RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: ARMY

CASE NUMBER: PD0900252 BOARD DATE: 20091001

SEPARATION DATE: 20071121

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SUMMARY OF CASE: This covered individual (CI) was an active duty SPC medically separated from the Army in 2007 after 3 years of service. The medical basis for the separation was post-concussion syndrome and mood disorder due to traumatic brain injury (TBI), as well as a neck condition. He suffered closed head trauma in November, 2006 from a 10 foot fall associated with combat operations (no enemy engagement) in Iraq. There was loss of consciousness for several minutes. He suffered headaches and visual disturbance afterwards, and was subsequently medevac’d from theater. He continued to suffer significant headaches, and underwent further neurological evaluation which included a normal MRI. In April, 2007 he presented to the outpatient mental health service complaining of insomnia and ‘visual illusions’ (talking to fellow soldiers from Iraq during the night). In June, 2007 he was admitted to a network civilian hospital after a suicide attempt (superficial wrist cutting). He was discharged from that admission with a diagnosis of PTSD and possible bipolar disorder. The CI’s neck condition resulted from a motor vehicle accident (rear-ended) in February, 2007. He suffered continued neck pain which did not respond adequately to conservative management. The MEB psychiatrist did not believe the CI’s diagnosis to be PTSD, but a mood disorder associated with TBI. The mood disorder was noted as a separate medically unacceptable condition on the MEB 3947. The post-concussive syndrome, including headache and tinnitus, was deemed to be medically unacceptable, as was the neck condition. The NARSUM noted an additional left knee condition, forwarded as medically acceptable on the DA 3947. The PEB combined post-concussive syndrome, mood disorder, headache and tinnitus as a single unfitting condition due to TBI. The cervical condition was adjudicated as unfitting; the knee was not. The CI was separated at 20% combined disability.

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CI CONTENTION: The CI’s application notes the disparity in the PEB and VA ratings and notes that the VA diagnosed PTSD, while the Army did not. He also cites the separate VA ratings for migraine and tinnitus, in addition to his knee condition. He contends for ‘a fair judgment of medical retirement’.

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RATING COMPARISON:

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| **Service PEB** | **VA (< 1 Mo. after Separation)** |
| **Condition** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| POSTCONCUSSION SYNDROME AND MOOD DISORDER DUE TO TRAUMATIC BRAIN INJURY WITH ASSOC. HEADACHES AND TINNITUS… | 8045-9304 | 10% | 20070924 | PTSD, MOOD DISORDER AND POSTCONCUSSION SYNDROME, RESIDUAL OF TBI | 8045-9411 | 100% | 20071207 | 20071122 |
| CHRONIC MIGRAINE HEADACHES, RESIDUAL OF TBI | 8045-8100 | 30% | 20071207 | 20071122 |
| TINNITUS | 6260 | 10% | 20071207 | 20071122 |
| CHRONIC NECK PAIN… | 5237 | 10% | 20070924 | CERVICALGIA… | 5237 | 10% | 20071207 | 20071122 |
| LEFT KNEE SPRAIN | NOT UNFITTING | 20070924 | PFS, LEFT KNEE | 5099-5019 | 10% | 20071207 | 20071122 |
| NO ADDITIONAL DA 3947 ENTRIES. | NON-PEB X 3 | 20071207 | 20071122 |
| **TOTAL Combined: 20%** | **TOTAL Combined (*Includes Non-PEB Conditions*): 100%**   |

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ANALYSIS SUMMARY:

