RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXX BRANCH OF SERVICE: MARINE CORPS

CASE NUMBER: PD0900631 SEPARATION DATE: 20061015

BOARD DATE: 20101207

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CASE SUMMARY: This covered individual (CI) was Staff Sergeant (Switch Technician, 2822) medically separated from the Marine Corps in 2006 after nine years of service for Post Concussion Syndrome and Post-Traumatic Stress Disorder (PTSD). These conditions and others occurred after a deployment to Iraq from February to October 2004. While deployed he served as a Rifleman, 0311. His injuries were secondary to an IED (improvised explosive) explosion that occurred on 15 Sep 04. He was placed on limited duty for Post Concussive Syndrome and Loss of Consciousness Episodes in December 2005. His restrictions were no driving, no weapons, and physical training as tolerated. PTSD was diagnosed in March 2006. The Navy Physical Evaluation Board (PEB) determined both Post Concussion Syndrome and PTSD were unfitting for continued Naval service. The CI was separated at a combined 20% disability with 10% for each condition using the Veterans Affairs Schedule for Rating Disabilities (VASRD) and applicable Naval and Department of Defense (DoD) regulations. An initial 50% rating for PTSD with re-evaluation of disability after six months was not required by the DoD in 2006.

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CI CONTENTION: The CI states: ”At the time that I was rated by Naval PEB for Post Concussion Syndrome (3102) the condition TBI was not fully understood, nor was there a provisioning to code such a condition, Also the PEB grouped a few of my conditions all under one and gave me 10% where the VA rated them separately. My VA rating is 70%, for the same condition but two. The VA has since changed my Post Concussion Syndrome to TBI.”

This case is court remanded under the *Sabo et al. v. United States* class action suit.

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RATING COMPARISON:

|  |  |
| --- | --- |
| **Service PEB – Dated 20060802** | **VA (4 Mo. Pre-Separation) – All Effective 20061016** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Post-Traumatic Stress Disorder of Mild to Moderate Severity | 9411 | 10% | Post Traumatic Stress Disorder (PTSD) | 9411 | 30% | 20060613 |
| Post concussion Syndrome | 9304 | 10% | Migraine Headaches Secondary to Post Concussion Syndrome | 8045-8100 | 30% | 20060614 |
| Post concussion Headache With Migraine Features | Related Category 2 Diagnosis |
| Cognitive Disorder | Related Category 2 Diagnosis | Absence Like Lapses and Dizziness Secondary to Post -- Concussion Syndrome | 8045 | 10% | 20060614 |
| Acoustic Injury to His Tympanic Membranes Bilaterally Requiring Pressure Equalization Tubes | Related Category 2 Diagnosis | Residuals, Status Post Pressure Equalization (PE) Tubes, Bilateral Eardrums | 6299-6200 | 10% | 20060614 |
|  | NeuropsychologyAddendum | Strain, Lumbar Spine | 5237 | 10% | 20060614 |
|  | Not in DES | Tinnitus | 6260 | 10% | 20060614 |
|  | Not in DES | Residuals. Status Post Exostectomy 1st Metatarsal (MT) Cuneiform Joint. Left Foot | 5284-7805 | 0% | 20060614 |
| **TOTAL Combined: 20%** | **TOTAL Combined (*Includes Non-PEB Conditions*): 70%**   |

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ANALYSIS SUMMARY:

The patient was traveling in a convoy heading out of Fallujah when his vehicle was hit. He believed he was temporarily stunned but fully participated in the ensuing firefight. During the firefight, he temporarily lost his hearing and remembers feeling blood from his mouth, ears and nose. Afterwards, he was told there was a second blast but he had no memory of this additional blast. He admitted to some confusion and disorientation after that blast and could not fully recall all of the surrounding details. After he returned to his base he had head and ear pain. A complete evaluation of his problem was deferred until his unit returned. During his post-deployment leave he had headaches severe enough to cause him to go to the emergency room a few times. He also continued having ear symptoms, dizziness, and nausea. He required pressure equalization tubes in both tympanic membranes and this surgery occurred in February 2005. He also had a documented hearing loss that later resolved. He was evaluated and followed by concussion clinic, otolaryngology, and neurology initially. Both neurology and the concussion clinic noticed symptoms of PTSD and he was first seen by mental health in March 2006. He received biofeedback therapy. Medication was recommended but it is not clear if he received any prior to his separation. His headaches were treated with Depakote and Midrin.

