RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: AIR FORCE

CASE NUMBER: PD0900544 BOARD DATE: 20100714

SEPARATION DATE: 20081009

 TDRL ENTRY DATE: 20070108

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SUMMARY OF CASE: This covered individual (CI) was a Airman First Class, Firefighter medically separated from the Air Force in 2007 after 2 years of service. The medical basis for the separation was Deafness in Left Ear with Tinnitus. The CI was referred to the Physical Evaluation Board (PEB), determined unfit for Deafness in Left Ear with Tinnitus, and separated at 10% disability using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Air Force and Department of Defense regulations.

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CI CONTENTION: The CI makes no contention.

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RATING COMPARISON:

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| --- | --- |
| **Service PEB**  | **VA (3 Mo. after Separation)** |
| **Condition** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| Significant Vertigo, vestibular nerve branch injury | 6204 | 30% | 20061127 | Vertigo | 6204 | 10% | 20070323 | 20070109 |
| Not addressed by PEB | 20080812 |
| Deafness Left Ear  | 6100 | 10% | 20061127 | Hearing Loss, left Ear | 6100 | 10% | 20070420 | 20070109 |
| Deafness Left Ear with Tinnitus | 6100 | 10% | 20080812 |
| Recurrent Tinnitus | 6260 | 10% | 20061127 | Tinnitus, Left Ear | 6100 | 10% | 20070420 | 20070109 |
| Traumatic Brain Injury, status –post Basilar Skull Fracture and Subdural Hematoma. Impairment for Military Duty: None | 9304 | Cat II | 20061127 | Amnestic Disorder with Anxiety due to Head Injury | 9304 | 50%50% | 20070071820091118 | 20070109 |
| Status Post Basilar Skull Fracture | 5299-5296 | Cat II | 20080812 | Residual Cranial Fracture | 5299-5296 | 0% | 20070323 | 20070109 |
| Facial Nerve palsy | 8207 | Cat IICat II | 2006112720080812 | Bell’s Palsy , Left | 8207 | 10% | 20070323 | 20070109 |
|  |  | Not in DES | Paresthesias, Left Scalp | 8205 | 0% | 20070323 | 20070109 |
|  |  | NARSUM 20061010 | Residuals Fracture of T1 Vertebrae | 5235 | 0% | 20070323 | 20070109 |
|  |  | NARSUM 20061010 | Residual Scars, Anchor Placement for Bone Anchored Hearing Aid | 7800 | 30% | 20070323 | 20070109 |
|  |  | Not in DES | Scar, Left Upper Eyelid | 7800 | 0% | 20070323 | 20070109 |
|  |  | Not in DES | Scar, Scalp | 7800 | 0% | 20070323 | 20070109 |
|  |  | Not in DES | Scar, Right Upper Extremity | 7805 | 0% | 20070323 | 20070109 |
|  |  | Not in DES | Scar, Left Upper Extremity | 7805 | 0% | 20070323 | 20070109 |
|  |  | Not in DES | Scar, Left Torso | 7805 | 0% | 20070323 | 20070109 |
|  |  | Not in DES | Scar, Left Hip | 7805 | 0% | 20070323 | 20070109 |
|  |  | Not in DES | NSC x 3: Left ankle Sprain, Pneumothorax, left chest pain |
| **TOTAL Combined: 40% from 20070108 (TDRL)** **10% from 20081009 (Final)** | **TOTAL Combined (*Includes Non-PEB Conditions*):** **80% from 20070109** |

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ANALYSIS SUMMARY:

Vertigo, Hearing Loss, and Tinnitus

The CI was involved in a motor vehicle accident on 20050509 and his vehicle rolled end over end multiple times. Although he was wearing a seatbelt he was ejected from the vehicle and had a brief period of unconsciousness. He suffered a left basilar skull fracture with fracture of left occipital bone extending to occipital condyle; fracture of the left vestibule of the semicircular canals from the vestibular aqueduct into the vestibule; fracture of transverse process of T1 vertebra; bilateral pulmonary contusions; subdural hematoma in left aspect of the posterior fossa, left occipital region, and left posterior temporal region; hemorrhagic contusions of the frontal lobes; deafness in left ear; and multiple contusions and abrasions of his upper body. The subdural hematoma resolved without any interventions. During rehabilitation he also had poor generalized coordination with left side upper and lower extremity weakness, frequent episodes of headaches, dizziness, and short term memory loss. He then went to his hometown to continue his rehabilitation with help from his parents. He did show gradual improvement with increased strength and coordination of his left upper and lower extremities. He also reported some improvement of his memory.

