RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXX BRANCH OF SERVICE: USMC

CASE NUMBER: PD0900420 BOARD DATE: 20100112

SEPARATION DATE: 20060415

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SUMMARY OF CASE: This covered individual (CI) was a Sergeant, Machine Gunner and Marksmanship Instructor medically separated from the USMC in 2006 after 8 years of service. The medical basis for the separation was Post Traumatic Stress Disorder (PTSD). This left-handed Marine sustained a head injury on 20040408 in Fallujah, when a mortar hit his vehicle. He sustained a right temporal shrapnel wound, was diagnosed with post concussive syndrome, and following hospital observation and bed rest was returned to his unit. He completed the remainder of his tour in Iraq (Jul 04). On return to the U.S. he started noticing problems with memory, developed headaches, and had personality changes. Neuropsychiatric testing revealed impairments in learning, being able to recall new information, difficulty with executive functioning and an overall decline in cognitive functioning. The evaluator noted testing disparities potentially due to level of effort or psychological factors. The CI was diagnosed with PTSD, Chronic Daily Headaches, Traumatic Brain Injury (TBI), Post Traumatic Headaches, History of Abnormal Vestibular Balance Functioning, and Overall Cognitive Decline; each as separate diagnoses. The CI was referred to the PEB and PTSD was determined to be medically unfitting. The CI's Chronic Daily Headaches were determined to be related (Category 2) and the conditions of TBI; Post Traumatic Headaches, and History of Abnormal Vestibular Balance Functioning were determined to be Category III, not unfitting. The CI, found unfit only for the PTSD condition, was determined unfit for continued military service and separated at 10% disability using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Navy and Department of Defense regulations.

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CI CONTENTION: The CI states: "The PEB did not rate the neurological and physical conditions caused by the TBI. Due to the severity of both the PTSD and the TBI, employment could not be retained, and I was increased to a disability rating of 100% from the VA and also from the State of Washington. It is also noted that I receive special monthly compensation from the VA due to the assistance needed from my wife for daily living activities." The CI also provided "VA decision letter dating back to May 1st 2006, VA description of disabilities, neuropsychology report from VA testing dated May 3, 2007 showing concurrent findings with one from three years earlier done at Balboa Naval Hospital." The CI also listed his VA conditions as: "Seizure disorder secondary to blast injury, residuals of traumatic brain injury, post-concussive headaches, cervical spine strain secondary to blast injury, irritable bowel syndrome, left shoulder strain, bilateral TMJ syndrome, vestibular disorder, speech impairment secondary to traumatic brain injury, bilateral patellofemoral syndrome, discoordination of fine motor skills and stiffness left and right hands secondary to traumatic brain injury, bilateral pes planus with orthotics, chronic sinusitis, post-traumatic stress disorder with cognitive disorder secondary to traumatic brain injury due to shrapnel wound in right temple, lumbar spine strain with degenerative changes noted on x-ray examination in service (claimed as MLBC with LOM), bilateral ankle strains (claimed as instability with LOS), scar secondary to traumatic brain injury due to shrapnel wound in right temple."

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RATING COMPARISON:

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Service PEB** | | | | **VA (Pre-Separation)** | | | | |
| **Condition** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| Post Traumatic Stress Disorder | 9411 | 10% | 20060127 | Post-Traumatic Stress Disorder (PTSD) with **Cognitive Disorder** Secondary to **Traumatic Brain Injury** Due to Shrapnel Wound, Right Temple | 8045-9411 | **50%**  100% | 20050823; 20051022 addendum & STR  20070516 & VA treatment notes | 20060416  20060416 #2 |
| Chronic Daily Headaches | Related Category 2 | | 20060127 |  |  |  |  |  |
| Traumatic Brain Injury | Category III: Conditions that are not separately unfitting and do not contribute to the unfitting condition(s) | | 20060127 | **Seizure Disorder Secondary to Blast Inj** | 8045-8911 | 40% | 20070516 | **20060416 #2** |
| Post Traumatic Headaches, History of Abnormal Vestibular Balance Functioning | Post-Concussive Headaches | 8045-9304 | **10%** | 20050812 | 20060416 |
| **Vestibular Disorder** | 6204 | 10% | 20070516 | **20060416 #2** |
| Overall Cognitive Decline |
| Overweight | Category IV | | 20060127 | - |  |  |  |  |
| Bilateral Pes Planus, problems with feet, Tinnitus, scar, and problems with joints were noted on the MEB History and Exam 20060123 | | | | Bilateral Pes Planus with Orthotics |  | **10%** | 20050812 | 20060416 |
| Bilateral Tinnitus | 6260 | **10%** | 20050812 | 20060416 |
| Scar Right Temple | 7804 | **0%**  10% | 20050812  20070516 | 20060416  20060416 #2 |
| Right Ankle Strain |  | **10%**  20% | 20050812  20070516 | 20060416  20060416 #2 |
|  | | | | Cervical Spine Strain Secondary to Blast Inj | 5237 | 20% | 20070516 | 20060416 #2 |
| Lumbar Spine w/ Degenerative Changes | 5242 | **0%**  20% | 20050812  20070516 | 20060416  20060416 #2 |
| Left ankle strain |  | **0%** | 20050812 | 20060416 |
| Bilateral High Frequency Hearing Loss |  | **0%** | 20050812 | 20060416 |
| NSC X3: Plantar Fasciitis, Right Knee, Trapezius Strain | | | 20050812 | 20060416 |
| **TOTAL Combined: 10%** | | | | **TOTAL Combined (*Includes Non-PEB Conditions*): 70%** from20060416  **Increased on #2 VA RD of 20070529: 100%** from20060416 | | | | |

