported holding and hypothetical were only *dicta*.

[196] Apparently sensing that a hypothetical stated in *dicta* is not the strongest legal authority for its current case, the *Petermann* majority simply declares the matter "academic" in footnote 3, a conclusory declaration that, rather than supporting an argument for, at least, the persuasive authority that might be derived from the hypothetical, instead suggests there is no actual legal authority for its replication of *King dicta*.

[197] *See* 38 C.F.R. § 4.3 (reasonable doubt is resolved in favor of a claimant); 38 C.F.R. § 4.7 (The higher possible rating applies "if the disability picture more nearly approximates the criteria required for that rating."); 38 C.F.R. § 4.2 (all elements specified in a disability grade need not necessarily be found to obtain the higher rating).

[198] The Rating Schedule proxies for average functional impairment include not just symptoms, but also measures, such as diagnosis, whether the disease is active, subjective reports alone, clinical measures by a medical professional, specialized clinical tests, the need for treatment or medication, types of treatment, time and wages lost from work, and the amount of time a person is incapacitated or is required to rest in bed.

[199] Note that in *Petermann*, the Board had remanded the issue of initial rating for nephropathy with hypertension, which shows that the Rating Schedule stands ready to separately rate (compensate) any and all complications of the diabetes, as well as to rate the diabetes itself.

[200] *See* 38 C.F.R. § 3.321(b) (finding that the "regular schedular standards" must rendered "impractical" by an "exceptional or unusual disability picture"); *Thun*, 22 Vet. App. at 115 ("The threshold factor for extraschedular consideration is a finding that the evidence before VA presents such an exceptional disability picture that the available schedular evaluations for

Pierce v. Principi,[201] the Veterans Court recognized that 38 C.F.R. § 4.21, which establishes the rule that every element that is listed by a disability grade sub-provision need not be found by the Board to justify awarding a higher rating, was applicable even to "successive" criteria ratings.[202] The Veterans Court in *Petermann* began its analysis with its 2008 decision in *Thun v. Peake* before fast forwarding over the intermittent case law in order to arrive at its very recent pair of self-referential decisions in *Yancy v. McDonald203* and *King v. Shulkin*.[204] The *Petermann* court failed to cite its earlier precedent or square its holding with precedent, in violation of legal principle no. 8, *supra*.

By its declaration that any uncompensated symptom in the higher successive Rating Schedule criteria are beyond the reach of the Rating Schedule, *Petermann*, like *King*, converts the potentially higher-end Rating Schedule symptom into a parallel, and possibly conflicting, extra-schedular-rated symptom. This conversion violates legal principle no. 1, *supra*, that extra-schedular and schedular ratings are mutually exclusive; it dispenses with the requirement of exhaustion of Rating Schedule remedies before proceeding to a determination as to whether the impairment qualifies for extra-schedular treatment. This conversion is also incompatible with legal principle no. 4, *supra*, which requires the preliminary identification of exceptional or unusual impairment before resort or referral to the extra-schedular system. Finally, this conversion does not square with legal principle no. 3, *supra*, as it dispenses with any requirement that an extra-schedular claim be raised.

By placing more barricades preventing access to the main rail, the Veterans Court has, by its case law, forced claimants and adjudicators onto the extra rail. This dual track promises that both tracks will arrive at the same destination, though none of the conductors has seen the end of the extra rail and few trains on the extra rail in fact ever reach the destination.

---

that service-connected disability are inadequate"); *Sowers*, 27 Vet. App. at 478 ("The rating schedule must be deemed inadequate before extraschedular consideration is warranted.").

[201] Pierce v. Principi, 18 Vet. App. 440, 445 (2004).

[202] Successive ratings require that all of the criteria listed at the lower percentage be met as a prerequisite to higher compensation. *See* Camacho v. Nicholson, 21 Vet. App. 360, 366 (2007) (holding that the conjunctive structure of the three relevant rating criteria, which were joined by "and," revealed drafters' vision that all, not just some or most, of both the lower and higher rating criteria must be met in order to establish entitlement to higher rating); Tatum v. Shinseki, 23 Vet. App. 152 (holding that the rating schedule criteria for hypothyroidism is not "successive," thus permitting the application of 38 C.F.R. § 4.7 to grant a higher rating where only two of three criteria for the higher rating were met).

