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On appeal from the
Department of Veterans Affairs Regional Office in Winston-Salem, North Carolina

THE ISSUES

1. Entitlement to service connection for avascular necrosis of the bilateral hips, to include as due to radiation exposure.

2. Entitlement to service connection for breathing problems, to include as due to radiation exposure.

3. Entitlement to an increased, compensable evaluation for residuals of basal cell carcinoma of the right ear, left cheek, and right forearm.

4. Entitlement to an initial compensable evaluation for bilateral hearing loss.

5. Entitlement to a 10 percent evaluation based on multiple, noncompensable service connected disabilities under 38 C.F.R. § 3.324.

(The issue of clear and unmistakable error (CUE) in a January 1986 Board of Veterans' Appeals (Board) decision is addressed in a separate decision.)

REPRESENTATION

Appellant represented by: Craig M. Kabatchnick, Attorney-at-Law

WITNESSES AT HEARING ON APPEAL

Appellant and Dr. M.F.

ATTORNEY FOR THE BOARD

W. H. Donnelly, Counsel

INTRODUCTION

The Veteran served on active duty with the United States Marine Corps from December 1951 to December 1953. The

appellant is the Veteran's spouse and payee, as he has been adjudicated incompetent for VA purposes.

This matter comes before the Board on appeal from June 2005 and February 2007 rating decisions by the Winston-Salem, North Carolina, Regional Office (RO) of the United States Department of Veterans Affairs (VA). The June 2005 decision reopened a previously denied claim of service connection for a bilateral hip disability, but confirmed and continued the denial on the merits. The February 2007 decision granted service connection for bilateral hearing loss, rated 0 percent disabling; denied service connection for breathing problems; denied increased evaluation for basal cell carcinoma; and denied entitlement to benefits under 38 C.F.R. § 3.324.

These issues were previously before the Board in June 2008; at that time, the matter was remanded for issuance of a statement of the case (SOC) regarding the February 2007 decision, and scheduling of a Board hearing.

The SOC was issued in September 2008, and following a request for extension of time in which to file a substantive appeal, the appeal was considered perfected through submission of December 2008 correspondence accepted in lieu of a VA Form 9.

A personal hearing was held before the undersigned Veterans Law Judge at the RO in March 2009. At that hearing, the appellant submitted additional evidence, as well as a waiver of initial RO consideration.

Please note this appeal has been advanced on the Board's docket pursuant to 38 C.F.R. § 20.900(c) (2007). 38 U.S.C.A. § 7107(a)(2) (West 2002).

FINDINGS OF FACT

1. The Veteran was exposed to radiation while on active duty service, during Operation Upshot-Knothole.

2. The evidence of record supports a finding of a causal relationship between currently diagnosed avascular necrosis of the bilateral hips and in service radiation exposure.

3. There is no competent medical evidence of a current chronic lung disability manifested by breathing problems.

4. Residuals of basal cell carcinomas of the face, to include the right ear and left cheek, are manifested by hypo- or hyper-pigmentation of the skin in an area over six square inches, and irregular skin texture in an area over six square inches.

5. Residuals of basal cell carcinomas of the right forearm are manifested by a superficial unstable scar.

6. Hearing loss disability is manifested by Level I acuity on the right and Level V acuity on the left.

7. The Veteran has at least one service connected disability which is compensable.

CONCLUSIONS OF LAW

1. Service connection for avascular necrosis of the bilateral hips is warranted. 38 U.S.C.A. §§ 1110, 1112, 5107 (West 2002); 38 C.F.R. §§ 3.102, 3.303, 3.309 (2008).

2. Service connection for a breathing problem is denied. 38 U.S.C.A. §§ 1110, 1112, 1113 5107 (West 2002); 38 C.F.R. §§ 3.102, 3.303, 3.307, 3.309, 3.311 (2008).

3. The criteria for a 30 percent evaluation, but no higher, for residuals of basal cell carcinoma of the face and head, are met. 38 U.S.C.A. §§ 1155, 5107 (West 2002); 38 C.F.R. § 4.1, 4.3, 4.118, Diagnostic Code 7800 (2007).

4. The criteria for a 10 percent evaluation, but no higher, for residuals of basal cell carcinoma of the right forearm, are met. 38 U.S.C.A. §§ 1155, 5107 (West 2002); 38 C.F.R. § 4.1, 4.3, 4.118, Diagnostic Code 7803 (2007).