ANALYSIS SUMMARY: CI had a TBI event in Iraq in 20040408 due to shrapnel with immediate symptoms of disorientation and cognitive symptoms. He had no period of loss of consciousness, but immediate signs of confusion, memory and behavioral changes and required multi-day observation. The CI completed his deployment and on return to the States had increasing symptoms of TBI including headaches, cognitive defects and a diagnosis of PTSD. The CI was found unfit and separated at 10% for PTSD on 20060415. TBI and Post Traumatic Headaches, History of Abnormal Vestibular Balance Functioning and Overall Cognitive Decline associated to blast injury were found to be Category III (Conditions that are not separately unfitting and do not contribute to the unfitting condition(s)). The CI was never on the TDRL and the provisions of §4.129 were not applied. The CI's psychiatric and poor neuropsychiatric testing for TBI was complicated by unusual results that may have been due to inadequate effort or psychological factors: "possible the results were affected by the patient's level of effort during the evaluation. It is also possible that his performance was negatively impacted by psychological factors." The CI's date of separation of 20060415 is after the application of VA Training Letter (TL) 06-03 (Rating TBI), FEB 06 which should be applied to this case. However, TL 07-05, AUG 2007 rating under VASRD code 8045 (TBI), §4.124a, was not in effect at the time of the CI's separation. The VASRD TBI rating criteria change for TBI in 2008 cannot be applied as the CI's separation was before the effective date of this change.

**Post-Traumatic Stress Disorder (PTSD):** The MEB noted PTSD as interfering with performance of duties ("…a condition that prevents him from performing the duties of his rank."). The PEB listed PTSD as unfitting and rated as 9411 at 10%. The MEB summary (20050401) listed PTSD, TBI and overall cognitive decline secondary to TBI as conditions that "prevents him from performing the duties in his rank." The Report to MEB Neuropsychological Addendum (20041215) details the CI's extensive evaluation. The PEB found PTSD unfitting as 9411 at 10%. The CI had multiple detailed evaluations for PTSD, TBI, and cognitive decline that focused primarily on TBI and cognitive decline. Per the Neuropsychological Addendum the CI was on continuous medication and had "recurrent intrusive images of his injury, is avoidant of activities and conversations that remind him of the event and he has feelings of detachment from others, He continues to be hypervigilant and he has an exaggerated startle response." Details of CI's PTSD are contained in the numerous neuropsychiatric evaluations (below), without a PTSD-specific assessment.

**VA:** Using an evaluation completed pre-separation; the VA rated this disability in conjunction with TBI as 8045-9411 at 50%, Post-Traumatic Stress Disorder (PTSD) with Cognitive Disorder Secondary to Traumatic Brain Injury Due to Shrapnel Wound, Right Temple. Following exams of 20070516 (13 months post separation), the VA rated this condition at 100% that was effective the date of CI's separation. The VA exams and treatment records up to the psychiatric addendum of 20051022 noted the CI had "objective evidence of an anxious mood; soft speech or decreased rate and rhythm: and neurovegetative signs and symptoms significant for decreased sleep and energy. The examiner noted that you meet the psychiatric criteria for PTSD and cognitive disorder secondary to traumatic brain injury and assigned a Global Assessment of Functioning (GAF) Score of about 60."