He continued to have significant left facial nerve palsy and on 20050722 he underwent a left translabyrinthine facial nerve decompression, excision of left incus and malleolus, and placement of gold weight in left upper eyelid to help with closure of upper lid.

The CI continued to slowly improve with physical therapy and eventually was able to walk without assistance. He returned to sedentary duties 20060829. He continued to progress and eventually reached the point where he was able to work a twelve hour shift and was only restricted from running and working above ground level secondary to his vertigo and unsteadiness. At the time of the original narrative summary (NARSUM) in October 2006 he was able to walk without vertigo or incoordination. However, he could not run in an open area without experiencing significant vertigo. He could run short distances if he concentrated on a fixed point ahead. He had tinnitus in the left ear constantly but he was able to sleep despite the noise. He initially had surgery for a bone anchored hearing aid (BAHA) in October 2005 and many revisions were required.

He was referred to the PEB and was placed on Temporary Disability Retired List (TDRL) because his condition had not yet stabilized. He also needed further surgery for his BAHA.

He was evaluated by neurology on 20080528 and Ear, Nose & Throat (ENT) on 20080605. At this time he no longer had any vertigo, incoordination, or headaches but continued to have tinnitus, absolute hearing loss in the left ear, and left facial nerve palsy. His neurologic examination showed normal motor strength throughout except for the seventh cranial or facial nerve. He had normal right facial strength. There were mild synkinetic movements of the left face during eye closure (left lip raises up) and there was complete absence of left forehead elevation and moderate weakness of left eye closure and cheek. The neurologist opined he had partial return of the left seventh cranial nerve injury but no appreciable gain of function of the eighth cranial nerve (vestibulocochlear nerve).

The ENT evaluation documented the CI had good eye closure and no problems with ocular pain, itching or diplopia. He reported no balance problems at that time. The BAHA was functioning quite nicely. Review of his audiometric testing revealed anacoustic, in other words no hearing measurable out of his left ear. His right ear had normal hearing. Examination noted fullness to his left upper eyelid consistent with a Gold weight implant

VA hearing evaluation completed in April 2007 documented profound sensorineural hearing loss of the left ear. Average puretone threshold values were 0 decibels (dB) for the right ear and 105 dB for the left ear. The Maryland CNC Word List Speech Recognition Score was 94 for the right ear and 0 for the left ear. Negative pure tone and speech Stenger tests were also documented and demonstrated the hearing loss was not feigned. IAW with VASRD §4.85 and Table VI and VII, the left ear is designated XI and the right as I and therefore the percentage evaluation is 10%.

Traumatic Brain Injury, status-post Basilar Skull Fracture and Subdural Hematoma. Impairment for Military Duty: None

The CI subjectively noticed decreased efficiency in memory abilities and processing speed. Maximal effort on the evaluation was noted. Neuropsychological testing did show some mild deficits but all measurements remained in the average range. However, his intellectual and cognitive abilities were measured at high average. So while his memory functioning was not commensurate with his intellectual and cognitive abilities, it remained at an average level. This would not cause any functional impairment. There is no evidence this condition interfered with performance of any required duties and no duty restrictions can be attributed to this condition.

Other Conditions

Status Post Basilar Skull Fracture; Facial Nerve Palsy; Residuals Fracture of T1 Vertebrae; and Residual Scars, Anchor Placement for Bone Anchored Hearing Aid. None of these conditions interfered with performance of any required duties and no duty restrictions are attributable to any of these conditions. At the time of the TDRL evaluation in 2008 he was able to close his eye and had no ocular problems.