5. The criteria for a compensable evaluation for bilateral hearing loss are not met. 38 U.S.C.A. §§ 1155, 5107 (West 2002); 38 C.F.R. §§ 4.1, 4.3, 4.85, Diagnostic Code 6100 (2008).

6. Entitlement to a separate 10 percent evaluation based on two or more noncompensable service-connected disabilities must be denied as a matter of law. 38 C.F.R. § 3.324 (2008).

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

VA's Duties to Notify and Assist

As provided for by the Veterans Claims Assistance Act of 2000 (VCAA), the United States Department of Veterans Affairs (VA) has a duty to notify and assist claimants in substantiating a claim for VA benefits. 38 U.S.C.A. §§ 5100, 5102, 5103, 5103A, 5107, 5126 (West 2002 & Supp. 2007); 38 C.F.R. §§ 3.102, 3.156(a), 3.159 and 3.326(a) (2007).

With respect to the claim of service connection for avascular necrosis of the bilateral hips and entitlement to compensable evaluation for residuals of basal cell carcinoma, the Board is granting in full the benefits sought on appeal. Accordingly, assuming, without deciding, that any error was committed regarding either the duty to notify or the duty to assist, such error was harmless and will not be further discussed. Similarly, as the appeal with regard to the evaluation of bilateral hearing loss arises from the

veteran's disagreement with the initial evaluation following the grant of service connection, the Courts have held that once service connection is granted the claim is substantiated, additional notice is not required, and any defect in the notice is not prejudicial. Hartman v. Nicholson, 483 F.3d 1311 (Fed. Cir. 2007); Dunlap v. Nicholson, 21 Vet. App. 112 (2007). No additional discussion of the duty to notify is therefore required in connection with hearing loss.

No further discussion of the VCAA is required in the context of the claim for a 10 percent evaluation for multiple, noncompensable service connected disabilities under 38 C.F.R. § 3.324, either, as this involves a claim that cannot be substantiated as a matter of law. See Sabonis v. Brown, 6 Vet. App. 426, 430 (1994) (where the law and not the evidence is dispositive the Board should deny the claim on the ground of the lack of legal merit or the lack of entitlement under the law); VAOPGCPREC 5-2004 (June 23, 2004) (VA is not required to provide notice of the information and evidence necessary to substantiate a claim where that claim cannot be substantiated because there is no legal basis for the claim or because undisputed facts render the claimant ineligible for the claimed benefit).

Notice is required with regard to the claim of service connection for a disability manifested by breathing problems. Legally adequate notice was provided in April 2006 correspondence, which informed the Veteran of the general elements of a claim for service connection, detailed the evidence and information necessary to substantiate the claim, and described the respective responsibilities of VA and the Veteran is providing such. The letter also included information on VA policies and procedures with respect to assignment of effective dates and disability evaluations. The Veteran has been afforded a full and fair opportunity to meaningfully participate in the adjudication of his claim.

VA also has a duty to assist the veteran in the development of the claim. This duty includes assisting the veteran in the procurement of service treatment records and pertinent treatment records and providing an examination when necessary. 38 U.S.C.A. § 5103A; 38 C.F.R. § 3.159. VA has here associated with the file service treatment records, VA inpatient and outpatient treatment records, and repeated statements from the Defense Threat Reduction Agency (DTRA) regarding the Veteran's radiation exposure. The Veteran has submitted, or VA has obtained on his behalf, private medical records from OM Hospital, JO Clinic, and a variety of private doctors. The Veteran has additionally provided copies of research studies and opinions from several private doctors, as well as statements from friends and relatives. The Veteran has been examined in connection with his claims on several occasions, and his wife, as his representative, testified at a March 2009 personal hearing. She also presented an expert witness. Neither the appellant nor her representative has identified, and the record does not

otherwise indicate, any additional existing evidence that is necessary for a fair adjudication of the claim that has not been obtained. Hence, no further notice or assistance to the appellant is required to fulfill VA's duty to assist the appellant in the development of the claim.

Avascular Necrosis of the Bilateral Hips

The Veteran contends that his currently diagnosed avascular necrosis of the hips is causally related to his in-service exposure to radiation from atmospheric testing of nuclear weapons. The record very clearly establishes that the Veteran and his unit were present at Shot Badger during Operation Upshot-Knothole. The Board concedes radiation exposure.

The appellant argues that presumptive service connection for the bilateral hip disability is warranted based on this exposure. However, avascular necrosis is not a listed presumptive condition under 38 C.F.R. §§ 3.309 or 3.311, and hence service connection cannot be so established.