The CI was found unfit for PTSD and evaluation IAW the VASRD criteria, using only the PEB documents, would not rate higher than 50%. The VA's initial rating for PTSD with TBI was 50% by criteria (versus application of §4.129) and is in substantial agreement. The increased VA rating to 100% that was effective the date of CI's separation was based on exams and treatments after separation. Independent rating of the MEB exam would be 30% absent the provisions of §4.129. There is no evidence in the record that any psychiatrist or other mental health provider was able to separate the contributions of PTSD from TBI regarding the CI's mental health symptoms. In multiple places the providers / evaluators noted the connection between the two conditions relating to the CI's mental health disability. This rationale does not apply to any non mental-health manifestations of TBI such as headache, or seizure, etc. However, for rating PTSD, there is no factual basis in the records to deduct for any TBI-attributed mental health disability. The CI's initial level of rating for PTSD for 6 months following his date of separation should be 50% IAW §4.129. The level of disability at the 6 months reevaluation timeframe following the CI's separation to determine a final rating for 9411 PTSD IAW VASRD §4.130 must be approximated. The CI's mental health functioning at 6-months post separation can be approximated by considering evaluation of the CI's discharge disability level and his progression using both VA treatment records closest to 20091221 (6 months post separation) and the VA's Mental Health exam of 20070516 (13 month post-separation). Post-discharge, the CI's mental health declined rather than improved. The CI's PTSD symptoms at the 6 month post-separation timeframe best approximate the 50% disability rating criteria of 9411 IAW §4.130. All evidence considered, the Board recommends 50% as the fair permanent separation rating for PTSD in this case.

**Traumatic Brain Injury (TBI):** The MEB noted TBI as interfering with performance of duties. The PEB listed TBI as not fitting (Category III). 20041215 Neuropsychology Addendum noted: "The patient sustained a head injury on 08 APR 04 in Fallujah, when a mortar hit his vehicle. He was initially seen at the Camp Pendleton Concussion Clinic, following his return from Iraq. He was then referred … to the Defense and Veterans Brain Injury Center (DVBIC) for a formal evaluation of his cognitive functioning as part of a medical board evaluation."

20050401 Neurosciences Addendum: He suffered the injury (head) in April 2004 while serving in Iraq. He was in and out of consciousness and went to the Fleet hospital for one hour before being sent back to the front. He stayed the entire tour until July 2004. He began to experience daily headaches and memory problems. On return to the U.S. is when he started noticing the problems - forgetting conversations, activities he participated in, etc. His headaches were constant and worsened with exertion. They did not respond to OTC meds. He underwent neuropsych testing that revealed significant impairments in learning, and being able to recall new verbal and visual information. He also had difficulty with executive functioning and had an overall decline in cognitive functioning. At the first of this year he had 2 episodes of paralysis lasting 5-10 seconds where he was fully aware of what was going on. There was no convulsive activity or syncope. MRI and EEG were normal.

20050505 NeuroPsych MEB: "At this point in time it is our opinion that the patient is not suitable for continued military service. He has a number of somatic symptoms including chronic head pain, abnormal vestibular balance functioning and psychiatric symptoms. These issues will interact and tend to have a negative impact on his outcome." Per patient history, he was standing next to a vehicle when a mortar hit the vehicle at his head-level. He was thrown approximately 10 feet and sustained a shrapnel injury to his right temporal region of his head. He remembers screaming because his face was covered in flames. He was dazed and disoriented, but he denied any loss of consciousness or post traumatic amnesia. Following the blast, he was able to get up on his own and run for safety. Because of his head wound, he was transported by vehicle to a local medical facility. Records from Trauma Resuscitation indicated that the patient presented with a right temporal laceration with retained shrapnel. The wound was irrigated and the shrapnel was removed with local anesthesia. He was admitted to the ward for behavioral observation and pain control. He was disoriented and his judgment was impaired. Reportedly, he left the medical facility UA via a stolen vehicle to search for his platoon members. He stated that he wanted to return to combat. Upon meeting his unit, he was escorted him back to medical. The patient stated that immediately following the blast incident; he experienced impaired equilibrium, diminished hearing, problems with motor skills and constant head pressure. Also, during this time, military staff and his peers noticed impairments in speech, including slurring, stuttering, and incoherent speech. He also had difficulty understanding and executing instructions. He was evaluated by psychiatry and given a brief neurocognitive assessment. Medical records dated 03 MAY 04, indicated that the patient "might be experiencing some impairment of cognitive processing;" however, it was determined that his "basic cognitive functions were intact and within normal limits." He was diagnosed with Post Concussive Syndrome with ongoing cognitive slowing and speech difficulty. He was returned to full duty, after one week of bed rest. The patient stayed with his unit until they left Iraq on 30 APR 04. He then began working in a satellite division conducting house raids until JULY 04. After returning from deployment, the patient went home on leave and noticed memory problems and constant head pressure. Reportedly, friends and family also noticed personality and cognitive changes compared to his pre-injury behavior; (Imaging CT, plain films and MRI were normal) Currently the patient reports that he continues to suffer constant head pressure (rated 1-2/10, analog pain scale) that begins at the temples bilaterally and extends to the crown. He continues to experience episodes of dizziness once or twice a week. A vestibular evaluation performed on 10 NOV 04, indicated abnormal vestibular-balance functioning (please refer to vestibular report). He continues to have short-term memory problems. He forgets where his car is parked and instructions from day to day. He has difficulty multitasking and reports that he gets lost making breakfast. He also reported poor dominant hand (left) fine motor coordination it is apparent when using a fork.

