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On appeal from the
Department of Veterans Affairs Regional Office in Los Angeles, California

THE ISSUE

Whether new and material evidence has been received to reopen service connection for a left knee disability.

REPRESENTATION

Appellant represented by: Disabled American Veterans

WITNESS AT HEARING ON APPEAL

Appellant

ATTORNEY FOR THE BOARD

[redacted]

INTRODUCTION

The Veteran, who is the appellant in this case, served on active duty from November 1969 to November 1970.

This matter comes on appeal before the Board of Veterans' Appeals (Board) from a May 2005 rating decision of the Department of Veterans Affairs (VA) Regional Office (RO) in Los Angeles, California, which denied service connection for a left knee disorder because evidence submitted was not new and material. In a subsequent October 2009 rating decision, the RO reopened the Veteran's claim for service connection for a left knee disorder, and denied the claim on the merits.

The Veteran testified at a June 2011 Board personal hearing in Washington, D.C. A hearing transcript has been associated with the claims file.

FINDINGS OF FACT

1. In an unappealed August 2004 rating decision, the RO denied service connection for a left knee disorder because evidence received was not new and material.

2. Evidence received since the August 2004 rating decision relates to an unestablished fact necessary to substantiate a claim of entitlement to service connection for a left knee disability.

3. A left knee disability was not "noted" at service entrance.

4. The evidence does not show, clearly and unmistakably, that a left knee disability both preexisted and was not aggravated by service.

5. The Veteran was seen for chronic left knee symptoms in service.

6. The Veteran had continuous left knee symptoms since his separation from service.

8. The left knee arthritis, status post total arthroscopy, is related to service.

CONCLUSIONS OF LAW

1. The August 2004 rating decision which denied service connection for a left knee disorder became final. 38 U.S.C.A. § 7104 (West 2002); 38 C.F.R. § 20.1103 (2011).

2. The evidence received subsequent to the August 2004 rating decision is new and material; the claim for service connection for a left knee disability is reopened.
38 U.S.C.A. §§ 5103, 5103A, 5107, 5108 (West 2002); 38 C.F.R. §§ 3.156(a), 3.303, 3.307, 3.309, 3.317, 20.1105 (2011).

3. Resolving reasonable doubt in the Veteran's favor, left knee arthritis, status post total arthroscopy, was incurred in service. 38 U.S.C.A. §§ 1110, 1111, 5103, 5103A, 5107 (West 2002); 38 C.F.R. §§ 3.102, 3.159, 3.303, 3.304, 3.307, 3.309 (2011).

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

Duties to Notify and Assist

The Veterans Claims Assistance Act of 2000 (VCAA) and implementing regulations imposes obligations on VA to provide claimants with notice and assistance. 38 U.S.C.A. §§ 5102, 5103, 5103A, 5107, 5126 (West 2002 & Supp. 2011); 38 C.F.R. §§ 3.102, 3.156(a), 3.326(a) (2011). In this case, the Board is reopening the claim for service connection for a left knee disability, and is granting the underlying claim for service connection. Because this decision constitutes a full grant of the benefits sought on appeal, the Board finds that no further action is necessary to comply with VCAA duties to notify and assist the Veteran.

Reopening Service Connection for Left Knee Disability

The RO previously considered and denied the Veteran's claim for service connection for a left knee disability in an unappealed August 2004 rating decision, which found that new and material had not been received.

Although the RO ultimately reopened the Veteran's claim for service connection in an October 2009 rating decision, the Board is required to determine whether new and material evidence has been presented before it can reopen a claim and readjudicate service connection or other issues on the merits. See Barnett v. Brown, 83 F.3d 1380, 1383-1384 (Fed. Cir. 1996).

In general, if new and material evidence is presented or secured with respect to a finally adjudicated claim, VA shall reopen and review the claim. 38 U.S.C.A.
§ 5108 (West 2002); 38 C.F.R. § 3.156. New evidence means existing evidence not previously submitted to

agency decisionmakers. 38 C.F.R. § 3.156(a). Material evidence means existing evidence that, by itself or when considered with previous evidence of record, relates to an unestablished fact necessary to substantiate the claim. Id. New and material evidence can be neither cumulative nor redundant of the evidence of record at the time of the last prior final denial of the claim sought to be reopened, and must raise a reasonable possibility of substantiating the claim. Id.