The Veteran may still show entitlement to benefits on a direct basis. Disorders diagnosed after discharge will still be service connected if all the evidence, including that pertinent to service, establishes that the disease was incurred in service. 38 C.F.R. § 3.303(d); see also Combee v. Brown, 34 F.3d 1039, 1043 (Fed. Cir. 1994).

It is not contended, nor do service treatment records show, any disease or injury of the hips during active military service. The earliest evidence of a hip disability was in May 1978, when the Veteran reported a four year history of increasing hip pain. He does state that pain actually began in 1960 or 1961, but Dr. JMH's reported history indicates that avascular necrosis was diagnosed by x-ray in 1977. The Veteran underwent his first hip replacement surgery in May 1978. Records reflect continuous complaints of hip pain since that time, with repeated bilateral replacement surgeries and revisions. Although both private and VA doctors noted the history of radiation exposure, no provider offered a definitive opinion on a possible nexus between the hip disability and radiation until January 2001.

In January 2001, Dr. REA reported that he had been treating the Veteran for 10 months. He noted the radiation exposure in service, and stated, "With all the difficulties [the Veteran] is having with his spine and hip problems it is definitely conceivable that the patient's problems stem from small vessel vascular disease secondary to his exposure to the radiation from the nuclear test sites." The doctor went on to opine, "I do feel that there is definite causality involved...." In February 2001, Dr. REA stated that the Veteran's "exposure to radiation from the nuclear blast is definitely more likely than not the cause of his skeletal problems especially with the extensive small vessel vascular disease that he has."

In May 2004, Dr. NBR, a long time treating physician, submitted a medical opinion regarding the Veteran's hip disability. While he had begun treating the Veteran only after the initial hip replacements and hence was not fully aware of the original diagnosis, he opined that radiation could be "an inciting cause" of degenerative arthritis of the hips due to aseptic necrosis. He was not sure, however, if that was indeed the original diagnosis.

In July 2004, a VA doctor, Dr. LC, stated that the delayed effects of radiation exposure may include worsening of degenerative bone changes and cartilage. Also in July 2004, the Veteran's sister in law, a registered nurse, opined that, based on her research and training, avascular necrosis could be caused by radiation exposure. She also opined that there was no acceptable level of exposure.

At the March 2009 hearing before the undersigned, the appellant presented additional evidence and argument regarding the extent of the Veteran's exposure to radiation in service, and the possible role of that exposure in causing the bilateral hip disability.

The accompanying evidence indicated that some studies showed that exposure to significant levels of ionizing radiation could cause bone degeneration. The exposure levels discussed were in excess of 6500 rads, though one study indicated that exposure to "as little as 16 Gy" or radiation (about 1600 rads or rems, based on gamma radiation) could cause avascular necrosis of the femoral head in some patients. Fractures became more common at 42 Gy.

The DTRA has certified that in this case the Veteran was likely exposed to a maximum on 550 rem on the skin, with 13.9 rem as an upper limit in bone exposure. These reflect exposures arrived at after DTRA modified the presumptions and formulae used to calculate dosimetry.

The Board finds that although the evidence of record reflects a fairly low dose of radiation, relative to the levels discussed in the studies relied upon by the appellant, the evidence does support a finding that it is scientifically sound to relate the development of avascular necrosis of the femoral head/hip to radiation exposure, as a general principle. Moreover, numerous private doctors have opined, after reviewing the Veteran's medical history and his exposure to radiation, and conducting examinations, that in his particular case it is likely that radiation played a role in causing the currently diagnosed bilateral hip disability. No contrary evidence has been presented; denials appear to rely upon the extent of exposure, which is a generalization and does not deal with the specific facts of this case.

Therefore, the Board finds that service connection for avascular necrosis of the bilateral hips is warranted, due to medical evidence establishing a nexus to in-service radiation

exposure

Breathing Problems

The Veteran additionally contends that an unspecified breathing problem is related to his established in-service radiation exposure. Although he did not identify a specific disease, the appellant did indicate that the claimed disability involved the lungs during her March 2009 testimony.

Service connection will be granted if it is shown that the veteran suffers from a disability resulting from personal injury suffered or disease contracted in the line of duty, or for aggravation of a preexisting injury suffered or disease contracted in the line of duty, during active military service. 38 U.S.C.A. §§ 1110, 1131; 38 C.F.R. § 3.303. Disorders diagnosed after discharge will still be service connected if all the evidence, including that pertinent to service, establishes that the disease was incurred in service. 38 C.F.R. § 3.303(d); see also Combee v. Brown, 34 F.3d 1039, 1043 (Fed. Cir. 1994).