PSYCHOSOCIAL HISTORY: The patient currently resides in the barracks at Camp Pendleton. He is on light duty status. He works from 0700 to 1300 instructing marines in a classroom environment. He denied any problems in this duty position. The patient denied any history of military disciplinary actions while serving in the U.S. Marine Corp. The patient completed 12 years of education. He reportedly achieved a 3.5 GPA. He reports that his best subjects were music and English. He denied any academic problems, history of learning disability or other neurological disorders likely to affect his cognitive functioning. The patient's medical history is significant for a broken nose at age 16 when he was a Martial Arts instructor. He was treated at the hospital to stop the bleeding. He denied a loss of consciousness or any subsequent sequelae. The patient reportedly drank one bottle of vodka a day before deploying to Iraq. He reported that he liked to drink and never had "hangovers." He denied any legal, occupational, or behavioral problems associated with alcohol use. He also denied any history of substance abuse treatment. He reports having his last drink before deploying to Iraq. He denied suffering any withdrawal symptoms. He was counseled about the negative affects of alcohol following a brain injury and he was encouraged to continue his abstinence

MENTAL STATUS EXAMINATION AND BEHAVIORAL OBSERVATIONS: The patient arrived on time for his appointment; he was generally cooperative with the evaluation. He completed the testing within the typical time. He was neatly groomed in civilian attire and he maintained good eye contact with the examiner. His speech was clear and understandable and he was able to establish good rapport with the examiner. He described his mood as "variable and irritable." He stated that he used to be relaxed and now he has a short fuse. He reported that his friend~ and family had noted that he was moody. He denied having problems at work because of his irritability. His affect was appropriate. He denied significant anhedonia. He also denied any current suicidal and homicidal ideation. The patient underwent a routine evaluation for Posttraumatic Stress Disorder at Family Services Camp Pendleton and was not diagnosed with PTSD. However, on direct questioning, it was determined that he currently meets criteria for PTSD. Specifically, he reports experiencing recurrent intrusive images of his injury, is avoidant of activities and conversations that remind him of the event and he has feelings of detachment from others. He continues to be hypervigilant and he has an exaggerated startle response. (During a follow-up on 08 MAR 05, the patient agreed to seek individual treatment). His thought processes were linear and on topic, without evidence of hallucinations or delusions. He reported that he usually sleeps four hours a night. He reported that despite taking Ambien He has difficulty staying asleep and wakes several times throughout the night. The night before the testing, he slept six hours. He stated that he felt rested at the time of testing. In terms of energy and endurance, he feels that both have declined due to lack of physical exercise. He denied a change in, but reported a 30-pound weight gain. Again, he attributes this to a decline in physical activity. Results of one test of effort and motivation (Word Memory Test) indicate that the patient did not put forth full effort. Therefore, the results of the testing may be an underestimation of the patient's current cognitive abilities.