The threshold for determining whether new and material evidence raises a reasonable possibility of substantiating a claim is "low." See Shade v. Shinseki,
24 Vet. App. 110, 117 (2010). Furthermore, in determining whether this low threshold is met, VA should not limit its consideration to whether the newly submitted evidence relates specifically to the reason why the claim was last denied, but instead should ask whether the evidence could reasonably substantiate the claim were the claim to be reopened, either by triggering the VA Secretary's duty to assist or through consideration of an alternative theory of entitlement. Id. at 118.

Evidence is presumed to be credible for the purpose of determining whether the case should be reopened; once the case is reopened, the presumption as to the credibility no longer applies. Justus v. Principi, 3 Vet. App. 510, 513 (1992). The evidence must be both new and material; if the evidence is new, but not material, the inquiry ends and the claim cannot be reopened. Smith v. West, 12 Vet. App. 312 (1999). If the Board determines that the evidence submitted is new and material, it must reopen the case and evaluate the appellant's claim in light of all the evidence. Justus v. Principi, 3 Vet. App. at 512 (1992).

The Veteran has attempted to reopen service connection for a left knee disability on numerous occasions. Service connection for a left knee disability was initially denied by the RO in an unappealed August 1971 rating decision, which found that the disorder preexisted service and was not aggravated by service.

The Board also denied an appeal for service connection for a left knee disability in a January 1977 decision, and denied reopening of service connection in a July 1979 decision. In January 1977, the Board found that the Veteran had fractured his left patella prior to entering service (preexisting disability) and that the left knee disorder did not undergo pathological advancement (not aggravated by service). In July 1979, the Board found that evidence submitted since the January 1977 decision was not new and material because it did not associate a present left knee disorder with the Veteran's period of service.

In June 1991, the Board denied an appeal to reopen service connection for a left knee disability, finding that new and material evidence had not been received. In a February 1993 memorandum decision, the United States Court of Appeals for Veterans Claims (Court) affirmed the Board's June 1991 denial. The Veteran's appeal to reopen service connection for a left knee disorder was again denied by the Board in June 1999, which again found that the newly received evidence was not material to reopen the claim.

In rating decisions in March 2003 and August 2004, the RO found that new and material evidence had not been submitted to reopen the claim. The last final unappealed decision in this case was in August 2004; in that decision, the RO denied reopening because new and material evidence had not been submitted.

The claim was previously denied because a left knee disability existed prior to service and did not undergo pathological advancement in service, and because evidence did not associate a present left knee disability to service. In light of the foregoing, the Board finds that new and material evidence must tend to show that a left knee disorder did not preexist service, that a left knee disability was aggravated (permanently worsened by) service, or that a left knee disability began in service.

Evidence received subsequent to the August 2004 rating decision, relevant to the claim for service connection for a left knee disability, includes: private treatment records dated from 2005 to 2006; VA treatment records dated from 2004 to 2009, to include a December 2009 opinion from an orthopedic surgeon; lay statements from the Veteran; a statement from the Veteran's father; regulations and lay statements addressing military medical records keeping procedures; duplicate service treatment records and preservice treatment records from the Kenner Army Hospital; a June 2011 Board hearing transcript; a

September 2006 opinion from Dr. C.J.; a December 2012 VHA opinion; and an April 2012 private opinion from Dr. C.B.

Service treatment records, preservice treatment records, and a lay statement from the Veteran's father are duplicative of evidence previously of record and are not new. VA and private treatment records and opinions, additional statements from the Veteran, and regulations and lay statements addressing military medical records keeping procedures, however, are new in that they have not previously been received or presented.

The Board finds that the additional medical evidence, lay evidence, and lay testimony submitted by the Veteran is material. Lay evidence from the Veteran shows that he injured his knee as a child, but was asymptomatic at service entrance. A September 2006 private opinion from Dr. C.J. and a December 2009 opinion from a VA orthopedic surgeon show, based on a review of service treatment records, that a currently diagnosed left knee disability is likely related to an in-service injury. An April 2012 private opinion from Dr. C.B. tends to show, based on a review of the claims file and the Veteran's medical history, that it is probable that the Veteran's left knee problems are due to experiences and trauma that he had during service. The Board finds that new evidence submitted relates to an unestablished fact necessary to substantiate the Veteran's claim. Accordingly, the Board finds that new and material evidence sufficient to reopen service connection for a left knee disability has been received, and the claim is reopened.