[203] 27 Vet. App. 484 (2016).

[204] 29 Vet. App. 174 (2017).

F. In Spellers, the Veterans Court Misses its Turn onto the Extra Rail

> "I'm riding on that New River Train / Riding on that New River Train / Same old train that brought me here gonna take me away again"
>
> —*New River Train*

In *Spellers v. Wilkie*,[205] the Veterans Court held that, because the Rating Schedule contemplates specific symptom of neurological disability necessitating the use of assistive devices and the severity of symptoms, referral for extra-schedular consideration was not warranted.[206]

Consistent with legal principle no. 2, *supra*—Rating Schedule maximizes benefits—*Spellers* rejected the argument asserted by the appellant that the use of assistive devices was evidence of worsened disability sufficient to support a higher *schedular* rating.[207] Beginning with the Rating Schedule to determine if the Rating Schedule criteria contemplate the symptoms and severity of symptoms for which the assistive devices are needed is an approach consistent with legal principle no. 1, *supra* (schedular and extra-schedular ratings are mutually exclusive).

G. In Johnson (Willie), the Veterans Court Establishes Further Barricades on Access to the Main Rail

In *Johnson (Willie) v. Wilkie*,[208] the Veterans Court held that the Rating Schedule for headaches is "successive"[209] rating criteria; therefore, the maximizing Rating Schedule mechanisms at 38 C.F.R. § 4.7 and 38 C.F.R. § 4.21 do not apply to headaches, leaving the VA adjudicator with only the Rating Schedule mechanism for resolving reasonable doubt in a veteran's favor (38 C.F.R. § 4.3).[210]

---

[205] Spellers v. Wilkie, 30 Vet. App. 211 (2018).

[206] The Veterans Court in *Spellers* left for another day the possibility of *extra*-schedular referral based on severity when a veteran reaches the maximum *schedular* rating, a holding the Court says was not raised by the facts of the case in *Spellers* and, notably, the court refrained from offering *dicta* or a matter-of-law holding applicable to all disabilities on this question. This poses an even more interesting question because the Veterans Court would be entertaining the relevance of the highest Rating Schedule criteria as the basis for extra-schedular referral—after it just rendered irrelevant (as a matter of law in *King* and *Petermann*) to the extra-schedular referral analysis the fact of availability of higher Rating Schedule criteria.

[207] *See* Spellers v. Wilkie, 30 Vet. App. 211, 220 n.5 (2018) (citing 38 C.F.R. §4.7).

[208] Johnson (Willie) v. Wilkie, 30 Vet. App. 245 (2018).

[209] *Id.* at 252 (holding that "DC 8100's rating criteria are successive").

[210] The court in *Johnson (Willie)* only partially distinguished *Pierce v. Principi*, 18 Vet. App. 440, 445 (2004), the prior precedential decision recognizing the Rating Schedule mechanisms (38 C.F.R. §§ 4.3, 4.7, 4.2) that allow for higher rating for headaches (38 C.F.R. § 4.124a,

Strictly speaking, *Johnson (Willie)* is not an extra-schedular case. The issue for the Veterans Court did not require invocation of the extra-schedular regulation; however, the holding has immediate extra-schedular implications, because, by further restricting the Rating Schedule, and applying the logic of other recent cases from the Veterans Court that did involve extra-schedular ratings, this holding promises a proliferation of claims under the extra-schedular rating system.