Mood Disorder vs. PTSD. There is no question that there is a psychiatric component to the CI’s clinical picture, and all agree that the primary offender is TBI. A challenging issue for the Board was whether to accept the VA diagnosis of PTSD, which was not supported by the MEB clinical psychologist or psychiatrist. The civilian psychiatrist for the psychiatric admission opined diagnoses of PTSD and Bipolar Disorder, but the rationales were unconvincing. The VA psychiatric rating examiner made an Axis I diagnosis of ‘Mood disorder secondary to brain disorder with a secondary diagnosis of post traumatic stress disorder’. He did not elaborate the rationale for tagging a ‘secondary’ diagnosis of PTSD onto the TBI-induced mood disorder, but the fact that PTSD was not an independent Axis I diagnosis does detract from its diagnostic weight. In the VA, civilian and MEB exams, the CI consistently related only one Criterion A stressor for PTSD. This was the viewing of combat casualties in the theater hospital while awaiting medevac. It is hard to reconcile the magnitude of that stressor with the severity of reported symptoms, although it meets the DSM IV definition. This fact was part of the reason for the MEB psychiatrist’s opinion that a diagnosis of PTSD was not justified. There were also other mitigating factors which weaken the argument for attributing a diagnosis of PTSD. On his post-deployment health assessment, the CI responded negatively to all PTSD and psychiatric symptoms except nightmares. His symptoms arose 18 months after the OIF experience, during the MEB process for his TBI. His responses on all of the standardized validity tests were suggestive of exaggeration: ‘He endorsed many more symptoms than even a group of severely mentally ill inpatients.’ and ‘the patient answered questions in a way that would tend to magnify any mental symptoms’. The VA did not conduct validity testing or comment on the Army ones.

The psychiatric addendum summarizes with,

There is evidence that the patient is exaggerating his symptoms. Further, clinical judgment and reasoning do not support a diagnosis of Bipolar Disorder or PTSD, despite the patient's endorsement of PTSD symptoms on a checklist. If the patient has a true mental illness, the most likely correct diagnosis given the available information would be a mood disorder due to head injury.

The MEB psychiatric addendum, backed by supporting psychiatric opinion, provides an analytical foundation not evidenced in the civilian or VA opinions. They consequently carry more probative value and provide more clinically convincing rationales counter to the diagnosis of PTSD than the civilian and VA opinions provide support for it. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change in the PEB adjudication of the CI’s condition as a mood disorder rather than PTSD. The Board therefore supports retention of the PEB diagnosis of the psychiatric condition and does not favor application of VASRD §4.129 to this case.

Psychiatric Rating. Although the MEB DA 3947 forwarded the mood disorder as a separate condition from TBI (post-concussion syndrome, including headaches and tinnitus), the PEB added mood disorder to TBI as a single condition under the analogous 8045-9304 code. This approach, although consistent with the VASRD in effect at that time, is not congruent with the current requirement for the PDBR to adhere solely to the VA disability rating guidelines, IAW DoDI 6040.44 and the NDAA 2008. This implicitly includes adherence to any concurrent applicable disability rating policy changes issued via 'FAST' or Training Letters (in this case, TL 07-05, AUG 2007). By precedent and legal opinion, the Board is obligated to comply with the Training Letter and 'unbundle' the elements of TBI (previously rated collectively as post-concussion syndrome). This provides a fairer and more complete disability rating assessment, and is aligned with the mission of the Board. The VA approach was consistent with the FAST guidance, and the Board is similarly applying separate rating of mood disorder as a residual of TBI.

The VA rating of 100% under §4.130 is not elucidated at all by the rating decision. In May of 2008, a VA psychiatric note detailed that the CI had just finished a successful semester of college and was getting along with other students. That implies that his enrollment occurred shortly after separation. A query to the CI’s VA primary caretaker regarding employability reads, ‘vet seemed essentially stable on evaluation with no significant physical limitations noted. Therefore, in my opinion, physically I consider the vet not as likely as not completely unemployable at this time’. Presumably the examiner meant not...completely unemployable, and the rater may have drawn the opposite conclusion based on the awkward wording. Be that as it may, the VA rating in this case is not a reliable gauge for the Board rating recommendation. The CI’s functional status in the Army at the time of separation is fairly well elucidated in the record. The Commander’s letter detailed physical impairments only, although it mentioned ‘PTSD’. The PEB made a specific request of the psychiatrist to elucidate impairment, and received a detailed response. The following is excerpted.

The commander’s letter of 6 September 2007 states that the patient is able to remember locations, procedures, and instructions. He maintains an acceptable level of attention and concentration, and he communicates satisfactorily with others on work related matters. He is usually able to relate civilly to supervisors and other workers, and he can sustain an ordinary routine without special supervision. He is usually able to work with and near others, and he can make simple work related decisions. He is not able to perform without reasonable rest periods, due to his physical symptoms. He is able to ask questions and request help when appropriate, and he is able to respond appropriately to changes in the work setting. He is aware of normal hazards and precautions.

