RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXX BRANCH OF SERVICE: MARINE CORPS

CASE NUMBER: PD0900562 BOARD DATE: 20101028

SEPARATION DATE: 20080515

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SUMMARY OF CASE: This covered individual (CI) was a Marine Corps Reserve Lance Corporal, (0311 Infantry Rifleman), mobilized for OEF/OIF and medically separated from the Marine Corps in 2008 after four years of combined service. His lower right leg was injured by a grenade explosion while deployed in Iraq. The medical basis for the separation was injury of lower extremity, right leg involving shrapnel with patellar chondromalacia as an associated CAT II diagnosis and Posttraumatic Stress Disorder (PTSD). He did not respond adequately to perform within his rate or participate in the Fitness test, was issued a 6 month period of limited duty (LIMDU) with a second LIMDU for 6 months, and then underwent a Medical Evaluation Board (MEB). The CI was referred to the Physical Evaluation Board (PEB), determined unfit for continued Naval service, and separated at 10% disability using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Naval and Department of Defense regulations.

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CI CONTENTION: The CI states: ‘’ New evidence of serious injury found post-discharge. Injuries were not found while being treated as an active duty member.’’ He additionally lists all of his VA conditions and ratings as per the rating chart below.

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RATING COMPARISON:

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Service PEB –20080107**  **NARSUM 20070831**  **Psychiatric Addendum 20071211** | | | | **VA (5 months after separation)**  **All Effective 20071031** | | | | |
| **Condition** | | **Code** | **Rating** | **Condition** | | **Code** | **Rating** | **Exam** |
| Injury of Lower Extremity, Right Leg, Involving Shrapnel | | 8799-8723 | 10% | Multiple Shrapnel Scars, Right Thigh And Right Lower Leg | | 7804 | 10% | 20071231 |
| Shrapnel Wound, Right Anterior Leg With Paresthesia in Peroneal Nerve Distribution | | 8723 | 10% | 20071231 |
| Posttraumatic Stress Disorder | | 9411 | 0% | Post Traumatic Stress Disorder | | 9411 | 10% | 20071210 |
| Patellar Chondromalacia | | CAT II | | Right Patellar Chondromalacia | 5099-5014 | | 10% | 20071231 |
| Urinary Urgency/ Enuresis/Urge Incontinence Small Mass in Scrotum, Shrapnel | | NARSUM  LIMDU  MEB H&P Physical | | Urinary Incontinence, Frequency, and Urgency, with Subjective Report of Abdominal Wall Weakness and Testicular Pain, Residual to Retained Shrapnel in the Anterior Lower Abdominal Wall | | 7517 | 60% | 20080912 |
|  | MEB H&P Physical | | | Scar, Right Groin | | 7804 | 10% | 20071231 |
|  | Not in DES | | | Bilateral Tinnitus | | 6260 | 10% | 20071220 |
|  | | | | NSC X 2 | | | |  |
| **TOTAL Combined: 10%** | | | | **TOTAL Combined (*Includes Non-PEB Conditions*):**  **80% from 20071031** | | | | |

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ANALYSIS SUMMARY:

Injury of Lower Extremity, Right Leg, Involving Shrapnel. The CI was activated and deployed to Iraq in April 2006. On 20060811 the CI sustained multiple fragmentation shrapnel injuries during a grenade attack. He was in the gun turret of a Humvee in Iraq. He had wounds to his right groin, right thigh, right knee, and his right lateral calf was partially avulsed. He underwent multiple surgeries to remove shrapnel both in Iraq and in CONUS. The CI complained of pain, numbness and tingling of his right lower extremity and pain involving his right knee. He was noted to have persistent right leg numbness, pain, and paresthesia and was treated with physical therapy. He continued to have chronic daily pain that significantly impaired his ability to engage in physical activity. He was followed by a neurologist in Groton, CT and was treated with Neurontin and Pamelor for neuropathic pain. At the time of the MEB narrative summary (NARSUM) 20070831 (ten months prior to separation) he was able to run once a week, usually up to only a mile at a time. His physical examination at that time documented decreased sensation over the shrapnel wounds of his right lower extremity and the dorsal side of his right foot and toes. A positive Tinel’s sign was present. Muscle tone and bulk was normal in the upper and lower extremities. The right knee was tender to palpation on the lateral aspect of the patella. However, there was no swelling erythema, warmth, joint instability or sign of meniscal tear. Right knee radiographs from April and July 2007 were reviewed and both showed multiple metallic foreign bodies. The July 2007 X-rays showed mild degenerative changes with sclerosis, narrowing, and osteophytosis of the patellofemoral joint and femorotibial joint. The NARSUM noted the CI’s medical problems significantly impacted his personal life by limiting his hobbies, interrupting normal sleep patterns, and making activities of daily living and interpersonal relationships difficult. His condition was considered stable and he was likely to require ongoing therapy and medical follow-up.

