RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: ARMY

CASE NUMBER: PD0900229 BOARD DATE: 20091001

SEPARATION DATE: 20070501

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SUMMARY OF CASE: This covered individual (CI) was a Guard NCO medically separated from the Army in 2007 after >20 years of combined service. The medical basis for the separation was a back condition and a psychiatric condition. The back injury dated to a service-connected injury in 2002 and a later MRI demonstrated L4/5 disc disease. The condition worsened over time and the CI declined surgical options. By 2007, he was unable to perform the duties of his MOS, was placed on a permanent profile and referred for a MEB. During the MEB, the CI was also evaluated for a psychiatric condition, which he dated to a 2003 deployment. His Guard unit was deployed to Jordan for 4 months in support of OIF in 2003. He received Axis I diagnoses of PTSD and Major Depressive Disorder by the MEB psychiatrist, and both were considered to be medically unacceptable. The combat stressors for the PTSD diagnosis were subsequently refuted by his Commanding Officer, and the PEB accepted only the depression as an unfitting ratable condition. The back condition was forwarded from the MEB as medically unacceptable and found unfitting by the PEB as well. There were two other conditions (noted on the rating chart below) forwarded as medically acceptable on the MEB’s DA 3947 and adjudicated as not unfitting by the PEB. The CI was medically separated at a combined rating of 20% for the back condition and depression.

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CI CONTENTION: The CI applies for PDBR review, stating that his case was adjudicated under AR 635-40 instead of the VASRD.

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RATING COMPARISON:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Service PEB** | | | | | **VA (Concurrent with Separation)** | | | | |
| **Condition** | | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| CHRONIC LOW BACK PAIN DUE TO DEGENERATIVE DISC DISEASE… | | 5243 | 10% | 20070329 | CHRONIC LOW BACK PAIN DUE TO DEGENERATIVE DISC DISEASE… | 5243 | 20% | MEB Exam | 20031124  (Post- Deployment) |
| MAJOR DEPRESSIVE DISORDER… | | 9434 | 10% | 20070329 | MAJOR DEPRESSIVE DISORDER AND PTSD | 9411-9434 | 50% | MEB Exam & outpatient records 2004-2007 | 20031124 |
| PTSD | Not Unfitting.  Not appropriate for rating. | | | 20070329 |
| GERD | | FIT | | 20070329 | IRRITABLE BOWEL … | NSC | | | 20070602 |
| EKG ABNORMALITY | | FIT | | 20070329 | NOT CODED ON INITIAL VARD | | | | 20070602 |
| NO ADDITIONAL DA 3947 ENTRIES. | | | | | NON-PEB X 3 | | |  | 20031124 |
| **TOTAL Combined: 20%** | | | | | **TOTAL Combined (*Includes Non-PEB Conditions*): 60%** | | | | |

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ANALYSIS SUMMARY:

Back Condition. The VA did not conduct an independent rating exam at the time of the CI’s separation, but relied on the MEB findings. Both the PEB (10%) and VA (20%) ratings were derived from the same goniometric exam. This is the one described in the NARSUM and was quoted in the VA rating decision. An error was discovered in the NARSUM, however. It quoted ‘flexion’ of 45⁰, and that was the value used by the VA rater to justify the 20% rating conferred. The range-of-motion (ROM) measurements quoted in the NARSUM were derived from a Physical Therapy (PT) exam performed a month earlier (referenced specifically in the NARSUM). The source PT exam clearly documented flexion of 65⁰. Nowhere in the medical record was the 45⁰ measurement, or any other formal ROM measurements, in evidence. The remaining ROM values from the PT exam were accurately transcribed to the NARSUM, and there was even a redundant entry of ‘forward bending’ of 65⁰ noted as well. Total ROM was 165⁰. The measurements were annotated as ‘discomfort at end of range’, implying that painful motion was not disregarded in deriving the measurements. There was paraspinal tenderness, but no abnormal gait or contour, documented. This exam is consistent with a 10% rating IAW the VASRD general rating formula for the spine. The language of the PEB adjudication would invoke the USAPDA pain policy (possibly reflecting a PEB assumption regarding the mistaken NARSUM entry), but this would not have influenced the rating decision. The 10% rating was fair, therefore, and the VA rating is in error as noted above. A recommendation of no recharacterization of the PEB’s adjudication for the back condition is therefore indicated.