In the absence of proof of a present disability there can be no valid claim. Brammer v. Derwinski, 3 Vet. App. 223, 225 (1992). Service connection requires a finding of the existence of a current disability and a determination of a relationship between that disability and an injury or disease incurred in service. Watson v. Brown, 4 Vet. App. 309, 314 (1993); see also Boyer v. West, 210 F.3d 1351, 1353 (Fed. Cir. 2000). To establish service connection, there must be a medical diagnosis of a current disability; medical or, in certain cases, lay evidence of in-service occurrence or aggravation of a disease or injury; and medical evidence of a nexus between an in-service injury or disease and the current disability. Hickson v. West, 12 Vet. App. 247, 252 (1999), citing Caluza v. Brown, 7 Vet. App. 498, 506 (1995), aff'd 78 F.3d 604 (Fed. Cir. 1996).

Competent medical evidence is evidence provided by a person who is qualified through education, training, or experience to offer medical diagnoses, statements, or opinions. Competent medical evidence may also include statements conveying sound medical principles found in medical treatises. It also includes statements contained in authoritative writings, such as medical and scientific articles and research reports or analyses. 38 C.F.R. § 3.159(a)(1). Competent lay evidence is any evidence not requiring that the proponent have specialized education, training, or experience. Lay evidence is competent if it is provided by a person who has knowledge of facts or circumstances and conveys matters that can be observed and described by a lay person. 38 C.F.R. § 3.159(a)(2).

Importantly, a layperson is generally not capable of opining on matters requiring medical knowledge. Routen v. Brown, 10 Vet. App. 183, 186 (1997). See also Bostain v. West,

11 Vet. App. 124, 127 (1998) citing Espiritu v. Derwinski, 2 Vet. App. 492 (1992) (a layperson without the appropriate medical training and expertise is not competent to provide a probative opinion on a medical matter, to include a diagnosis of a specific disability and a determination of the origins of a specific disorder).

In determining whether service connection is warranted for a disability, VA is responsible for determining whether the evidence supports the claim or is in relative equipoise, with the veteran prevailing in either event, or whether a preponderance of the evidence is against the claim, in which case the claim is denied. 38 U.S.C.A. § 5107; Gilbert v. Derwinski, 1 Vet. App. 49 (1990). When there is an approximate balance of positive and negative evidence regarding any issue material to the determination, the benefit of the doubt is afforded the claimant.

A review of the medical evidence of record reveals no diagnosis of any chronic lung condition or disease. In VA treatment records, the Veteran has consistently denied any lung problems, such as wheezing, coughing, or shortness or breath, and physical examination has been similarly negative. No private doctor has diagnosed or treated the Veteran for a lung disorder. At the March 2009 hearing, the appellant stated that the Veteran has been treated frequently for pneumonia, but no such treatment or diagnosis is reflected in the medical evidence, and as a layperson, the appellant is not competent to render a diagnosis. Espiritu v. Derwinski, 2 Vet. App. 492 (1992).

In the absence of competent medical evidence of a current disability, service connection cannot be granted. Brammer v. Derwinski, 3 Vet. App. 223, 225 (1992). The Board need not reach the question of etiology.

The Board notes that VA and private records do show treatment for congestion related to allergies, and Dr. HJM, a private primary care physician, treated the Veteran for a deviated septum and blocked nasal passages secondary to a December 1994 fracture of the nose. Dr HJM also commented that the Veteran's glasses compressed his nasal passages to some degree. Neither the allergies nor the physical deformity of the nose are alleged to be related to service, ether directly or through exposure to radiation, and hence are not considered here. Moreover, treating doctors have very clearly identified nonservice connected etiologies for the conditions.

Evaluation of Residuals of Basal Cell Carcinoma

In evaluating the severity of a particular disability, it is essential to consider its history. 38 C.F.R. § 4.1; Peyton v. Derwinski, 1 Vet. App. 282 (1991). Where entitlement to compensation has already been established and an increase in the disability rating is at issue, the present level of disability is of primary importance. Francisco v. Brown,

7 Vet. App. 55, 58 (1994). Separate ratings may be assigned for separate periods of time based on the facts found, however. This practice is known as "staged" ratings." Fenderson v. West, 12 Vet. App. 119, 126-127 (1999); Hart v. Mansfield, 21 Vet. App. 505 (2007).

