BOARD OF VETERANS' APPEALS

FOR THE SECRETARY OF VETERANS AFFAIRS

IN THE APPEAL OF
PETRA L. GARDENHIRE
IN THE CASE OF
CHARLES F. GARDENHIRE
Appellant Represented by
Gordon A. Graham, Agent

[redacted]
Docket No. 220422-238079
Advanced on the Docket

DATE: December 4, 2024

ORDER

Entitlement to an initial rating in excess of 10 percent for the service-connected status-post encephalitis from November 16, 1953, to January 14, 1955, is denied.

Entitlement to a rating in excess of 10 percent for the service-connected status-post encephalitis from March 17, 1956, to September 29, 2009, is denied.

FINDINGS OF FACT

1. From November 16, 1953, to January 14, 1955, the Veteran's service-connected status-post encephalitis has been manifested by no more than minimal residuals and there was no evidence of subjective residuals for which separate ratings are warranted. Active febrile disease was not shown.

2. From March 17, 1956, to September 29, 2009, the Veteran's service-connected status-post encephalitis has been manifested by no more than minimal residuals and there was no evidence of subjective residuals for which separate ratings are warranted. Active febrile disease was not shown.

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CONCLUSIONS OF LAW

1. The criteria for an initial rating in excess of 10 percent for the service-connected status-post encephalitis from November 16, 1953, to January 14, 1955, have not been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 4.1, 4.2, 4.3, 4.7, 4.14, 4.20, 4.27, 4.112, 4.113, 4.124a, Diagnostic Code 8000.

2. The criteria for a rating in excess of 10 percent for the service-connected status-post encephalitis from March 17, 1956, to September 29, 2009, have not been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 4.1, 4.2, 4.3, 4.7, 4.14, 4.20, 4.27, 4.112, 4.113, 4.124a, Diagnostic Code 8000.

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

The Veteran served on active duty from September 1950 to September 1953 and January 1955 to March 1956. The Veteran died in July 2021, and the Appellant is his surviving spouse. *See* September 2021 Substitution Determination. This appeal has been advanced on the Board's docket pursuant to 38 C.F.R. § 20.800(c).

On August 23, 2017, the President signed into law the Veterans Appeals Improvement and Modernization Act, Pub. L. No. 115-55 (codified as amended in scattered sections of 38 U.S.C.), 131 Stat. 1105 (2017), also known as the Appeals Modernization Act (AMA). This law creates a new framework for Veterans dissatisfied with VA's decision on their claim to seek review. This decision has been written consistent with the new AMA framework.

Given the extensive history and lengthy appeal period for consideration, the Board finds that a brief recitation of pertinent facts and the procedural history of this appeal would be helpful.

In a December 1965 rating decision, the Agency of Original Jurisdiction (AOJ) granted service connection for a history of encephalitis and assigned a noncompensable (zero percent) initial rating was assigned, effective from August

18, 1965. The Veteran was apprised of these actions, but he did not express timely disagreement with the AOJ's assigned effective date and/or initial rating for this award. As such, the downstream elements (the effective date for the award of service connection and the initial rating assigned for the disability) of this award became final. 38 U.S.C. § 7105(c); 38 C.F.R. §§ 3.104, 3.156(b), 20.302, 20.1103; *Grantham v. Brown*, 114 F.3d 1156, 1158-59 (Fed. Cir. 1997).

On September 30, 2009, the Veteran expressed disagreement with several determinations made in a September 2009 rating decision and asserted that he was unable to maintain a substantially gainful occupation due to his service-connected disabilities. Based on this latter assertion, the AOJ scheduled the Veteran for several VA examinations to determine the functional impairment stemming from his service-connected disabilities, to include his encephalitis.

In a June 2011 rating decision, the AOJ explained that the Veteran's September 2009 statement was accepted as an implied claim for an increased rating for his service-connected encephalitis and assigned an increased rating of 100 percent, effective from September 30, 2009. The Veteran initiated an appeal concerning the effective dates for the award of service connection for encephalitis and for the assignment for a 100 percent rating for this disability; however, these issues were denied by the Board of Veterans' Appeals (Board) in a final June 2013 decision.

In August 2013, the Veteran filed a motion for revision of the December 1965 decision based on clear and unmistakable error (CUE) in the assignment of a noncompensable rating for encephalitis from August 18, 1965. This motion was denied by the AOJ in an August 2014 rating decision which considered the effective date for the grant of service connection and the initial disability rating. In September 2014, the Veteran filed a NOD and expressed disagreement with the denial of "CUE for encephalitis."

For unclear reasons, when the AOJ readjudicated this motion in a May 2015 Statement of the Case (SOC), the issue was limited to entitlement to an earlier effective date for the award of service connection for encephalitis due to CUE in the December 1965 rating decision. The matter of a revision of the portion of the December 1965 rating decision that assigned an initial noncompensable rating for

encephalitis was not addressed by the AOJ. The Veteran subsequently perfected an appeal to the Board.

In a July 2016 decision, the Board found that the December 1965 rating decision contained CUE with regard to the assignment of the effective date for the award of service connection. The Board found that an effective date of November 16, 1953, was warranted, not inclusive of the period of the Veteran's second period of active duty (January 1955 to March 1956). Again, the Board notes that, due to the AOJ's limitation of the Veteran's CUE motion to only the effective date of service connection in the May 2015 SOC, the CUE claim regarding the initial compensable rating assigned in the December 1965 rating decision was not addressed by the Board.

In a rating decision dated on July 25, 2016, the AOJ implemented the July 2016 Board decision and assigned a noncompensable rating from November 16, 1953. This rating included the Veteran's second period of active duty; however, it does not appear that the AOJ released this rating decision to the Veteran or fully implemented such.

In a rating decision dated on July 30, 2016, the AOJ further implemented the July 2016 Board decision. In this rating decision, for unclear reasons, the AOJ stated that the Board's finding of CUE in the December 1965 rating decision "abated" the AOJ's assigned effective date and initial rating, even though the latter matter was not addressed in the July 2016 Board decision. The AOJ assigned an initial 10 percent rating for the service-connected encephalitis from November 16, 1953, to January 14, 1955, suspended compensation from January 14, 1955, to March 16, 1965, during the Veteran's second period of service, and assigned a 10 percent rating from March 17, 1956, to September 29, 2009. It is unknown when the Veteran was notified of this decision, as the AOJ's notification letter is undated.

In March 2017, the Veteran requested that the AOJ reconsider assigning a 100 percent rating for encephalitis from the day after separation from his first period of active duty. In April 2017, the Veteran filed a formal claim seeking an increased rating for service-connected encephalitis. In May 2017, he clarified that the April

2017 claim was seeking a 100 percent rating for service-connected encephalitis from November 16, 1953.

In June 2017, the AOJ notified the Veteran that VA would not reconsider entitlement to an initial rating in excess of 10 percent for service-connected encephalitis. Later that month, the Veteran filed a NOD with the assigned effective date for the 100 percent rating for service-connected encephalitis. The AOJ acknowledged this filing and the initiation of an appeal in a July 2017 letter.

In August 2017, the President signed into law the Veterans Appeals Improvement and Modernization Act of 2017 (Appeals Modernization Act or AMA), Pub. Law 115-55, which created a new claims and appeals process for pursuing VA benefits.

In May 2018, the Veteran opted to withdraw his pending appeal from VA's Legacy via Rapid Appeals Modernization Program (RAMP) and requested the Supplemental Claim option in seeking an earlier effective date for the assignment of a 100 percent rating for the service-connected encephalitis.

The AOJ readjudicated this issue in a December 2018 RAMP rating decision. The Veteran filed a formal Legacy NOD in December 2018. In an August 2019 statement, the Veteran clarified that he was seeking an initial rating in excess of 10 percent for service-connected encephalitis from November 1953.

In September 2019, the AOJ notified the Veteran that his December 2018 Legacy NOD was ineffective to appeal the December 2018 RAMP rating decision. Later in September 2019, the Veteran attempted to submit an appeal through RAMP via the Board's hearing docket. In October 2019, the AOJ notified the Veteran that his September 2019 request could not be accepted, as the RAMP program had concluded. In November 2019, the Veteran filed a VA Form 10182 (Notice of Disagreement) to continue his appeal under the AMA and he requested the Board's hearing docket.

Later in November 2019, the Veteran filed a Higher-Level Review (HLR) request. In a December 2019 letter, the AOJ notified the Veteran that his HLR request was not accepted because the rating decision was promulgated prior to February 2019–

which is untrue under the governing laws. Despite this, the Board sent the Veteran a docketing letter in December 2019, and the Veteran presented testimony before an Acting Veterans Law Judge (VLJ) in March 2020. A transcript of this hearing is associated with the claims file.

In an August 2020 decision, the Board remanded the increased rating matter. In a February 2021 rating decision, the AOJ denied entitlement to an earlier effective date for the assignment of a 100 percent rating and continued the 100 percent rating from September 30, 2009. The Veteran filed a VA 10182 in May 2021, and requested the Evidence docket.

The Veteran died in July 2021. The Board issued a decision in August 2021 dismissing the appeal in light of the Veteran's death. In September 2021, the Appellant was substituted in the appeal.

In a December 2021 decision, the Board again remanded the increased rating matter. In a February 2022 rating decision, the AOJ again denied entitlement to an earlier effective date for the assignment of a 100 percent rating and continued the 100 percent rating from September 30, 2009. The Appellant submitted a HLR request in February 2022.

In an April 2022 HLR rating decision, the AOJ denied entitlement to an increased rating for the service-connected status-post encephalitis. The Appellant submitted a timely VA Form 10182 in April 2022 and, in so doing, requested direct review by the Board.

Based on the Appellant's choice to pursue a direct review of this appeal, the Board will decide the appeal "based on the evidence of record at the time of the prior decision." Accordingly, no additionally submitted evidence may be considered.

Increased Ratings for Service-Connected Status-Post Encephalitis

Disability ratings are determined by applying the criteria set forth in VA's Schedule for Rating Disabilities, which is based on the average impairment of earning capacity. Individual disabilities are assigned separate diagnostic codes. 38 U.S.C.

§ 1155; 38 C.F.R. § 4.1. The basis of disability ratings is the ability of the body as a whole, or of the psyche, or of a system or organ of the body, to function under the ordinary conditions of daily life, including employment. 38 C.F.R. § 4.10.

The determination of whether an increased rating is warranted is based on review of the entire evidence of record and the application of all pertinent regulations. *Schafrath v. Derwinski*, 1 Vet. App. 589 (1991). Where there is a question as to which of two ratings shall be applied, the higher rating will be assigned if the disability picture more nearly approximates the criteria for that rating. Otherwise, the lower rating will be assigned. 38 C.F.R. § 4.7.

While a Veteran's entire history is reviewed when making a disability decision, where service connection has already been established and increase in the disability rating is at issue, it is the present level of the disability that is of primary concern. *Francisco v. Brown*, 7 Vet. App. 55 (1994). However, staged ratings are appropriate for an increase rating claim when the factual findings show distinct time periods where the service-connected disability exhibits symptoms that would warrant different findings. *Fenderson v. West*, 12 Vet. App. 119 (1999); *Hart v. Mansfield*, 21 Vet. App. 505 (2007).

The Veteran's encephalitis is evaluated under 38 C.F.R. § 4.124a, Diagnostic Code 8000, which remains unchanged since November 1953. Diagnostic Code 8000 provides that epidemic and chronic encephalitis is rated at the 10 percent rate for minimum residuals and at 100 percent for an active febrile disease. 38 C.F.R. § 4.124a, Diagnostic Code 8000.

With the exceptions noted, an introductory note to 38 C.F.R. § 4.124a advises that disability from the following diseases and their residuals may be rated from 10 percent to 100 percent in proportion to the impairment of motor, sensory, or mental function. Consideration is to be given especially to psychotic manifestations, complete or partial loss of use of one or more extremities, speech disturbances, impairment of vision, disturbances of gait, tremors, visceral manifestations, etc., referring to the appropriate bodily system of the schedule. With partial loss of use of one or more extremities from neurological lesions, rate by comparison with the mild, moderate, severe, or complete paralysis of peripheral nerves.

A note following Diagnostic Code 8025 indicates that it is required for the minimum ratings for residuals under diagnostic codes 8000-8025 that there be ascertainable residuals. Determinations as to the presence of residuals not capable of objective verification, i.e., headaches, dizziness, fatigability, must be approached on the basis of the diagnosis recorded; *subjective residuals will be accepted when consistent with the disease and not more likely attributable to other disease or no disease*. [Emphasis added by the Board]. When ratings in excess of the prescribed minimum ratings are assigned, the diagnostic codes utilized as bases of evaluation must be cited, as well as the codes identifying the diagnoses. 38 C.F.R. § 4.124a, note following Diagnostic Code 8025.

The Board notes that many of the regulations and Diagnostic Codes pertinent to the Veteran's reported residuals of encephalitis have changed several times during the appeal period. As such, the rater must consider whether application of any iteration of pertinent former criteria is more favorable to the Veteran regarding each symptom. Further, under 38 C.F.R. § 4.124a, subjective reports of symptoms are sufficient for rating purposes (i.e., no objective medical evidence of any symptoms and/or severity of such) as long as they are "consistent with the disease and not more likely attributable to other disease or no disease."

The Veteran's encephalitis has been assigned a 10 percent rating from November 16, 1953, to January 14, 1955, and from March 17, 1956, to September 29, 2009. The Appellant contends, as did the Veteran before his death, that a higher rating is warranted.

The Appellant's representative contends that the notes relating to Diagnostic Code 8000 and 38 C.F.R. § 4.124a require that other subjective disabling conditions arising from a single disease entity be rated separately under the proper diagnostic codes applicable. The representative has argued that a higher initial rating is warranted for cognitive impairments of moderate memory, attention, concentration, and executive functions, moderately severely impaired judgment, and fatigability. The representative further contends that separate ratings are warranted for subjective residuals of migraine headaches, chronic dizziness, tinnitus, loss of sense of smell, lower lip numbness, and for chronic brain syndrome associated with intracranial infections other than syphilis under Diagnostic Code 9302 (1953)

with definite impairment of social and industrial adaptability. *See* May 2021 VA Form 10182 and April 2022 VA Form 10182. The representative also contends that the VA examiners misevaluated the weight and credibility of the Veteran's contentions in assessing his symptoms and residuals of encephalitis.

A November 1965 VA examiner noted that the Veteran had no particular neuropsychiatric complaints at that time other than an occasional headache. At that time, the Veteran additionally reported abdominal distention as well as his belief that he had noticed some memory defects. The Veteran's neurological examination was entirely negative, and the Veteran showed no outward signs of anxiety or tension but reported that he becomes quite tense and nervous at times. The Veteran reported sleeping poorly at times and occasionally having a poor appetite. The examiner indicated that the Veteran demonstrated no definite evidence of mental deterioration, and no neuropsychiatric disability was evidenced at the time of the examination.