There exists a tension between use of "successive" Rating Schedule criteria, which requires that all lower criteria are met before granting a higher rating, and the Rating Schedule mechanisms of 38 C.F.R. § 4.7, appeal to which require only the disability picture "more nearly approximate" the higher rating criteria, and 38 C.F.R. § 4.21, which states that not all listed criteria for a higher rating need be met. Prior to *Petermann* (diabetes) and *Johnson* (*Willie*) (headaches), the VA adjudicator could apply both of these provisions to grant a higher schedular rating where the overall disability picture is closer to the next higher schedular rating.[211]

By eliminating the safeguards for veterans of the Rating Schedule's compensation maximizing mechanisms from "successive" rating criteria in *Petermann* (diabetes) and *Johnson (Willie)* (headaches), the result is a hard, literal line drawn in successive criteria cases to require that *all* Rating Schedule criteria be met. This effectively places another barrier to access of the main rail by restricting some of the Rating Schedule's benefits maximizing provisions. This reading out of the Rating Schedule symptoms or impairment in the higher ratings creates *de facto* extra-schedular symptoms or impairment identical to what were previously Rating Schedule criteria, contrary to legal principle no. 1, *supra* (extra-schedular and schedular ratings are mutually exclusive), legal principle no. 3, *supra* (extra-schedular claims must be raised), and legal principle no. 4, *supra* (exceptional or unusual impairment must be identified).

H. Morgan (en banc): How Do We Choose a Track?

"The train always arrives at your station. The question is which one to take?"

—*Mehmet Murat ildan*

DC 8100), even when the Rating Schedule criteria are not strictly met, apply to successive rating criteria. The Veterans Court in *Johnson (Willie)* interpreted that *Camacho v. Nicholson*, 21 Vet. App. 360 (2007), subsequent to *Pierce*, had held that the Rating Schedule mechanisms, at 38 C.F.R. § 4.7 and 4.21, did not apply to "successive" rating criteria.

[211] A question beyond the scope of this Article is whether interpretations of 38 C.F.R. § 4.119, DC 7913 (*Petermann*) and 38 C.F.R. § 4.124a, DC 8100 (*Johnson (Willie)*), as "successive" Rating Schedule criteria that restrict application of the pro-claimant provisions of 38 C.F.R. § 4.7 and 38 C.F.R. § 4.21 to only certain Rating Schedule criteria, qualify as "review" of the Rating Schedule prohibited by 38 U.S.C. § 7252(b) (2018).

At the time of publication, the Veterans Court, sitting *en banc*, is searching for extra-schedular guidance in *Morgan v. Wilkie*,[212] which involves compensation rating of a hearing loss impairment.[213] The court has called for supplemental briefing in which parties have proposed a "framework" that the court could adopt, in whole or in part, to govern the administration of extra-schedular ratings.[214] The Veterans Court solicited guidance as to whether they (rather than the Board) are able to determine what is or is not a "symptom" of hearing loss[215] where the Board never discussed the question; whether there are distinctions between "functional effect," "functional impairment," and "symptoms" in the extra-schedular context; and whether the veteran must allege the impairment.[216]

Even though the Veterans Court has requested briefings with the aim of developing a workable "framework" for extra-schedular ratings, the questions posed and focus in briefings that have been received to date are limited, a fact which suggests consideration of only a slice of the relevant factors a court would need in order to develop and implement a framework for the administration of extra-schedular claims. The current discussion regarding hearing loss ratings is largely still in terms of symptomatology and misses the mark on the topic of measuring impairment.

The briefing and oral arguments in *Morgan* do not seriously question how the Veterans Court, by virtue of its matter-of-law stance, has already presumed a secondary service connection relationship for tinnitus, ear pain, dizziness, and psychological symptoms. Furthermore, the papers in *Morgan* fail to meaningfully probe whether to make a similar secondary association for having to roll down a window to hear sounds, even though no claim for recognition of such a secondary disability was presented, which is in direct contravention of legal principle no. 5, *supra*, secondary service connection requires a claim and adjudication.

Regarding such secondary association, while the Veterans Court in *Morgan* is finally questioning which symptoms or disorders should be automatically presumed to be related to service-connected hearing loss, the court is not asking the more relevant question regarding whether it has the medical

[212] *See* Morgan v. Wilkie, Dkt. No. 17-0098 (Vet. App. Jan. 1, 2017).

[213] Earlier in 2018, the Veterans Court was similarly searching for extra-schedular guidance from the parties and asking which criteria the Board should apply to determine whether a higher extra-schedular rating was warranted. *See Rowe v. O'Rourke*, 30 Vet. App. 72 (2018) (per curiam).