Before adjudicating the reopened claim for service connection for a left knee disability on the merits, the Board must first determine whether such action will prejudice the Veteran. Bernard v. Brown, 4 Vet. App. 384, 393-94 (1993). In this case, the Veteran was given adequate VCAA notice of the need to submit evidence or argument on the issue of service connection in a February 2005 letter, and he has submitted lay and medical evidence addressing the merits of his claim during the pendency of this appeal. The RO reopened and ultimately denied this claim on the merits in an October 2009 rating decision. For these reasons, the Board may proceed to adjudicate the merits of the claim of service connection for a left knee disability without prejudice to the Veteran. See Bernard, 4 Vet. App. at 394 (1993).

Service Connection Law and Analysis

Service connection may be granted for a disability resulting from disease or injury incurred in or aggravated by active military, naval, or air service. 38 U.S.C.A.
§ 1110; 38 C.F.R. § 3.303(a). For the showing of chronic disease in service, there is required a combination of manifestations sufficient to identify the disease entity, and sufficient observation to establish chronicity at the time. With chronic disease as such in service, subsequent manifestations of the same chronic disease at any later date, however remote, are service-connected, unless clearly attributable to intercurrent causes. If a condition noted during service is not shown to be chronic, then generally, a showing of continuity of symptoms after service is required for service connection. 38 C.F.R. § 3.303(b). Service connection may be granted for any disease diagnosed after discharge when all the evidence, including that pertinent to service, establishes that the disease was incurred in service. 38 C.F.R.
§ 3.303(d).

In addition, certain chronic diseases, including arthritis, may be presumed to have been incurred or aggravated during service if they become disabling to a compensable degree within one year of separation from active duty. 38 U.S.C.A. §§ 1101, 1112, 1137 (West 2002 & Supp. 2011); 38 C.F.R. §§ 3.307, 3.309. This presumption is rebuttable by affirmative evidence to the contrary. 38 U.S.C.A.
§ 1113 (West 2002).

A veteran is considered to have been in sound condition when examined, accepted and enrolled for service, except as to defects, infirmities, or disorders noted at entrance into service, except where clear and unmistakable evidence demonstrates that an injury or disease existed before acceptance and enrollment and was not aggravated by such service. 38 U.S.C.A. § 1111. Thus, veterans are presumed to have entered

service in sound condition as to their health.

This presumption attaches only where there has been an induction examination in which the later complained-of disability was not detected. See Bagby v. Derwinski, 1 Vet. App. 225, 227 (1991). The regulation provides expressly that the term "noted" denotes "[o]nly such conditions as are recorded in examination reports,"
38 C.F.R. § 3.304(b), and that "[h]istory of pre-service existence of conditions recorded at the time of examination does not constitute a notation of such conditions." Id. at (b)(1).

A preexisting injury or disease will be considered to have been aggravated by active service where there is an increase in disability during such service, unless there is a specific finding that the increase in disability is due to the natural progress of the disease. 38 U.S.C.A. § 1153; 38 C.F.R. § 3.306; Wagner v. Principi, 370 F.3d 1089, 1096 (Fed. Cir. 2004).

If a disorder was not "noted" on entering service, the government must show clear and unmistakable evidence of both a preexisting condition and a lack of in-service aggravation to overcome the presumption of soundness. A lack of aggravation may be shown by establishing that there was no increase in disability during service or that any "increase in disability [was] due to the natural progress of the preexisting condition." 38 U.S.C.A. § 1111; 38 C.F.R. § 3.306; Wagner, 370 F.3d 1089, 1096 (Fed. Cir. 2004). If the government fails to rebut the presumption of soundness, the claim is one for service connection, not aggravation. Wagner, 370 F.3d at 1097.

In explaining the meaning of an increase in disability, the Court has held that "temporary or intermittent flare-ups during service of a preexisting injury or disease are not sufficient to be considered "aggravation in service" unless the underlying condition, as contrasted to symptoms, is worsened." Hunt v. Derwinski, 1 Vet. App. 292, 297 (1992); see also Davis v. Principi, 276 F.3d 1341, 1346 (Fed. Cir. 2002) (explaining that, for non-combat veterans, a temporary worsening of symptoms due to flare ups is not evidence of an increase in disability). However, the increase need not be so severe as to warrant compensation. Browder v. Derwinski, 1 Vet. App. 204, 207 (1991).