If the evidence for and against a claim is in equipoise, the claim will be granted. A claim will be denied only if the preponderance of the evidence is against the claim. See 38 U.S.C.A. § 5107 (West 2002); 38 C.F.R. § 3.102; Gilbert v. Derwinski, 1 Vet. App. 49, 56 (1990). Any reasonable doubt regarding the degree of disability should be resolved in favor of the claimant. 38 C.F.R. § 4.3. Where there is a question as to which of two evaluations shall be applied, the higher rating will be assigned if the disability picture more nearly approximates the criteria required for that evaluation. Otherwise, the lower rating will be assigned. 38 C.F.R. § 4.7.

Disability evaluations are determined by the application of the facts presented to VA's Schedule for Rating Disabilities (Rating Schedule) at 38 C.F.R. Part 4. The percentage ratings contained in the Rating Schedule represent, as far as can be practicably determined, the average impairment in earning capacity resulting from diseases and injuries incurred or aggravated during military service and the residual conditions in civilian occupations. 38 U.S.C.A. § 1155; 38 C.F.R. §§ 3.321(a), 4.1.

Here, the residuals of basal cell carcinoma are rated under 38 C.F.R. § 4.118 (2007), for skin disabilities. The evaluation criteria were recently amended, effective October 23, 2008. The Board has determined that the newer criteria are not as advantageous to the Veteran, and hence continued evaluation under the criteria in effect prior to that date is appropriate.

Under those older criteria, malignant neoplasms of the skin are rated under Code 7818. Diagnostic Code 7818 provides that malignant skin neoplasms (other than malignant melanoma) are rated as disfigurement of the head, face, or neck (Diagnostic Code 7800), scars (Diagnostic Codes 7801, 7802, 7803, 7804, or 7805), or rated on impairment of function. There is no showing or allegation of impaired function due to scars in this instance. The RO has evaluated the Veteran as noncompensable under Code 7800, for disfigurement of the head, face, or neck. Note (1) to Diagnostic Code 7800 provides that the 8 characteristics of disfigurement, for purposes of rating under 38 C.F.R. § 4.118 (2007), are:

1) Scar is 5 or more inches (13 or more cm.) in length.
2) Scar is at least one-quarter inch (0.6 cm.) wide at the widest part.
3) Surface contour of scar is elevated or depressed on palpation.
4) Scar is adherent to underlying tissue.

5) Skin is hypo-or hyper-pigmented in an area exceeding six square inches (39 sq. cm.).
6) Skin texture is abnormal (irregular, atrophic, shiny, scaly, etc.) in an area exceeding six square inches (39 sq. cm.).
7) Underlying soft tissue is missing in an area exceeding six square inches (39 sq. cm.).
8) Skin is indurated and inflexible in an area exceeding six square inches (39 sq. cm.).

Diagnostic Code 7800 provides that a skin disorder with one characteristic of disfigurement of the head, face, or neck is rated 10 percent disabling. A skin disorder of the head, face, or neck with visible or palpable tissue loss and either gross distortion or asymmetry of one feature or paired set of features (nose, chin, forehead, eyes (including eyelids), ears (auricles), cheeks, lips), or; with two or three characteristics of disfigurement, is rated 30 percent disabling. A skin disorder of the head, face, or neck with visible or palpable tissue loss and either gross distortion or asymmetry of two features or paired sets of features (nose, chin, forehead, eyes (including eyelids), ears (auricles), cheeks, lips), or; with four or five characteristics of disfigurement, is rated 50 percent disabling. A skin disorder of the head, face, or neck with visible or palpable tissue loss and either gross distortion or asymmetry of three or more features or paired sets of features (nose, chin, forehead, eyes (including eyelids), ears (auricles), cheeks, lips), or; with six or more characteristics of disfigurement, is rated 80 percent disabling.

Note (2) to Diagnostic Code 7800 provides that tissue loss of the auricle is to be rated under Diagnostic Code 6207 (loss of auricle), and anatomical loss of the eye under Diagnostic Code 6061 (anatomical loss of both eyes) or Diagnostic Code 6063 (anatomical loss of one eye), as appropriate. Note (3) provides that unretouched color photographs are to be taken into consideration when rating under these criteria. 38 C.F.R. § 4.118 (2007).