Another VA examination is of record from July 2008. The Veteran reported no seizure disorder. The Veteran endorsed headaches and described them as throbbing, frontal headaches that require medication but that he was still able to go to work. The Veteran reported that he experienced headaches on average 4 times per week lasting for about 40 minutes. Dizziness as often as 2 times per day was indicated. The examiner indicated that the Veteran was not receiving any treatment for his condition and did not experience any functional impairment from his encephalitis. The examiner noted that the Veteran's other medical conditions include tinnitus, hypertension, and PTSD. An examination of the cranial nerves revealed normal findings and the Veteran's coordination, motor function, and sensory function of the upper and lower extremities were noted to be within normal limits with the exception of decreased sensation in both feet. No paralysis was indicated, and the Veteran was observed to walk with a normal gait and did not use an assistive device for ambulation.

The July 2008 VA examiner indicated that the Veteran's condition did not affect the joints or result in any vision problem. The Veteran was observed to speak normally and was alert and oriented with normal comprehension and intact memory. The examiner noted that the Veteran's diagnosis was changed to status-post encephalitis

as his cranial examination was objectively normal and there were no findings of smell or taste problems.

During an October 2008 VA treatment visit, the Veteran reported headaches and dizziness off and on that were attributed to hypertension. The Veteran had trace peripheral edema, good muscle strength in all extremities, and his cranial nerves were grossly intact to observation. During a November 2008 VA treatment visit, the Veteran reported regular nightmares and disturbing memories related to combat events as well as serious sleep disturbance, hypervigilance, and emotional numbing. In January 2009, the Veteran reported many years of insomnia with sleep loss primarily from mid-sleep awakenings. He reported feeling tired during the day and a previous history of extended depressive episodes and occasional intrusive thoughts. The Veteran indicated that he felt on edge most of the time, experienced mood swings, and did not feel safe even in familiar locations. The Veteran denied any audio and visual hallucinations.

In February 2009 VA treatment visits, the Veteran reported slightly improved sleep with continued nightmares and reported his mood was "alright." He additionally reported having significant problems with his hearing in addition to other health problems. In March 2009, he reported his mood as "up and down" and reported his sleep was unchanged. In April 2009, the Veteran reported his mood as "kinda rough" related to his wife's recovery from an illness and reported continued combat-related nightmares. At that time, the Veteran additionally reported decreased hearing, tinnitus, vertigo, and dizziness as well as ear pain.

In June 2009 VA treatment visits, the Veteran reported improved sleep but continued nightmares a few times a week. He indicated his mood was "sad" and he was observed to be without evidence of mania and psychosis.

An August 2009 VA examiner found the Veteran had hearing loss and tinnitus related to his military service and exposure to explosions, mines, demolition, and other hazardous noise.

During a September 2009 VA treatment visit, the Veteran reported his mood as "not good" and attributed this to his strained relationship. He reported decreased sleep

and continued nightmares and indicated his sleep disturbance was primarily due to his wife's substance dependency. The Veteran was observed to be without evidence of mania and psychosis and was assessed with PTSD.

Another VA examination was obtained in January 2010. At the time of the examination, the Veteran reported symptoms of loss of sense of smell, altered sense of taste, numbness of the lower lip, headaches, and dizziness. The examiner noted an abnormality of the cranial nerve VII on the left as evidenced by paralysis with abnormal sensation in the left lower lip. Further testing revealed complete loss of smell on the right, partial loss of smell on the left, and partial loss of taste. The examiner indicated that the Veteran's headache and dizziness are not related to the Veteran's encephalitis. While the examiner indicated that the Veteran's encephalitis condition was active and that he had residuals related to his history of brain inflammation, the examiner did not indicate whether the Veteran's reported residuals had been present throughout the appeal periods or whether such were only present at the time of the examination and beyond.

During the April 2013 Board hearing, the Veteran reported that he could not recall what symptoms he was experiencing between 1953 and 1955. During the May 2016 Board hearing, the Veteran reported that he was experiencing memory difficulties during his second period of service from January 1955 to March 1956 and ultimately could not stay in service because of these challenges.

The Veteran additionally reported that, after leaving service, he experienced headaches, memory difficulties, fatigue, shortness of breath, anxiety, and impatience. He explained that it felt like his muscles were tired and he felt achy most of the time. He further contended that he had problems speaking, slurred speech, dizziness, and numbness of his lips. *See* May 2016 and March 2020 Board Hearings. The Veteran additionally contended that he was tense and agitated all the time and that he did not sleep or eat well. The Appellant reported witnessing the Veteran's volatility and outbursts over the years. The Veteran reported that his headaches would onset if he came under pressure and that his headaches in 1956 were the main reason why he left the service. He, somewhat contradictorily, indicated that he did not receive any treatment through VA but that he went to a VA hospital and was put on medicine.

During the March 2020 Board hearing, the Veteran denied experiencing hallucinations or seeing things that should not be there. He reported that he has fallen because of his dizziness and that it usually took him a little bit before he could get going from sitting or lying down. He indicated that he had bouts of anxiety and tension and had not slept more than four hours at a time in the last 60 years. He contended that he had these symptoms constantly over the years dating back to 1956. The Board notes that, while the Veteran testified at the March 2020 Board hearing that he had received intermittent VA treatment for his encephalitis residuals since the time of his March 1956 service separation, the AOJ acknowledged in a March 2013 Formal Finding that the Veteran's VA treatment records dated prior to October 2008 were unavailable for review.

In light of the absence of contemporaneous medical evidence for much of the relevant appeal periods, the Board remanded this matter in August 2020. At that time, the Board noted that the Veteran had testified that symptoms of numbness in his lower lip, headaches, fatigue, dyspnea, memory impairment, sleep impairment, anxiety, agitation, dizziness, and slurred speech had been present and chronic since 1953. Despite this, a November 1965 VA examination (discussed in the following section) indicated that the Veteran was "fully recovered" from his in-service diagnosis of encephalitis. The Board found that the AOJ failed to obtain retrospective medical examinations and opinions to determine the nature and residuals of the Veteran's service-connected encephalitis for both appeal periods and remanded the matter to obtain such opinions.

A VA examination was obtained in October 2020. At the time of the examination, the Veteran reported current symptoms of tinnitus, headaches 4 times a day lasting 1 hour each, dizziness with occasional trouble walking, numbness of the face around lips, slurred speech, insomnia, uncontrolled anger outbursts, melancholy, depression, crying, and an inability to understand instruction. He reported that the symptoms he had when the condition began were high fever, coma for 4 weeks, tremors in extremities, headaches, ringing in ears, dizziness, fatigue, heavy breathing, anxiety, and agitation. The Veteran reported requiring over the counter medications for headaches and insomnia and reported that he has been unable to hold a job due to uncontrollable anger, brain fog, confusion, and forgetfulness.

The October 2020 VA examiner included a review of the evidence, and the examiner provided a diagnosis of encephalitis. The examiner recorded the Veteran's medical history and noted that the Veteran recovered from encephalitis in 1951 and was reevaluated in 1965 and found to have no disability. The Veteran was observed to have muscle weakness in the upper and lower extremities, insomnia, voiding dysfunction causing signs and/or symptoms of urinary frequency and obstructed voiding, erectile dysfunction, abnormal gait, ataxia, inability to touch nose with finger, positive Romberg test, posttraumatic stress disorder (PTSD), personality disorder, and dementia. The examiner indicated that the Veteran's erectile dysfunction was due to age, and his abnormal gait was due to foot pain and hallux valgus. The examiner noted that the Veteran has depression, cognitive impairment, or dementia or any other mental health conditions attributable to a central nervous system disease and that such results in gross impairment in thought process or communication. However, the examiner remarked that the Veteran has been diagnosed with PTSD and anger management issues with evidence of mild dementia and it is possible to differentiate what portion of the symptomatology or neurologic effects are caused by each diagnosis. The examiner explained that, based on prior evaluations, there are minimal residuals from the history of encephalitis and that, at present, his main issues are his PTSD, personality disorder, and dementia. The examiner noted that the Veteran left the hospital in 1951 symptom-free other than an occasional headache which may or may not have been related to his encephalitis diagnosis. Follow-up evaluations revealed no identified residuals of the encephalitis.

The October 2020 VA examiner opined it is less likely than not that the Veteran status-post encephalitis has been active and manifested by febrile disease at any time from November 16, 1953, to January 14, 1955, and/or from March 17, 1956, to September 29, 2009. The examiner explained that the Veteran was discharged in 1951 symptom-free and returned to duty without any subsequent symptoms other than occasional headache for the duration of his military service. The Veteran was evaluated in 1965 and found to have no identifiable residuals from his encephalitis. While the examiner noted that the Veteran had been unable to hold a steady job since leaving service, the examiner found such to be due to personality and anger issues related to his PTSD. The examiner opined that the Veteran's variety of

symptoms are caused by his age and evidence of dementia and his problems walking are due to balance problems of uncertain etiology and foot pain with deformity. The examiner concluded by stating that there is no evidence in the record other than the Veteran's claim that he has residual problems from encephalitis for the applicable appeal periods.

A private treatment record from October 2020 notes that the Veteran had a history of headaches, dizziness, loss of balance, and facial numbness as well as a history of encephalitis during service. Further information regarding the Veteran's medical history and these symptoms was not provided.

Another VA medical opinion was obtained in November 2020. The examiner included an extensive review of the Veteran's claims file and indicated that 8 hours was spent reviewing and completing the report. The examination report was completed by a board-certified neurologist and included summaries of relevant evidence with discussion of the conclusions reached by prior examiners in earlier examinations. The examiner opined it is less likely than not that the Veteran had any residuals due to his service-connected encephalitis from November 1953 to January 1955 and from March 1956 to September 2009. The examiner further opined that it is at least as likely as not that the Veteran's encephalitis condition resolved following his in-service treatment for such.

The November 2020 VA examiner found that the available evidence of record and the weight of the medical literature supports finding that the Veteran had no chronic and disabling conditions, to include any residuals of encephalitis, subsequent to his recovery from encephalitis in 1951. The examiner further noted that the Veteran would not have been accepted into active-duty service in 1955 if he had had any chronic and disabling conditions at that time. The examiner noted that the Veteran's available service treatment records (STRs) show that the Veteran recovered from encephalitis within several weeks and was reported to be "cured." Furthermore, the Veteran's September 1953 separation examination resulted in an objectively normal clinical evaluation of the Veteran and rendered no diagnosis of encephalopathy or residuals of such. The Veteran subsequently reenlisted in 1955 and was found to have no chronic and disabling conditions upon entrance to service, to include any residuals of encephalitis. The examiner noted that, during

his second period of service, the Veteran had no subsequent complaints of or objective clinical diagnoses of any symptoms congruent with residuals of encephalitis. The examiner noted that the November 1965 VA examination showed that the Veteran had recovered from encephalitis and had no neurological or psychiatric residuals. The examiner indicated that the Veteran's lay statements and testimony were considered in completing the examination report, but the examiner found that the Veteran's testimony regarding his claimed residuals of encephalitis was not congruent with the evidence of record and the weight of the medical literature. The examiner concluded that the evidence of record supports that the Veteran was diagnosed with encephalitis in April 1951, received inpatient treatment, and was released and returned to active service prior to finishing his enlistment in September 1953. The Veteran then reentered active-duty service in January 1955 and was discharged in March 1956. The examiner indicated that the Veteran's encephalitis condition resolved without residuals as supported by the evidence of record and weight of medical literature.

The November 2020 VA examiner explained that encephalitis, or brain inflammation, is an acute condition that resolves with antibiotic therapy. Any residuals are apparent at the time immediately following recovery from the initial brain infection and usually resolve completely over days to weeks. In the event there are permanent residuals, they are apparent at the time of acute infection or immediately upon recovery and remain persistent overtime; the residuals do not resolve and then reappear years to decades later. The November 1965 VA examination indicates that the Veteran had completely recovered from encephalitis with no residuals. The examiner noted that, although the Veteran had reported his experiences and the examiner believed that those experiences occurred, the Veteran is not qualified to make a medical diagnosis based on those experiences.

An additional VA medical opinion is of record dated January 2021. The examiner included an extensive review of the evidence. The examiner was asked to identify all of the residuals of the Veteran's service-connected encephalitis that he experienced from November 16, 1953, to January 14, 1955, and from November 17, 1956, to September 29, 2009. The examiner noted that the Veteran's medical records were read and reviewed along with the prior neurologist's opinion and that

special attention was given to the January 2010 examination. The examiner indicated that there is no evidence that the Veteran had active encephalitis in 2010 or any residual of encephalitis on the January 2010 examination. The Veteran's lower lip numbness was found to be highly unlikely due to his 1951 encephalitis. The examiner concluded that there is no evidence that the Veteran experienced residuals from his encephalitis from November 1953 to January 1955 and from March 1956 to September 2009 and concurred with the opinions rendered by the prior examining neurologist.

A private medical opinion is of record dated April 2021. The private examiner reviewed the Veteran's complete claims file, including more recent examinations and statements from the Veteran. The examiner opined that it is as likely as not that the insomnia, memory difficulties, anxiety, agitation, headaches, and dizziness are related to the prior case of encephalitis. The examiner explained that the Veteran did not currently have encephalitis but rather that he has residuals of encephalitis. The examiner noted the absence of medical records and that the available medical records do not paint a thorough picture of the Veteran's conditions and argued that the Veteran's statements bear more weight in this specific case. The Veteran reported that his symptoms have "waxed and waned" over the years but remained present and the examiner noted that this included chronic headaches, dizziness, tinnitus, personality changes (agitation), memory loss, anxiety, and insomnia.

The April 2021 private examiner remarked that encephalitis often results in substantial sequelae including, but not limited to, headaches, dizziness/vertigo, tinnitus, visual disturbances, insomnia, memory difficulties, impaired focus/concentration, seizures, paralysis, anosmia (loss of smell), dysgeusia (altered taste), and behavioral abnormalities. The examiner noted that there are numerous and credible references in the records to many of these ailments and it is at least as likely as not that the agitation, anxiety, insomnia, memory trouble, headaches, and dizziness are directly attributable to the Veteran's case of very severe encephalitis. The examiner noted that, while there are no studies documenting the frequency of the long-term and permanent sequelae of encephalitis, there are also no studies that rule out the long-term effects or if they can be permanent. The examiner explained that complications of severe illness can vary greatly in severity and may persist for

months or be permanent. Despite indicating there were no studies regarding the frequency or long-term effects of encephalitis, the examiner went on to suggest that there are multiple studies and research that associate long-term effects of encephalitis that show symptoms such as insomnia, memory difficulties, anxiety, agitation, headaches, and dizziness as part of the symptomatology. The examiner opined that, given the facts outlined in the report, it is medically reasonable and at least as likely as not that his previous and current headaches, dizziness, insomnia, memory impairments, anxiety, and agitation are residuals of his encephalitis.

In a December 2021 decision, the Board again remanded this matter. The Board found the October 2020, November 2020, and January 2021 VA medical opinions to be inadequate for adjudication purposes. The Board noted that, while the VA physicians knew of the Veteran's reports of numbness in his lower lip, headaches, fatigue, dyspnea, memory impairment, sleep impairment, anxiety, agitation, dizziness, psychiatric symptoms, and slurred speech, the Veteran's lay statements were discounted due to a lack of supporting medical evidence. The Board observed that such is contrary to the United States Court of Appeals for Veterans Claims' (CAVC/Court) holding in *Buchanan v. Nicholson*, 451 F.3d 1331, 1337 (Fed. Cir. 2006), especially given that VA has lost the Veteran's VA treatment records which may bolster his assertions. The Board further found that the conclusions reached by the VA examiners are brought into question by the April 2021 private examiner who opined that the Veteran's reported symptoms are residuals of his in-service encephalitis.