Of note is that the burdens and evidentiary standard to determine whether conditions noted at entrance into service were aggravated by service are different than the burdens and evidentiary standard to determine whether conditions not noted at entrance into service were aggravated. If a preexisting condition noted at entrance into service is not shown to have as likely as not increased in severity during service, the analysis stops. Only if such condition is shown by an as likely as not standard to have increased in severity during service does the analysis continue. In such cases, the increase is presumed to have been due to service unless there is clear and unmistakable evidence that the increase during service was not beyond the natural progression of the condition. See 38 U.S.C.A. § 1153; 38 C.F.R. § 3.306.

In rendering a decision on appeal the Board must also analyze the credibility and probative value of the evidence, account for the evidence which it finds to be persuasive or unpersuasive, and provide the reasons for its rejection of any material evidence favorable to the claimant. Gabrielson v. Brown, 7 Vet. App. 36, 39-40 (1994); Gilbert v. Derwinski, 1 Vet. App. 49, 57 (1990). Competency of evidence differs from weight and credibility. Competency is a legal concept determining whether testimony may be heard and considered by the trier of fact, while credibility is a factual determination going to the probative value of the evidence to be made after the evidence has been admitted. Rucker v. Brown, 10 Vet. App. 67, 74 (1997); Layno v. Brown, 6 Vet. App. 465, 469 (1994); see also Cartright v. Derwinski, 2 Vet. App. 24, 25 (1991) ("although interest may affect the credibility of testimony, it does not affect competency to testify").

The Board is charged with the duty to assess the credibility and weight given to evidence. Wensch v. Principi, 15 Vet. App. 362, 367 (2001); Wood v. Derwinski,
1 Vet. App. 190, 193 (1991). In weighing credibility, VA may consider interest, bias, inconsistent statements, bad character, internal inconsistency, facial plausibility, self interest, consistency with other evidence of record, malingering, desire for monetary gain, and demeanor of the witness. Caluza v. Brown,

7 Vet. App. 498 (1995). The Board may weigh the absence of contemporaneous medical evidence against the lay evidence in determining credibility, but the Board cannot determine that lay evidence lacks credibility merely because it is unaccompanied by contemporaneous medical evidence. Buchanan v. Nicholson, 451 F.3d 1331 (Fed. Cir. 2006).

Generally, the degree of probative value which may be attributed to a medical opinion issued by a VA or private treatment provider takes into account such factors as its thoroughness and degree of detail, and whether there was review of the veteran's claims file. See Prejean v. West, 13 Vet. App. 444, 448-9 (2000). Also significant is whether the examining medical provider had a sufficiently clear and well-reasoned rationale, as well as a basis in objective supporting clinical data.
See Bloom v. West, 12 Vet. App. 185, 187 (1999); Hernandez-Toyens v. West,
11 Vet. App. 379, 382 (1998); see also Claiborne v. Nicholson, 19 Vet. App. 181, 186 (2005) (rejecting medical opinions that did not indicate whether the physicians actually examined the veteran, did not provide the extent of any examination, and did not provide any supporting clinical data). The Court has held that a bare conclusion, even one reached by a health care professional, is not probative without a factual predicate in the record. Miller v. West, 11 Vet. App. 345, 348 (1998).

Medical evidence that is speculative, general or inconclusive in nature cannot support a claim. See Obert v. Brown, 5 Vet. App. 30, 33 (1993); see also Beausoleil v. Brown, 8 Vet. App. 459, 463 (1996); Libertine v. Brown, 9 Vet. App. 521, 523 (1996). A physician's statement framed in terms such as "may" or "could" is not probative. See Warren v. Brown, 6 Vet. App. 4, 6 (1993).

A significant factor to be considered for any opinion is the accuracy of the factual predicate, regardless of whether the information supporting the opinion is obtained by review of medical records or lay reports of injury, symptoms and/or treatment. See Harris v. West, 203 F.3d 1347, 1350-51 (Fed. Cir. 2000) (examiner opinion based on accurate lay history deemed competent medical evidence in support of the claim); Kowalski v. Nicholson, 19 Vet. App. 171, 177 (2005) (holding that a medical opinion cannot be disregarded solely on the rationale that the medical opinion was based on history given by the veteran); Reonal v. Brown, 5 Vet. App. 458, 461 (1993) (holding that the Board may reject a medical opinion based on an inaccurate factual basis).