This 26-year-old, left-handed, Caucasian man, an active duly E-5 marine sustained a head injury on 08 APR 04, in Fallujah when a mortar hit his vehicle. The patient was initially seen at the Camp Pendleton Concussion Clinic, following his return from Iraq with his battalion. Because of persistent problems, he was then referred to Dr. P---, Staff Neurologist at Naval Medical Center San Diego. Dr P--- referred him to the DVBIC for a formal evaluation of his cognitive functioning as part of a medical board evaluation. The patient has had multiple scans and x-rays of his brain and skull, which have all been within normal limits, according to records received. It is unclear from available records of the severity of his injury. It appears given his initial assessment in the field, and his normal imaging studies done since his return from Iraq that he suffered a relatively mild injury. However, we have very limited experience with the effects of blast injury on the brain, especially in combination with other issues, such as headaches, combat stress, etc. The results from the current evaluation show a pattern of performance that is somewhat inconsistent with a brief neurocognitive assessment conducted by Lt. R---, PhD, following his injury (03 MAY 04) The results of that evaluation were reported as "largely within normal limits," although the note did indicate that the patient showed some slowed reaction times, and questionable "problems with Visuospatial abilities and motor skills." However, the patient was seen at the same clinic one week later (10 MAY 04) and at that time he denied cognitive problems and any psychological distress. Based on that evaluation, he was found fit for full duty, and returned to his battalion, where he completed his lour. He returned to Camp Pendleton, but began complaining of problems at this point. Diagnostic Impression: Axis lR/O Cognitive Disorder; Posttraumatic Stress Disorder, Chronic; Personality Change due to Traumatic Brain Injury, Labile Type; Axis Ill; Post Traumatic Headaches; Abnormal vestibular-balance functioning; GAF 60

The results of the current evaluation are considerably worse than at the brief screening completed in the field. Although the patient said that he was all right, it is quite common to have military personnel minimize problems they are experiencing in the field. However, the observed pattern of decline is not typically seen in the recovery stage after mild head injury. In fact, an improvement in cognitive functioning is most typicality seen over time. Therefore, these findings should be interpreted extremely cautiously as they may be an underestimation of his current abilities. When interpreted within the context of his history of mild TBI and current levels of occupational and dally functioning, he performed quite poorly over a broad range or tests. In fact, there were relatively few tests that the patient performed within expectations This pattern of performance is especially puzzling, considering we would expect to see improvement at the very least in some cognitive domains. Although, the patient's working memory and processing speed was within the low end of the average range, this cannot account for the level of impairment noted on other tasks that are mediated by these abilities. It is possible the results were affected by the patient's level of effort during the evaluation. It is also possible that his performance was negatively impacted by psychological factors. "…it is our opinion that the patient is not suitable for continued military service. He has a number of somatic symptoms including chronic head pain, abnormal vestibular balance functioning and psychiatric symptoms. These issues will interact and tend to have a negative impact on his outcome."

**VA:** Using an evaluation (Aug and Oct 2005) completed prior to separation from the USMC, the Veterans Administration (VA) initially rated this disability as part of the CI's overall mental health diagnosis with PTSD as 8045-9411 at 50% (by criteria), and Post Concussive Headaches as 8045-9304 [*9304=Dementia due to Head Trauma*] at 10%. On later rating determination following exams in 20070503, the VA increased the 8045-9411 rating to 100% and also added Seizure disorder secondary to Blast Injury as 8045-8911 at 40% effective the date of separation. The VA rating exam and narrative linked the CI's Vestibular Disorder 6204 at 10% as due to the CI's TBI event, but did not use a hyphenated 8045-6204 coding. The VA did not link the CI's Bilateral Tinnitus 6260 at 10% to the CI's TBI diagnosis, and delineated that it preceded the CI's TBI event.

**Rating Decision (date 20060711):** VA contract Psychiatric Examination dated August 23, 2005, with Addendum dated October 22, 2005.

20070503 Neuropsych Report (w/application; 13 months post separation) Mr. B--- presents as a pleasant and sincere veteran who was excelling in the Marines and serving in Iraq in 2004, at which time he sustained a mild to moderately severe traumatic brain injury when exposed to an IED at extremely close range. Per his report of the event, the immediate sequelae, and per neuropsychological testing, he demonstrates severe cognitive impairment in memory as a result of this event, as well as personality and mood changes. Based on history and neuropsychological testing, Mr. B--- appears to have been of at least average intelligence pre-morbidly, with particular aptitude for his Navy/Marine duties. By his report (and per his history), he appears to have been functioning successfully and without difficulty in both personal and professional roles, and to have been in excellent health. Mr. B--- continues to demonstrate areas of relative strength in the following areas: pre-morbid fund of knowledge some working memory tasks, problem solving and planning. Today Mr. B--- demonstrates areas of marked impairments that are congruent with the late effects of brain injury. Specifically, he has severe impairment in both visual and verbal memory, even in the quiet test setting of an office. He has taken steps to compensate for memory problems, using his cell phone and computer. However, he still experiences significant difficulty and increasing professional disability and social isolation related to these memory difficulties. Functionally, we would predict that memory problems are exacerbated in the "real world" (compared to the test setting), where multiple distractions and stressors would be expected to exacerbate attention and memory problems, as well as make affective regulation more challenging. He also has impairments in processing speed, ability to regulate his mood, and in some types of attention tasks. On a more probable than not basis, and based upon reasonable neuropsychological probability, Mr. B--- is unlikely to sustain competitive employment at the present time, either on a full-time or part-time basis, because of these deficits. Indeed, his current employment situation (factory work making apple-packing materials) is tenuous (he is on probation) based on cognitive/performance issues, behavioral issues, and Mr. B---'s difficulty tolerating the job (which requires night shifts and extended periods of standing). Mr. B--- is also concerned about the impact of multiple medical appointments on his employment. Should the patient receive supportive employment services, cognitive rehabilitation, mental health services, as well as medical care for his seizures, back and foot pain, headaches, and tinnitus, and with improvement of his current symptoms related to TBI, PTSD, and sleep, he is more likely to be able to maintain a competitive employment position. While the TBI likely accounts for Mr. B---'s cognitive impairments, it is worth noting that these are likely exacerbated functionally by PTSD, sleep disturbance, seizures, and chronic pain issues. Each of these areas warrants specific treatments, and improvement in any of these areas may result in reduction of other symptoms.