The Board found that the AOJ's failure to ensure the adequacy of the October 2020, November 2020, and January 2021 VA opinions represented a pre-decisional duty to assist error. The November 2020 and January 2021 VA examiners additionally failed to comment on whether the Veteran's reported symptoms were consistent with a diagnosis of encephalitis and the frequency, severity, and duration of such throughout the appeal period as per the rating criteria provided in 38 C.F.R. § 4.124a. Accordingly, the Board directed the AOJ to obtain an advisory medical opinion from a medical expert specializing in neurology and requested that the examiner address whether the Veteran's symptoms are consistent with encephalitis

and not more likely attributable to another disease or no disease and that the examiner detail the frequency, severity, and duration of any such symptoms.

A new VA medical opinion was obtained in January 2022. The examiner, a board-certified neurologist, included an extensive review of the Veteran's claims file, including the Veteran's statements and medical history, as well as assessments of the prior medical examinations. The Board finds this opinion to be adequate and complete in its rendering. Accordingly, the Board finds there has been substantial compliance with the December 2021 Board remand directives. *Stegall v. West*, 11 Vet. App. 268, 271 (1998).

The January 2022 VA examiner opined that it is less likely than not that the Veteran's claimed symptoms of numbness of the lower lip, headaches, fatigue, dyspnea, memory impairment, sleep impairment, anxiety, agitation, dizziness, and slurred speech are consistent with the Veteran's encephalitis, either when the condition is active or as a residual of the disease. The examiner found no symptoms to be consistent with encephalitis and explained that the reported symptoms are at least as likely as not related to other conditions. The Veteran's claimed symptom of numbness of the lower lip, the examiner opined, is at least as likely as not due to a condition of the third branch of the trigeminal nerve at some point outside of the skull and within the lower jaw, as supported by the weight of the medical literature and the examiner's expertise concerning human neuroanatomy. The examiner explained that if the trigeminal nerve were affected within the brainstem, the Veteran's symptoms would at least as likely as not entail the entire side of his face rather than only the lower lip. Regarding the Veteran's headaches, the examiner opined such to be at least as likely as not due to the Veteran's nonservice-connected condition of occipital neuralgia based on a July 2014 VA neurology consult report. The Veteran's claimed symptoms of fatigue, memory impairment, anxiety, agitation, and sleep impairment, to include insomnia, were determined to be at least as likely as not due to the Veteran's service-connected PTSD based on the examiner's review of multiple VA psychiatry notes contained within the record.

The January 2022 VA examiner opined that the Veteran's claimed symptom of memory impairment may be explained by an October 2020 MRI (magnetic

resonance imaging) brain study that included findings of chronic microscopic vessel disease and atrophy of the brain. The examiner explained that these findings are congruent with vascular dementia as supported by the evidence of record and the weight of the medical literature and vascular dementia is not caused by remote encephalitis or residuals of encephalitis. The examiner further noted that the Veteran's claimed fatigue may be caused by the Veteran's nonservice-connected chronic congestive heart failure and chronic renal failure conditions as reflected in the evidence of record and weight of the medical literature and these conditions are not caused by remote encephalitis or residuals of such. The Veteran's claimed symptoms of dyspnea, dizziness, and slurred speech were determined to be at least as likely as not due to the Veteran's nonservice-connected conditions of heart failure and hypertension based on the review of pertinent records and the weight of medical literature.

As the Veteran's symptoms were determined to not be consistent with a diagnosis of encephalitis or residuals of such, the examiner found there was no clinical indication or basis upon which to detail the frequency, severity, and duration of any such symptoms. The examiner concluded that the weight of the medical literature as well as the evidence of record support that the Veteran's service-connected encephalitis resolved without residuals. The examiner noted that the Veteran's in-service infection was cured with in-patient antibiotic therapy in 1951 and the Veteran went on to complete his tour of duty and then reenlist for a second tour of duty. In reviewing the prior medical evidence, the examiner noted that they stand by the opinion provided in November 2020 and took into consideration the Veteran's lay testimony but found the Veteran's reports were not consistent with the evidence of record and weight of the medical literature. The examiner emphasized that the Veteran had no subsequent complaints of or objective clinical diagnoses of any symptoms consistent with encephalitis after such resolved during his first period of service and the Veteran's separation and entrance examinations are silent for any chronic and disabling conditions consistent with residuals of encephalitis.

The January 2022 VA examiner emphasized that encephalitis is an acute condition that resolves with antibiotic therapy and any residuals are apparent at that time immediately following recovery from the initial brain function and usually resolve

completely over days to weeks. In the event there are permanent residuals, they are apparent at the time of acute infection or immediately upon recovery and remain persistent over time. The residuals do not resolve and then reappear years to decades later or "wax and wane" over time. The examiner noted that the post-service November 1965 neuropsychiatric examination showed that the Veteran had completely recovered from encephalitis with no residuals and that the Veteran had no particular complaints at the time other than an occasional headache. No diagnoses of any neurological or psychiatric conditions were indicated at that time. While the Veteran reported headaches, the examiner noted that the medical literature demonstrates that headaches are extremely common in the adult population and the evidence of record indicates that the Veteran never complained of, sought medical attention for, or was clinically diagnosed with any chronic and disabling headache condition in service and such is not related to his service-connected encephalitis.

The January 2022 VA examiner reviewed the July 2008 VA examination and noted that the examination revealed an objectively normal neurological exam, including an objectively normal cranial nerve exam and normal sense of taste and smell. The examiner concurred with the findings of the July 2008 examiner who rendered a diagnosis of status-post encephalitis and that there were no residuals associated with the Veteran's service-connected encephalitis. The examiner similarly noted that the evidence from an October 2008 VA treatment indicated that the Veteran's reports of headaches and intermittent dizziness represent symptoms of hypertension and are not residuals of the Veteran's encephalitis. The examiner noted that the findings of the January 2010 VA psychiatrist that the Veteran's complaints of fatigue represent a symptom of PTSD rather than a residual of encephalitis and found that such is supported by the evidence of record and weight of medical literature. The examiner disagreed with the findings of active disease noted by the January 2010 VA examiner and found that the opinion is not supported by the weight of the medical literature and other evidence of record. Furthermore, the examiner explained that, if the Veteran's encephalitis was "active" at that time, that would mean he would have had an active brain infection requiring emergent admission to a hospital for immediate treatment and there are no records indicating such treatment.

Finally, the January 2022 VA examiner noted the Veteran did not report any complaints of symptoms consistent with residuals of encephalopathy during his April 2013 Board hearing. The examiner found the Veteran's November 2019 report of residuals dating back to 1953 to be unsubstantiated by the objective evidence of record and weight of the medical literature. The examiner reiterated that an individual who has had encephalitis does not have residuals resolve and then reappear later in life or "wax and wane" and the Veteran's reports of non-specific symptoms during his March 2020 Board hearing are not supported by the objective evidence of record. The examiner concurred with the findings of the July 2008 and January 2021 VA examiners in finding that there were no residuals associated with the Veteran's service-connected encephalitis and found the April 2021 private evaluation to be unsupported by the evidence of record or medical literature.

1. Entitlement to an initial rating in excess of 10 percent for the service-connected status-post encephalitis from November 16, 1953, to January 14, 1955

The Board finds that entitlement to an initial rating in excess of 10 percent for the service-connected status-post encephalitis from November 16, 1953, to January 14, 1955, is not warranted.

As reflected in the review of the medical evidence, lay statements, and arguments above, there is no contemporaneous medical evidence available for review for the appeal period from November 1953 to January 1955. The Veteran contended that he met the requirements for a 100 percent rating from November 1953 as his encephalitis was febrile and chronic at that time. *See* May 2017 Correspondence.

Based on the evidence of record, particularly the retrospective medical opinions provided in the October 2020, November 2020, January 2021, and January 2022 VA examinations, the Veteran did not have active febrile disease as required for a 100 percent disability rating under Diagnostic Code 8000. Furthermore, the Veteran's status-post encephalitis was manifested by no more than minimal residuals and there were no subjective residuals for which separate ratings are warranted.

The November 1965 VA examiner found that the Veteran had no particular neuropsychiatric complaints at the time other than an occasional headache and the Veteran reported noticing some memory deficits. However, the neurological examination was entirely negative, and the Veteran showed no outward signs of anxiety or tension. While the Veteran reported sleeping poorly at times and occasionally have a poor appetite, the examiner indicated that the Veteran demonstrated no definite evidence of mental deterioration, and no neuropsychiatric disability was evidenced at the time of the examination.

While the Veteran endorsed headaches and dizziness during his July 2008 VA examination, the examiner noted that the Veteran had other medical conditions including tinnitus, hypertension, and PTSD. The Veteran's cranial nerves were revealed to be normal upon examination and the Veteran's coordination, comprehension, memory, motor function, and sensory function of the upper and lower extremities were noted to be within normal limits with the exception of decreased sensation in both feet. No paralysis was indicated, and the Veteran was observed to walk with a normal gait and did not use an assistive device for ambulation. Importantly, the July 2008 VA examiner found that the Veteran's diagnosis was changed to status-post encephalitis as his cranial examination was objectively normal and there were no findings of smell or taste problems.

During various VA treatment visits, the Veteran's reported symptoms of headaches, dizziness, sleep disturbances, insomnia, and mood swings were attributed to the Veteran's hypertension and PTSD conditions.

The October 2020 VA examiner recorded the Veteran's reports of symptoms and concluded that the Veteran recovered from encephalitis in 1951 and, upon reevaluation in 1965, he was found to have no disability. The examiner attributed the Veteran's symptoms to conditions other than encephalitis and indicated that, based on prior evaluation, there were only minimal residuals from the history of encephalitis. The examiner opined it is less likely than not that the Veteran's status-post encephalitis has been active and manifested by febrile disease at any time from November 16, 1953, to January 14, 1955, and found that there is no evidence in the record other than the Veteran's claim that he has had residual problems from encephalitis for the applicable appeal period.

While a private treatment record from October 2020 noted that the Veteran had a history of headaches, dizziness, loss of balance, and facial numbness as well as a history of encephalitis during service, further information regarding the Veteran's medical history and these symptoms was not provided.

The November 2020 VA examiner opined it is less likely than not that the Veteran had any residuals due to his service-connected encephalitis from November 1953 to January 1955. The examiner further opined that it is at least as likely as not that the Veteran's encephalitis condition resolved following his in-service treatment for such. The examiner, after reviewing the available evidence of record and medical literature, noted that the Veteran did not have any complaints of or objective clinical diagnoses of any symptoms congruent with residuals of encephalitis during his second period of service and the November 1965 VA examination showed that the Veteran had recovered from encephalitis and had no neurological or psychiatric residuals. Importantly, the examiner explained that encephalitis is an acute condition that resolves with antibiotic therapy and any residuals are apparent at the time immediately following recovery from the initial brain infection and usually resolve completely over days to weeks. In the event there are permanent residuals, they are apparent at the time of acute infection or immediately upon recovery and remain persistent over time; the residuals do not resolve and then reappear years to decades later. The examiner noted that, although the Veteran had reported his experiences and the examiner believed that those experiences occurred, the Veteran is not qualified to make a medical diagnosis based on those experiences.

The January 2021 VA examiner agreed with the findings of the November 2020 VA examiner and found that there was no evidence that the Veteran experienced residuals from his encephalitis from November 1953 to January 1955.

While the April 2021 private examiner opined that it is as likely as not that the Veteran's insomnia, memory difficulties, anxiety, agitation, headaches, and dizziness are related to his encephalitis, this finding is contradicted by the other medical evidence of record which attributed many of the Veteran's symptoms to conditions other than encephalitis. The January 2022 VA examiner discussed and evaluated the findings of the April 2021 private examiner, as well as all of the other medical evidence and examinations of record, and thoroughly explained why the

April 2021 examiner's findings were inconsistent with encephalitis. The Board ascribes more probative weight to the January 2022 VA examination in finding that the Veteran's contended symptoms have symptoms have been more likely than not attributed to other service-connected and nonservice-connected conditions and not found to be consistent with encephalitis.

The representative has argued that separate ratings are warranted for subjective residuals of migraine headaches, chronic dizziness, tinnitus, loss of sense of smell, lower lip numbness, and for chronic brain syndrome associated with intracranial infections other than syphilis, but the competent evidence of record does not support the assignment of separate ratings for these contended residuals. A diagnosis of chronic brain syndrome was not indicated. The Veteran's headaches, dizziness, and lower lip numbness were regularly found not to be related to the Veteran's encephalitis. The Veteran's tinnitus was determined to be related to his military noise exposure and the Veteran's reports of a loss of sense of smell were inconsistent or waxed and waned, which the January 2022 VA examiner explained is inconsistent with the healing process from encephalitis.

The Board acknowledges the Veteran's and Appellant's contentions that the Veteran's reported symptoms warrant an increased rating for his status-post encephalitis. However, the Board finds that the Veteran and Appellant do not have the requisite training and education necessary to make that medical decision. *See Jandreau v. Nicholson*, 492 F.3d 1372 (Fed. Cir. 2007). To the extent that the Veteran contends he had active encephalitis, the persuasive weight of the evidence indicates that the Veteran's encephalitis resolved during his first period of service following his in-service treatment for the condition.

To the extent that the Veteran and the Appellant contended that his residual symptoms as described above are related to his service-connected encephalitis, the persuasive weight of the evidence indicates that these symptoms have been more likely than not attributed to other service-connected and non-service-connected conditions and not found to be consistent with encephalitis. While subjective residuals will be accepted under 38 C.F.R. § 4.124a, such are only accepted when consistent with the disease and not more likely attributable to other disease or no disease. The January 2022 VA examiner explained that the Veteran's reports of

symptoms of numbness of the lower lip, headaches, fatigue, dyspnea, dizziness, slurred speech, anxiety, agitation, sleep impairment, and memory impairment were at least as likely as not due to other service-connected and nonservice-connected conditions. Furthermore, the persuasive weight of the available medical evidence of record described many of the Veteran's reported symptoms as associated with other conditions, such as hypertension and PTSD, rather than encephalitis.

The Board has considered whether a higher rating under another Diagnostic Code is available. However, the Board emphasizes that Diagnostic Code 8000, which is specific to encephalitis, is the only Diagnostic Code that may be used to rate the Veteran's encephalitis residuals. *See Copeland v. McDonald*, 27 Vet. App. 333, 337 (2015) (when a condition is specifically listed in the rating schedule, it may not be rated by analogy and should be rated under the diagnostic code that specifically pertains to it).

Accordingly, the Board finds that entitlement to an initial rating in excess of 10 percent for the service-connected status-post encephalitis from November 16, 1953, to January 14, 1955, is not warranted.

2. Entitlement to a rating in excess of 10 percent from March 17, 1956, to September 29, 2009

The Board finds that entitlement to a rating in excess of 10 percent from March 17, 1956, to September 29, 2009, is not warranted.