The Medical Evaluation Board (MEB) Narrative Summary (NARSUM) was completed by Neurology in April 2006. Psychiatric, Neuropsychologic, and Otolaryngologic Addenda to the NARSUM were completed in May and June 2006. At the time of these evaluations the CI had weekly postconcussion headaches with migraine features (photosensitivity and nausea), intermittent dizziness with blurred vision and “seeing stars”, irritability, short temper, decreased motivation, anhedonia, general malaise, insomnia due to nightmares, flashbacks, psychomotor agitation, memory problems, concentration problems, staring spells, hypervigilance, increased startle, diminished motivation for activities, social withdrawal, and avoidance of cues. He was emotionally labile. Neuropsychological testing revealed a pattern of intact intellect with impairment in concentration, verbal memory, verbal fluency, psychomotor speed, and cognitive flexibility consistent with the effects of a concussion. The CI had normal brain CT (tomography) and magnetic resonance imaging (MRI) and a borderline electroencephalogram (EEG) test. The treating neurologist did not believe he had a seizure disorder but that his staring spells were part of his PTSD symptoms.

His mental health symptoms had improved somewhat with approximately three months of biofeedback but his cognitive symptoms did not change in level of severity. Neuropsychological testing was considered valid and documented problems consistent with a traumatic brain injury (TBI). During the examination process the CI appeared cooperative and no staring spells were observed. However, his speech was halting at times and he was observed to stumble over words. He was compliant with the tests but his ability to focus waned over time and he needed prompting. He also had difficulty understanding instructions and needed multiple explanations to complete some tasks. The examiner thought this inability to sustain full effort was a valid representation of the CI’s current level of functioning and not due to intentional lack of effort. The neuropsychological testing showed the CI’s general intellectual abilities were intact in verbal and nonverbal domains as well as reasoning, problem solving, visuospatial and constructional skills. However his performance of tests of attention and concentration varied from impaired to average. He had mild to moderate impairment of verbal learning and memory and a tendency to produce intrusion errors. He had a tendency to perseverate, repeating a previously but no longer appropriate type of response on tests of cognitive flexibility. He also had difficulty with tests involving reading but he had a possible history of dyslexia and this may have been developmental in origin.

His Personality Assessment Inventory was valid. His responses showed anxiety probably related to a traumatic event, aggressiveness, problems with concentration, and affective instability with poorly controlled anger and these were consistent with his reports in multiple clinical interviews. The CI had both Post Concussive Syndrome or TBI and PTSD that were considered unfitting by the Navy PEB. He had a multitude of symptoms that could be grouped in various ways for rating purposes. Each symptom may only be used to support the disability evaluation of a single condition. The TBI condition included cognitive symptoms as well as the subjective complaints of dizziness, headaches, and nausea. The CI also had multiple behavioral symptoms, some of which could be caused by either condition or by both.