DSM-IV Diagnosis:

Axis I: 294.9 Cognitive Disorder NOS secondary to blast injury/TBI; *907.0* Late Effects of intracranial injury without skull fracture; 309.81 Posttraumatic Stress Disorder

Axis II: None

Axis III: Musculoskeletal pain, esp. in feet and back, seizures

Axis IV: Transition back to civilian life

Axis 5: GAF Score 35-40

Regarding TBI as a possible new unfitting condition: As noted in the discussion of TBI, the CI's level of cognitive functioning at the time of separation as demonstrated by testing was potentially complicated as: "It is possible the results were affected by the patient's level of effort during the evaluation. It is also possible that his performance was negatively impacted by psychological factors." The evaluating providers did note that there would be overlap of the CI's diagnoses and that "the patient is not suitable for continued military service. He has a number of somatic symptoms including chronic head pain, abnormal vestibular balance functioning and psychiatric symptoms. These issues will interact and tend to have a negative impact on his outcome." Although the military evaluation cautioned about using the poor testing results without due consideration of all factors, it is more likely than not that those factors were due to the CI's PTSD; especially in light of the pre-separation VA evaluations and the CI's subsequent medical evaluations in 2007 by the VA that were not available to the PEB. Reasonable doubt is resolved in favor of the CI for recommending TBI and its secondary effects of headaches, vestibular disorder, and minor seizures as additionally unfitting condition(s) by the Board. The CI's TBI should be recharacterized to unfitting, combining with the CI's unfitting PTSD mental Health diagnosis, and the TBI-related symptoms, which individually may not be unfitting, should be rated IAW the VASRD in effect at the time including the provisions of TL 06-03 (Rating TBI), FEB 06. However, TL 07-05, AUG 2007 rating under VASRD code 8045 (TBI), §4.124a, was not in effect at the time of the CI's separation or at the 6-month post separation date when the CI's permanent rating should be calculated IAW §4.129 and DOD guidance. Neither TL 07-05 nor the VASRD TBI rating criteria change for TBI in 2008 can be applied in this case. In addition to including TBI in the PTSD condition as 8045-9411 (without changing the above 50% rating recommendation) as above; possible additional TBI coding is: either 1) including the associated blast-related diagnoses as either a single 8045 at 10% for subjective symptoms (TBI: Post-Concussive Headaches and Vestibular Disorder); or 2) separating out the TBI-related symptoms for individual coding (Post-Concussive Headaches 8045 at 10%; Vestibular disorder secondary to TBI 8045-6204 at 10%; and/or seizure disorder due to blast injury 8045-8911 at 10%).

**Post Traumatic Headaches/ Post Concussive Headaches:**  The military evaluations, PEB, and VA evaluations all noted Post Traumatic Headaches. The PEB listed this as a Category III Condition.

The VA coded the CI's Post-Concussive Headaches as 8045-9304 Dementia due to head trauma at 10%.

This condition was not separately unfitting. However, TBI should be recharacterized to unfitting and this condition should be linked to TBI under 8045 and rated at 10% IAW the VASRD and TL 06-03.

**History of Abnormal Vestibular Balance Functioning:**

20050505 NeuroPsych MEB: "He continues to experience episodes of dizziness once or twice a week. A vestibular evaluation performed on 10 NOV 04, indicated abnormal vestibular-balance functioning."