The Veteran contended after leaving service, he experienced headaches, memory difficulties, fatigue, shortness of breath, anxiety, and impatience. He contended that it felt like his muscles were tired and he felt achy most of the time and that he had problems speaking, slurred speech, dizziness, and numbness of his lips. *See* May 2016 and March 2020 Board Hearings. He reported that he felt tense and agitated all the time and did not sleep or eat well. The Veteran reported that he had headaches that would onset if he came under pressure and that his headaches in 1956 were the main reason why he left the service. He reported falls related to dizziness and that he had bouts of anxiety and tension and had not slept more than

four hours at a time in the last 60 years. The Veteran contended that he had these symptoms constantly over the years dating back to 1956.

Based on the evidence of record, particularly the retrospective medical opinions provided in the October 2020, November 2020, January 2021, and January 2022 VA examinations, the Veteran did not have active febrile disease as required for a 100 percent disability rating under Diagnostic Code 8000 from March 17, 1956, to September 29, 2009. Furthermore, the Veteran's status-post encephalitis was manifested by no more than minimal residuals and there were no subjective residuals for which separate ratings are warranted.

The November 1965 VA examiner found that the Veteran had no particular neuropsychiatric complaints at the time other than an occasional headache and the Veteran reported noticing some memory deficits. However, the neurological examination was entirely negative, and the Veteran showed no outward signs of anxiety or tension. While the Veteran reported sleeping poorly at times and occasionally have a poor appetite, the examiner indicated that the Veteran demonstrated no definite evidence of mental deterioration, and no neuropsychiatric disability was evidenced at the time of the examination.

While the Veteran endorsed headaches and dizziness during his July 2008 VA examination, the examiner noted that the Veteran had other medical conditions including tinnitus, hypertension, and PTSD. The Veteran's cranial nerves were revealed to be normal upon examination and the Veteran's coordination, comprehension, memory, motor function, and sensory function of the upper and lower extremities were noted to be within normal limits with the exception of decreased sensation in both feet. No paralysis was indicated, and the Veteran was observed to walk with a normal gait and did not use an assistive device for ambulation. Importantly, the July 2008 VA examiner found that the Veteran's diagnosis was changed to status-post encephalitis as his cranial examination was objectively normal and there were no findings of smell or taste problems.

During various VA treatment visits, the Veteran's reported symptoms of headaches, dizziness, sleep disturbances, insomnia, and mood swings were attributed to the Veteran's hypertension and PTSD conditions.

The October 2020 VA examiner recorded the Veteran's reports of symptoms and concluded that the Veteran recovered from encephalitis in 1951 and, upon reevaluation in 1965, he was found to have no disability. The examiner attributed the Veteran's symptoms to conditions other than encephalitis and indicated that, based on prior evaluation, there were only minimal residuals from the history of encephalitis. The examiner opined it is less likely than not that the Veteran's status-post encephalitis has been active and manifested by febrile disease at any time from March 17, 1956, to September 29, 2009, and found that there is no evidence in the record other than the Veteran's claim that he has had residual problems from encephalitis for the applicable appeal period.

While a private treatment record from October 2020 noted that the Veteran had a history of headaches, dizziness, loss of balance, and facial numbness as well as a history of encephalitis during service, further information regarding the Veteran's medical history and these symptoms was not provided.

The November 2020 VA examiner opined it is less likely than not that the Veteran had any residuals due to his service-connected encephalitis from March 1956 to September 2009. The examiner further opined that it is at least as likely as not that the Veteran's encephalitis condition resolved following his in-service treatment for such. The examiner, after reviewing the available evidence of record and medical literature, noted that the Veteran did not have any complaints of or objective clinical diagnoses of any symptoms congruent with residuals of encephalitis during his second period of service and the November 1965 VA examination showed that the Veteran had recovered from encephalitis and had no neurological or psychiatric residuals. Importantly, the examiner explained that encephalitis is an acute condition that resolves with antibiotic therapy and any residuals are apparent at the time immediately following recovery from the initial brain infection and usually resolve completely over days to weeks. In the event there are permanent residuals, they are apparent at the time of acute infection or immediately upon recovery and remain persistent over time; the residuals do not resolve and then reappear years to decades later. The examiner noted that, although the Veteran had reported his experiences and the examiner believed that those experiences occurred, the Veteran is not qualified to make a medical diagnosis based on those experiences.

The January 2021 VA examiner agreed with the findings of the November 2020 VA examiner and found that there was no evidence that the Veteran experienced residuals from his encephalitis from March 1956 to September 2009.

While the April 2021 private examiner opined that it is as likely as not that the Veteran's insomnia, memory difficulties, anxiety, agitation, headaches, and dizziness are related to his encephalitis, this finding is contradicted by the other medical evidence of record which attributed many of the Veteran's symptoms to conditions other than encephalitis. The Veteran's insomnia, memory impairments, anxiety, and agitation were regularly noted as symptoms of his service-connected PTSD and the Veteran regularly reported difficulty sleeping, anxiety, and agitation related to mental health difficulties in VA treatment visits. Furthermore, the January 2022 VA examiner discussed and evaluated the findings of the April 2021 private examiner, as well as all of the other medical evidence and examinations of record, and thoroughly explained why the April 2021 examiner's findings were inconsistent with the nature of encephalitis. The Board ascribes more probative weight to the January 2022 VA examination in finding that the Veteran's contended symptoms have symptoms have been more likely than not attributed to other service-connected and nonservice-connected conditions and not found to be consistent with encephalitis.

The representative has argued that separate ratings are warranted for subjective residuals of migraine headaches, chronic dizziness, tinnitus, loss of sense of smell, lower lip numbness, and for chronic brain syndrome associated with intracranial infections other than syphilis, but the competent evidence of record does not support the assignment of separate ratings for these contended residuals. A diagnosis of chronic brain syndrome was not indicated. The Veteran's headaches, dizziness, and lower lip numbness were regularly found not to be related to the Veteran's encephalitis. The Veteran's tinnitus was determined to be related to his military noise exposure and the Veteran's reports of a loss of sense of smell were inconsistent or waxed and waned, which the January 2022 VA examiner explained is inconsistent with the healing process from encephalitis.

The Board acknowledges the Veteran's and Appellant's contentions that the Veteran's reported symptoms warrant an increased rating for his status-post

encephalitis. However, the Board finds that the Veteran and Appellant do not have the requisite training and education necessary to make that medical decision. *See Jandreau v. Nicholson*, 492 F.3d 1372 (Fed. Cir. 2007). To the extent that the Veteran contends he had active encephalitis, the persuasive weight of the evidence indicates that the Veteran's encephalitis resolved during his first period of service following his in-service treatment for the condition. Between 1956 and 2009, there was no evidence indicating that the Veteran's encephalitis was active and febrile.

To the extent that the Veteran and the Appellant contended that his residual symptoms as described above are related to his service-connected encephalitis, the persuasive weight of the evidence indicates that these symptoms have been more likely than not attributed to other service-connected and nonservice-connected conditions and not found to be consistent with encephalitis. While subjective residuals will be accepted under 38 C.F.R. § 4.124a, such are only accepted when consistent with the disease and not more likely attributable to other disease or no disease. The January 2022 VA examiner explained that the Veteran's reports of symptoms of numbness of the lower lip, headaches, fatigue, dyspnea, dizziness, slurred speech, anxiety, agitation, sleep impairment, and memory impairment were at least as likely as not due to other service-connected and nonservice-connected conditions. Furthermore, the persuasive weight of the available medical evidence of record described many of the Veteran's reported symptoms as associated with other conditions, such as hypertension and PTSD, rather than encephalitis.

The Board has considered whether a higher rating under another Diagnostic Code is available. However, the Board emphasizes that Diagnostic Code 8000, which is specific to encephalitis, is the only Diagnostic Code that may be used to rate the Veteran's encephalitis residuals. *See Copeland v. McDonald*, 27 Vet. App. 333, 337 (2015) (when a condition is specifically listed in the rating schedule, it may not be rated by analogy and should be rated under the diagnostic code that specifically pertains to it).

(Continued on the next page)

IN THE APPEAL OF
PETRA L. GARDENHIRE
IN THE CASE OF
CHARLES F. GARDENHIRE

[redacted]
Docket No. 220422-238079
Advanced on the Docket

Accordingly, the Board finds that entitlement to a rating in excess of 10 percent for the service-connected status-post encephalitis from March 17, 1956, to September 29, 2009, is not warranted.



Marcus N. Fulton
Veterans Law Judge
Board of Veterans' Appeals

Attorney for the Board Goreham, A.

The Board's decision in this case is binding only with respect to the instant matter decided. This decision is not precedential and does not establish VA policies or interpretations of general applicability. 38 C.F.R. § 20.1303.

If you disagree with VA's decision

VA 10183-SB
FEB 2019 Page 1 of 2

Choose one of the following review options to continue your case. If you aren't satisfied with that review, you can try another option. Submit your request before the indicated deadline in order to receive the maximum benefit if your case is granted.

Review option	**Supplemental Claim** **Add new and relevant evidence**	**Higher-Level Review** Not Available **Ask for a new look from a senior reviewer**	**Board Appeal** Not Available **Appeal to a Veterans Law Judge**	**Court Appeal** **Appeal to Court of Appeals for Veterans Claims**
Who and what	A reviewer will determine whether the new evidence changes the decision.	Because your appeal was decided by a Veterans Law Judge, you cannot request a Higher-Level Review. Please choose a different option for your next review.	You cannot request two Board Appeals in a row. Please choose a different option for your next review.	The U.S. Court of Appeals for Veterans Claims will review the Board's decision. You can hire an attorney to represent you, or you can represent yourself. Find more information at the Court's website: uscourts.cavc.gov
Estimated time for decision	**About 4-5 months**			
Evidence	You must submit evidence that VA didn't have before that supports your case.			
Discuss your case with VA				
Request this option	Submit VA Form 20-0995 Decision Review Request: Supplemental Claim VA.gov/decision-reviews			File a Notice of Appeal uscourts.cavc.gov Note: A Court Appeal must be filed with the Court, not with VA.
Deadline	You have **1 year** from the date on your VA decision to submit VA Form 20-0995.			You have **120 days** from date on your VA decision to file a Court Appeal.
How can I get help?	A Veterans Service Organization or VA-accredited attorney or agent can represent you or provide guidance. Contact your local VA office for assistance or visit VA.gov/decision-reviews/get-help. For more information, you can call the White House Hotline **1-855-948-2311**.			

What is new and relevant evidence?
In order to request a Supplemental Claim, you must add evidence that is both new and relevant. New evidence is information that VA did not have before the last decision. Relevant evidence is information that could prove or disprove something about your case.

VA cannot accept your Supplemental Claim without new and relevant evidence. In addition to submitting the evidence yourself, you can identify evidence, like medical records, that VA should obtain.

What is the Duty to Assist?
The Duty to Assist means VA must assist you in obtaining evidence, such as medical records, that is needed to support your case. VA's Duty to Assist applied during your initial claim, and it also applies if you request a Supplemental Claim.

If you request a Higher-Level Review or Board Appeal, the Duty to Assist does not apply. However, the reviewer or judge will look at whether VA met its Duty to Assist when it applied, and if not, have VA correct that error by obtaining records or scheduling a new exam. Your review may take longer if this is needed.

What if I want to file a Court Appeal, but I'm on active duty?
If you are unable to file a Notice of Appeal due to active military service, like a combat deployment, the Court of Appeals for Veterans Claims may grant additional time to file. The 120-day deadline would start or resume 90 days after you leave active duty. Please seek guidance from a qualified representative if this may apply to you.

What if I miss the deadline?
Submitting your request on time will ensure that you receive the maximum benefit if your case is granted. Please check the deadline for each review option and submit your request before that date.

If the deadline has passed, you can either:

- Add new and relevant evidence and request a Supplemental Claim. Because the deadline has passed, the effective date for benefits will generally be tied to the date VA receives the new request, not the date VA received your initial claim. Or,
- File a motion to the Board of Veterans' Appeals.

What if I want to get a copy of the evidence used in making this decision?
Call 1-800-827-1000 or write a letter stating what you would like to obtain to the address listed on this page.

Motions to the Board
Please consider the review options available to you if you disagree with the decision. In addition to those options, there are three types of motions that you can file with the Board to address errors in the decision. Please seek guidance from a qualified representative to assist you in understanding these motions.

Motion to Vacate
You can file a motion asking the Board to vacate, or set aside, all or part of the decision because of a procedural error. Examples include if you requested a hearing but did not receive one or if your decision incorrectly identified your representative. You will need to write a letter stating how you were denied due process of law. If you file this motion within 120 days of the date on your decision letter, you will have another 120 days from the date the Board decides the motion to appeal to the Court of Appeals for Veterans Claims.

Motion to Reconsider
You can file a motion asking the Board to reconsider all or part of the decision because of an obvious error of effect or law. An example is if the Board failed to recognize a recently established presumptive condition. You will need to write a letter stating specific errors the Board made. If the decision contained more than one issue, please identify the issue or issues you want reconsidered. If you file this motion within 120 days of the date on your decision letter, you will have another 120 days from the date the Board decides the motion to appeal to the Court of Appeals for Veterans Claims.

Motion for Revision of Decision based on Clear and Unmistakable Error
Your decision becomes final after 120 days. Under certain limited conditions, VA can revise a decision that has become final. You will need to send a letter to VA requesting that they revise the decision based on a Clear and Unmistakable Error (CUE). CUE is a specific and rare kind of error. To prove CUE, you must show that facts, known at the time, were not before the judge or that the judge incorrectly applied the law as it existed at the time. It must be undebatable that an error occurred and that this error changed the outcome of your case. Misinterpretation of the facts or a failure by VA to meet its Duty to Assist are not sufficient reasons to revise a decision. Please seek guidance from a qualified representative, as you can only request CUE once per decision.

Mail to:
Board of Veterans' Appeals
PO Box 27063
Washington, DC 20038

Or, fax:
1-844-678-8979

BOARD OF VETERANS' APPEALS

FOR THE SECRETARY OF VETERANS AFFAIRS

IN THE APPEAL OF
PETRA L. GARDENHIRE
IN THE CASE OF
CHARLES F. GARDENHIRE
Appellant Represented by
Gordon A. Graham, Agent

XC XX XXX 265
Docket No. 220422-238079

DATE: March 18, 2026

ORDER

Entitlement to an initial rating in excess of 10 percent for the service-connected status-post encephalitis from November 16, 1953, to January 14, 1955, is denied.

Entitlement to a rating in excess of 10 percent for the service-connected status-post encephalitis from March 17, 1956, to September 29, 2009, is denied.

FINDINGS OF FACT

1. From November 16, 1953, to January 14, 1955, the Veteran's service-connected status-post encephalitis has been manifested by no more than minimal residuals and there was no evidence of subjective residuals for which separate ratings are warranted. Active febrile disease was not shown.

2. From March 17, 1956, to September 29, 2009, the Veteran's service-connected status-post encephalitis has been manifested by no more than minimal residuals and there was no evidence of subjective residuals for which separate ratings are warranted. Active febrile disease was not shown.