Diagnostic Code 7801 provides ratings for scars, other than the head, face, or neck, that are deep or that cause limited motion. Scars that are deep or that cause limited motion in an area or areas exceeding 6 square inches (39 sq. cm.) are rated 10 percent disabling. Scars in an area or areas exceeding 12 square inches (77 sq. cm.) are rated 20 percent disabling. Scars in an area or areas exceeding 72 square inches (465 sq. cm.) are rated 30 percent disabling. Scars in an area or areas exceeding 144 square inches (929 sq.cm.) are rated 40 percent disabling. Note (1) to Diagnostic Code 7802 provides that scars in widely separated areas, as on two or more extremities or on anterior and posterior surfaces of extremities or trunk, will be separately rated and combined

in accordance with 38 C.F.R. § 4.25. Note (2) provides that a deep scar is one associated with underlying soft tissue damage. 38 C.F.R. § 4.118 (2007).

Diagnostic Code 7802 provides ratings for scars, other than the head, face, or neck, that are superficial or that do not cause limited motion. Superficial scars that do not cause limited motion, in an area or areas of 144 square inches (929 sq. cm.) or greater, are rated 10 percent disabling. Note (1) to Diagnostic Code 7802 provides that scars in widely separated areas, as on two or more extremities or on anterior and posterior surfaces of extremities or trunk, will be separately rated and combined in accordance with 38 C.F.R. § 4.25. Note (2) provides that a superficial scar is one not associated with underlying soft tissue damage. 38 C.F.R. § 4.118 (2007).

Diagnostic Code 7803 provides a 10 percent rating for superficial unstable scars. Note (1) to Diagnostic Code 7803 provides that an unstable scar is one where, for any reason, there is frequent loss of covering of skin over the scar. Note (2) provides that a superficial scar is one not associated with underlying soft tissue damage. 38 C.F.R. § 4.118 (2007).

Diagnostic Code 7804 provides a 10 percent rating for superficial scars that are painful on examination. Note (1) to Diagnostic Code 7804 provides that a superficial scar is one not associated with underlying soft tissue damage. Note (2) provides that a 10-percent rating will be assigned for a scar on the tip of a finger or toe even though amputation of the part would not warrant a compensable rating. 38 C.F.R. § 4.118 (2007). Diagnostic Code 7804 also directs the rater to see 38 C.F.R. § 4.68 (amputation rule). 38 C.F.R. § 4.118 (2007).

Diagnostic Code 7805 provides that other scars are to be rated on limitation of function of affected part. 38 C.F.R. § 4.118 (2007).

The Veteran is seeking increased evaluations for scars at the sites of basal cell carcinoma removals in two widely separated areas of the body. Scars of the right ear and left cheek clearly fall under Code 7800. Scars of the right forearm, however, are not contemplated by the criteria of Code 7800, and may therefore be evaluated independently.

Medical records establish the occurrence and removal of multiple cancerous and precancerous lesions from the face, to include treatment for rash-type texture and color changes. The cheeks and right ear were the focus of treatment.

At an October 2003 VA contract examination, the Veteran accurately reported a history of recurrent lesions of his ears, cheeks and arms. He complained of scaly skin, rash, redness, ulcer formation, itching, shedding, tenderness, crusting and bleeding, and recurrent lesions. He must stay

out of the sun. He was treated with immunosuppressive medications, topical ointments and creams, laser, cauterization, steroids, excision, and antibiotics, but lesions continue to recur. The examiner identified areas of ulceration, exfoliation, crusting, and hyperpigmentation and abnormal skin texture of less than six square inches. About 18 percent of the whole body was involved. Scars of the ear and nose measuring .5cm by .1cm were noted.

In a May 2006, following further surgical removal of lesions from the face and arms, the Veteran saw Dr. PPG, a dermatologist, in consultation. The doctor noted the presence of scaly erythematous dermatitis of the nasal creases and numerous (20-30) hyperkeratotic skin lesions of the face. The doctor stated that the in-service radiation exposure had had contributed to the current skin damage.

Also in May 2006, a friend of the Veteran submitted a statement regarding her lay observations of the Veteran's skin condition. She cut his hair, and expressed concern over the many easily damaged lesions covering his head. She was afraid of damaging them with scissors or a comb. They bled easily and would crack.