Psychiatric Condition. The key issue of the case regarding the psychiatric condition is evaluation of the PEB decision to deny a rating for PTSD. The CI had, in fact, been evaluated and followed by the VA as a PTSD outpatient since the 2003 deployment. The psychiatric rating examination performed by the VA on November 2, 2004 stated that the CI ‘said he was in combat, received sniper fire and then had to shoot back'. He reported all of the typical symptoms of PTSD, including nightmares, hypervigilance, trouble with crowds and people and exaggerated startle response. These same symptoms were elaborated throughout his VA outpatient group therapy and were endorsed in the MEB psychiatric addendum. Combat experiences were referred to in PTSD group therapy notes. A VA psychiatric intake note on April 27, 2005 quoted ‘combat in Iraq War’. His MEB psychiatric addendum states, ‘he and his unit were exposed to gunfire as well as unpredictable explosions’. This statement was quoted verbatim in the VA rating decision of June 2, 2007. Another deployment stressor related consistently in the CI’s PTSD clinical evaluations was exposure to a fellow soldier in psychiatric crisis threatening to kill members of the unit.

In frank contradiction to all of the CI’s self-reported traumatic experiences was a sworn statement from CPT Anthony D. Ford on December 15, 2006 (2 weeks *after* the MEB psychiatric evaluation). CPT Ford was the CI’s unit Commander for the 4 month deployment to Prince Hasan Air Base in Jordan. The statement is witnessed and sworn on DA Form 2823. It was not noted in evidence for subsequent VA rating decisions, which list only the MEB, PEB and NARSUM as source documents. The Commander states unambiguously that the CI remained on the air base, and the closest combat activity was ‘well over 100 miles from our compound’. The base ‘was not under any direct or indirect fire’. Regarding the incident with the psychiatric casualty, CPT Ford states that the soldier’s ‘threat was to the doctor and never to the soldiers of the unit’. He further states, ‘the only personnel who were aware of the threat were myself, the 1SG and the psychiatrist’, and the soldier was evacuated within 2 days. CPT Ford elaborated his belief that the unit only became aware of the situation when the affected soldier visited the armory after the Company’s return home. Supporting his history of the incident, the CI forwarded 5 hand-written statements from peers (one possibly his wife). All were dated January 7, 2007 and worded equivalently. They were 1-2 sentence statements that the individuals ‘felt threatened’ by the soldier’s remarks ‘that he was going to kill everyone in the company’, implying that this was common knowledge at the time. There is no evidence or statement that any unit member was ever physically vulnerable to the verbal threats, and CPT Ford expressed the opinion that the CI was never ‘under any threat of bodily harm’.

It is exceedingly unlikely that the CI’s Commander would convey false, inaccurate or even misleading statements in such a formal venue. Much more likely than not, the CI did *not* experience any DSM IV, Criterion A traumatic experiences prerequisite to the diagnosis of PTSD. The probative value of the MEB and VA psychiatric opinions is significantly undermined by the compromised history. Furthermore, the probative value of all of the CI’s stated psychiatric history is adversely affected. It is more likely than not, for example, that many of the ‘textbook’ PTSD symptoms were either not present at all or greatly exaggerated. Most are fairly unique to PTSD and dependent on traumatizing events. What were the traumatic memories underlying the reported nightmares and intrusive thoughts? What threats conditioned the reported hypervigilance and exaggerated startle reflex? Ideally, the PEB (and the VA) would have had the CI’s case re-evaluated after the PTSD history was contradicted. It was reasonable, however, for the PEB to dismiss PTSD as a ratable condition and rate only the second diagnosis of Major Depressive Disorder (MDD). MDD is likewise accepted as the only ratable condition by the Board, and VASRD §4.129 does not apply. Furthermore, the rating of the CI’s psychiatric illness should reflect the compromised probative value of PTSD-dependent symptoms.