VA "Both your SMRs and VA treatment records show that you have had transient disequilibrium spells and visual blurriness that persist to the present. You have noted no episodes of staggering. Service connection for vestibular disorder has been established as directly related to military service. An evaluation of 10 percent is assigned from April 16, 2006. An evaluation of 10 percent is assigned for symptoms involving occasional dizziness. A higher evaluation of 30 percent is not warranted unless evidence shows dizziness and occasional staggering." "You sustained a blast injury in combat in Iraq and since that time you have had difficulty with your vision being blurry at times." "A 10 percent evaluation is warranted for your visual symptoms."

This condition was not separately unfitting. As TBI should be recharacterized to unfitting, this condition should be linked to TBI as 8045 at 10% or a separately coded 8045-6204 at 10% IAW the VASRD and TL 06-03. (Hyphenated coding is predominate to the VA's use of 6204 alone).

**Overall Cognitive Decline:** This condition was not a separately unfitting condition and should instead be considered under the CI's mental health diagnosis of PTSD with cognitive decline secondary to TBI.

**Seizure Disorder Secondary to Blast Injury.**

20050401 Neurosciences Addendum: "At the first of this year he had 2 episodes of paralysis lasting 5-10 seconds where he was fully aware of what was going on. There was no convulsive activity or syncope. MRI and EEG were normal."

VA: RD 20070529 with exam of 20070516: "Your VA medical records show that you have been having a history of simple partial seizures and complex partial seizures since your injury. You get these several times a week. These are classified as minor seizures form the symptom picture presented. You are still undergoing diagnostic work up for this condition Service connection for seizure disorder secondary to blast injury has been established as directly related to military service. An evaluation of 40 percent is assigned from April 16, 2006. An evaluation of 40 percent is assigned if there is at least one major seizure in the last six months or two in the last year, or averaging at least five to eight minor seizures weekly. A higher evaluation of 60 percent is not warranted unless the record shows an average of at least one major seizure in four months over the last year, or nine to ten minor seizures per week. Since there is a likelihood of improvement, the assigned evaluation is not considered permanent and is subject to a future review examination. The evidence of seizures several times a week warrants a 40 percent evaluation."

This diagnosis was not listed on the MEB or PEB. It is considered part of the DES file as symptoms were noted in the NARSUM Addendum. The CI's history of dissociative states may be equivalent to minor seizures. However, the CI was not diagnosed with seizures and MRI and EEG were normal. This type of subjective, very short-term feeling of paralysis may be considered "freezing-up" related to PTSD, or it could be from epileptiform activity (minor seizure) following the CI's TBI. There was no evidence in the record to support one etiology over the other aside from a normal EEG. If considered as analogous to minor seizures, then at the time of separation there were two episodes in four months near the time of separation. This would equate to the 10% criteria of "at least 2 minor seizures in the last 6 months". By the 13 month post-separation follow-up by the VA, the frequency had increased to "several times a week". It is not possible to clearly note the frequency of seizures at what would theoretically be the 6-month post separation timeframe that would equate to the end of a "6-month PTSD TDRL period" IAW retroactive application of §4.129 in this case. This condition can either be considered under the CI's general mental health rating (8045-9411) or as related to TBI and coded as 8045-8911 at 10%.

**Tinnitus.** History in both the military and VA records indicate that the CI's bilateral tinnitus originated from a shooting incident in 1998 that predates the CI's TBI. Tinnitus did not rise to the level of being unfitting. There were no indicators in the records there was any permanent aggravation from the TBI incident. Tinnitus should not be separately unfitting, not related to the TBI incident, and should not be rated.

**Other Conditions.**

The Bilateral Pes Planus, Tinnitus, scar, and problems with joints were noted on the MEB History and Exam 20060123. They were not indicated as not meeting standards, and did not appear to have any adverse effect on the CI's ability to perform his duties. The Board, therefore, has no reasonable basis for recommending any of these as additional unfitting conditions for separation rating.

The Lumbar Spine w/ Degenerative Changes, Cervical Spine Strain, bilateral TMJ syndrome, chronic sinusitis conditions did not appear to have any adverse effect on the CI's ability to perform his duties; however, there is no evidence that these conditions were considered in the DES file, so they are not within the scope of the Board to adjudicate.

The CI's contended issues of speech impairment, discoordination of fine motor skills and stiffness left and right hands secondary to traumatic brain injury are considered within the older VASRD code 8045 although not specified in the disability description. None of these conditions were separately rated by the VA.

