RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: AIR FORCE

CASE NUMBER: PD0900273 BOARD DATE: 20100831

SEPARATION DATE: 20060313

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SUMMARY OF CASE: This covered individual (CI) was an ANG Capt/O-3 (92T, Pilot Trainee) medically separated from the Air Force in 2006 after 10 years of combined service. The medical basis for the separation was Post-Traumatic Stress Disorder (PTSD). His first history of psychiatric disorder occurred in 2002 during pilot training, soon after commissioning from a prior successful enlisted career. He was diagnosed with Acute Stress Disorder provoked by the behavior of a specific Instructor Pilot (IP), linked with a reported history of childhood sexual and physical abuse by his stepfather. He stated that the IP resembled his stepfather and inflicted emotional trauma which provoked memories of the previously repressed childhood trauma. The CI was deferred from the training and underwent a six month period of outpatient psychotherapy. His therapist deemed that he was able to resume the stress of military duty and he underwent a Medical Evaluation Board (MEB) in 2003. The MEB psychiatrist opined that the stress disorder was resolved, and the Physical Evaluation Board (PEB) found him fit. He was returned to duty and re-entered flight training in 2005. His symptoms resurfaced during the 2005 course. They were triggered by “abusive” IP’s and varied in severity based on teaching style. The CI self-reported as unfit to fly and was referred for further evaluation. This resulted in a diagnosis of PTSD, for which he was issued an S-4 profile and underwent a second MEB. An Informal PEB (IPEB) determined that the PTSD was unfitting but that it was EPTS (existed prior to service) on the basis of childhood origin. The CI appealed for a Formal PEB (FPEB) and an additional psychiatric opinion was obtained. This consultant opined that the diagnosis was service connected since there was no mental health condition or treatment until the flight training in 2002. The FPEB adjudicated the PTSD condition as service aggravated and unfitting, rated 10% IAW DoDI 1332.39 (E2.A1.5). No other conditions were forwarded to the PEB for adjudication. A back condition contended by the CI is discussed below. Additional conditions supported in the Disability Evaluation System (DES) file are discussed below, but were not forwarded on the MEB’s AF Form 518. The CI did not appeal the FPEB decision and was thus medically separated with a disability rating of 10%.

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CI CONTENTION: The CI’s application refers to an attached document from counsel which states, “Applicant requests correction of his military records to reflect that he was retired due to PTSD, rated at 50% and due to his back condition rated at 20%, for a combined rating of 60%.” The application additionally lists IBS (Inflammatory Bowel Syndrome) linked to PTSD and tinnitus as other VA conditions (each rated 10%). A contention for their inclusion in the separation rating is implied. As a matter of policy, all service conditions are reviewed by the Board for consideration as unfitting and ratable.

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RATING COMPARISON:

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| --- | --- | --- | --- | --- | --- | --- |
| **Service FPEB – Dated 20060130** | | | **VA (6 Mo. after Separation) – All Effective 20060314** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| PTSD | 9411 | 10% | PTSD | 9411 | 50% | 20060927 |
| ↓No Additional MEB Entries↓ | | | Lumbosacral Strain | 5237 | 20% | 20061020 |
| Tinnitus | 6260 | 10% | 20061020 |
| **Other X 1 / NSC X 2 / Deferred X 9\*** | | | 20061020 |
| **TOTAL Combined: 10%** | | | **TOTAL Combined: 60%** | | | |

\* IBS included in deferred conditions. See discussion (Other Conditions) below.

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ANALYSIS SUMMARY:

PTSD Rating. The PEB rating, as noted above, was derived from DoDI 1332.39 and preceded the promulgation of the National Defense Authorization Act (NDAA) 2008 mandate for DOD adherence to Veterans Administration Schedule for Rating Disabilities (VASRD) §4.129. IAW DoDI 6040.44 and DOD guidance (which applies current VASRD §4.129 to all Board cases), the Board is obligated to recommend a minimum 50% PTSD rating for a retroactive six month period of TDRL (Temporary Disability Retired List). The Board then determines the most appropriate fit with VASRD §4.130 criteria at six months for its permanent rating recommendation. The CI’s VA psychiatric rating examination was performed at this six month interval, but is subject to probative value concerns which will be discussed. The Board concedes the service aggravation link for PTSD to military service, and this case accordingly merits the Board’s recommendation for the six month retroactive application of §4.129 as above. The permanent rating recommendation, however, must be tempered by a host of mitigating issues to be discussed. The Board will remain adherent to §4.130 standards as the measure of disability for its permanent rating recommendation, but exercises its prerogative to judiciously scrutinize the probative value and applicability of the evidence to which the §4.130 criteria are applied.