An initial VA Compensation and Pension (C&P) exam was completed on 20061219. It noted a massive grenade injury to his right groin, thigh, knee and foot while in Fallujah. He subsequently required several surgeries and still has limited weight bearing on his right leg. With aggressive PT and appropriate knee brace to maintain the stability, he should regain full use of his right lower extremity. He was noted to have a severe functional impairment as a result. A second VA C&P exam was completed 20071231. It documented he had progressed from a wheelchair to crutches and had been using a cane until one month prior to this date. At that time he was not having any difficulties with activities of daily living and was continuing physical therapy. He continued to have paresthesias in his right leg in the distribution of the peroneal nerve along with right knee pain and giving way with uneven ground walking/stairs. He still used the cane for walking longer distances. He was walking with a cane at this visit and was limping. Corrective shoes and a special brace had been ordered by the VA clinic but had not arrived yet. His right foot was painful on motion and very limited due to guarding and subjective pain and stiffness. Plantar flexion was 0-25 degrees and dorsiflexion was 0-5 degrees. Range of motion of the right foot was additionally limited by pain, fatigue, weakness, or lack of endurance after repetitive use and measurements decreased 5 degrees, were slower and more guarded. There was loss of sensation to light touch with monofilament under right great and second toe back to the ball of the foot. Due to loss of sensation, he had difficulty walking on the ball of his foot. He was also unable to pronate, squat, supinate, rise on toes and heel on right foot. The left foot was normal. Pes planus was not present.

He was considered to have severe functional impairment secondary to massive grenade injury with continued limited weightbearing on his right leg and paresthesias as likely neuropraxia to the peroneal nerve. The VA rated this condition at a combined 20% with an additional 10% for the right knee chondromalacia patella as discussed below. A 10% evaluation was assigned for 8723 Shrapnel wound, Right anterior Leg with Paresthesia in the Peroneal Nerve Distribution. Another 10% was applied for 7804 Multiple Shrapnel Scars, Right Thigh and Right Lower Leg. The rating was based on the 20071231 C&P examination and treatment records through 20080428, approximately two weeks prior to separation. There was likelihood of improvement and therefore the assigned evaluation was not considered permanent and was subject to a future review examination. The PEB assigned a 10% rating under VASRD 8799-8723. VA treatment records from December 2008 document improvement in functional limitations over time but the paresthesias and pain persisted.

Post-Traumatic Stress Disorder (PTSD). While the CI was on active duty in Medical Hold a VA C&P for PTSD was completed 20070111. The diagnosis was Adjustment Disorder with Anxiety (Sub-clinical PTSD) and a current Global Assessment of Functioning (GAF) of 68 was applied. The highest GAF in the past year was assessed at 70. No rating was applied by the VA until after he separated from active duty. Another VA PTSD C&P examination was done 20071210, one day prior to the date of the MED NARSUM Psychiatric Addendum was completed.