A VA contract examination was conducted in August 2006. The Veteran continued to complain of exudation, ulcer formation, shedding, crusting, and frequent bleeding. The head, face, arms, hands, and ears, all areas exposed to the sun, were involved. He limited his activity and use of hearing aids to avoid bleeding. A scar of the right ear, measuring 1 cm by .3 cm, was noted. The scar was not tender, disfiguring, adherent, unstable, deep, hypo or hyper pigmented, or abnormal in texture. There was no asymmetry or distortion of features. The right forearm was ulcerated, with exfoliation and abnormal texture over less than six square inches. The doctor stated that 100 percent of exposed areas were involved, and 5 percent of the whole body.

Photographs of the Veteran's face and arms have been submitted, both by examining doctors and the appellant. Photographs of the right arm clearly show a small area of ulceration and unstable skin. There is evidence that the ulcers had bled. The total area involved on the forearm appears to be greater than 6 square inches, but less than 10, by the Board's estimate.

The photographs of the Veteran's face show isolated marks and scars, as well as areas of discoloration around the mouth and nasal creases. The marks are slightly discolored, and are distinguishable by an apparently different texture from the surrounding skin; they appear slightly elevated, particularly on the right ear. One area of scarring and/or lesion, behind the right ear, appears well over a quarter inch wide in any direction. Finally, the areas of discoloration, with marked redness, to either side of the nose and down the creases to the mouth, as well as smaller, isolated areas of yellowing lesions or treated skin, are estimated by the total in excess

of six square inches.

Based upon the medical evidence of record, the Board finds that under the applicable rating criteria in effect prior to October 23, 2008, increased, compensable evaluations for residuals of basal cell carcinoma of the face and head, and residuals of basal cell carcinoma of the right arm are warranted.

With respect to the face and head, under Code 7800, the Board finds that there are three characteristics of disfigurement present, warranting a 30 percent evaluation. There is one scar/lesion behind the right ear which is over one quarter inch wide. The same scar/lesion appears elevated in photographs; this same scar apparently interferes with the wearing of hearing aids, supporting the finding of elevation from the surrounding skin. Finally, the discoloration of all areas of the face and head, taken as a whole, appears in the estimation of the Board to cover an area over six square inches.

With respect to the right arm, the Board finds that the criteria of Code 7803 are most applicable. As was noted above, the arm is not included in the criteria under Code 7800, and hence a separate evaluation for the arm is allowable. There is a small area observed on the right forearm which shows several scars or lesion sites. These are red, and at least one is shown to be unstable by the bleeding and redness of the ulceration in photographs. The scars are not noted to cause limitation of motion or function of the arm, and the area involved is less than 144 square inches. A 10 percent evaluation is warranted for the right forearm residuals of basal cell carcinoma.

Evaluation of Hearing Loss

Relevant laws and regulations stipulate that evaluations of defective hearing range from noncompensable to 100 percent based on the organic impairment of hearing acuity. Hearing impairment is measured by the results of controlled speech discrimination tests together with the average hearing threshold levels (which, in turn, are measured by puretone audiometry tests in the frequencies of 1,000, 2,000, 3,000, and 4,000 cycles per second). See Lendenmann v. Principi, 3 Vet.App. 345, 349 (1992) (defective hearing is rated on the basis of a mere mechanical application of the rating criteria). The provisions of 38 C.F.R. § 4.85 establish eleven auditory acuity levels from I to XI. Tables VI and VII as set forth in § 4.85(h) are used to calculate the rating to be assigned. In instances where, because of language difficulties, the Chief of the Audiology Clinic certifies that the use of both puretone averages and speech discrimination scores is inappropriate, Table VIa is to be used to assign a rating based on puretone averages. 38 C.F.R. § 4.85(h).

For cases involving exceptional patterns of hearing

impairment, the schedular criteria stipulates that, when the puretone threshold at each of the four specified frequencies (1000, 2000, 3000, and 4000 Hertz) is 55 decibels or more, the rating specialist will determine the Roman numeral designation for hearing impairment from either Table VI or Table VIa, whichever results in the higher numeral. Each ear will be evaluated separately. 38 C.F.R. § 4.86(a). Additionally, when the puretone threshold is 30 decibels or less at 1000 Hertz, and 70 decibels or more at 2000 Hertz, the rating specialist will determine the Roman numeral designation for hearing impairment from either Table VI or Table VIa, whichever results in the higher numeral. That numeral will then be elevated to the next higher Roman numeral. Each ear will be evaluated separately. 38 C.F.R. § 4.86(b).