IN THE APPEAL OF
PETRA L. GARDENHIRE
IN THE CASE OF
CHARLES F. GARDENHIRE

XC XX XXX 265
Docket No. 220422-238079

CONCLUSIONS OF LAW

1. The criteria for an initial rating in excess of 10 percent for the service-connected status-post encephalitis from November 16, 1953, to January 14, 1955, have not been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 4.1, 4.2, 4.3, 4.7, 4.14, 4.20, 4.27, 4.112, 4.113, 4.124a, Diagnostic Code 8000.

2. The criteria for a rating in excess of 10 percent for the service-connected status-post encephalitis from March 17, 1956, to September 29, 2009, have not been met. 38 U.S.C. §§ 1155, 5107; 38 C.F.R. §§ 4.1, 4.2, 4.3, 4.7, 4.14, 4.20, 4.27, 4.112, 4.113, 4.124a, Diagnostic Code 8000.

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

The Veteran served on active duty from September 1950 to September 1953 and January 1955 to March 1956. The Veteran died in July 2021, and the Appellant is his surviving spouse. *See* September 2021 Substitution Determination. This appeal has been advanced on the Board's docket pursuant to 38 C.F.R. § 20.800(c).

On August 23, 2017, the President signed into law the Veterans Appeals Improvement and Modernization Act, Pub. L. No. 115-55 (codified as amended in scattered sections of 38 U.S.C.), 131 Stat. 1105 (2017), also known as the Appeals Modernization Act (AMA). This law creates a new framework for Veterans dissatisfied with VA's decision on their claim to seek review. This decision has been written consistent with the new AMA framework.

Given the extensive history and lengthy appeal period for consideration, the Board finds that a brief recitation of pertinent facts and the procedural history of this appeal would be helpful.

In a December 1965 rating decision, the Agency of Original Jurisdiction (AOJ) granted service connection for a history of encephalitis and assigned a noncompensable (zero percent) initial rating was assigned, effective from August

18, 1965. The Veteran was apprised of these actions, but he did not express timely disagreement with the AOJ's assigned effective date and/or initial rating for this award. As such, the downstream elements (the effective date for the award of service connection and the initial rating assigned for the disability) of this award became final. 38 U.S.C. § 7105(c); 38 C.F.R. §§ 3.104, 3.156(b), 20.302, 20.1103; *Grantham v. Brown*, 114 F.3d 1156, 1158-59 (Fed. Cir. 1997).

On September 30, 2009, the Veteran expressed disagreement with several determinations made in a September 2009 rating decision and asserted that he was unable to maintain a substantially gainful occupation due to his service-connected disabilities. Based on this latter assertion, the AOJ scheduled the Veteran for several VA examinations to determine the functional impairment stemming from his service-connected disabilities, to include his encephalitis.

In a June 2011 rating decision, the AOJ explained that the Veteran's September 2009 statement was accepted as an implied claim for an increased rating for his service-connected encephalitis and assigned an increased rating of 100 percent, effective from September 30, 2009. The Veteran initiated an appeal concerning the effective dates for the award of service connection for encephalitis and for the assignment for a 100 percent rating for this disability; however, these issues were denied by the Board of Veterans' Appeals (Board) in a final June 2013 decision.

In August 2013, the Veteran filed a motion for revision of the December 1965 decision based on clear and unmistakable error (CUE) in the assignment of a noncompensable rating for encephalitis from August 18, 1965. This motion was denied by the AOJ in an August 2014 rating decision which considered the effective date for the grant of service connection and the initial disability rating. In September 2014, the Veteran filed a NOD and expressed disagreement with the denial of "CUE for encephalitis."

For unclear reasons, when the AOJ readjudicated this motion in a May 2015 Statement of the Case (SOC), the issue was limited to entitlement to an earlier effective date for the award of service connection for encephalitis due to CUE in the December 1965 rating decision. The matter of a revision of the portion of the December 1965 rating decision that assigned an initial noncompensable rating for

encephalitis was not addressed by the AOJ. The Veteran subsequently perfected an appeal to the Board.

In a July 2016 decision, the Board found that the December 1965 rating decision contained CUE with regard to the assignment of the effective date for the award of service connection. The Board found that an effective date of November 16, 1953, was warranted, not inclusive of the period of the Veteran's second period of active duty (January 1955 to March 1956). Again, the Board notes that, due to the AOJ's limitation of the Veteran's CUE motion to only the effective date of service connection in the May 2015 SOC, the CUE claim regarding the initial compensable rating assigned in the December 1965 rating decision was not addressed by the Board.

In a rating decision dated July 25, 2016, the AOJ implemented the July 2016 Board decision and assigned a noncompensable rating from November 16, 1953. This rating included the Veteran's second period of active duty; however, it does not appear that the AOJ released this rating decision to the Veteran or fully implemented such.

In a rating decision dated July 30, 2016, the AOJ further implemented the July 2016 Board decision. In this rating decision, for unclear reasons, the AOJ stated that the Board's finding of CUE in the December 1965 rating decision "abated" the AOJ's assigned effective date and initial rating, even though the latter matter was not addressed in the July 2016 Board decision. The AOJ assigned an initial 10 percent rating for the service-connected encephalitis from November 16, 1953, to January 14, 1955, suspended compensation from January 14, 1955, to March 16, 1965, during the Veteran's second period of service, and assigned a 10 percent rating from March 17, 1956, to September 29, 2009. It is unknown when the Veteran was notified of this decision, as the AOJ's notification letter is undated.

In March 2017, the Veteran requested that the AOJ reconsider assigning a 100 percent rating for encephalitis from the day after separation from his first period of active duty. In April 2017, the Veteran filed a formal claim seeking an increased rating for service-connected encephalitis. In May 2017, he clarified that the April

2017 claim was seeking a 100 percent rating for service-connected encephalitis from November 16, 1953.

In June 2017, the AOJ notified the Veteran that VA would not reconsider entitlement to an initial rating in excess of 10 percent for service-connected encephalitis. Later that month, the Veteran filed a NOD with the assigned effective date for the 100 percent rating for service-connected encephalitis. The AOJ acknowledged this filing and the initiation of an appeal in a July 2017 letter.

In August 2017, the President signed into law the Veterans Appeals Improvement and Modernization Act of 2017 (Appeals Modernization Act or AMA), Pub. Law 115-55, which created a new claims and appeals process for pursuing VA benefits.

In May 2018, the Veteran opted to withdraw his pending appeal from VA's Legacy via Rapid Appeals Modernization Program (RAMP) and requested the Supplemental Claim option in seeking an earlier effective date for the assignment of a 100 percent rating for the service-connected encephalitis.

The AOJ readjudicated this issue in a December 2018 RAMP rating decision. The Veteran filed a formal Legacy NOD in December 2018. In an August 2019 statement, the Veteran clarified that he was seeking an initial rating in excess of 10 percent for service-connected encephalitis from November 1953.

In September 2019, the AOJ notified the Veteran that his December 2018 Legacy NOD was ineffective to appeal the December 2018 RAMP rating decision. Later in September 2019, the Veteran attempted to submit an appeal through RAMP via the Board's hearing docket. In October 2019, the AOJ notified the Veteran that his September 2019 request could not be accepted, as the RAMP program had concluded. In November 2019, the Veteran filed a VA Form 10182 (Notice of Disagreement) to continue his appeal under the AMA and he requested the Board's hearing docket.

Later in November 2019, the Veteran filed a Higher-Level Review (HLR) request. In a December 2019 letter, the AOJ notified the Veteran that his HLR request was not accepted because the rating decision was promulgated prior to February 2019–

which is untrue under the governing laws. Despite this, the Board sent the Veteran a docketing letter in December 2019, and the Veteran presented testimony before an Acting Veterans Law Judge (VLJ) in March 2020. A transcript of this hearing is associated with the claims file.

In an August 2020 decision, the Board remanded the increased rating matter. In a February 2021 rating decision, the AOJ denied entitlement to an earlier effective date for the assignment of a 100 percent rating and continued the 100 percent rating from September 30, 2009. The Veteran filed a VA 10182 in May 2021, and requested the Evidence docket.

The Veteran died in July 2021. The Board issued a decision in August 2021 dismissing the appeal in light of the Veteran's death. In September 2021, the Appellant was substituted in the appeal.

In a December 2021 decision, the Board again remanded the increased rating matter. In a February 2022 rating decision, the AOJ again denied entitlement to an earlier effective date for the assignment of a 100 percent rating and continued the 100 percent rating from September 30, 2009. The Appellant submitted a HLR request in February 2022.

In an April 2022 HLR rating decision, the AOJ denied entitlement to an increased rating for the service-connected status-post encephalitis. The Appellant submitted a timely VA Form 10182 in April 2022 and, in so doing, requested direct review by the Board.

Based on the Appellant's choice to pursue a direct review of this appeal, the Board will decide the appeal "based on the evidence of record at the time of the prior decision." Accordingly, no additionally submitted evidence may be considered.

In a December 2024 decision, the Board denied the Appellant's claims for increased ratings for the service-connected status-post encephalitis. The Appellant appealed this decision to the United States Court of Appeals for Veterans Claims (CAVC/Court). In October 2025, the Court issued an order granting an October 2025 Joint Motion for Remand (JMR). The parties to the JMR agreed that the

Board erred by failing to provide an adequate statement of reasons or bases for its decision. Specifically, the parties agreed that the Board erred when it failed to adequately explain its reliance on the October 2020, November 2020, and January 2021 VA medical opinions for its finding that the Veteran did not have active febrile disease from March 17, 1956, to September 29, 2009. The matter has been returned to the Board for action consistent with the Court Order.

Increased Ratings for Service-Connected Status-Post Encephalitis

Disability ratings are determined by applying the criteria set forth in VA's Schedule for Rating Disabilities, which is based on the average impairment of earning capacity. Individual disabilities are assigned separate diagnostic codes. 38 U.S.C. § 1155; 38 C.F.R. § 4.1. The basis of disability ratings is the ability of the body as a whole, or of the psyche, or of a system or organ of the body, to function under the ordinary conditions of daily life, including employment. 38 C.F.R. § 4.10.

The determination of whether an increased rating is warranted is based on review of the entire evidence of record and the application of all pertinent regulations. *Schafrath v. Derwinski*, 1 Vet. App. 589 (1991). Where there is a question as to which of two ratings shall be applied, the higher rating will be assigned if the disability picture more nearly approximates the criteria for that rating. Otherwise, the lower rating will be assigned. 38 C.F.R. § 4.7.

While a Veteran's entire history is reviewed when making a disability decision, where service connection has already been established and increase in the disability rating is at issue, it is the present level of the disability that is of primary concern. *Francisco v. Brown*, 7 Vet. App. 55 (1994). However, staged ratings are appropriate for an increase rating claim when the factual findings show distinct time periods where the service-connected disability exhibits symptoms that would warrant different findings. *Fenderson v. West*, 12 Vet. App. 119 (1999); *Hart v. Mansfield*, 21 Vet. App. 505 (2007).

The Veteran's encephalitis is evaluated under 38 C.F.R. § 4.124a, Diagnostic Code 8000, which remains unchanged since November 1953. Diagnostic Code 8000 provides that epidemic and chronic encephalitis is rated at the 10 percent rate for

minimum residuals and at 100 percent for an active febrile disease. 38 C.F.R. § 4.124a, Diagnostic Code 8000.

With the exceptions noted, an introductory note to 38 C.F.R. § 4.124a advises that disability from the following diseases and their residuals may be rated from 10 percent to 100 percent in proportion to the impairment of motor, sensory, or mental function. Consideration is to be given especially to psychotic manifestations, complete or partial loss of use of one or more extremities, speech disturbances, impairment of vision, disturbances of gait, tremors, visceral manifestations, etc., referring to the appropriate bodily system of the schedule. With partial loss of use of one or more extremities from neurological lesions, rate by comparison with the mild, moderate, severe, or complete paralysis of peripheral nerves.

A note following Diagnostic Code 8025 indicates that it is required for the minimum ratings for residuals under diagnostic codes 8000-8025 that there be ascertainable residuals. Determinations as to the presence of residuals not capable of objective verification, i.e., headaches, dizziness, fatigability, must be approached on the basis of the diagnosis recorded; *subjective residuals will be accepted when consistent with the disease and not more likely attributable to other disease or no disease*. [Emphasis added by the Board]. When ratings in excess of the prescribed minimum ratings are assigned, the diagnostic codes utilized as bases of evaluation must be cited, as well as the codes identifying the diagnoses. 38 C.F.R. § 4.124a, note following Diagnostic Code 8025.

The Board notes that many of the regulations and Diagnostic Codes pertinent to the Veteran's reported residuals of encephalitis have changed several times during the appeal period. As such, the rater must consider whether application of any iteration of pertinent former criteria is more favorable to the Veteran regarding each symptom. Further, under 38 C.F.R. § 4.124a, subjective reports of symptoms are sufficient for rating purposes (i.e., no objective medical evidence of any symptoms and/or severity of such) as long as they are "consistent with the disease and not more likely attributable to other disease or no disease."

The Veteran's encephalitis has been assigned a 10 percent rating from November 16, 1953, to January 14, 1955, and from March 17, 1956, to September 29, 2009.

The Appellant contends, as did the Veteran before his death, that a higher rating is warranted.

The Appellant's representative contends that the notes relating to Diagnostic Code 8000 and 38 C.F.R. § 4.124a require that other subjective disabling conditions arising from a single disease entity be rated separately under the proper diagnostic codes applicable. The representative has argued that a higher initial rating is warranted for cognitive impairments of moderate memory, attention, concentration, and executive functions, moderately severely impaired judgment, and fatigability. The representative further contends that separate ratings are warranted for subjective residuals of migraine headaches, chronic dizziness, tinnitus, loss of sense of smell, lower lip numbness, and for chronic brain syndrome associated with intracranial infections other than syphilis under Diagnostic Code 9302 (1953) with definite impairment of social and industrial adaptability. *See* May 2021 VA Form 10182 and April 2022 VA Form 10182. The representative also contends that the VA examiners misevaluated the weight and credibility of the Veteran's contentions in assessing his symptoms and residuals of encephalitis.

In November 2025 correspondence, the representative further argued that the medical experts have failed to understand the degree to which the Veteran was disabled by the residuals of his encephalitis and how much it impaired his ability to remember all of his symptoms at one time, such as in the setting of a medical examination. The representative separately contends that, given the Veteran's lack of medical knowledge, he could never have been expected to delineate symptoms attributable to his status-post encephalitis as opposed to other etiologies. The representative contends that the Veteran had suffered from numbness of the lower lip, headaches, fatigue, dyspnea, memory impairment, sleep impairment, anxiety, agitation, dizziness, and slurred speech since 1953 but that the Veteran's statements have been discounted due to a lack of medical evidence confirming that he suffered from these symptoms or conditions.

A November 1965 VA examiner noted that the Veteran had no particular neuropsychiatric complaints at that time other than an occasional headache. At that time, the Veteran additionally reported abdominal distention as well as his belief that he had noticed some memory defects. The Veteran's neurological examination

was entirely negative, and the Veteran showed no outward signs of anxiety or tension but reported that he becomes quite tense and nervous at times. The Veteran reported sleeping poorly at times and occasionally having a poor appetite. The examiner indicated that the Veteran demonstrated no definite evidence of mental deterioration, and no neuropsychiatric disability was evidenced at the time of the examination.