At the time of the C&P examination in December 2007, the CI was unemployed and was a full-time college student. He was still on reserve status at this time and did not separate from the reserves until 20080515. This C&P examination documented symptoms of irritability, fatigue, decreased motivation, nightmares three times a week, recurrent intrusive memories when driving, occasional avoidance of social situations, and anxiety in large groups of people. He had recently ended an engagement because he did not want to be close to anybody. He avoided listening to war-related news reports because he was not interested in the political aspects of the war in Iraq. He was hypervigilant of strangers and distrustful of those who had not been in the military. He also endorsed an exaggerated startle response triggered by loud noises, like the July 4th fireworks. He complained of problems with short-term memory with poor attention and concentration. He had received psychotherapy at the VA and was not currently taking any psychotropic medications. On mental status exam his mood was stable and his affect was mildly anxious. PTSD and Adjustment Disorder with Mixed Anxiety and Depressed Mood were diagnosed and a GAF of 70 was assessed. The examiner noted the CI did not appear to be significantly limited by his symptoms of PTSD as evidenced by his ability to manage full-time college study and to continue his commitment as a reservist in the US Marines.

A Psychiatric Addendum to the Navy MEB was completed 20071211, one day after the VA C&P examination described above. This examination noted, that although the CI had gradually improved over the course of treatment with psychotherapy, he continued to manifest significant symptoms of PTSD that impaired his fitness for duty. It was also felt that continued service would aggravate the condition. The CI reported a strong social support in his family and friends, was currently enrolled in college, and was on limited duty secondary to the shrapnel injuries described above. The CI had sought care for symptoms of nightmares, intrusive thoughts about Iraq, anxiety, restlessness, agitation, poor sleep, decreased concentration, memory impairment, getting lost easily, and irritability. On mental status examination his mood was typically pleasant but mildly anxious and his affect was mood congruent. He was cooperative and appeared motivated to work on his symptoms and became more emotionally expressive and frustrated when he discussed his injuries and symptoms. There were a few episodes of memory impairment surrounding recent events. At the time of the exam he was re-experiencing traumatic events as distressing dreams, intrusive thoughts and flashbacks. He had persistent avoidance, marked diminished interest in significant activities, feelings of detachment from others, and a restricted range of affect. He also had persistent symptoms of increased arousal including difficulty falling asleep, irritability, difficulty concentrating, and hypervigilance. His degree of Military/Psychiatric Impairment was considered marked and his Impairment for social and industrial adaptability was considered considerable. PTSD was diagnosed and a GAF of 60 was assessed.

The service treatment record (STR) includes a progress note from an outpatient VA primary care visit on 20080110. A positive PTSD screen was noted at this visit. However, the CI had been seeing a psychologist every couple weeks at Groton but did not feel he needed any further services. He declined further mental health services at this visit. The STR also includes record of a 20081210 VA Psychiatry consult. It is not clear why this consult was obtained. It documented that over the previous two years the CI’s physical problems had lessened but he became more aware of the emotional issues. Others had told him he had changed and he realized this was true. He was experiencing feelings and symptoms that were disturbing to him. He felt out of place with his former friends and colleagues. He tended to hang around others with similar experiences, other veterans, and noticed many of them had seemed to move on while he remained static. He had symptoms of avoidance of others, isolation, increased startle, hypervigilance, nightmares and intrusive thoughts, increased irritability, increased rumination and worry about the future, decreased sleep and appetite, and generally increased anxiety. He was anxious to talk about his problems and see if he could get better. He was noted to have disrupted sleep and appetite as well as problems with concentration and attention. He admitted feeling mildly to moderately depressed. On mental status examination his mood was bright and affect was full-range. His insight was good and judgment was fair. He also had significant anxiety. Weekly psychotherapy was planned.

There are no records in the STR of any psychotherapy sessions after this visit. The CI appealed the VA rating of 10% for PTSD and a review was made by the VA. The VA determined entitlement to evaluation in excess of 10 percent for PTSD was not warranted. The Statement of the Case 20090818 noted that no psychiatric treatment at the Connecticut VA since January 2009, nor was there evidence of any psychiatric treatment anywhere else. This was one month after the mental health consult described above where weekly psychotherapy was planned. The CI separated from active duty on 20071230 and from the reserves on 20080515. At the time of December 2007 his PTSD warranted a 10% rating based on both the military NARSUM Addendum and the VA C&P examination. One month later in Jan 2008 the CI was not in treatment and, in fact, declined treatment despite a positive PTSD screening. It appears he was not in treatment between January and December 2008 but then weekly psychotherapy for PTSD was planned in December 2008. The PTSD symptoms reported in December 2007 and December 2008 appeared to be at a similar level of severity and it is reasonable to assume they remained constant throughout this time period. The date the CI separated from service (20080515) and six months after this date (20081115) both fall within this time period. Therefore after the required 50% rating is applied for the first six months after separation, a 10% rating should be applied as the permanent rating for PTSD.