The first issue confronted in this case is the contribution of EPTS factors to the etiology of the condition and subsequently to the degree of psychiatric impairment. Although it is clear that PTSD did not arise *de novo* from the Service stressors and would not be present without the EPTS childhood substrate, the IPEB’s EPTS determination was reasonably refuted by the inherent Service aggravation. It is noted that an Axis II diagnosis of personality disorder was made by the VA psychiatrist. This would also constitute unratable pathology, but it cannot be concluded with certainty nor separated from the overall psychiatric impairment.

The Board is wary however of the increasing degree of speculation required to assign all of the evolving psychiatric impairment in this case as a permanent Service disability rating. The evolution began as totally repressed childhood trauma surfacing for the first time as a psychiatric condition in response to emotional trauma connected with military service; i.e., a verbally and physically aggressive IP reminiscent of the childhood perpetrator. Typical symptoms for PTSD were not manifest at that time. The Axis I diagnosis of Acute Stress Disorder was judged by the first MEB psychiatrist to be “totally resolved” after six months of treatment. No psychopathology is in evidence for the next 18 months, until the emergence of PTSD-like symptoms precipitated by new Service stressors. The diagnosis of PTSD was derived from the link between the new and prior Service stressors; i.e., IP’s with a teaching style reminiscent of the more aggressive earlier instructor. The first IP was reported to have humiliated the CI before his peers, slammed his helmet against the cockpit canopy and subjected him to other abusive behaviors. No such incidents were documented in the second attempt at flight training. The CI stated that he fared well with IP’s who did not have a critical teaching style or threatening demeanor. Nevertheless at the time of the second MEB psychiatric evaluation, multiple symptoms were endorsed that were not associated with the initial Service stressor at the time it occurred. Per the second MEB examiner, the new symptoms included “feelings of intense fear, helplessness and terror…and numbness”. Flashbacks were also documented, but were of events with the first IP, not of the childhood trauma. All of the avoidance behaviors and triggers were linked to flight training. Only his final outpatient note mentioned “flashbacks of childhood trauma”. Other than a startle reflex to loud noises, there was no documentation of baseline PTSD-type symptoms outside the flight training environment. By the time of the VA psychiatric examination, however, the symptoms were constant and linked to the childhood stressors. The VA psychiatrist in fact stated that, “Since Criterion A is clearly not met with regard to his Air Force experiences, the remaining questions on the CAPS-DX (a PTSD screening tool) were asked with regard to the childhood trauma that he described which do meet Criterion A.” Although the same PTSD symptoms were cited by the MEB and VA examiners, the intrusive memories, flashbacks, triggers and avoidance symptoms related to the VA examiner were linked to the childhood trauma. The VA psychiatrist’s opinion confirms that he would not have made a diagnosis of PTSD based on linkage of the symptoms with the Service stressor.

The Board must therefore make a chain of increasingly tenuous concessions to arrive at the conclusion that a permanent Service disability rating can be fairly based on the severity of symptoms cited by the CI at six months after separation. It must first concede that the recovered memory from childhood arose for the first time from the incidents in 2002, triggering the cascade to a final diagnosis of PTSD. Otherwise the EPTS adjudication by the IPEB would be more difficult to refute. Psychiatric support for this phenomenon is not resolute. The Board must then concede that a completely resolved stress disorder evolved into a full blown PTSD condition two years later by virtue of less severe stressors, reminiscent of a more severe stressor which, in turn, was reminiscent of the definitive childhood stressor. It must further accept the initial Service trauma as the *de facto* Criterion A stressor for the MEB’s PTSD diagnosis, since all of the symptoms invoked in the narrative summary (NARSUM) to satisfy the DSM-IV diagnostic criteria for PTSD were directly linked to the first IP experience. Finally the Board must conclude that six months after separation the PTSD symptoms were now attached to the childhood events and concede that all of the psychiatric impairment remains attached to the Service disability rating.