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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 both DoDI 1332.39 and SECNAVINST 1850.4E for rating 9411 PTSD was operant in this case and the condition was adjudicated independently of those instructions by the Board. Additionally, the VASRD in effect at the time includes application of TL 06-03 (Rating TBI), FEB 06 to the adjudication of this case. However, the provisions of TL 07-05, AUG 2007 and the new VASRD TBI coding and criteria were not in effect and were not applied. This case was finalized by the Navy at the very beginning of the recognition of the complexities of TBI and the VA's TL 06-03 that started the broadening of TBI coding beyond the prior strict interpretation of notes within VASRD Code 8045.

In the matter of the PTSD condition, the Board unanimously recommends an initial TDRL rating of 50% in retroactive compliance with VASRD §4.129 as DOD directed; and a 50% permanent rating at 6 months IAW VASRD §4.130. In the matter of the TBI condition and blast-related disabilities, the Board unanimously recommends that TBI be added to the above unfitting PTSD (coding changed to 8045-9411 without changing the 50% rating level agreed to above), and as an additionally unfitting condition for separation rating. The Board determined that given the older VASRD guidance in effect at the time, that the CI's multiple TBI related symptoms should not be individually coded beyond a combined single TBI coded as 8045 at 10%. The Board considered that the CI's PTSD and complex aggregate of TBI symptoms combined and were not clearly separable as in both the unusual neurocognitive testing results and the CI's ability to perform the duties of a machine gunner. The caveats in testing results were not adjudged sufficient to disregard the apparent level of disability demonstrated by the CI during military and VA evaluations. The CI's increasing level of disability following separation was considered only during the 6 month post-separation time period retrospectively applying §4.129 to the CI's PTSD condition.

The diagnoses of Bilateral Pes Planus, Tinnitus, scar, and problems with joints were noted in the DES package and did not interfere with duty. All evidence considered, the Board, has no reasonable basis for recommending any of these as additional unfitting conditions for separation rating. The other diagnoses of Lumbar Spine w/ Degenerative Changes, Cervical Spine Strain, bilateral TMJ syndrome, and chronic sinusitis conditions were not mentioned in the Disability Evaluation System (DES) package and are therefore outside the scope of the Board. The CI retains the right to request his service Board of Correction for Naval Records (BCNR) to consider adding these conditions as unfitting.

The Board voted unanimously to rate the CI as Post-Traumatic Stress Disorder and cognitive disorder secondary to TBI, 8045-9411 at 50%; and voted by simple majority for rating TBI: Post-Concussive Headaches, Vestibular Disorder, and subjective symptoms as 8045 at 10% with the same rating levels for an initial 6 month TDRL period and as his permanent rating. The single voter for dissent (who recommended removing the non-Headache TBI symptoms from the single 8045 code and adding the VA ratings of Seizure Disorder secondary to TBI 8045-8911 at 10%, and Vestibular Disorder secondary to TBI 8045-6204 at 10%) did not elect to submit a minority opinion.

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RECOMMENDATION: The Board recommends that the CI’s prior determination be modified as follows; TDRL at 60% for 6 months following CI’s prior medical separation (PTSD at minimum of 50% IAW §4.129 and DoD direction, and other conditions as listed) and then a permanent combined 60% disability retirement as below.

|  |  |  |  |
| --- | --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **TDRL RATING** | **PERMANENT**  **RATING** |
| Post-Traumatic Stress Disorder and Cognitive Disorder Secondary to TBI | 8045-9411 | 50% | 50% |
| TBI: Post-Concussive Headaches, Vestibular Disorder, and subjective symptoms | 8045 | 10% | 10% |
| **COMBINED** | **60%** | **60%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090621, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

President

Physical Disability Board of Review

MEMORANDUM FOR DEPUTY COMMANDANT, MANPOWER & RESERVE

AFFAIRS

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATION

ICO XXXX, XXX XX XXXX

Ref: (a) DoDI 6040.44

Encl: (1) PDBR ltr dtd 25 Jan 10

1. I have reviewed the subject case pursuant to reference (a) and accept the recommendation of the Physical Disability Board of Review (enclosure (1)).

2. The subject member’s official records are to be corrected to reflect the following disposition:

a. Separation from the naval service due to physical disability rated at 60% with placement on the Permanent Disability Retired List effective April 15, 2006, the date of his discharge from naval service.

3. Please ensure all necessary actions are taken to implement this decision, including the recoupment of previously paid funds if appropriate, and notification to the member once those actions are completed.

Principal Deputy

Assistant Secretary of the Navy

(Manpower & Reserve Affairs)