Other Conditions Not in the Disability Evaluation System (DES)

Paresthesias, Left Scalp; Scar, Left Upper Eyelid; Scar, Scalp; Scar, Right Upper Extremity; Scar, Left Upper Extremity; Scar, Left Torso; and Scar, Left Hip

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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. After careful consideration of all available evidence the Board unanimously determined that the CI’s condition is most appropriately rated at a combined 20% disability rating with 10% for 6100 Deafness Left Ear and 10% for 6260 Tinnitus.

The initial PEB in 2006 determined the CI was unfit for three conditions: Significant Vertigo, Vestibular Nerve Branch Injury; Deafness Left Ear; and Recurrent Tinnitus. When the CI separated from the TDRL in 2008 his vertigo had resolved and therefore was no longer unfitting and no disability rating was applied. The 2008 PEB determined the CI was unfit for ‘Deafness Left Ear with Tinnitus’ but only documented one disability rating of 10% for 6100 (Hearing Loss). The tinnitus was present at the time of both the initial PEB and of the TDRL evaluation and there was no intervening change in symptoms. Both PEBs listed it as an unfitting condition. Hearing loss and tinnitus are separate conditions that cannot both be rated using only one VASRD code. Tinnitus is not required to support the 10% rating for Hearing Loss. Therefore, IAW Note 1 under VASRD 6260, the two conditions should be rated using separate VASRD codes.

The Board considered the condition of Traumatic Brain Injury (TBI) and unanimously determined that his condition was not unfitting at the time of separation from TDRL and therefore no disability rating is applied. While neuropsychological testing documented his memory functioning was not commensurate with his high average level of intellectual and cognitive abilities, it remained at an average level. This would not cause any functional impairment.

The Board also considered Status Post Basilar Skull Fracture; Facial Nerve Palsy; Residuals Fracture of T1 Vertebrae; and Residual Scars, Anchor Placement for Bone Anchored Hearing Aid and unanimously determined that none of these conditions were unfitting at the time of separation from TDRL and therefore no disability rating is applied. None of these conditions interfered with performance of any required duties.

The other diagnoses, rated by the VA (Paresthesias, Left Scalp; Scar, Left Upper Eyelid; Scar, Scalp; Scar, Right Upper Extremity; Scar, Left Upper Extremity; Scar, Left Torso; and Scar, Left Hip) were not mentioned in the Disability Evaluation System package and are therefore outside the scope of the Board. The CI retains the right to request his service Board of Correction for Military Records (BCMR) to consider adding these conditions as unfitting.

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RECOMMENDATION: The Board recommends that the CI’s prior determination be modified as follows, effective as of the date of his prior medical separation.

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| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Deafness Left Ear  | 6100 | 10% |
| Tinnitus  | 6260 | 10% |
| **COMBINED** | **20%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090829, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

 President

 Physical Disability Board of Review

SAF/MRB

1535 Command Drive, Suite E-302

Andrews AFB, MD 20762-7002

 Reference your application submitted under the provisions of DoDI 6040.44 (Section 1554, 10 USC), PDBR Case Number PD-2009-00544.

 After careful consideration of your application and treatment records, the Physical Disability Board of Review determined that the rating assigned at the time of final disposition of your disability evaluation system processing was not appropriate under the guidelines of the Veterans Administration Schedule for Rating Disabilities. Accordingly, the Board recommended modification of your assigned disability rating without re-characterization of your separation with severance pay.

 I have carefully reviewed the evidence of record and the recommendation of the Board. I concur with that finding, accept their recommendation and direct that your records be corrected as set forth in the attached copy of a Memorandum for the Chief of Staff, United States Air Force. The office responsible for making the correction will inform you when your records have been changed.

 Sincerely

Director

Air Force Review Boards Agency

Attachments:

1. Directive

2. Record of Proceedings

cc:

SAF/MRBR

DFAS-IN

PDBR PD-2009-00544

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) it is directed that:

 The pertinent military records of the Department of the Air Force relating XXXXXXXXXX be corrected to show that the diagnosis in his finding of unfitness was Deafness Left Ear, VASRD Code 6100, rated at 10% and Tinnitus, VASRD Code 6260, rated at 10% with a combined total rating of 20%; rather than Deafness in Left Ear with Tinnitus, VASRD Code 6100, rated at 10%.

 Director

 Air Force Review Boards Agency