Another significant issue confronted in this case is the probative value of the CI’s stated history as it relates to the severity of symptoms. The Board’s default posture regarding the accuracy of history and severity of symptoms as reported by the applicant in the medical record is one of acceptance as factual evidence. The Board however must assign limitations to that principle in some cases. If there are provider notes questioning the accuracy of the history, or logical inconsistencies of the reported and subjective history with the overall evidence, the Board must take these into account in arriving at its recommendations. It was judged that such factors were evidenced in this case and they are elaborated below. The Board hastens to add that such factors are treated as variables, with the emphasis remaining on achieving a “fair and equitable” (DoDI 6040.44) recommendation.

The NARSUM, the clinical psychologist’s opinion for the FPEB, the outpatient Behavioral Health notes from separate providers and the VA rating examination all cite symptoms verbatim from the DSM-IV diagnostic criteria for PTSD. Although it is possible that these entries were paraphrased by the providers, that is not the usual form of documentation and the symptom wording was uniform among five clinicians. Additionally the symptoms were occasionally placed in quotes (a good example is found in the VA examiner’s excerpt later in this discussion). This raises the question of rehearsed symptoms, especially in the light of the atypical presentation discussed above. This obviously cannot be concluded, but there is no contradicting evidence to discount the possibility. The mental status examination (MSE) documented in the NARSUM stated, “He seemed irritated during the interview at Maxwell AFB, until we started discussing disability options. On this topic he had many questions and had a different demeanor about him.” This statement suggests that the examiner had reservations regarding the CI’s sincerity. There were several OQ-45 (a standard psychiatric Outcomes Questionnaire) score sheets in evidence. These reflected a significantly higher number of endorsed symptoms than the concurrent MSE’s and GAF (global assessment of functioning) scores would suggest. In that same vein, the elevated depression and anxiety inventory scales reported in the clinical psychologist’s note were disproportionately elevated compared to the more objective measures (MSE, GAF, factual performance). Genuinely elevated OQ-45 scores and inventory scales are possible in this setting, but are often inflated by over-reporting of symptoms. This again is not concluded, but cannot be entirely discounted. Similar concerns surfaced during VA psychological testing. The CI was administered an MMPI-2 (Minnesota Multiphasic Personality Inventory) and the Mississippi Scale for Combat Related Stress (administered inadvertently since the PTSD was not combat related). Regarding the MMPI-2, the examiner stated, “[CI Name] approached the MMPI-2 by endorsing many deviant items. Indeed, he endorsed more deviant items than most seriously disturbed psychiatric inpatients. Such a result is often obtained from individuals who are seeking help, sympathy, or benefits. The profile should be considered invalid and should not be interpreted further.” Regarding the Mississippi Scale, the examiner stated “[His] raw score of 152 is significantly above the average score for veterans with verified combat PTSD, and suggests that there is likely an over-endorsement of symptoms.” These observations raise concerns that can neither be concluded nor discounted.

The six month VA rating examination documented history and features which contrasted significantly with the MEB evidence. Although these could represent a change in condition, they are likewise suggestive of over-endorsement and exaggeration of symptoms in light of the concerns just discussed. The first of these is a marked change in the CI’s general appearance and overall presentation. The following entry is excerpted from the VA rating examination.

He was disheveled in appearance. His hair was messy. He had a several day beard growth. His pants appeared to be pajama bottoms. His shoes were covered with paint spots. His eye contact was poor. His speech and gait were within normal limits. He was cooperative, although guarded. His observed affect was flat. He tended to talk in jargon. He would reference his previous psychologist naming his symptoms, for example: "hypervigilance” and "dissociative state".

It is difficult to reconcile this picture with the history in the same exam that he was employed daily. It contrasts sharply with “neat and well-groomed” remarks in his outpatient MEB clinical notes. His final training report (six days prior to separation) stated “appearance and conduct were commensurate with rank”. In the general (non-psychiatric) rating examination by the VA three weeks after the psychiatric rating exam, his general appearance was noted as “an alert, cooperative, and oriented gentleman in no acute distress”. The CI stated to the VA rating examiner that he had “obsessive-compulsive tendencies” and displayed nail-biting during the interview. This would represent a new development from the MEB examinations. He stated that he had “spent most of his time in bed” and was socially withdrawn during the MEB period, relating that his symptoms were worsening over time. This does not correlate with numerous outpatient notes documenting his daily activities nor with his final training report on the eve of separation. This stated that although he was eliminated for medical reasons, his performance in key areas had remained “above average”. The NARSUM documented that his symptoms were improving and that he was socially active and golfing on weekends. The only MEB documentation of any social withdrawal was found in the last outpatient Behavioral Health prior to separation. The CI related graphic accounts of his childhood abuse to the VA psychiatrist. This included such details as having his pillow “soaked with his own blood” and being force fed mustard, leading to avoidance of certain foods. These events were not documented in numerous accounts of his abuse to Service providers. Individually these enumerated observations from the VA rating examination are reasonably attributable to progression of psychiatric acuity, further evolution and surfacing of the childhood trauma or other clinically rational developments. Collectively, however, they introduce another layer of probative value concern which the Board must deliberate. The following excerpt from the VA rating psychiatrist’s conclusions evidence his own reservations in that regard.