Right Patellar Chondromalacia. The NARSUM of 20070831 does not provide specific information about the history of the right knee injury except to say a shrapnel wound was sustained in this area. The CI had undergone an anteromedial traumatic arthrotomy 20060821 and no intraarticular injury was noted. The CI complained of pain, numbness and tingling of his right lower extremity and pain involving his right knee. The CI was only able to run one day per week and could not run greater than one mile. The examination documented the right knee was tender to palpation on the lateral aspect of his patella. No swelling, warmth, or erythema was noted. There was no joint line tenderness or instability. McMurray test was also negative. Shrapnel fragments and mild degenerative changes were noted on X-ray. No ROM examination was documented.

The VA C&P examination of 20071231 documented serial use of a wheelchair, then crutches, and then a cane. At the time of the exam, the CI stated he had stopped using the cane about one month prior but still used it when walking for prolonged periods. He was using it and walking with a limp, favoring the right leg at the exam. A special brace and shoes had been ordered by his VA clinic but had not yet been received. The CI reported paresthesias in the peroneal nerve distribution as well as knee pain and giving way with uneven ground walking/stairs. He also felt his knee was weaker and he described stiffness, swelling, heat and redness, "locking," fatigability, lack of endurance. He could not "trust the right knee and almost fell down descending stairs". He was taking Mobic and using lidocaine 5% topically for pain. He was going to physical therapy in Waterbury. He had periods of flare-up of joint disease exacerbated by weight bearing and prolonged sitting and standing; had loss feeling which comes and goes toes and arch and shooting nerve pain. The knee pain is 8-9 out of 10 when standing and weight-bearing and 2-3/ 10 at rest. If he stood longer than ten minutes in one position or walked longer than 10 minutes, he had additional functional impairment and would have to sit and rest until his pain is gone. He could not run, play any contact sports, or lift weights as he could not stand for longer than 10 minutes. At the exam he was limping and walking with a crutch. The examination noted the range of motion in the chart below. The knee was stable to varus and valgus and crepitus was present at 30 degrees. There was a mild laxity of the MCL/LCL with mild edema. Lachman’s and McMurray’s tests were negative. Pain was noted on repeated use and during flare-ups. With repetitive movements the CI had weakness, fatigue, lack of endurance and ROM decreased 5 additional degrees. A positive Tinel’s was noted at mid-calf over the peroneal nerve.

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| **KNEE Movement** | **Normal ROM** | ROM VA 20061128 | ROM VA PAIN 20071231 |
| Right Flex | 0 - 140 | 130 Crepitus 0-30 | 0-125: pain at 110: mild guarding -5 with repetitive motion. |
| Right Ext | 0 - 0 |  |  |
| Left Flex | 0 - 140 |  |  |
| Left Ext | 0 - 0 |  |  |

The VA rated this condition at 10% for painful or limited motion of a major joint under VASRD 5099-5014. With repetitive testing there was a decrease of 5 degrees of motion and there was pain, fatigue, weakness, and lack of endurance. The PEB determined this condition was category II, related to the unfitting diagnosis of shrapnel injury of the right lower extremity but not separately unfitting. Both injuries resulted from the grenade blast but two separate areas of the right lower extremity were affected and this condition is not related to the peroneal nerve injury. Both conditions contribute to the same functional impairments related to prolonged standing, walking, and running. Both conditions were included on the CI’s LIMDU and both limited his ability to perform required tasks. The commander’s letter mentions only the injury in Iraq and no specific condition that makes the CI unfit for continued service. This condition is related to the right lower leg injury and does not produce any additional disability beyond that caused by the Injury of Lower Extremity, Right Leg, involving Shrapnel.