[214] *See* CVAC Order, Dkt. No. 17-0098 (Nov. 28, 2018) (en banc) (per curiam).

[215] The suggested impairments in *Morgan* were having to roll down the car window to hear traffic, as well as social isolation and marital discord, similar to the previous court-plead assertions in *Doucette*.

[216] *See* Nov. 28 CVAC Order.

competence (legal principle no. 6, *supra*, only doctors can make medical associations) or legal authority (finding facts as to which disorders are related to hearing loss, rather than reviewing facts found by VA adjudicators) to secondarily relate symptoms or other disabilities to service-connected hearing loss.

While the *Morgan* briefs and arguments are primarily focused on answering the question as to which track should the court ride, there is not even a train in the station. The identified need for the veteran to have to roll down his own car window to hear sounds is simply not a functional impairment. The evidentiary record did not show that the veteran was impaired in his ability to roll down his window and the accommodation is more accurately labeled a safety precaution rather than a limitation. Furthermore, the disability impairment was not analyzed as an *occupational* impairment, as the law requires. The Veterans Court in *Morgan*, by improperly addressing this question, has also violated legal principle no. 4, *supra*, which mandates that, as a threshold matter, a facially plausible "exceptional or unusual" occupational impairment be identified. For these reasons, the prospect is slim that the very same court that has distorted the analysis so completely will also be able to produce a comprehensive, legally sound extra-schedular "framework."

V. The Implications of a Dual Track VA Rating System

The Veterans Court has tried, on a case-by-case basis, to remedy the oft-occurring scenario in which a veteran with a symptom or impairment has not been correctly compensated under the Rating Schedule. This individualized approach, as discussed above, has, unfortunately led the veterans court to inappropriately consult and grade under the extra-schedular rating system, thereby elevating and legitimizing the second track as on par with the primary one. It is the position of this Author that this practice is a mistake in need of immediate correction. Predictably, VA adjudicators are uncertain as to when extra-schedular claims have been properly raised and when referral is warranted.

The modern Veterans Court's jurisprudence has created parallel, or dual, track rating systems by separating the extra-schedular rating question from the Rating Schedule question,[217] thereby converting conventional Rating Schedule impairment claims into extra-schedular claims. Extra-schedular claims are, by definition, rare. These claims require additional proof as to their ineligibility under the Rating Schedule. While appealing, traveling on the extra rail is not an easier or faster ride than traveling on the main rail.

[217] *See* Floyd v. Brown, 9 Vet. App. 88, 96 (1996) (holding that the assignment of an "extra"-schedular rating is not a separate "matter" from the rating issue on appeal) ("[T]he extraschedular rating issue is always part of the same claim even though certain procedural requirements must be met in the adjudication process.").

A. How Did We Arrive on the Extra Track?

"The only way to be sure of catching a train is to miss the one before it."
—*G.K. Chesterton*

One practice of the Veterans Court that has institutionalized and normalized reliance on the dual-track rating system has been the court's failure to recognize that certain symptoms or impairments are already provided for under the Rating Schedule—either expressly, as part of the disability at issue, by analogy, or as a secondary complication to an established service-connected disability. Heavy use of the extra-schedular rating system creates the appearance that the symptom or impairment at issue has been omitted from the Rating Schedule. When courts make this pronouncement, whether inadvertently or intentionally, their statement that a given injury is not covered by the regular rating system becomes a prominent part of the corpus of decisional law that the next judge consults when making a similar future decision. The feedback loop that this practice has created, namely that departure from the primary Rating Schedule and resort to the extra-schedular system becomes easier and more commonplace for future adjudicators each time a departure is made, sends the erroneous message to veterans that the Rating Schedule is inadequate and undercompensates them, thus producing the feeling on the parts of veterans who engage with the VA compensation system that they leave the process with less than they were entitled to due to bureaucratic failure.[218] This is a shameful reputation to create for a compensation system that, for all its flaws, is single-mindedly geared toward compensating veterans and provides, via its intricate compendium of possible ratings, many, many routes to compensation. The use of dual systems, while ostensibly creating more options for veterans to achieve compensation, will lead to widespread dissatisfaction with the VA disability compensation system. Furthermore, the proliferation of extra-schedular claims will also generate misplaced hopes of separate or higher extra-schedular compensation for the same impairment that is already ratable under the Rating Schedule.