Although [CI Name] clearly has mental health problems, the validity of the conclusions of this examination is reduced due to a number of factors. As a result, there is some degree of uncertainty with regard to the nature and extent of [CI Name]’s mental health problems. This is due to a number of factors. First, the veteran over-endorsed items on the MMPI-2. He describes somewhat of a contentious relationship with the Air Force previously over benefits, and it is possible that he is attempting to make it more likely that he will obtain benefits in this manner. Second, he declined to discuss alcohol or drug use issues. It is possible that under some circumstances severe alcohol or drug abuse could be exacerbating his mental health problems or producing some of the symptoms that he described. Third, his presentation and history are somewhat atypical. He described recovered memories of childhood abuse in response to a much less severe trigger in adulthood. The role of such recovered memories is controversial in the PTSD literature and there is some evidence that suggests that people do not completely forget their abuse experiences. … [CI Name]’s occupational functioning and social functioning appear severely impaired due to his PTSD symptoms. However, it is possible that his level of impairment is somewhat less severe due to his tendency to over-endorse symptoms.

The VA psychiatrist went on to concede the diagnosis and Service connection, but expressed no further opinions regarding an accurate assessment of impairment. The VA rating decision (VARD) derived its 50% determination from this exam, citing §4.130 criteria rather than application of 4.129. Although the VARD documented some of the examiner’s reservations, it fully applied the stated symptoms and history to the §4.130 criteria it cited for a 50% rating. The Board will focus as much as possible on the objective evidence from the Service and VA records in correlating the degree of impairment with VASRD §4.130 standards. As previously stated and for reasons just elaborated, the Board cannot premise its permanent PTSD rating recommendation solely on inferring impairment at six months from the subjective and speculative evidence contained in the VA rating examination.

The NARSUM characterized social and industrial impairment as “mild” and military impairment as “marked”. It noted relatively severe symptoms in the flight training environment, which were “greatly improved when he come off the flight line”. As previously mentioned, good social functioning was documented. Conversely, social anxiety and “borderline” social functioning were documented on the final outpatient note. The presence of panic type episodes with physiologic symptoms was described in the same note, but was not corroborated in the NARSUM or elsewhere in the MEB record. No legal or violent behavioral issues were in evidence and the absence of alcohol or substance abuse was documented. Psychotherapeutic medications consisted of an antidepressant and a sleep medication. The GAF score assigned in the NARSUM was 71 (consistent with slight to no impairment). The GAF score assigned in the last outpatient note was 55 (consistent with moderate impairment). The lowered GAF does not correlate with the good performance documented in the last training report dated closely to that entry. The last outpatient note also predicted a “serious employment handicap”, although the CI returned to his prior civilian job soon after separation. The NARSUM examiner has been previously quoted relative to mood on the MSE and affect was noted as restricted. There was no suicidal ideation, delusional or hallucinatory symptoms, speech disturbance, cognitive impairment or other abnormalities. Despite the new symptoms and lowered GAF score as previously described in the final outpatient note, the documented MSE was completely normal. MSE’s in 28 of 29 outpatient notes during the MEB period were documented as normal; one noted an anxious mood. All documented the absence of suicidal ideation or other acute symptoms.