Knee pain was noted as separate from the paresthesia and pain below the knee as early as 20070524 at an outpatient visit to clinic at Groton and the CI was referred to physical therapy for his knee. At a visit to Groton Orthopedic clinic in 20070802 chondromalacia patella was diagnosed and a continuation of physical therapy for his knee was ordered. An outpatient VA progress note 20080715 documented painful motion and use of a brace on the right knee. VA treatment records from December 2008 document improvement in functional limitations over time but the paresthesias and pain persisted.

Other Conditions:

Urinary Incontinence, Frequency, and Urgency. The MEB NARSUM of 20070831 stated the CI was being followed by urology for enuresis, initially occurring about three times a week, and daily urgency with incomplete voiding. However, the CI denied any fevers, chills, nausea, vomiting, diarrhea, discharge or dysuria and all of his urinary symptoms had resolved. A VA General Medical C&P exam 20071231 documented that in terms of his right groin, the CI denied erectile dysfunction but it was painful to hold his urine. He could still hold it but it was uncomfortable. He denied dysuria, hematuria, or incontinence. The blast was close to groin area and he did not have this before his injury. No urologic diagnosis was documented on the C&P exam and none was rated on the 20080530 VARD.

A VA Genitourinary C&P examination was completed 20080912, four months after the CI separated from the reserves. This exam reported the CI could still hold his urine but it is uncomfortable to do so. The same exam reported the CI currently had voiding intervals of about once an hour during the day with multiple occurrences of incontinence requiring Depends (2-3 pads per day-in the daytime). At night he voided 3-4 times per night. He wore Depends at night because he would often leak. In both circumstances some were intentional and some were incontinence. He could not always hold his urine. He had hesitancy 6-8 times a day and had urgency resulting in incontinence. The same exam also reported he used 6-8 pads a day total (day and night). Residuals of incontinence after IED explosion were noted. The CI denied impotence or erectile dysfunction. CI did report at times he had some discomfort during intercourse. CI was not employed but was a college student. He had to use the bathroom often and many times, due to urgency. He was often embarrassed when he is incontinent as it required him to carry extra pads with him in school. Often, he was unaware he wet his pants and had to keep a pair of clean underwear and trousers when he left home. On physical exam, the CI was tender to palpation directly over the bladder and the pain radiated to the right groin. No hernia was present and he had previously had right hernia repair. The epididymis and spermatic cord were very sensitive to exam manipulation and there was hypersensitivity to monofilament testing in the right inguinal area. X-rays showed shrapnel in the soft tissue of the midpelvis and proximal right femur. Scrotal and abdominal ultrasounds were scheduled and the CI was to follow-up on 7 October 2008. The diagnosis was chronic urinary incontinence and urgency, requiring use of absorbent material. He had severe functional impairment in his activities of daily living from this condition as he needed to have easy and frequent access to a rest room to urinate and change absorbent pads several times during the day.

At follow-up with urology 20081007 CI stated he had bedwetting after the injury that had gradually diminished. His last episode was reported as about three months previously (July 2008) and prior to that was occurring once a month. He had some urgency with difficulty postponing urination for more than 5 minutes. He had slight hesitancy (10-15 seconds). He said he would be able to live with his voiding symptoms as they are now with moderate bother. A KUB (kidney, ureter, and bladder) x-ray showed shrapnel over the bladder shadow and a CT was ordered to further evaluate. The CT 20081021 documented shrapnel contiguous with the right bladder dome. There was no bladder wall thickening, perivesical change, or shrapnel within the bladder lumen. No further urology clinic visits were noted in the STR. However, the CI did visit his primary care clinic 20081208 that documented the CI felt like he was urinating normally then and the urgency had decreased. While it appears the CI had problems with urinary incontinence and frequency it is not clear how long after the initial injury these symptoms persisted. At both the NARSUM examination and the final visit with VA urology present in the STR, symptoms appeared to have diminished a great deal. The increased symptoms on the C&P exam may have been historical. The internal inconsistencies within that document suggest this as well. There is not sufficient evidence to determine this condition was unfitting at either the time of entry onto TDRL 20080515 or separation from the TDRL 2008115.