Another VA examination is of record from July 2008. The Veteran reported no seizure disorder. The Veteran endorsed headaches and described them as throbbing, frontal headaches that require medication but that he was still able to go to work. The Veteran reported that he experienced headaches on average 4 times per week lasting for about 40 minutes. Dizziness as often as 2 times per day was indicated. The examiner indicated that the Veteran was not receiving any treatment for his condition and did not experience any functional impairment from his encephalitis. The examiner noted that the Veteran's other medical conditions include tinnitus, hypertension, and PTSD. An examination of the cranial nerves revealed normal findings and the Veteran's coordination, motor function, and sensory function of the upper and lower extremities were noted to be within normal limits with the exception of decreased sensation in both feet. No paralysis was indicated, and the Veteran was observed to walk with a normal gait and did not use an assistive device for ambulation.

The July 2008 VA examiner indicated that the Veteran's condition did not affect the joints or result in any vision problem. The Veteran was observed to speak normally and was alert and oriented with normal comprehension and intact memory. The examiner noted that the Veteran's diagnosis was changed to status-post encephalitis as his cranial examination was objectively normal and there were no findings of smell or taste problems.

During an October 2008 VA treatment visit, the Veteran reported headaches and dizziness off and on that were attributed to hypertension. The Veteran had trace peripheral edema, good muscle strength in all extremities, and his cranial nerves were grossly intact to observation. During a November 2008 VA treatment visit, the Veteran reported regular nightmares and disturbing memories related to combat events as well as serious sleep disturbance, hypervigilance, and emotional

numbing. In January 2009, the Veteran reported many years of insomnia with sleep loss primarily from mid-sleep awakenings. He reported feeling tired during the day and a previous history of extended depressive episodes and occasional intrusive thoughts. The Veteran indicated that he felt on edge most of the time, experienced mood swings, and did not feel safe even in familiar locations. The Veteran denied any audio and visual hallucinations.

In February 2009 VA treatment visits, the Veteran reported slightly improved sleep with continued nightmares and reported his mood was "alright." He additionally reported having significant problems with his hearing in addition to other health problems. In March 2009, he reported his mood as "up and down" and reported his sleep was unchanged. In April 2009, the Veteran reported his mood as "kinda rough" related to his wife's recovery from an illness and reported continued combat-related nightmares. At that time, the Veteran additionally reported decreased hearing, tinnitus, vertigo, and dizziness as well as ear pain.

In June 2009 VA treatment visits, the Veteran reported improved sleep but continued nightmares a few times a week. He indicated his mood was "sad" and he was observed to be without evidence of mania and psychosis.

An August 2009 VA examiner found the Veteran had hearing loss and tinnitus related to his military service and exposure to explosions, mines, demolition, and other hazardous noise.

During a September 2009 VA treatment visit, the Veteran reported his mood as "not good" and attributed this to his strained relationship. He reported decreased sleep and continued nightmares and indicated his sleep disturbance was primarily due to his wife's substance dependency. The Veteran was observed to be without evidence of mania and psychosis and was assessed with PTSD.

Another VA examination was obtained in January 2010. At the time of the examination, the Veteran reported symptoms of loss of sense of smell, altered sense of taste, numbness of the lower lip, headaches, and dizziness. The examiner noted an abnormality of the cranial nerve VII on the left as evidenced by paralysis with abnormal sensation in the left lower lip. Further testing revealed complete loss of

smell on the right, partial loss of smell on the left, and partial loss of taste. The examiner indicated that the Veteran's headache and dizziness are not related to the Veteran's encephalitis. While the examiner indicated that the Veteran's encephalitis condition was active and that he had residuals related to his history of brain inflammation, the examiner did not indicate whether the Veteran's reported residuals had been present throughout the appeal periods or whether such were only present at the time of the examination and beyond.

In March 2013, VA issued a formal finding on the unavailability of any additional VA treatment records. In this circumstance, VA has a heightened obligation to explain its findings and conclusions and carefully consider applying the benefit-of-the-doubt rule. *Cf. O'Hare v. Derwinski*, 1 Vet. App. 365, 367 (1991).

The Board must also point out, however, that *O'Hare* does not raise a presumption that the missing medical records, if available for consideration, necessarily would support the claim. That is to say, missing records concerning the Veteran's claim do not lower the threshold for an allowance of a claim; there is no reverse presumption for granting a claim. Rather, the Board's obligation to evaluate and discuss in its decision all of the evidence that may be favorable to the Veteran is heightened. *See Russo v. Brown*, 9 Vet. App. 46 (1996). There is no presumption, either in favor of the claimant or against VA, arising from missing records. *Cromer v. Nicholson*, 19 Vet. App. 215 (2005).

During the April 2013 Board hearing, the Veteran reported that he could not recall what symptoms he was experiencing between 1953 and 1955. During the May 2016 Board hearing, the Veteran reported that he was experiencing memory difficulties during his second period of service from January 1955 to March 1956 and ultimately could not stay in service because of these challenges.

The Veteran additionally reported that, after leaving service, he experienced headaches, memory difficulties, fatigue, shortness of breath, anxiety, and impatience. He explained that it felt like his muscles were tired and he felt achy most of the time. He further contended that he had problems speaking, slurred speech, dizziness, and numbness of his lips. *See* May 2016 and March 2020 Board Hearings. The Veteran additionally contended that he was tense and agitated all the

time and that he did not sleep or eat well. The Appellant reported witnessing the Veteran's volatility and outbursts over the years. The Veteran reported that his headaches would onset if he came under pressure and that his headaches in 1956 were the main reason why he left the service. He, somewhat contradictorily, indicated that he did not receive any treatment through VA but that he went to a VA hospital and was put on medicine.

During the March 2020 Board hearing, the Veteran denied experiencing hallucinations or seeing things that should not be there. He reported that he has fallen because of his dizziness and that it usually took him a little bit before he could get going from sitting or lying down. He indicated that he had bouts of anxiety and tension and had not slept more than four hours at a time in the last 60 years. He contended that he had these symptoms constantly over the years dating back to 1956. The Board notes that, while the Veteran testified at the March 2020 Board hearing that he had received intermittent VA treatment for his encephalitis residuals since the time of his March 1956 service separation, the AOJ acknowledged in a March 2013 Formal Finding that the Veteran's VA treatment records dated prior to October 2008 were unavailable for review.

In light of the absence of contemporaneous medical evidence for much of the relevant appeal periods, the Board remanded this matter in August 2020. At that time, the Board noted that the Veteran had testified that symptoms of numbness in his lower lip, headaches, fatigue, dyspnea, memory impairment, sleep impairment, anxiety, agitation, dizziness, and slurred speech had been present and chronic since 1953. Despite this, a November 1965 VA examination (discussed in the following section) indicated that the Veteran was "fully recovered" from his in-service diagnosis of encephalitis. The Board found that the AOJ failed to obtain retrospective medical examinations and opinions to determine the nature and residuals of the Veteran's service-connected encephalitis for both appeal periods and remanded the matter to obtain such opinions.

A VA examination was obtained in October 2020. At the time of the examination, the Veteran reported current symptoms of tinnitus, headaches 4 times a day lasting 1 hour each, dizziness with occasional trouble walking, numbness of the face around lips, slurred speech, insomnia, uncontrolled anger outbursts, melancholy,

depression, crying, and an inability to understand instruction. He reported that the symptoms he had when the condition began were high fever, coma for 4 weeks, tremors in extremities, headaches, ringing in ears, dizziness, fatigue, heavy breathing, anxiety, and agitation. The Veteran reported requiring over the counter medications for headaches and insomnia and reported that he has been unable to hold a job due to uncontrollable anger, brain fog, confusion, and forgetfulness.

The October 2020 VA examiner included a review of the evidence, and the examiner provided a diagnosis of encephalitis. The examiner recorded the Veteran's medical history and noted that the Veteran recovered from encephalitis in 1951 and was reevaluated in 1965 and found to have no disability. The Veteran was observed to have muscle weakness in the upper and lower extremities, insomnia, voiding dysfunction causing signs and/or symptoms of urinary frequency and obstructed voiding, erectile dysfunction, abnormal gait, ataxia, inability to touch nose with finger, positive Romberg test, posttraumatic stress disorder (PTSD), personality disorder, and dementia. The examiner indicated that the Veteran's erectile dysfunction was due to age, and his abnormal gait was due to foot pain and hallux valgus. The examiner noted that the Veteran has depression, cognitive impairment, or dementia or any other mental health conditions attributable to a central nervous system disease and that such results in gross impairment in thought process or communication. However, the examiner remarked that the Veteran has been diagnosed with PTSD and anger management issues with evidence of mild dementia and it is possible to differentiate what portion of the symptomatology or neurologic effects are caused by each diagnosis. The examiner explained that, based on prior evaluations, there are minimal residuals from the history of encephalitis and that, at present, his main issues are his PTSD, personality disorder, and dementia. The examiner noted that the Veteran left the hospital in 1951 symptom-free other than an occasional headache which may or may not have been related to his encephalitis diagnosis. Follow-up evaluations revealed no identified residuals of the encephalitis.

The October 2020 VA examiner opined it is less likely than not that the Veteran status-post encephalitis has been active and manifested by febrile disease at any time from November 16, 1953, to January 14, 1955, and/or from March 17, 1956,

to September 29, 2009. The examiner explained that the Veteran was discharged in 1951 symptom-free and returned to duty without any subsequent symptoms other than occasional headache for the duration of his military service. The Veteran was evaluated in 1965 and found to have no identifiable residuals from his encephalitis. While the examiner noted that the Veteran had been unable to hold a steady job since leaving service, the examiner found such to be due to personality and anger issues related to his PTSD. The examiner opined that the Veteran's variety of symptoms are caused by his age and evidence of dementia and his problems walking are due to balance problems of uncertain etiology and foot pain with deformity. The examiner concluded by stating that there is no evidence in the record other than the Veteran's claim that he has residual problems from encephalitis for the applicable appeal periods.

A private treatment record from October 2020 notes that the Veteran had a history of headaches, dizziness, loss of balance, and facial numbness as well as a history of encephalitis during service. Further information regarding the Veteran's medical history and these symptoms was not provided.

Another VA medical opinion was obtained in November 2020. The examiner included an extensive review of the Veteran's claims file and indicated that 8 hours was spent reviewing and completing the report. The examination report was completed by a board-certified neurologist and included summaries of relevant evidence with discussion of the conclusions reached by prior examiners in earlier examinations. The examiner opined it is less likely than not that the Veteran had any residuals due to his service-connected encephalitis from November 1953 to January 1955 and from March 1956 to September 2009. The examiner further opined that it is at least as likely as not that the Veteran's encephalitis condition resolved following his in-service treatment for such.

The November 2020 VA examiner found that the available evidence of record and the weight of the medical literature supports finding that the Veteran had no chronic and disabling conditions, to include any residuals of encephalitis, subsequent to his recovery from encephalitis in 1951. The examiner further noted that the Veteran would not have been accepted into active-duty service in 1955 if he had had any chronic and disabling conditions at that time. The examiner noted

that the Veteran's available service treatment records (STRs) show that the Veteran recovered from encephalitis within several weeks and was reported to be "cured." Furthermore, the Veteran's September 1953 separation examination resulted in an objectively normal clinical evaluation of the Veteran and rendered no diagnosis of encephalopathy or residuals of such. The Veteran subsequently reenlisted in 1955 and was found to have no chronic and disabling conditions upon entrance to service, to include any residuals of encephalitis. The examiner noted that, during his second period of service, the Veteran had no subsequent complaints of or objective clinical diagnoses of any symptoms congruent with residuals of encephalitis. The examiner noted that the November 1965 VA examination showed that the Veteran had recovered from encephalitis and had no neurological or psychiatric residuals. The examiner indicated that the Veteran's lay statements and testimony were considered in completing the examination report, but the examiner found that the Veteran's testimony regarding his claimed residuals of encephalitis was not congruent with the evidence of record and the weight of the medical literature. The examiner concluded that the evidence of record supports that the Veteran was diagnosed with encephalitis in April 1951, received inpatient treatment, and was released and returned to active service prior to finishing his enlistment in September 1953. The Veteran then reentered active-duty service in January 1955 and was discharged in March 1956. The examiner indicated that the Veteran's encephalitis condition resolved without residuals as supported by the evidence of record and weight of medical literature.

The November 2020 VA examiner explained that encephalitis, or brain inflammation, is an acute condition that resolves with antibiotic therapy. Any residuals are apparent at the time immediately following recovery from the initial brain infection and usually resolve completely over days to weeks. In the event there are permanent residuals, they are apparent at the time of acute infection or immediately upon recovery and remain persistent overtime; the residuals do not resolve and then reappear years to decades later. The November 1965 VA examination indicates that the Veteran had completely recovered from encephalitis with no residuals. The examiner noted that, although the Veteran had reported his experiences and the examiner believed that those experiences occurred, the Veteran is not qualified to make a medical diagnosis based on those experiences.

An additional VA medical opinion is of record dated January 2021. The examiner included an extensive review of the evidence. The examiner was asked to identify all of the residuals of the Veteran's service-connected encephalitis that he experienced from November 16, 1953, to January 14, 1955, and from November 17, 1956, to September 29, 2009. The examiner noted that the Veteran's medical records were read and reviewed along with the prior neurologist's opinion and that special attention was given to the January 2010 examination. The examiner indicated that there is no evidence that the Veteran had active encephalitis in 2010 or any residual of encephalitis on the January 2010 examination. The Veteran's lower lip numbness was found to be highly unlikely due to his 1951 encephalitis. The examiner concluded that there is no evidence that the Veteran experienced residuals from his encephalitis from November 1953 to January 1955 and from March 1956 to September 2009 and concurred with the opinions rendered by the prior examining neurologist.

A private medical opinion is of record dated April 2021. The private examiner reviewed the Veteran's complete claims file, including more recent examinations and statements from the Veteran. The examiner opined that it is as likely as not that the insomnia, memory difficulties, anxiety, agitation, headaches, and dizziness are related to the prior case of encephalitis. The examiner explained that the Veteran did not currently have encephalitis but rather that he has residuals of encephalitis. The examiner noted the absence of medical records and that the available medical records do not paint a thorough picture of the Veteran's conditions and argued that the Veteran's statements bear more weight in this specific case. The Veteran reported that his symptoms have "waxed and waned" over the years but remained present and the examiner noted that this included chronic headaches, dizziness, tinnitus, personality changes (agitation), memory loss, anxiety, and insomnia.