In respect to objective application of §4.130 criteria to the VA psychiatric rating examination, the examiner’s general conclusions regarding occupational and social impairment have been quoted above. Relative to objective employment functioning, the examiner noted that the CI had returned to his previously held civilian position within 2-3 months of separation. The exam states, “He says he generally has done a good job at work. He only works 1-2 hours a day at UPS and primarily works there for the health care benefits. He has not had any disciplinary problems there. He has yelled at coworkers, but has never been disciplined for that”. There is nothing stated in the record which suggests that the CI was under-employed on the basis of psychiatric impairment. The examiner in the VA general rating examination documented some lumbar symptoms with lifting and other work activities, but no mental health limitations. His note also documented that there had been no missed work. Regarding social functioning, the CI stated that he had lost interest in golf and recreational activities and was not close to anyone. Emotional estrangement from family members and difficulty with intimate relationships was noted as a long-standing issue by the VA psychiatrist, but it is assumed that social interaction at the time of the VA exam was diminished from baseline. There is no documentation that the CI was intolerant of public places or that he was totally isolating at home. The VA examiner described symptoms of hypervigilance and exaggerated startle response, but did not note the panic symptoms documented in the MEB note. No hallucinations, debilitating flashbacks, extreme response to triggers or other unpredictable incapacitating symptoms were documented. There were no legal issues or violence reported, but the CI declined to answer questions regarding drug and alcohol use. He stated that his “service officer” had advised him to do so because "it may impact me getting benefits”. He remained on the same two psychotherapeutic medications (antidepressant and sleep medication) prescribed during the MEB. The MSE documented by the VA psychiatrist was significant for a flat affect and “anhedonic” (unable to attain pleasure) appearance. The CI stated that he was forgetful and had difficulty concentrating, but no formal cognitive exam findings were documented. There were no delusions, homicidal/suicidal ideation or other abnormalities on MSE. The VA psychiatrist assigned a GAF score of 45, connoting serious impairment. The same reservations the examiner had expressed regarding the accuracy of the reported severity of symptoms, as quoted previously, would have been equally applicable to estimation of the GAF score. The estimated GAF score would also have been significantly lowered by an inference of personal neglect from the general appearance.

The Board deliberated at length regarding the most reasonable and fair permanent rating recommendation for PTSD in this case. The general description for a 50% rating as stated in §4.130 is “occupational and social impairment with reduced reliability and productivity”. Although some degree of social impairment was established, there is no convincing evidence that there was significant occupational impairment from PTSD. In addition to the general description of occupational and social impairment, the §4.130 general formula fleshes out each rating description with a list of features or symptoms as examples for this level of impairment. Of nine such descriptors under the 50% rating, four were related by the CI to the VA examiner. All Board members agreed that too much speculation was required to concede a 50% permanent rating recommendation in this case and that the balance of the evidence did not rationally support it. The discussion settled around consideration for a 30% vs. 10% permanent rating recommendation for PTSD. A 30% recommendation could be supported if: a) as previously elaborated, all concessions are made in favor of the CI regarding the links in the chain of Service connected psychiatric impairment; b) most or all reported symptoms are accepted at face value with no significant lowering of probative value, favorably conceding most or all of the contradictory issues discussed above; and, c) VASRD §4.3 (reasonable doubt) is liberally and repeatedly invoked. All of the evidence, bolstering and weakening an argument for the higher rating, was debated. As many conflicting opinions as possible were resolved in favor of the CI when it was logically supportable to do so. The Board failed, on balance, to find adequate reasonable doubt favoring the CI in support of a recommendation for the higher rating. The Board therefore concludes that the permanent rating for PTSD in this case is best recommended as 10%.

Contended Lumbar Spine Condition. A complaint of back pain was evidenced in the service treatment record (STR) chiefly by a provider note five weeks prior to separation with a follow-up note two weeks later. The condition apparently developed fairly late in the MEB process. A Life Skills evaluation six months prior to separation specifically denied musculoskeletal complaints. There is no mention of a back condition in the NARSUM from either MEB. There are several physical profiles in the record, and all were designated L-1 with no mention of orthopedic conditions. The provider note referenced above described an onset of pain with jogging and documented a normal lumbar range of motion (ROM). The CI was prescribed ibuprofen and a muscle relaxant and followed up two weeks later. The follow-up note was cursory and provided no exam or historical detail. There was no referral to physical therapy or specialty care, no imaging performed no documentation of continuing treatment. The last DD Form 2697 (Report of Medical Assessment) in the STR was dated three weeks prior to separation and after the FPEB adjudication. It listed back pain among other complaints, but provided no exam or medical assessment. The 2005, DD Form 2697 accessible to the PEB listed no back complaints. Although there is documentation in the STR which establishes Service connection for the condition, there is no suggestion that the severity or ROM impairment evidenced in the VA exam developed prior to separation.