In this case, the veteran underwent a VA contract audiology examination in August 2006. At that time, pure tone thresholds, in decibels, were as follows:

HERTZ

1000
2000
3000
4000
RIGHT
25
30
50
70
LEFT
30
55
60
80

The average pure tone threshold was 44 in the right ear and 56 in the left ear. Speech audiometry revealed speech recognition ability of 96 percent in the right ear and 72 percent in the left ear. The Veteran reported difficulty hearing, particularly in noisy settings. The examiner diagnosed mild to severe sensorineural hearing loss bilaterally, with fair word recognition. The use of hearing aids was recommended bilaterally.

At the March 2009 hearing, the appellant testified that the Veteran could no longer use hearing aids because they made his ears bleed, secondary to his skin condition. She stated that the Veteran could not hear, and that talking to him was "like talking to the wall."

The appellant submitted a statement from the Veteran's current nursing home indicating that due to the progression of his Alzheimer's Disease, he would be unable to cooperate with an examination that depended on his responses.

Based on the audiometric testing of record, a hearing acuity level of I is set for the right ear, and V for the left ear, using Table VI. Table VII then shows that a noncompensbale evaluation is warranted for those two hearing acuity levels. No compensable evaluation is warranted under the schedule.

The appellant appears to argue that an extraschedular evaluation is warranted for hearing loss disability due to the inability to wear a hearing aid. The threshold factor for extraschedular consideration is a finding on part of the RO or the Board that the evidence presents such an exceptional disability picture that the available schedular evaluations for the service connected disability at issue are inadequate. See Fisher v. Principi, 4 Vet. App. 57, 60 (1993); 38 C.F.R. § 3.321(b)(1); VA Adjudication Procedure Manual, Pt. III, Subpart iv, Ch. 6, Sec. B(5)(c). Therefore, initially, there must be a comparison between the level of severity and the symptomatology of the claimant's disability with the established criteria provided in the rating schedule for this disability. If the criteria reasonably describe the claimant's disability level and symptomatology, then the disability picture is contemplated by the rating schedule, the assigned evaluation is therefore adequate, and no referral for extraschedular consideration is required. See VA Gen. Coun. Prec. Op. 6-1996 (Aug. 16, 1996). Thun v. Peake, No. 05-2066 (U.S. Vet. App. April 23, 2008)

If the schedular evaluation does not contemplate the claimant's level of disability and symptomatology, and it is found inadequate, the RO or Board must determine whether the claimant's exceptional disability picture exhibits other related factors such as those provided by the regulation as "governing norms" (including marked interference with employment and frequent periods of hospitalization). 38 C.F.R. § 3.321(b)(1). If so, then the case must be referred to the Under Secretary for Benefits or the Director of the Compensation and Pension Service for completion of the third step: a determination of whether, to accord justice, the claimant's disability picture requires the assignment of an extraschedular rating. Thun, supra.

Here, the rating schedule for evaluation of hearing loss disability expressly provides that the disability is to be evaluated based on hearing acuity without the use of hearing aids. 38 C.F.R. § 4.85(a). The criteria applied to the claim therefore squarely address the reported symptomatology and manifestations of the Veteran's hearing loss disability. The Schedule is therefore adequate, and further consideration of entitlement to an extraschedular evaluation is not warranted.

38 C.F.R. § 3.324

Regulations provide that where a Veteran has two or more service connected disabilities, and none of these disabilities is rated compensable under the Schedule, a

single 10 percent evaluation is assignable based on a showing that the noncompensable disabilities interfere with normal employability. This rating may not be combined with any other compensation rating. 38 C.F.R. § 3.324.

Here, entitlement to a 10 percent evaluation under this regulation must be denied in light of the above decisions awarding compensable evaluations for several of the Veteran's service connected disabilities. As a matter of law, the Veteran cannot meet the basic threshold eligibility requirements for entitlement.

ORDER

Service connection for avascular necrosis of the bilateral hips is granted.

Service connection for breathing problems is denied.

Entitlement to a 30 percent evaluation for residuals of basal cell carcinoma of the face, to include the right ear and cheek, is granted, subject to the laws and regulations governing payment of monetary benefits.

Entitlement to a 10 percent evaluation for residuals of basal cell carcinoma of the right forearm is granted, subject to the laws and regulations governing payment of monetary benefits.

Entitlement to an initial compensable evaluation for bilateral hearing loss is denied

Entitlement to a 10 percent evaluation based on multiple, noncompensable service connected disabilities under 38 C.F.R. § 3.324 is denied.

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CHERYL L. MASON
Veterans Law Judge, Board of Veterans' Appeals