Multiple Scars. The CI had multiple scars as a result of his injuries. However, there is no evidence any of these scars interfered with performance of any required duties and none are considered unfitting.

Other Conditions Not in the DES: Tinnitus

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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. The PEB did not apply VASRD §4.129 to the CI’s PTSD adjudication as required by NDAA 2008 in effect at the time, for which the Board also provides remedy. After careful consideration of all available information, the Board unanimously determined that the CI’s PTSD is most appropriately rated with an initial Temporary Disabled Retired List (TDRL) rating of 50% in retroactive compliance with VASRD §4.129 as DOD directed; and a 10% permanent rating at six months IAW VASRD §4.130.

The CI was diagnosed with PTSD and received psychotherapy as treatment. At the time of the MEB NARSUM Addendum in December 2007, he had improved but was persistently experiencing significant symptoms of PTSD that impaired his fitness for duty. At that time a GAF of 60 was assessed and the CI was felt to have marked impairment for military service and considerable impairment for social and industrial adaptability. This examination and a VA C&P examination in December 2007 documented symptoms of similar severity with a December 2008 VA Psychiatric Evaluation. All three exams support a disability rating of 10% based on persistent symptoms of PTSD due to mild symptoms that decrease work efficiency and ability to perform occupational tasks only during periods of significant stress. A permanent rating for PTSD must be ascertained based on the CI’s condition on 20081115. There is no evidence to suggest his condition was significantly worse one month prior to the December 2008 VA C&P evaluation.

The Board considered Injury of Lower Extremity, Right Leg, involving Shrapnel and unanimously determined that this condition is most appropriately rated as VASRD 8723 with a 10% disability at both 20080515 and 20071115. The 10% rating is based on persistent pain and paresthesias in the distribution of the peroneal nerve and is considered a moderate incomplete paralysis of this nerve. The Board considered the condition of Right Patellar Chondromalacia and unanimously determined that this condition was not unfitting at the time of separation from service and therefore no disability rating should be applied. This condition is related to the right lower leg injury and does not produce any additional disability beyond that caused by the Injury of Lower Extremity, Right Leg, involving Shrapnel.

The Board considered the condition of Urinary Incontinence, Frequency, and Urgency and unanimously determined that this condition was not unfitting at the time of separation from service and therefore no disability rating is applied. There is not sufficient evidence in the STR to consider this condition as unfitting on 20080515. While the VA C&P examination of 20080912 states the CI had frequent episodes of incontinence, there is no evidence these symptoms were present at the time of separation. Outpatient visit notes before and after 20080912 document the current absence of any symptoms which could have been considered unfitting. The Board also considered the multiple scars that resulted from the CI’s injuries and unanimously determined none of the scars were unfitting at the time of separation from service and therefore no disability rating is applied.

The other condition rated by the VA (Tinnitus) was not mentioned in the Disability Evaluation System (DES) package and is 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 this condition as unfitting.

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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 then a permanent combined 20% disability retirement as below.

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| --- | --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **TDRL RATING**  **20080515** | **PERMANENT**  **RATING**  **20081115** |
| Post-Traumatic Stress Disorder | 9411 | 50% | 10% |
| Injury of Lower Extremity, Right Leg, involving Shrapnel | 8799-8723 | 10% | 10% |
| **COMBINED** | **60%** | **20%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090913, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

Deputy Director

Physical Disability Board of Review

MEMORANDUM FOR DEPUTY COMMANDANT, MANPOWER & RESERVE AFFAIRS

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATION

ICO XXXXXX, FORMER USMCR, XXX XX XXXXX

Ref: (a) DoDI 6040.44

Encl: (1) PDBR ltr dtd 16 Nov 10

1. I have reviewed the subject case pursuant to reference (a). 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 with placement on the Temporary Disability Retired List with a disability rating of 60 percent for the period 31 October 2007 thru 30 April 2008.

b. Final separation from naval service due to physical disability effective 1 May 2008 with a disability rating of 20 percent and entitlement to disability severance pay.

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

Principal Deputy

Assistant Secretary of the Navy

(Manpower & Reserve Affairs)