The PEB rating for MDD invoked language consistent with DoDI 1332.39, quoting the ‘mild’ social and industrial impairment noted in the psychiatric addendum. The Commander’s letter, noting a six year affiliation of the CI with the unit, stated that he was working outside of his primary MOS. It enumerated the physical requirements of the MOS and his physical limitations. It made no mention of any psychiatric impairment or poor general performance in assigned duties. The PEB 10% rating, per the DoDI, was accurate. The Board must, of course, recommend a rating IAW VASRD §4.130. The VA rating decision (VARD) at the time of separation quoted the §4.130 criteria, but did not elaborate specific criteria met for the 50% rating which was granted. The VARD emphasized the PTSD history and symptoms. It referenced a letter from the CI’s staff psychologist which was exclusively committed to PTSD symptomology and its impact on occupational and social function. For MDD, the VARD simply noted ‘problems with decreased interest, poor concentration, depression and hopelessness’. It is well documented in the VA record that the CI has held full time employment as a corrections officer from his post-deployment outpatient treatment through to his most recent rating decision (April 3, 2008). Other than a comment documented from a group therapy note on September 5, 2007 that he ‘felt picked on at work’, there is no reference in numerous entries of any work-related issues. The ability to function consistently in a relatively stressful occupation is not consistent with the VA’s 50% rating. The rating would appear to rely on the stated severity of PTSD symptoms. The most prudent course for the Board, given the weakened probative value of subjective symptoms, is to recommend a rating based on objective information. The CI’s domestic and social life was likely affected by the depressive symptoms, and his insomnia is not necessarily dismissed by mitigating PTSD. It is clear from the record that his marriage has remained intact, however, and any estimation of social impairment in this case is too speculative for influencing the Board rating recommendation. It is clear that the CI requires continuous medication, and it is unknown if work efficiency is impaired during stress. This meets the threshold for a 10% rating under §4.130. The existence of ‘decrease in work efficiency and intermittent periods of inability to perform occupational tasks’, required for 30% rating, is dubious. All evidence considered, there is not reasonable doubt in the CI’s favor to support recommendation for a 30% or higher rating by the Board. A recommendation of no recharacterization of the PEB’s adjudication for MDD is therefore indicated.

Other Conditions. Regarding the other DA 3947 entries, the CI was on no medication for his gastric reflux condition and there are no records connoting any clinical significance at the time of separation. The ‘EKG abnormality’ referred to some non-specific changes which are common and of no significance without chest pain or active symptoms. Neither condition was service-connected by the VA. The CI had various service connected conditions rated by the VA, but the only compensable one was tinnitus which is not a candidate for consideration as unfit. The Board, therefore, has no reasonable basis for recommending any additional unfitting conditions for separation rating.

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BOARD FINDINGS: IAW DoDI 6040.44, provisions of DoD or Military Department regulations or guidelines relied upon by the PEB will not be considered by the PDBR to the extent they were inconsistent with the VASRD in effect at the time of the adjudication. As discussed above, PEB reliance on the USAPDA pain policy for rating the back condition was apparent in this case and the condition was adjudicated independently of that policy by this Board. Also as discussed above, PEB reliance on DoDI 1332.39 for rating major depressive disorder was apparent in this case and the condition was adjudicated independently of that instruction by this Board. In the matter of the low back pain condition, the Board unanimously recommends no recharacterization of the PEB coding or rating IAW VASRD §4.71a. In the matter of the psychiatric condition, the Board recommends no recharacterization of the PEB coding or rating IAW VASRD §4.130. In the matter of the reflux condition, EKG abnormality and all of the CI’s other medical conditions; the Board does not recommend a finding of unfit for additional rating at separation.

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RECOMMENDATION: The Board therefore recommends that there be no recharacterization of the CI’s disability and separation determination.

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090313, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