By policy and precedent the Board has defined its jurisdiction for recommending unadjudicated conditions as unfitting and subject to additional separation rating (barring exception for cases judged to be egregious). Said jurisdiction has been limited to those conditions which are evidenced in the core DES file. The core DES file consists of the MEB referral document, PEB adjudication document(s), NARSUM and any addendums or referenced examinations, MEB physical exam (includes DD Form 2697), Commander’s statement, physical profiles, written appeals and internal DES correspondence. The ANG Commander’s statement is not in the record before this Board and the DD Form 2797 referencing the condition was not available at the time of the PEB. The Board recommends therefore that the lumbar condition remain eligible for an appeal to the Air Force Board of Correction for Military Records (BCMR). Barring new or currently unavailable evidence, however, there would be little to support a finding that it was unfitting at separation.

Other Conditions. The IBS condition, as noted in the CI’s application, was not documented in the STR and is not eligible for Board consideration. It was deferred in the post-separation VA exam and was denied as Service connected in the subsequent VARD. The Board is not in possession of the VARD which linked the IBS condition to PTSD and granted a 10% rating, as implied in the application. Since the condition is neither eligible for consideration nor conceivably linked to fitness, there was no need to delay this case further in an attempt to obtain the referenced VA documentation. The IBS condition remains eligible for BCMR consideration. The tinnitus condition was noted in the DD Form 2797 and judged to be eligible for consideration. Since the profile was H-1 and the condition was never noted to interfere with flight status or other duties, however, it cannot be recommended as unfitting. There was a host of other conditions noted in the final DD Form 2797 and/or in the VA separation rating exam. Some of them meet the eligibility criteria detailed above (including the oral lesions mentioned below) and some of them do not. None were Service connected by the VA except for one (oral lesions) which received a 0% rating. None were profiled or under active treatment during the MEB period. No link to fitness is in evidence for any eligible conditions. 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 Board to the extent they were inconsistent with the VASRD in effect at the time of the adjudication. As discussed above, PEB reliance on DoDI 1332.39 for rating PTSD was operant in this case and the condition was adjudicated independently of that instruction by the Board. In the matter of the post-traumatic stress disorder condition, the Board unanimously recommends an initial TDRL rating of 50% in retroactive compliance with VASRD §4.129 as DOD directed; and a 10% permanent rating at 6 months IAW VASRD §4.130. In the matter of the lumbar spine condition, the Board opines that it remains eligible for consideration by the Board of Correction for Military Records. In the matter of the tinnitus condition, oral lesions condition or any other medical conditions eligible for Board consideration; the Board unanimously agrees that it cannot recommend any findings of unfit for additional rating at separation.

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RECOMMENDATION:

The Board recommends that the CI’s prior separation be recharacterized to reflect that, rather than discharge with severance pay, the CI was placed on the TDRL at 50% for a period of 6 months (PTSD at 50% IAW §4.129 and DoD direction) and then upon final disposition, discharged by reason of physical disability with a final 10% rating as indicated below.

|  |  |  |  |
| --- | --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **TDRL RATING** | **PERMANENT**  **RATING** |
| Post-Traumatic Stress Disorder | 9411 | 50% | 10% |
| **COMBINED** | **50%** | **10%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090225, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

Office of the Assistant Secretary

PDBR PD-2009-00273

**DEPARTMENT OF THE AIR FORCE**

WASHINGTON, DC

MEMORANDUM FOR THE CHIEF OF STAFF

Having received and considered the recommendation of the Physical Disability Board of

Review and under the authority of Section 1554, Title 10, United States Code (122 Stat. 466) and

Section 1552, Title 10, United States Code (70A Stat. 116) it is directed that:

The pertinent military records of the Department of the Air Force relating to xxxxxxxxxxxx, are corrected to show that:

a. He was not discharged on 13 March 2006 with entitlement to disability

severance pay; rather, on that date he was relieved from active duty and on 14 March 2006 his

name was placed on the Temporary Disability Retired List (TDRL) with a diagnosis of PostTraumatic Stress Disorder, VASRD Code 9411, rated at 50%.

b. On 14 September 2006 he was removed from TDRL and discharged with

severance pay with a final disability rating of 10% rating.

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Director

Air Force Review Boards Agency