By its own purportedly matter-of-law declaration by the Veterans Court that certain legally and medically *un*related symptoms or disorders are associated with Rating Schedule criteria, VA will try to treat such unrelated symptoms as already associated with the service-connected disability, which will trigger a full-blown extra-schedular referral analysis. Again, by institutionalizing the

[218] *See* Doucette v. Shulkin, 28 Vet. App. 366, 371 (2017) ("If the Board were required to conduct an extra-schedular discussion in all hearing loss cases, that would suggest that the majority of, if not all, hearing loss claimants are under-compensated, which would, in turn, suggest an issue with the schedular rating criteria rather than with the individual claimants' disability.").

second track, rather than make it easier for veterans to obtain compensation, the Veterans Court has created a system that will be marked by delay. This focus and promise that many more impairments can now be extra-schedular will distract veterans from claiming secondary service connection for related complications.

In its zeal to expand extra-schedular rating claims by converting Rating Schedule criteria into extra-schedular claims, which is the effect of the *King-Petermann* holdings, the Veterans Court has inadvertently limited the VA's ability to compensate some veterans under the Rating Schedule. For example, in successive rating cases, the Veterans Court has barred VA adjudicators from using compensation maximizing provisions that previously resulted in higher compensation under the Rating Schedule, forcing the VA to deny veterans rating claims where anything less than all the Rating Schedule criteria are met. Unfortunately, this increase in extra-schedular rating claims will offset the denials of veterans' successive Rating Schedule claims necessary to create them. It is deeply ironic that the Veterans Court's holdings have restricted the Rating Schedule in the name of expanding the set of options under the more experimental extra-schedular ratings system.

B. Where Does the Extra Track Lead?

> "Running down the track / Trying to reach the end / But the end never comes / No, the end never comes"
>
> —*Innocent Bystander, Leo Sayer*

In reality, the odds are against a veteran who seeks extra-schedular compensation. Even after having properly alleged an extra-schedular-eligible compensation claim by identifying a functional impairment not covered by the Rating Schedule, proving the extra-schedular claim is no small burden for a veteran.[219] Many veterans will be diverted onto the extra-schedular track by the Veterans Court's recent decisions with an uncertain hope of compensation, instead of receiving what once was routine treatment under the Rating Schedule system, where compensation is immediately available to disabled veterans with little additional evidentiary support for the increased schedular rating or by grant of a secondary service connection claim.[220] Claims for a higher rating under the Rating Schedule or for a secondary service connection designation are more easily proven.

---

[219] Once an extra-schedular rating claim is raised, in order to prevail, 38 C.F.R. § 3.321(b) requires the evidence to also show that the identified, unique impairment also involved "related factors as marked interference with employment or frequent periods of hospitalization."

[220] 38 C.F.R. § 3.310.

The dual track extra-schedular claim will result in delays on both tracks. Intertwined extra-schedular rating issues will delay the schedular rating issue from which they arise, and there will be more Board remands of schedular rating issues years into the claims process for initial adjudication of a newly raised but intertwined extra-schedular issue.

C. Merging the Tracks

"He mounted to the cabin with the orders in his hand, / And he took his farewell trip to that promis'd land / For there's two locomotives that are going to bump"

—*Casey Jones*

The fact that the exclusivity of schedular and extra-schedular ratings have been compromised threatens several complications. When a veteran's service-connected disability worsens sufficiently such that it subsequently evolves to meet the higher Rating Schedule criteria, moving between dual systems when a veteran appears for a second adjudication will be problematic and, in some situations, prejudicial to the veteran.