Based on this description, a 10% rating IAW §4.130 could be entertained. It is recalled, however, that 3 months prior to the status described above, the CI was a psychiatric inpatient with active suicidal ideation. This would imply that the CI’s symptoms were not ‘transient’ and not completely ‘controlled by continuous medication’. The disability picture at separation was more in line with the 30% characterization per §4.130, and the CI manifested most of the ‘due to’ descriptors elaborated under that rating. The description above is less compatible with the 50% characterization and the CI manifested few of the ‘due to’ descriptors for that rating. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a higher rating, and the Board recommends 30% as a fair rating for the CI’s psychiatric disability at the time of separation.

TBI and Headache. Once the mood disorder component is removed from the TBI rating, the only ratable conditions remaining are headache and tinnitus. One might justify a 30% rating for headache as a separate condition (with liberal interpretation of ‘prostrating’) as did the VA. However, that would leave only tinnitus under TBI. Tinnitus, although not forwarded as such on the DA 3947, was identified in the NARSUM as a separate medically acceptable condition. It would not meet the unfitting threshold as a stand-alone manifestation of TBI for rating at separation. It is not reasonable to eliminate TBI as a condition altogether, since it was specified by the PEB as an unfitting condition and is the unifying pathology in this case. If headache is removed from its rating, there is no substance left to the condition. ‘Post-Concussion Syndrome’ is meaningless without symptoms, since syndrome is defined as a symptom complex. Without cognitive testing and the 2008 TBI rating scheme, despite application of the FAST letter, there is no clinically reasonable approach to rating TBI independently of headache in this case. The most reasonable Board recommendation, therefore, is that headache be incorporated in the single condition of TBI as described and coded by the PEB (excluding mood disorder). This yields a rating of 10% and, combined with the additional psychiatric rating, does fairly represent the CI’s overall disability picture at separation.

Cervical Condition. The MEB goniometric exam, specifying pain as end-point, yielded 35⁰ flexion (275⁰ total). The VA exam, specifying onset of pain, yielded 40⁰ flexion (340⁰ total). Both exams are consistent with a §4.71a rating of 10%. There is no foundation for a Board recommendation contrary to this rating.

Knee and Other Conditions. The record indicates that the CI had undergone arthroscopic surgery of his left knee in the past, but there are no entries regarding any active complaints during the MEB period. Knee impairment was not noted in the Commander’s letter. The medical profile was L1, and the MEB deemed the condition as medically acceptable. The Board, therefore, has no rationale for recommending recharacterization of the PEB’s fitness determination for the left knee condition. The only additional compensable condition noted by the VA was lumbar strain. There is no evidence of back pain as an active condition at the time of separation. 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, some Board recommendations in this case are IAW application of TL 07-05, AUG 2007 to rating under VASRD code 8045, §4.124a, prior to the VASRD revision for TBI in 2008. In the matter of the mood disorder as a residual of TBI, the Board unanimously recommends that it be added as an additionally unfitting condition for separation rating, coded 8045-8435. By a 2:1 vote, the Board recommends a 30% rating for the mood disorder IAW VASRD §4.130. The single voter for dissent (who recommended a 50% rating) did not elect to submit a minority opinion. In the matter of post-concussive syndrome due to traumatic brain injury with associated headache and tinnitus, the Board unanimously recommends that there be no further separate rating applied. This constitutes a recommendation of no recharacterization of the coding and rating applied by the PEB, other than separate rating of the mood disorder as elaborated above. In the matter of the cervical condition, the Board unanimously recommends no recharacterization of the PEB coding or rating IAW VASRD §4.71a. In the matter of the left knee condition 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 recommends that the CI’s prior determination be modified as follows and that the discharge with severance pay be recharacterized to reflect permanent disability retirement, effective as of the date of his prior medical separation.

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| MOOD DISORDER DUE TO TRAUMATIC BRAIN INJURY | 8045-9435 | 30% |
| POST-CONCUSSION SYNDROME WITH ASSOCIATED HEADACHES AND TINNITUS DUE TO TRAUMATIC BRAIN INJURY | 8045-9304 | 10% |
| CHRONIC NECK PAIN | 5237 | 10% |
| **COMBINED** | **40%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090316, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