Post Concussion Syndrome or Traumatic Brain Injury (TBI). The 2006 VASRD (8045 Brain disease due to trauma) states that purely subjective complaints such as headache, dizziness, insomnia, etc., recognized as symptomatic of brain trauma, will be rated 10 percent and no more under diagnostic code 9304 Dementia due to head trauma. The Navy PEB rated the CI’s nausea and dizziness as 9304 at 10% IAW with the VASRD. The cognitive impairment is objectively documented with the neuropsychological testing and cannot not be included in the 10% rating for subjective symptoms. These symptoms could be evaluated under 9304 but the rating would be determined by using the VASRD General Rating Formal for Mental Disorders and would be based on functional impairment. However, the 2006 VASRD clearly states that a rating of 10% under 9304 for subjective symptoms of brain trauma will not be combined with any other rating for a disability due to brain trauma. The PEB designated Cognitive Disorder as a category 2 diagnosis related to post concussion syndrome but not unfitting by itself. The non-medical assessments state that when the CI was present, he was able to perform the essential functions of his job. There is not sufficient evidence in the service treatment record (STR) to determine the Cognitive Disorder was unfitting at the time of separation and therefore 9304 cannot be rated under the General Rating Formula for Mental Disorders or be greater than 10%. The STR contains no treatment records for the post concussion syndrome or any condition other than back pain after June 2006. The PEB also determined the Post Concussion Headache with Migraine Features and Acoustic Injury to his Tympanic Membranes Bilaterally Requiring Pressure Equalization Tubes were not unfitting but were Category 2 diagnoses related to the Post Concussion Syndrome. There is not sufficient evidence to determine either condition was unfitting at the time of separation from service and therefore no rating is applied.

The VA released Training Letter 06-03 on 20060213 as an educational tool for understanding the nature and causes of TBI and general rating considerations. This letter was in effect prior to the CI’s separation. However no changes in the VASRD rating criteria were made at this time. Training Letter 07-05 was released 20070831, approximately ten months after the CI separated. This letter addressed evaluation of mental disorder due to TBI and stated if the cluster of symptoms, which may include cognitive impairment, is encompassed by the mental disorder, the condition would be appropriately evaluated under the General Rating Formula for Mental Disorders. This appears to be a clarification rather than a new method of evaluation as previous VASRDs have included this directive. All mental disorders are evaluated using the General Rating Formula for Mental Disorders. Current TBI rating criteria were released in VA Fast Letter 08-36 on 20091024. If the current TBI rating criteria were applied, the CI’s neuropsychological testing results would warrant a 40% rating for TBI based on a level 2 cognitive impairment. This is based on objective evidence on testing of at least mild impairment of memory, attention, concentration, or executive functions resulting in mild impairment. However, this method of rating cannot be applied to veterans who separated from service prior to the release of this letter.

PTSD. In a July 2005 visit to the concussion clinic, the provider noted symptoms of combat stress and recommended the CI see mental health. His treating neurologist noted the same symptoms and also recommended he be seen by mental health. At a December 2005 visit the neurologist documented that he highly suspected PTSD. A complete evaluation of the CI’s staring spells resulted in a characterization of absence-like lapses of unknown etiology. The CI had a normal neurologic examination, normal brain MRI and a borderline EEG. The neurologist doubted the lapses were a true epileptiform manifestation and he suspected they might be PTSD related.

The CI had two major events while deployed that could serve as the stressor proximate to his PTSD. Both are clearly documented in the STR. The CI’s initial mental health evaluation was completed 20060302 by a licensed clinical social worker. She diagnosed PTSD and recommended biofeedback therapy as well as medication for sleep. She estimated a GAF of 61-70. The CI was also evaluated by a clinical psychologist and this provider later wrote the MEB NARSUM Psychiatric Addendum. The MEB evaluation was completed 20060627 and the GAF at that time was 55-65. The Neuropsychological MEB Addendum was completed 20060524 and it reported a GAF of 65. The CI’s VA C&P examination was completed prior to separation from service. It was done 20060613 and documented a GAF of 55-60. These three MEB and C&P evaluations show similar symptoms and were completed over slightly more than one month’s time. There is no information in the STR concerning PTSD after this time period. However a note from the concussion clinic of 20041110 documents many of the same symptoms later attributed to PTSD. These include mood changes including increased irritability, shortened temper, increased isolation, decreased motivation and loss of interest in things that he used to enjoy. The provider documented that the CI denied needing additional evaluation or treatment for the mood problems and recommended he consider this if his symptoms worsened. Multiple visits to neurology and the concussion clinic document the same symptoms and suspicion of a mental health diagnosis.