At the outset, it is noted that the Board has reviewed all of the evidence in the Veteran's claims file. Although the Board has an obligation to provide reasons and bases supporting this decision, there is no need to discuss, in detail, the extensive evidence of record. Indeed, the United States Court of Appeals for the Federal Circuit (Federal Circuit) has held that the Board must review the entire record, but does not have to discuss each piece of evidence. Gonzalez v. West, 218 F.3d 1378, 1380-81 (Fed. Cir. 2000). Therefore, the Board will summarize the relevant evidence where appropriate.

The Veteran alleges that his left knee was sound at service entrance, that he injured his left knee in service falling down a flight of stairs, and that his current left knee disability is directly related to his in-service fall.

A left knee disability was not "noted" at service entrance. An October 1969 enlistment examination shows that an examination of the lower extremities was normal at entrance. A small left knee scar was noted at both entrance and discharge. There was no indication of any problems or complaints relating to a left knee disability at the time of service-entrance; therefore, the presumption of soundness, with regard to a left knee disability, at service entrance attached. See
38 U.S.C.A. § 1111.

The Board finds that the evidence does not show, clearly and unmistakably, that a left knee disability both preexisted and was not aggravated by service. The claims file includes preservice treatment records from the Kenner Army Hospital dated in the 1960s. Although the specific date is not clear on the emergency clinic note, this preservice note shows that the Veteran was seen for a laceration of the left knee and shows that the left knee was sutured. No further treatment was indicated. The Veteran has provided lay testimony

and statements, as well as statements from his father, indicating that he fell while running after his sister on a bike, and was treated for a laceration to the knee at age 12 or 14. He indicated that he did not fracture his knee during this incident and that his knee had healed. The Board finds that the Veteran is competent to describe his preservice treatment, and the Board finds that these statements are credible as they are consistent with objective findings shown by contemporaneous treatment records.

Service treatment records show that the Veteran was seen in August 1970 for pain in the left patella. An August 1970 clinical note states that x-rays revealed an apparent old patellar fracture with no obvious new fracture; however, post-service VA x-rays dated in July 1971 did not reflect a fracture of the left knee, but instead diagnosed the Veteran with bipartite patella. A December 1975 VA treatment reports reflect conflicting diagnoses of an old fracture of the patella versus bipartite patella, and bipartite patella without fracture. March 1977 x-rays reflect bipartite patella.

The Board finds that evidence of preservice treatment for a left knee laceration and an "old patellar fracture" noted in service treatment records are not sufficient to rebut the presumption of soundness. In that regard, the Board notes that a history of pre-service existence of a condition is not sufficient to rebut the presumption of soundness. See 38 C.F.R. § 3.304(b)(1). A patellar fracture is not shown to have been diagnosed or treated prior to service, and it is not clear, based on post-service x-ray findings that the Veteran had conclusive evidence of an old patellar fracture. There is no clinical evidence of a preexisting chronic left knee disability prior to service. A left knee disability, including relevant findings or complaints, was not noted at the time of entrance onto active duty. For these reasons, the Board finds that evidence of a preservice left knee injury and an old patellar fracture does not constitute clear and unmistakable evidence showing that a left knee disability preexisted service.

The Board finds that the December 2011 Veterans Health Administration (VHA) opinion does not amount to clear and unmistakeable evidence sufficient to rebut the presumption of soundness. The VHA examiner opines that bipartite patella existed prior to service, was not "significantly" aggravated by service, and that the progression of the knee disease was not related to service. See Bagby v. Derwinski, 1 Vet. App. 225, 227 (1991). While the VHA examiner based his opinion on information available in the claims file, he did not provide a clear statement of reasons and bases for explaining why he determined that bipartite patella existed prior to service. He opined that a left knee disorder was not significantly aggravated in service. The VHA examiner also opined that the progression of the knee disease was not related to service, reasoning that the available information did not document an aggravation or injury that occurred in service. The Board finds that the VHA opinion is conclusory, and the Board finds that the VHA examiner did not adequately state the reasons and bases for the opinions rendered. See Nieves-Rodriguez v. Peake, 22 Vet.App. 295, 304 (2008) ("[i]t is the fully articulated, sound reasoning for the conclusion . . . that contributes probative value to a medical opinion.").