It is unclear whether an extra-schedular rating must always be maintained as a separate rating from the main schedular rating.[221] If the extra-schedular rating must remain separate, then the extra-schedular rating cannot at any point after the fact be collapsed into a rating under the Rating Schedule criteria in order to provide the veteran a more favorable rating under the Rating Schedule. As a result of this unforeseen complexity, once his disability worsens, a veteran will be automatically disadvantaged by having been branded as extra-schedular. In other words, there can be no subsequent switch by a veteran from the extra-schedular track on the main rail once the initial determination to refer a disability for extra-schedular treatment has been made, even in instances where classification under the Rating Schedule is distinctly superior for a subsequently worsened impairment.

If the separate extra-schedular rating can later be abandoned in favor of a higher rating under the Rating Schedule, then, by definition, the extra-schedular designation was erroneously assigned; the uniqueness and exceptionality of the extra-schedular disability is annulled. In this scenario, there exists the looming possibility that a worsening of the initial disability would render the veteran eligible for a higher schedular disability rating, but only by reference to the extra-schedular symptoms.[222] The reconversion of extra-schedular

---

[221] It would seem to be a logical application of the matter-of-law declaration in *King* that consideration of higher Rating Schedule criteria would likewise not be legally relevant to an existing extra-schedular rating; thus, the veteran must keep the extra-schedular rating, and cannot abandon the extra-schedular rating for higher rating under the Rating Schedule.

[222] While it appears to be a veteran-friendly proposition, allowing a veteran to elect the more favorable rating, that is, to merge an extra-schedular rating into a higher schedular

rating back to a rating under the Rating Schedule will make an already ornate rating system entirely unintelligible to veterans.

D. Can We Ride Both Tracks at Once?

Another alternative—that the veteran be allowed to keep both the extra-schedular rating while obtaining an increased schedular rating—is double dipping, that is, obtaining payment twice for the very same impairment, in violation of legal principle no. 7, *supra*.

A truly extra-schedular disability, by its very definition as exceptional, is not ratable under the Rating Schedule. Thus, it must be maintained and managed separately.[223] Maintaining the separateness of a claim that later overlaps with Rating Schedule criteria will lead to both legal and practical difficulties for both rating systems.

Conclusion

> "The eastbound train was on the westbound track / The northbound train was on the southbound track / The conductor hollered 'now ain't this fine' / What a peculiar way to run a railway line"
>
> —*Rock Island Line*

Extra-schedular jurisprudence is in need of principled guidance. The Veterans Court has diverted us onto the extra rail and has created a dual track VA rating system that may be too complex for *pro se*, disabled veterans to navigate. It is to this Court we must appeal for a solution. The Veterans Court wields outsized influence in providing substantive meaning to legal authority relied upon by VA adjudicators. VA adjudicators generally hold the Veterans Court in highest esteem, effectively interpreting even primary laws and regulations through the language and reasoning of the Veterans Court. Respect for the Veterans Court is enhanced when its decisions are consistent with other Veterans Law legal authorities, including the Court's own precedents. Respecting precedents maintains "public respect for and confidence in the judiciary."[224] Uniformity and consistency as to what is an extra-schedular claim engenders veteran confidence in a disability rating system, the decision

---

rating, effectively transforms the veteran-claimant into adjudicator with the power to dissolve an extra-schedular rating. This shift of power works to annul a VA adjudication with respect to the uniqueness and exceptionality of the extra-schedular disability.

[223] A true extra-schedular rating can only be dissolved by invoking onerous rating reduction procedures that only allow reduction of the extra-schedular rating if the unique and exceptional impairment has somehow resolved itself. *See* 38 C.F.R. §§ 3.105(e), 3.344(a).

[224] John Hanna, *The Role of Precedent in Judicial Decision*, 2 Vill. L. Rev. 367, 377 (1957).

of whether to compensate and at what rate, that factors so prominently in their daily lives.

The Veterans Court will undoubtedly be forced to revisit the assumptions that have guided its extra-schedular jurisprudence. The ten principles outlined in this Article are offered as guidance to the Veterans Court in this notoriously difficult area of law. This Author invites the Veterans Court to rediscover the main rail (the VA Rating Schedule) when reformulating its rules for choosing when to ride the extra rail.