The initial mental health evaluation in March 2006 noted the symptoms described above as well as hypervigilance, recurrent distressing thoughts and dreams about his deployment to Iraq, and sleep disturbance. The mental status examination was normal. A note from 20060327 noted insomnia, nightmares, and flashbacks. Mental status examination was normal and biofeedback was recommended. GAF was estimated at 51-60. The Neuropsychological Addendum to the MEB NARSUM in May 2006 reported that despite biofeedback treatment for PTSD, the CI continued to experience increased startle, hypervigilance, irritability, diminished motivation for activities, social withdrawal, avoidance of cues, and sleep problems to some degree. On 20060607 the MEB was initiated and the psychologist again reported a GAF of 51-60. The VA C&P examination was performed on 20060613 and it documented the CI first had symptoms of PTSD in July 2004 after the first stressful event when deployed and continued to have symptoms, some constantly and some intermittently. He was worried all the time, had sleep disturbance, flashbacks, nightmares, high alertness, and hypervigilance. The CI reported he had been in biofeedback weekly for three weeks and did not think it had been of any help. The CI was married and had one daughter. He reported he did not socialize because he did not feel like it. He reexperienced the traumatic events with nightmares and flashbacks with intense distress when exposed to events that remind him of the deployment events. He therefore avoided stimuli associated with the trauma including places and people. He reported markedly diminished interest in participation in significant activities and had a restricted range of affect. He also had difficulty falling and staying asleep, irritability, anger outbursts, exaggerated startle response, difficulty concentrating, and hypervigilance. There was no history of substance abuse. On mental status exam he was felt to be a reliable historian. His examination was normal and noted some memory problems which were mild forgetting of names, directions, and recent events. The diagnostic criteria for PTSD were met and the psychiatrist assigned a GAF of 55-60. The condition duration was chronic (more than three months) and it did cause distress and impairment in social, occupational, and other areas of functioning.

The MEB NARSUM Addendum was completed 20060627 and it reported a slightly improved GAF of 55-65. The provider noted that with individual therapy and biofeedback, the CI’s emotional symptoms did improve somewhat but he continued to have pervasive symptoms of daily intrusive images of the above events, general malaise, anhedonia, insomnia due to nightmares, flashbacks, psychomotor agitation, memory problems, headaches, concentration problems, blackouts, hypervigilance, and emotionally labile particularly irritability. Some of the emotional symptoms had decreased to a more mild level but the cognitive symptoms remained at the moderate level. The provider noted impairment to military service was moderate and civilian industrial capacity to be mild to moderate. The level of symptoms appears to be similar in all comprehensive evaluations noted above. The one discrepancy is the NARSUM Addendum stated there was some improvement in behavioral symptoms with biofeedback. However, at the VA exam two weeks prior, the CI denied any improvements.

Although some aspects of the 2006 VASRD 50% rating criteria for PTSD are present (difficulty in understanding complex commands; impairment of short-term memory and disturbances of motivation and mood) the CI was generally functioning satisfactorily, with routine behavior, self-care, and conversation normal and his condition at the time of the MEB more closely approximates the 30% criteria. As there is no further clinical information after the time period of these examinations the Board must assume his condition was the same at the time of separation in October 2006. This appears reasonable and the condition appears to have been stable over time with possible slight improvement after biofeedback. While it appears less reasonable to also assume the CI’s condition persisted at the same level of functional impairment for the six months following separation, there is no evidence available to determine if the condition worsened or improved. Therefore the Board must assume there was no change during the six months following separation and a permanent disability rating of 30% is recommended after the required six month 50% rating.

Other Conditions. Strain, Lumbar Spine. There is no evidence in the STR that this condition was unfitting at the time of separation from service.