Additionally, the Board finds that the opinion, stating that the left knee disorder was not significantly aggravated in service, does not rise to the level of clear and mistakable evidence. In its recent decision in Horn v. Shinseki, No. 10-0853, 2012 WL 2355544 (Vet. App. June. 21, 2012), the Court emphasized that concerns for articulated, sound reasoning for a medical conclusion are "at their zenith" when VA attempts to carry its burden of rebutting either prong of the presumption of soundness by clear and unmistakable evidence. Horn, No. 10-0853, 2012 WL 2355544, citing to Nieves-Rodriguez v. Peake, 22 Vet.App. 295 (2008). For these reasons, the Board finds that the evidence does not show, clearly and unmistakably, that a left knee disability was both preexisting and not aggravated by service.

Because the evidence does not show, clearly and unmistakably, that a left knee disability both preexisted service and was aggravated therein; the Board will next determine if a currently diagnosed left knee disability was incurred in service.

After reviewing all the lay and medical evidence, including the Veteran's statements and testimony, the Board finds that the evidence in support of the claim for service connection for a left knee disability is in equipoise. The Veteran has provided lay statements and testimony describing an in-service fall which

occurred in August 1970. He has consistently reported having left knee pain since his fall in 1970 during the course of his VA and private treatment. The Veteran contends that he was pushed down a flight of stairs in service and injured his knee in this incident. The Veteran is competent to describe an injury to the left knee in service

However, the Board finds, due to inconsistencies in the Veteran's statements with findings in the service treatment records, that he is not credible in describing the nature of his in-service injury. In that regard, service treatment records show that the Veteran was seen for sick call with a complaint of pain in the left patella; however, no specific trauma or injury was noted in conjunction with this complaint; a fall down the stairs was not noted. Approximately one month later, in September 1970, the Veteran was seen for pain in the lower left arm at the wrist due to a fall down stairs. He was sent to the 3rd Hospital Company for x-rays that same day to rule out a fracture of the left wrist. The 3rd Hospital Company note also shows that the Veteran had fallen down a flight of stairs. During a June 2011 Board hearing, Veteran testified that he injured his knee falling down the steps, but that it was not in the record. He stated that the only thing it showed when he fell down the steps, was his wrist, but reported that the date of his wrist injury was "mixed up" because it showed a later date. On further questioning, the Veteran indicated that there was a separate fall, where he injured his wrist.

The Board finds that a date mix-up is unlikely given that service treatment records include two separate notations of a September 1970 fall. Additionally, service treatment records reflect chronological treatment for other complaints between the claimed August 1970 knee injury and the September 1970 fall down the stairs. Only in later statements does the Veteran contend that he fell multiple times in service. In light of the inconsistencies in the record, the Board finds, in these later statements, that self-interest is likely to be a factor weighing against the credibility to the Veteran's report. See Caluza v. Brown, 7 Vet. App. 498 (1995); Cartwright v. Derwinski, 2 Vet. App. 24 (1991). For these reasons, the Board finds that the Veteran's lay statements regarding the specific nature of his knee injury are not credible, and greater probative weight has been afforded to objective evidence of record.

The Board finds, nonetheless, that the evidence does show that the Veteran was seen for the onset of left knee pain in service. The Veteran was seen for left knee symptoms three months prior to his separation from service. Service treatment records show that the Veteran was seen in August 1970 for swelling and pain in the left patella. X-rays revealed an apparent old patellar fracture was noted at that time.

The Veteran had chronic left knee symptoms since his separation from service. A July 1971 VA examination, completed within one year of separation from service, shows that the Veteran complained of left knee pain with running. X-rays taken at that time showed a slight separation of the small fragment of the patella at the proximal anterolateral margin. This was most likely a bipartite patella. There also appeared to be a small cystic lesion slightly below the knee. No bone or joint abnormality was seen.

VA and private treatment records show that the Veteran had continuous left knee symptoms since his separation from service, as well as continuous treatment for the left knee. A December 1975 note shows that the Veteran had tenderness across the joint of the left knee, pain, and patellar grinding. X-rays revealed either an old fracture of the patella or bipartite patella. The Veteran was referred for knee surgery in February 1976. A September 1978 treatment report from Dr. T.L. shows that the Veteran had reported knee pain since an in-service fall. Since that time, he had recurrent symptoms of fluid in the knee, occasional locking, and giving way of the knee. No particular abnormality was found on x-rays. The Veteran's symptoms persisted and it was felt that an arthroscopy would give a definitive diagnosis. He developed a secondary knee infection, most likely from the arthroscopic procedure. At the time of the arthroscopy, no definitive diagnosis could be made. The Veteran was noted, however, to have a markedly hypertrophic fat pad with adhesions in the anterior aspect of the knee joint, and it was felt that the Veteran may have a fat pad syndrome.