The April 2021 private examiner remarked that encephalitis often results in substantial sequelae including, but not limited to, headaches, dizziness/vertigo, tinnitus, visual disturbances, insomnia, memory difficulties, impaired focus/concentration, seizures, paralysis, anosmia (loss of smell), dysgeusia (altered taste), and behavioral abnormalities. The examiner noted that there are numerous and credible references in the records to many of these ailments and it is at least as

likely as not that the agitation, anxiety, insomnia, memory trouble, headaches, and dizziness are directly attributable to the Veteran's case of very severe encephalitis. The examiner noted that, while there are no studies documenting the frequency of the long-term and permanent sequelae of encephalitis, there are also no studies that rule out the long-term effects or if they can be permanent. The examiner explained that complications of severe illness can vary greatly in severity and may persist for months or be permanent. Despite indicating there were no studies regarding the frequency or long-term effects of encephalitis, the examiner went on to suggest that there are multiple studies and research that associate long-term effects of encephalitis that show symptoms such as insomnia, memory difficulties, anxiety, agitation, headaches, and dizziness as part of the symptomatology. The examiner opined that, given the facts outlined in the report, it is medically reasonable and at least as likely as not that his previous and current headaches, dizziness, insomnia, memory impairments, anxiety, and agitation are residuals of his encephalitis.

In a December 2021 decision, the Board again remanded this matter. The Board found the October 2020, November 2020, and January 2021 VA medical opinions to be inadequate for adjudication purposes. The Board noted that, while the VA physicians knew of the Veteran's reports of numbness in his lower lip, headaches, fatigue, dyspnea, memory impairment, sleep impairment, anxiety, agitation, dizziness, psychiatric symptoms, and slurred speech, the Veteran's lay statements were discounted due to a lack of supporting medical evidence. The Board observed that such is contrary to the United States Court of Appeals for Veterans Claims' (CAVC/Court) holding in *Buchanan v. Nicholson*, 451 F.3d 1331, 1337 (Fed. Cir. 2006), especially given that VA has lost the Veteran's VA treatment records which may bolster his assertions. The Board further found that the conclusions reached by the VA examiners are brought into question by the April 2021 private examiner who opined that the Veteran's reported symptoms are residuals of his in-service encephalitis.

The Board found that the AOJ's failure to ensure the adequacy of the October 2020, November 2020, and January 2021 VA opinions represented a pre-decisional duty to assist error. The November 2020 and January 2021 VA examiners additionally failed to comment on whether the Veteran's reported symptoms were

consistent with a diagnosis of encephalitis and the frequency, severity, and duration of such throughout the appeal period as per the rating criteria provided in 38 C.F.R. § 4.124a. Accordingly, the Board directed the AOJ to obtain an advisory medical opinion from a medical expert specializing in neurology and requested that the examiner address whether the Veteran's symptoms are consistent with encephalitis and not more likely attributable to another disease or no disease and that the examiner detail the frequency, severity, and duration of any such symptoms.

A new VA medical opinion was obtained in January 2022. The examiner, a board-certified neurologist, included an extensive review of the Veteran's claims file, including the Veteran's statements and medical history, as well as assessments of the prior medical examinations. The Board finds this opinion to be adequate and complete in its rendering. Accordingly, the Board finds there has been substantial compliance with the December 2021 Board remand directives. *Stegall v. West*, 11 Vet. App. 268, 271 (1998).

The January 2022 VA examiner opined that it is less likely than not that the Veteran's claimed symptoms of numbness of the lower lip, headaches, fatigue, dyspnea, memory impairment, sleep impairment, anxiety, agitation, dizziness, and slurred speech are consistent with the Veteran's encephalitis, either when the condition is active or as a residual of the disease. The examiner found no symptoms to be consistent with encephalitis and explained that the reported symptoms are at least as likely as not related to other conditions. The Veteran's claimed symptom of numbness of the lower lip, the examiner opined, is at least as likely as not due to a condition of the third branch of the trigeminal nerve at some point outside of the skull and within the lower jaw, as supported by the weight of the medical literature and the examiner's expertise concerning human neuroanatomy. The examiner explained that if the trigeminal nerve were affected within the brainstem, the Veteran's symptoms would at least as likely as not entail the entire side of his face rather than only the lower lip. Regarding the Veteran's headaches, the examiner opined such to be at least as likely as not due to the Veteran's nonservice-connected condition of occipital neuralgia based on a July 2014 VA neurology consult report. The Veteran's claimed symptoms of fatigue, memory impairment, anxiety, agitation, and sleep impairment, to include insomnia,

were determined to be at least as likely as not due to the Veteran's service-connected PTSD based on the examiner's review of multiple VA psychiatry notes contained within the record.

The January 2022 VA examiner opined that the Veteran's claimed symptom of memory impairment may be explained by an October 2020 MRI (magnetic resonance imaging) brain study that included findings of chronic microscopic vessel disease and atrophy of the brain. The examiner explained that these findings are congruent with vascular dementia as supported by the evidence of record and the weight of the medical literature and vascular dementia is not caused by remote encephalitis or residuals of encephalitis. The examiner further noted that the Veteran's claimed fatigue may be caused by the Veteran's nonservice-connected chronic congestive heart failure and chronic renal failure conditions as reflected in the evidence of record and weight of the medical literature and these conditions are not caused by remote encephalitis or residuals of such. The Veteran's claimed symptoms of dyspnea, dizziness, and slurred speech were determined to be at least as likely as not due to the Veteran's nonservice-connected conditions of heart failure and hypertension based on the review of pertinent records and the weight of medical literature.

As the Veteran's symptoms were determined to not be consistent with a diagnosis of encephalitis or residuals of such, the examiner found there was no clinical indication or basis upon which to detail the frequency, severity, and duration of any such symptoms. The examiner concluded that the weight of the medical literature as well as the evidence of record support that the Veteran's service-connected encephalitis resolved without residuals. The examiner noted that the Veteran's in-service infection was cured with in-patient antibiotic therapy in 1951 and the Veteran went on to complete his tour of duty and then reenlist for a second tour of duty. In reviewing the prior medical evidence, the examiner noted that they stand by the opinion provided in November 2020 and took into consideration the Veteran's lay testimony but found the Veteran's reports were not consistent with the evidence of record and weight of the medical literature. The examiner emphasized that the Veteran had no subsequent complaints of or objective clinical diagnoses of any symptoms consistent with encephalitis after such resolved during his first

period of service and the Veteran's separation and entrance examinations are silent for any chronic and disabling conditions consistent with residuals of encephalitis.

The January 2022 VA examiner emphasized that encephalitis is an acute condition that resolves with antibiotic therapy and any residuals are apparent at that time immediately following recovery from the initial brain function and usually resolve completely over days to weeks. In the event there are permanent residuals, they are apparent at the time of acute infection or immediately upon recovery and remain persistent over time. The residuals do not resolve and then reappear years to decades later or "wax and wane" over time. The examiner noted that the post-service November 1965 neuropsychiatric examination showed that the Veteran had completely recovered from encephalitis with no residuals and that the Veteran had no particular complaints at the time other than an occasional headache. No diagnoses of any neurological or psychiatric conditions were indicated at that time. While the Veteran reported headaches, the examiner noted that the medical literature demonstrates that headaches are extremely common in the adult population and the evidence of record indicates that the Veteran never complained of, sought medical attention for, or was clinically diagnosed with any chronic and disabling headache condition in service and such is not related to his service-connected encephalitis.

The January 2022 VA examiner reviewed the July 2008 VA examination and noted that the examination revealed an objectively normal neurological exam, including an objectively normal cranial nerve exam and normal sense of taste and smell. The examiner concurred with the findings of the July 2008 examiner who rendered a diagnosis of status-post encephalitis and that there were no residuals associated with the Veteran's service-connected encephalitis. The examiner similarly noted that the evidence from an October 2008 VA treatment indicated that the Veteran's reports of headaches and intermittent dizziness represent symptoms of hypertension and are not residuals of the Veteran's encephalitis. The examiner noted that the findings of the January 2010 VA psychiatrist that the Veteran's complaints of fatigue represent a symptom of PTSD rather than a residual of encephalitis and found that such is supported by the evidence of record and weight of medical literature. The examiner disagreed with the findings of active disease

noted by the January 2010 VA examiner and found that the opinion is not supported by the weight of the medical literature and other evidence of record. Furthermore, the examiner explained that, if the Veteran's encephalitis was "active" at that time, that would mean he would have had an active brain infection requiring emergent admission to a hospital for immediate treatment and there are no records indicating such treatment.

Finally, the January 2022 VA examiner noted the Veteran did not report any complaints of symptoms consistent with residuals of encephalopathy during his April 2013 Board hearing. The examiner found the Veteran's November 2019 report of residuals dating back to 1953 to be unsubstantiated by the objective evidence of record and weight of the medical literature. The examiner reiterated that an individual who has had encephalitis does not have residuals resolve and then reappear later in life or "wax and wane" and the Veteran's reports of non-specific symptoms during his March 2020 Board hearing are not supported by the objective evidence of record. The examiner concurred with the findings of the July 2008 and January 2021 VA examiners in finding that there were no residuals associated with the Veteran's service-connected encephalitis and found the April 2021 private evaluation to be unsupported by the evidence of record or medical literature.

As noted above, the Board denied the Appellant's claims for increased ratings for the service-connected status-post encephalitis in a December 2024 decision and the Veteran appealed this decision to CAVC. In the October 2025 JMR, the parties to the JMR agreed that the Board erred by failing to provide an adequate statement of reasons or bases for its decision. Specifically, the parties agreed that the Board erred when it failed to adequately explain its reliance on the October 2020, November 2020, and January 2021 VA medical opinions for its finding that the Veteran did not have active febrile disease from March 17, 1956, to September 29, 2009. The parties noted that the Board previously found these VA medical opinions to be inadequate in its prior December 2021 decision as the examiners discounted the Veteran's lay statements about his symptoms due to a lack of medical evidence confirming such. The parties agreed that, while the Board noted that these examinations were inadequate, the Board did not explain how this factors into its

findings when it relied on those opinions to find that the Veteran did not have active encephalitis prior to September 29, 2009. As such, the parties agreed that the Board's reliance on these medical opinions without addressing the prior findings as to the inadequacies of these opinions rendered the Board's reasons and bases for its decision inadequate.

The parties to the JMR additionally noted that there is evidence showing that requested VA treatment records were unavailable. As such, the Court directed the Board to address the evidence indicating VA treatment records were unavailable and the benefit of the doubt in light of such evidence.

1. Entitlement to an initial rating in excess of 10 percent for the service-connected status-post encephalitis from November 16, 1953, to January 14, 1955

The Board finds that entitlement to an initial rating in excess of 10 percent for the service-connected status-post encephalitis from November 16, 1953, to January 14, 1955, is not warranted.

As reflected in the review of the medical evidence, lay statements, and arguments above, there is no contemporaneous medical evidence available for review for the appeal period from November 1953 to January 1955. In light of these circumstances, the Board reiterates that VA has a heightened obligation to explain its findings and conclusions and carefully consider applying the benefit-of-the-doubt rule. *Cf. O'Hare v. Derwinski*, 1 Vet. App. 365, 367 (1991). However, there is no presumption, either in favor of the claimant or against VA, arising from missing records. *Cromer v. Nicholson*, 19 Vet. App. 215 (2005).

The Veteran contended that he met the requirements for a 100 percent rating from November 1953 as his encephalitis was febrile and chronic at that time. *See* May 2017 Correspondence.

Based on the evidence of record, particularly the retrospective medical opinion provided in the January 2022 VA examination, the Veteran did not have active febrile disease as required for a 100 percent disability rating under Diagnostic

Code 8000. Furthermore, the Veteran's status-post encephalitis was manifested by no more than minimal residuals and there were no subjective residuals for which separate ratings are warranted.

The November 1965 VA examiner found that the Veteran had no particular neuropsychiatric complaints at the time other than an occasional headache and the Veteran reported noticing some memory deficits. However, the neurological examination was entirely negative, and the Veteran showed no outward signs of anxiety or tension. While the Veteran reported sleeping poorly at times and occasionally have a poor appetite, the examiner indicated that the Veteran demonstrated no definite evidence of mental deterioration, and no neuropsychiatric disability was evidenced at the time of the examination.

While the Veteran endorsed headaches and dizziness during his July 2008 VA examination, the examiner noted that the Veteran had other medical conditions including tinnitus, hypertension, and PTSD. The Veteran's cranial nerves were revealed to be normal upon examination and the Veteran's coordination, comprehension, memory, motor function, and sensory function of the upper and lower extremities were noted to be within normal limits with the exception of decreased sensation in both feet. No paralysis was indicated, and the Veteran was observed to walk with a normal gait and did not use an assistive device for ambulation. Importantly, the July 2008 VA examiner found that the Veteran's diagnosis was changed to status-post encephalitis as his cranial examination was objectively normal and there were no findings of smell or taste problems.

During various VA treatment visits, the Veteran's reported symptoms of headaches, dizziness, sleep disturbances, insomnia, and mood swings which were attributed to the Veteran's hypertension and PTSD conditions rather than his status-post encephalitis.

As noted above, while the October 2020, November 2020, and January 2021 VA examiners recorded the Veteran's reports of numbness in his lower lip, headaches, fatigue, dyspnea, memory impairment, sleep impairment, anxiety, agitation, dizziness, psychiatric symptoms, and slurred speech, the examiners improperly discounted the Veteran's lay statements due to a lack of supporting medical

evidence. As this is contrary to the Court's holding in *Buchanan v. Nicholson*, 451 F.3d 1331, 1337 (Fed. Cir. 2006), the examinations are inadequate for rating purposes and are afforded no consideration in addressing the increased rating claim.

While a private treatment record from October 2020 noted that the Veteran had a history of headaches, dizziness, loss of balance, and facial numbness as well as a history of encephalitis during service, further information regarding the Veteran's medical history and these symptoms was not provided.

While the April 2021 private examiner opined that it is as likely as not that the Veteran's insomnia, memory difficulties, anxiety, agitation, headaches, and dizziness are related to his encephalitis, this finding is contradicted by the other medical evidence of record which attributed many of the Veteran's symptoms to conditions other than encephalitis. The January 2022 VA examiner discussed and evaluated the findings of the April 2021 private examiner, as well as all of the other medical evidence and examinations of record, and thoroughly explained why the April 2021 examiner's findings were inconsistent with encephalitis. The Board ascribes more probative weight to the January 2022 VA examination in finding that the Veteran's contended symptoms have symptoms have been more likely than not attributed to other service-connected and nonservice-connected conditions and not found to be consistent with encephalitis.

The representative has argued that separate ratings are warranted for subjective residuals of migraine headaches, chronic dizziness, tinnitus, loss of sense of smell, lower lip numbness, and for chronic brain syndrome associated with intracranial infections other than syphilis, but the competent evidence of record does not support the assignment of separate ratings for these contended residuals. A diagnosis of chronic brain syndrome was not indicated. The Veteran's headaches, dizziness, and lower lip numbness were regularly found not to be related to the Veteran's encephalitis. The Veteran's tinnitus was determined to be related to his military noise exposure and the Veteran's reports of a loss of sense of smell were inconsistent or waxed and waned, which the January 2022 VA examiner explained is inconsistent with the healing process from encephalitis.