Other Conditions Not in the Disability Evaluation System (DES). Tinnitus and Residuals, Status Post Exostectomy 1st Metatarsal (MT) Cuneiform Joint. Left Foot

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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 information the Board recommends the following: In the matter of the Post-Traumatic Stress Disorder (PTSD) condition, the Board unanimously recommends an initial TDRL rating of 50% in retroactive compliance with VASRD §4.129 as DOD directed; and a 30% permanent rating at six months IAW VASRD §4.130. In the matter of Post Concussion Syndrome, the Board unanimously recommends an initial 10% rating and a continuation of this rating at six months. The PTSD condition met the criteria for a 30% rating at the time of the MEB and VA evaluations in May and June 2006. The CI had persistent mild to moderate symptoms of PTSD documented on three separate evaluations. While he did have some elements of the 50% rating criteria, his disability picture more closely approximated the 30% rating. His symptoms had been present since November 2004 and the condition appears to have been stable over the intervening time period of approximately eighteen months. The Psychiatric MEB NARSUM Addendum did note some improvement with biofeedback but the VA C&P examination stated no improvement occurred. However, if the improvement had occurred the CI would still meet the 30% rating criteria. There is no information in the service treatment record (STR) about PTSD after the time of these evaluations. However, as the condition had been stable for eighteen months it, more likely than not, did not significantly improve or worsen in the six months following separation. Therefore the permanent rating should be 30%. The Navy PEB determined that while the CI’s Post Concussive Syndrome was unfitting, his Post Concussion Headache with Migraine Features, Cognitive Disorder, and Acoustic Injury to Tympanic Membranes Bilaterally Requiring Pressure Equalization Tubes were not unfitting. The CI’s subjective symptoms of Post Concussion Syndrome cannot be rated more than 10% under VASRD 9304 Dementia due to Head Trauma and this rating cannot be combined with any other rating for disability due to brain trauma. The Board considered the conditions of Post Concussion Headache with Migraine Features, Cognitive Disorder, and Acoustic Injury to Tympanic Membranes Bilaterally Requiring Pressure Equalization Tubes. It unanimously determined that none of these conditions were unfitting at the time of separation from service and therefore no disability rating is applied. There was no evidence in the STR that these conditions prevented satisfactory performance of the CI’s required duties. The Board also considered the condition of Strain, Lumbar Spine and unanimously determined that this condition was not unfitting at the time of separation from service and therefore no disability rating is applied. There was no evidence in the STR that this condition prevented satisfactory performance of the CI’s required duties. The other diagnoses rated by the VA (Tinnitus and Residuals, Status Post Exostectomy 1st Metatarsal (MT) Cuneiform Joint, Left Foot) 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 Military Naval Records (BCNR) to consider adding these conditions as unfitting.

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RECOMMENDATION: The Board recommends that the CI’s prior separation be re-characterized to reflect that, rather than discharge with severance pay, the CI was placed on the TDRL at a combined 60% for a period of 6 months (PTSD at 50% IAW §4.129 and DoD direction and Post Concussion Syndrome at 10%) and then permanently retired by reason of physical disability with a final combined 40% rating as indicated below.

|  |  |  |  |
| --- | --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **TDRL RATING** | **PERMANENT RATING** |
| Post-Traumatic Stress Disorder of Mild to Moderate Severity | 9411 | 50% | 30% |
| Post Concussion Syndrome | 8045-9304 | 10% | 10% |
| **COMBINED**  | **60%** | **40%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20091015, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

Deputy Director

Disability Board of Review

MEMORANDUM FOR DEPUTY COMMANDANT, MANPOWER & RESERVE AFFAIRS

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATION

 ICO XXXX, FORMER USMC, XXX XX XXXX

Ref: (a) DoDI 6040.44

 (b) PDBR ltr of 21 Dec 10

1. Pursuant to reference (a), the recommendation of the PDBR as set forth in reference (b) was reviewed. 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 15 October 2006 thru 14 April 2007.

 b. Final separation from naval service due to physical disability effective 15 April 2007 with a disability rating of 40 percent and placement on the Permanent Disability Retired List.

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)