Arthritis did not manifest within one year of the Veteran's separation from service. VA x-rays dated in 1984 reflect degenerative changes in the left knee. A diagnosis of arthritis was not shown in x-rays taken shortly

after the Veteran's separation from service.

VA treatment records dated from 1989 to 2009 show that the Veteran continued to receive treatment for left knee complaints, and reflect a current diagnosis of left knee, status post total arthroplasty, and degenerative arthritis.

The Board finds that the favorable and unfavorable medical opinion evidence that is of record is in equipoise. In a September 1978 treatment report and a January 1979 letter, Dr. T.L. opined that it was possible if not probable that the Veteran's fat pad syndrome had its onset at the time of his original knee injury in service. In a December 1984 opinion, Dr. T.L. found that the Veteran's degenerative changes in the knee probably correlate to his original injury.

In a September 2006 opinion, Dr. C.J. indicated that he reviewed the service treatment records. He noted the Veteran's childhood injury, but found that the Veteran was asymptomatic when he entered service. The Veteran was noted to have an injury in 1970, and did well following that with sporadic pain. He stated, given this history, he could see why the Veteran considered that the results were from the injury in the military rather than a previous injury as there was an asymptomatic interval between the two injuries.

A December 2009 opinion from a VA orthopedic surgeon reflects the opinion that it was as likely as not that a portion of the Veteran's pain was indeed service-connected and that it was as likely as not that his knee degeneration may be related to service-connected injury.

Finally, in April 2012, Dr. C.B. opined, to at least a 90 percent level of probability, that the Veteran's left knee problems were due to experiences and trauma that he had during service. Dr. C.B. specifically noted relevant findings from a history taken by Dr. T.L., and provided information on fat pad impingement. He noted that that the Veteran's arthritis prior to surgery was out of proportion to his age without antecedent trauma, and noted the Veteran's chronicity of symptomatology in making his determination.

Unfavorable medical opinion evidence includes a December 2011 VHA opinion. The VHA examiner alternately opined, based on a review of the evidence of record, that the progression of the knee disease was not related to service, reasoning that the available information did not document an aggravation or injury that occurred in service.

The probative value of medical opinion evidence is based on the medical expert's personal examination of the patient, the physician's knowledge and skill in analyzing the data, and the medical conclusion the physician reaches. Guerrieri v. Brown, 4 Vet. App. 467, 470 (1993). The credibility and weight to be attached to these opinions is within the province of the Board. Id.

The Board finds that opinions from a VA orthopedic surgeon and Dr. C.B. provide probative evidence showing that the Veteran's current left knee disability is etiologically related to service versus a December 2011 VHA opinion which shows that the progression of the Veteran's left knee was not related to service. While opinions from a VA orthopedic surgeon and Dr. C.B. are based, in part on a history of injury related by the Veteran, the reliance on this factual background is not dispositive in this case as these opinions were also based on a review of the claims file and accurately noted pertinent findings in service. Earlier opinions from
Dr. T.L. did not include a review of relevant evidence of record, and an opinion from Dr. C.J. is too speculative to provide sufficient evidence of a nexus or relationship when considered on its own. See 38 C.F.R. § 3.102; Obert v. Brown,
5 Vet. App. 30, 33 (1993); Tirpak v. Derwinski, 2 Vet. App. 609, 611 (1992).

The Board finds, however, that these opinions do lend further support to Veteran's claim. The Board finds that the VHA opinion is less probative in this case, as it did not include an adequate statement of reasons and bases for the opinions rendered. For these reasons, and resolving reasonable doubt in the Veteran's favor, the Board finds that a left knee disability is related to service.

[redacted]

The Veteran was treated for left knee complaints in service, had continuous left knee symptoms since his separation from service, and medical evidence of record relates a current left knee disability to service. For these reasons, and resolving reasonable doubt in the Veteran's favor, the Board finds that service connection for a left knee disability, currently diagnosed as left knee arthritis, status post total arthroscopy, is warranted. 38 U.S.C.A. § 5107(b); 38 C.F.R. § 3.102.

ORDER

New and material evidence having been received, service connection for a left knee disability is reopened.

Service connection for left knee arthritis, status post total arthroscopy, is granted.

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J. PARKER
Veterans Law Judge, Board of Veterans' Appeals

Department of Veterans Affairs