The Board acknowledges the Veteran's and Appellant's contentions that the Veteran's reported symptoms warrant an increased rating for his status-post encephalitis. However, the Board finds that the Veteran and Appellant do not have the requisite training and education necessary to make that medical decision. *See Jandreau v. Nicholson*, 492 F.3d 1372 (Fed. Cir. 2007). To the extent that the Veteran contends he had active encephalitis, the persuasive weight of the evidence indicates that the Veteran's encephalitis resolved during his first period of service following his in-service treatment for the condition.

To the extent that the Veteran and the Appellant contended that his residual symptoms as described above are related to his service-connected encephalitis, the persuasive weight of the evidence indicates that these symptoms have been more likely than not attributed to other service-connected and non-service-connected conditions and not found to be consistent with encephalitis. While subjective residuals will be accepted under 38 C.F.R. § 4.124a, such are only accepted when consistent with the disease and not more likely attributable to other disease or no disease. The January 2022 VA examiner explained that the Veteran's reports of symptoms of numbness of the lower lip, headaches, fatigue, dyspnea, dizziness, slurred speech, anxiety, agitation, sleep impairment, and memory impairment were at least as likely as not due to other service-connected and nonservice-connected conditions. Furthermore, the persuasive weight of the available medical evidence of record described many of the Veteran's reported symptoms as associated with other conditions, such as hypertension and PTSD, rather than encephalitis.

The Board has considered whether a higher rating under another Diagnostic Code is available. However, the Board emphasizes that Diagnostic Code 8000, which is specific to encephalitis, is the only Diagnostic Code that may be used to rate the Veteran's encephalitis residuals. *See Copeland v. McDonald*, 27 Vet. App. 333, 337 (2015) (when a condition is specifically listed in the rating schedule, it may not be rated by analogy and should be rated under the diagnostic code that specifically pertains to it).

Accordingly, the Board finds that entitlement to an initial rating in excess of 10 percent for the service-connected status-post encephalitis from November 16, 1953, to January 14, 1955, is not warranted.

2. Entitlement to a rating in excess of 10 percent for the service-connected status-post encephalitis from March 17, 1956, to September 29, 2009

The Board finds that entitlement to a rating in excess of 10 percent from March 17, 1956, to September 29, 2009, is not warranted.

The Veteran contended that after leaving service, he experienced headaches, memory difficulties, fatigue, shortness of breath, anxiety, and impatience. He contended that it felt like his muscles were tired and he felt achy most of the time and that he had problems speaking, slurred speech, dizziness, and numbness of his lips. *See* May 2016 and March 2020 Board Hearings. He reported that he felt tense and agitated all the time and did not sleep or eat well. The Veteran reported that he had headaches that would onset if he came under pressure and that his headaches in 1956 were the main reason why he left the service. He reported falls related to dizziness and that he had bouts of anxiety and tension and had not slept more than four hours at a time in the last 60 years. The Veteran contended that he had these symptoms constantly over the years dating back to 1956.

Based on the evidence of record, particularly the retrospective medical opinion provided in the January 2022 VA examination, the Veteran did not have active febrile disease as required for a 100 percent disability rating under Diagnostic Code 8000 from March 17, 1956, to September 29, 2009. Furthermore, the Veteran's status-post encephalitis was manifested by no more than minimal residuals and there were no subjective residuals for which separate ratings are warranted.

As noted above, while some VA treatment records are available for later portions of the appeal period, these records do not cover the entire appeal period. Furthermore, the VA determined that any additional VA treatment records were unavailable in a March 2013 memorandum. In light of these circumstances, the Board reiterates that VA has a heightened obligation to explain its findings and conclusions and carefully consider applying the benefit-of-the-doubt rule. *Cf. O'Hare v. Derwinski*, 1 Vet. App. 365, 367 (1991). However, there is no presumption, either in favor of the claimant or against VA, arising from missing records. *Cromer v. Nicholson*, 19 Vet. App. 215 (2005).

The November 1965 VA examiner found that the Veteran had no particular neuropsychiatric complaints at the time other than an occasional headache and the Veteran reported noticing some memory deficits. However, the neurological examination was entirely negative, and the Veteran showed no outward signs of anxiety or tension. While the Veteran reported sleeping poorly at times and occasionally have a poor appetite, the examiner indicated that the Veteran demonstrated no definite evidence of mental deterioration, and no neuropsychiatric disability was evidenced at the time of the examination.

While the Veteran endorsed headaches and dizziness during his July 2008 VA examination, the examiner noted that the Veteran had other medical conditions including tinnitus, hypertension, and PTSD. The Veteran's cranial nerves were revealed to be normal upon examination and the Veteran's coordination, comprehension, memory, motor function, and sensory function of the upper and lower extremities were noted to be within normal limits with the exception of decreased sensation in both feet. No paralysis was indicated, and the Veteran was observed to walk with a normal gait and did not use an assistive device for ambulation. Importantly, the July 2008 VA examiner found that the Veteran's diagnosis was changed to status-post encephalitis as his cranial examination was objectively normal and there were no findings of smell or taste problems.

During various VA treatment visits, the Veteran's reported symptoms of headaches, dizziness, sleep disturbances, insomnia, and mood swings were attributed to the Veteran's hypertension and PTSD conditions rather than to his status-post encephalitis.

As noted above, while the October 2020, November 2020, and January 2021 VA examiners recorded the Veteran's reports of numbness in his lower lip, headaches, fatigue, dyspnea, memory impairment, sleep impairment, anxiety, agitation, dizziness, psychiatric symptoms, and slurred speech, the examiners improperly discounted the Veteran's lay statements due to a lack of supporting medical evidence. As this is contrary to the Court's holding in *Buchanan v. Nicholson*, 451 F.3d 1331, 1337 (Fed. Cir. 2006), the examinations are inadequate for rating purposes and are afforded no consideration in addressing the increased rating claim.

While a private treatment record from October 2020 noted that the Veteran had a history of headaches, dizziness, loss of balance, and facial numbness as well as a history of encephalitis during service, further information regarding the Veteran's medical history and these symptoms was not provided.

While the April 2021 private examiner opined that it is as likely as not that the Veteran's insomnia, memory difficulties, anxiety, agitation, headaches, and dizziness are related to his encephalitis, this finding is contradicted by the other medical evidence of record which attributed many of the Veteran's symptoms to conditions other than encephalitis. The Veteran's insomnia, memory impairments, anxiety, and agitation were regularly noted as symptoms of his service-connected PTSD and the Veteran regularly reported difficulty sleeping, anxiety, and agitation related to mental health difficulties in VA treatment visits. Furthermore, the January 2022 VA examiner discussed and evaluated the findings of the April 2021 private examiner, as well as all of the other medical evidence and examinations of record, and thoroughly explained why the April 2021 examiner's findings were inconsistent with the nature of encephalitis. The Board ascribes more probative weight to the January 2022 VA examination in finding that the Veteran's contended symptoms have symptoms have been more likely than not attributed to other service-connected and nonservice-connected conditions and not found to be consistent with encephalitis.

The representative has argued that separate ratings are warranted for subjective residuals of migraine headaches, chronic dizziness, tinnitus, loss of sense of smell, lower lip numbness, and for chronic brain syndrome associated with intracranial infections other than syphilis, but the competent evidence of record does not support the assignment of separate ratings for these contended residuals. A diagnosis of chronic brain syndrome was not indicated. The Veteran's headaches, dizziness, and lower lip numbness were regularly found not to be related to the Veteran's encephalitis. The Veteran's tinnitus was determined to be related to his military noise exposure and the Veteran's reports of a loss of sense of smell were inconsistent or waxed and waned, which the January 2022 VA examiner explained is inconsistent with the healing process from encephalitis.

The Board acknowledges the Veteran's and Appellant's contentions that the Veteran's reported symptoms warrant an increased rating for his status-post encephalitis. However, the Board finds that the Veteran and Appellant do not have the requisite training and education necessary to make that medical decision. *See Jandreau v. Nicholson*, 492 F.3d 1372 (Fed. Cir. 2007). To the extent that the Veteran contends he had active encephalitis, the persuasive weight of the evidence indicates that the Veteran's encephalitis resolved during his first period of service following his in-service treatment for the condition. Between 1956 and 2009, there was no evidence indicating that the Veteran's encephalitis was active and febrile.

To the extent that the Veteran and the Appellant contended that his residual symptoms as described above are related to his service-connected encephalitis, the persuasive weight of the evidence indicates that these symptoms have been more likely than not attributed to other service-connected and nonservice-connected conditions and not found to be consistent with encephalitis. While subjective residuals will be accepted under 38 C.F.R. § 4.124a, such are only accepted when consistent with the disease and not more likely attributable to other disease or no disease. The January 2022 VA examiner explained that the Veteran's reports of symptoms of numbness of the lower lip, headaches, fatigue, dyspnea, dizziness, slurred speech, anxiety, agitation, sleep impairment, and memory impairment were at least as likely as not due to other service-connected and nonservice-connected conditions. Furthermore, the persuasive weight of the available medical evidence of record described many of the Veteran's reported symptoms as associated with other conditions, such as hypertension and PTSD, rather than encephalitis.

The Board has considered whether a higher rating under another Diagnostic Code is available. However, the Board emphasizes that Diagnostic Code 8000, which is specific to encephalitis, is the only Diagnostic Code that may be used to rate the Veteran's encephalitis residuals. *See Copeland v. McDonald*, 27 Vet. App. 333, 337 (2015) (when a condition is specifically listed in the rating schedule, it may not be rated by analogy and should be rated under the diagnostic code that specifically pertains to it).

IN THE APPEAL OF
PETRA L. GARDENHIRE
IN THE CASE OF
CHARLES F. GARDENHIRE

XC XX XXX 265
Docket No. 220422-238079

Accordingly, the Board finds that entitlement to a rating in excess of 10 percent for the service-connected status-post encephalitis from March 17, 1956, to September 29, 2009, is not warranted.



Marcus N. Fulton
Veterans Law Judge
Board of Veterans' Appeals

Attorney for the Board Goreham, A.

The Board's decision in this case is binding only with respect to the instant matter decided. This decision is not precedential and does not establish VA policies or interpretations of general applicability. 38 C.F.R. § 20.1303.

If you disagree with VA's decision

Choose one of the following review options to continue your case. If you aren't satisfied with that review, you can try another option. Submit your request before the indicated deadline in order to receive the maximum benefit if your case is granted.

Review option	**Supplemental Claim** **Add new and relevant evidence**	**Higher-Level Review** Not Available **Ask for a new look from a senior reviewer**	**Board Appeal** Not Available **Appeal to a Veterans Law Judge**	**Court Appeal** **Appeal to Court of Appeals for Veterans Claims**
Who and what	A reviewer will determine whether the new evidence changes the decision.	Because your appeal was decided by a Veterans Law Judge, you cannot request a Higher-Level Review. Please choose a different option for your next review.	You cannot request two Board Appeals in a row. Please choose a different option for your next review.	The U.S. Court of Appeals for Veterans Claims will review the Board's decision. You can hire an attorney to represent you, or you can represent yourself. Find more information at the Court's website: uscourts.cavc.gov
Estimated time for decision	**About 4-5 months**			
Evidence	You must submit evidence that VA didn't have before that supports your case.			
Discuss your case with VA				
Request this option	Submit VA Form 20-0995 Decision Review Request: Supplemental Claim VA.gov/decision-reviews			File a Notice of Appeal uscourts.cavc.gov Note: A Court Appeal must be filed with the Court, not with VA.
Deadline	You have **1 year** from the date on your VA decision to submit VA Form 20-0995.			You have **120 days** from date on your VA decision to file a Court Appeal.
How can I get help?	A Veterans Service Organization or VA-accredited attorney or agent can represent you or provide guidance. Contact your local VA office for assistance or visit VA.gov/decision-reviews/get-help. For more information, you can call the White House Hotline **1-855-948-2311**.			

What is new and relevant evidence?
In order to request a Supplemental Claim, you must add evidence that is both new and relevant. New evidence is information that VA did not have before the last decision. Relevant evidence is information that could prove or disprove something about your case.

VA cannot accept your Supplemental Claim without new and relevant evidence. In addition to submitting the evidence yourself, you can identify evidence, like medical records, that VA should obtain.

What is the Duty to Assist?
The Duty to Assist means VA must assist you in obtaining evidence, such as medical records, that is needed to support your case. VA's Duty to Assist applied during your initial claim, and it also applies if you request a Supplemental Claim.

If you request a Higher-Level Review or Board Appeal, the Duty to Assist does not apply. However, the reviewer or judge will look at whether VA met its Duty to Assist when it applied, and if not, have VA correct that error by obtaining records or scheduling a new exam. Your review may take longer if this is needed.

What if I want to file a Court Appeal, but I'm on active duty?
If you are unable to file a Notice of Appeal due to active military service, like a combat deployment, the Court of Appeals for Veterans Claims may grant additional time to file. The 120-day deadline would start or resume 90 days after you leave active duty. Please seek guidance from a qualified representative if this may apply to you.

What if I miss the deadline?
Submitting your request on time will ensure that you receive the maximum benefit if your case is granted. Please check the deadline for each review option and submit your request before that date.

If the deadline has passed, you can either:

- Add new and relevant evidence and request a Supplemental Claim. Because the deadline has passed, the effective date for benefits will generally be tied to the date VA receives the new request, not the date VA received your initial claim. Or,
- File a motion to the Board of Veterans' Appeals.

What if I want to get a copy of the evidence used in making this decision?
Call 1-800-827-1000 or write a letter stating what you would like to obtain to the address listed on this page.

Motions to the Board
Please consider the review options available to you if you disagree with the decision. In addition to those options, there are three types of motions that you can file with the Board to address errors in the decision. Please seek guidance from a qualified representative to assist you in understanding these motions.

Motion to Vacate
You can file a motion asking the Board to vacate, or set aside, all or part of the decision because of a procedural error. Examples include if you requested a hearing but did not receive one or if your decision incorrectly identified your representative. You will need to write a letter stating how you were denied due process of law. If you file this motion within 120 days of the date on your decision letter, you will have another 120 days from the date the Board decides the motion to appeal to the Court of Appeals for Veterans Claims.

Motion to Reconsider
You can file a motion asking the Board to reconsider all or part of the decision because of an obvious error of effect or law. An example is if the Board failed to recognize a recently established presumptive condition. You will need to write a letter stating specific errors the Board made. If the decision contained more than one issue, please identify the issue or issues you want reconsidered. If you file this motion within 120 days of the date on your decision letter, you will have another 120 days from the date the Board decides the motion to appeal to the Court of Appeals for Veterans Claims.

Motion for Revision of Decision based on Clear and Unmistakable Error
Your decision becomes final after 120 days. Under certain limited conditions, VA can revise a decision that has become final. You will need to send a letter to VA requesting that they revise the decision based on a Clear and Unmistakable Error (CUE). CUE is a specific and rare kind of error. To prove CUE, you must show that facts, known at the time, were not before the judge or that the judge incorrectly applied the law as it existed at the time. It must be undebatable that an error occurred and that this error changed the outcome of your case. Misinterpretation of the facts or a failure by VA to meet its Duty to Assist are not sufficient reasons to revise a decision. Please seek guidance from a qualified representative, as you can only request CUE once per decision.

Mail to:
Board of Veterans' Appeals
PO Box 27063
Washington, DC 20038

Or, fax:
1-844-678-8979