RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXX BRANCH OF SERVICE: MARINE CORPS

CASE NUMBER: PD0900640 BOARD DATE: 20101027

SEPARATION DATE: After 20080301

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SUMMARY OF CASE: This covered individual (CI), Corporal/E4 (2111/ Small Arm Specialist) was medically separated from the Marine Corps after 20080301. On 20041222, while stationed in Iraq, the CI was injured during an improvised explosive device (IED) explosion. He sustained an open wound to his right arm with a non-displaced radial shaft fracture. He had shrapnel in the right arm and also in both lower extremities. The CI also had a small area of burn along the ulnar aspect of the left hand and injuries to his back. He also suffered bilateral Tympanic membrane (TM) perforations. He was stabilized in a field hospital and air evacuated to Germany and then to Brook Army Medical Center (BAMC), Antonio, TX. At BAMC he was aggressively treated by a multi-disciplinary team of DoD, VA, and civilian physicians (ENT, Neurology, Orthopedics, Plastic Surgery and Psychiatry). His care was then transferred to his home area in Illinois. The CI was issued a P3 Profile placing him on light duty. The CI continued to experience right arm pain, and continued to struggle with mental health issues. The CI attempted suicide two times and had a third suicidal ideation. The CI completed an inpatient Drug and Alcohol Program. Command confirmed that the CI was unable to maintain his physical readiness requirements consistent with being an active duty Marine. The member requested he be referred to a medical board for evaluation. The CI was referred for Medical Evaluation Board (MEB) proceedings. The MEB forwarded a 6001-1 listing Pain in the Limb to the Physical Evaluation Board (PEB). The 20060628 narrative summary (NARSUM) found persistent upper extremity pain with mild dysfunction prohibiting him from maintaining his physical fitness requirements consistent with being in the United States Marine Corps. Because of the CI’s mental health issues the PEB suspended the case and requested a neuropsychiatric evaluation to include testing. Upon receipt of the psychiatry evaluation, the Informal PEB found the CI unfit for continuation of duty and separated him from active duty with severance pay with a combined rating of 20%. The medical basis for the separation was Persistent Upper Extremity Pain with Mild Dysfunction, Veterans Administration Schedule for Rating Disabilities (VASRD) Code of 8614, rating at 20%. The PEB listed two other conditions, Post Traumatic Stress Disorder and Cognitive Disorder as Category III: Conditions that were not separately unfitting and did not contribute to the unfitting conditions.

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CI CONTENTION: The CI states: “I was far more disabled than the military medical examiner thought and I was not examined thoroughly enough. The examiner did not listen to my complaints”.

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Rating Comparison table is located on the next page.

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service PEB – Dated 20070124** | **VA (2 or More Months Prior to Separation)** **All (except 8517) Effective 20060303** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Persistent Upper Extremity Pain With Mild Dysfunction | 8614 | 20% | SFW Right Arm with Retained Fragments(increased to 50% effective 20070801) | 8515 | 10% | 20051208 |
| SFW Residual Scar, Right Arm Associated with SFW Fracture , Right Arm | 7801 | 10% | 20051208 |
| Right Forearm Muscle Injury With Retained Foreign Body | 5305 | 40% | 20051208 |
| Peripheral Neuropathy, Medial Cutaneous and Musculocutaneous Nerve Associated with Right Forearm Muscle Injury with Retained Foreign Body | 8517 | 20%From 20070801 |  |
| SFW Fracture, Right Arm | 5201 | 0% | 20051208 |
| Post Traumatic Stress Disorder (PTSD) | CAT IIINot Unfitting | Post Traumatic Stress Disorder (PTSD) | 9411 | 50%70% | 20051208Same  |
| Cognitive Disorder |
| Psychiatric Addendum, MEB H&P | Residual Headaches from Concussion | 8100 | 30% | 20051208 |
| Not in DES | Tinnitus | 6260 | 10% | 20051208 |
| Not in DES | Tympanic Membrane, Perforation of | 6211 | 0% | 20051208 |
| Not in DES | Left Lower Arm Scar Ass-ociated with Left Hand Burn | 7801 | 0% | 20051208 |
| Not in DES | SFW Residual Scar, Left Leg | 7801 | 0% | 20051208 |
| Not in DES | Left Hand Burn Residual Scar | 7801 | 0% | 20051208 |
| **TOTAL Combined: 20%** | **TOTAL Combined (*Includes Non-PEB Conditions*):** **90% from 20060303****100% from 20070801** |

\*SFW = shell fragment wound

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ANALYSIS SUMMARY:

Persistent Upper Extremity Pain with Mild Dysfunction. The CI was a Marine who sustained injuries during a car bomb blast in Iraq on 20041222. The injuries identified included a non-displaced radial shaft fracture, a 2% total body surface area burn on the volar aspect of the left hand and shrapnel wounds to the right forearm and bilateral thighs. He also sustained bilateral tympanic membrane ruptures. The CI developed swelling and pain in his right forearm and it was felt to be due to a lacerated radial artery with subsequent development of a compartment syndrome. He was taken to the operation room in theater for a right forearm fasciotomy and his right radial artery was tied off. He was transported to Germany where he received a repeat irrigation and debridement on 20041224. He was air-evacuated to CONUS and arrived at BAMC on 20041230 for definitive treatment. On the 3rd of January he underwent another irrigation and debridement of his forearm wound with delayed closure. X-rays revealed metallic fragments within the mid forearm and an incomplete fracture of the mid right radial diaphysis. He was referred to plastic surgery for skin grafting of his right hand burn. Seven weeks after the closure of his right fasciotomy he was doing well but had a scar band at the antecubital fossa. His care was transferred to the Orthopedic Institute of Illinois, Peoria, IL. The CI continued to progress well but the scar band at the level of the antecubital fossa was causing tension and with force the CI could only get to -7 degrees at the elbow with extension. However, the CI did have full wrist motion and hand motion; and full pronation and supination. With each follow-up appointment the CI continued to show improvement with range of motion (ROM). The CI continued to complain of continuous pain and it was noted that the CI’s right forearm had decreased sensation to palpation and a positive Allen’s test consistent with occlusion/disruption of radial artery. There were two areas of concern regarding his right forearm wound. There was noted a 4 mm in diameter skin breakdown near the elbow and a large foreign body in the ulnar neurovascular bundle mid forearm. The orthopedic team referred the CI to Plastic Surgery for possible wound revision and contracture release. The service treatment records (STR) indicate that the CI had two additional surgeries to the right forearm. On 20050422 surgeons removed the foreign body from the right forearm. The operative note states the foreign body was in the flexor digitorum profunda muscle. In December of 2005 the CI still complained of pain in his right forearm and hand. He was tender to palpation at the border of the superficial branch of the radial nerve. The pre-operative diagnosis was a neuroma and during surgery it was found that the superficial radial nerve was entrapped. The nerve was dissected free during surgery on 20060103. In May of 2006 the CI had worsening pain and continued numbness in the superficial branch of the radial nerve distribution. He was unable to maintain his physical readiness requirements consistent with being an active duty Marine. The MEB NARSUM of 20060628 reported that he had 4/5 muscle strength in the right upper extremity with maximal effort. The NARSUM did not specifically state which muscles were involved and as written, but it implies all forearm muscles were affected. Involvement of multiple muscles is consistent with the type of injury involved. This examination also noted numbness in the distribution of the superficial branch of the radial nerve.

The Commander’s letter of 20060710 noted the CI’s condition precluded firing a weapon. The CI had left active duty but was still in the Reserves and was attending drill. The Navy PEB determined he was unfit as a result of this condition and rated it at 20% under VASRD 8614 for mild Incomplete Paralysis of the Radial Nerve. This code was chosen presumably because the sensory deficits were in the radial nerve distribution. However, involvement of this sensory nerve alone could not account for weakness throughout the right forearm documented in the NARSUM and the VA Compensation and Pension (C&P) examination.

A VA orthopedic C&P examination completed six months previously on 20051208 also noted weakness in the long extensors and long flexors of the right wrist and rated this as mildly weak, 4 out of 5. No limited range of motion was noted but there was a mild lack of endurance in addition to the mild weakness of the right forearm. A VA neurologic C&P examination also on 20051208 noted the right grip was 5-/5. This examination also documents decreased pinprick sensation over the dorsal median surface of his right hand and the dorsal surface of his first and second fingers on the right. The VA examiner stated he expected continued recovery of function in the right forearm. However, when the NARSUM was completed six months later, the motor weakness was documented as 4/5 as opposed to 5-/5 and the sensory deficits persisted. The military examiner stated the CI had reached maximum medical improvement. No further improvement was expected. The VA determined that at the time of separation from active duty, the CI’s right arm condition warranted a total rating of 50%. The condition later worsened and was rated with a total of 80% effective 20070801. The VA initially rated the injury under three separate VASRD codes: 8515 at 10%, 7801 at 10%, and 5201 at 0%. The 10% rating under 8515 was based on mild incomplete paralysis of hand movements. The 10% rating under 7801 was based on the presence of two depressed, red, and tender scars on his right forearm. The VA later acknowledged an error in failing to rate the muscle injury that had existed all along and included 5305 at 40% effective 20060303, the day after separation from active duty. The 40% rating for muscle injury under 5305 was based on severe muscle disability. The CI had another surgery on his right forearm in 2007 and effective 20070801, the rating for 8515 was increased to 50% and 8517 was added at 20%. Neither the combined 50% rating applied by the VA effective 20060303 nor the later increase to 80% violate the amputation rule. For amputations of the upper extremity the rating for major side amputation of the arm below insertion of the deltoid, 5122, is 80% and the rating for forearm amputation for the major side above the insertion of pronator teres, 5123, is 80%. The rating for amputation of the major forearm below insertion of the pronator teres, 5124, is 70%.

**§4.68 Amputation rule.**

 The combined rating for disabilities of an extremity shall not exceed the rating for the amputation at the elective level, were amputation to be performed. For example, the combined evaluations for disabilities below the knee shall not exceed the 40 percent evaluation, diagnostic code 5165. This 40 percent rating may be further combined with evaluation for disabilities above the knee but not to exceed the above the knee amputation elective level. Painful neuroma of a stump after amputation shall be assigned the evaluation for the elective site of reamputation.

VASRD §4.68 Principles of Combined Ratings for Muscle Injuries states that a muscle injury rating will not be combined with a peripheral nerve paralysis rating of the same body part, unless the injuries affect entirely different functions. It appears that the VA used the CI’s sensory deficits to support the peripheral nerve paralysis rating and all other symptoms and functional impairment to support the muscle injury rating. It is not entirely clear what the PEB meant to include in “Persistent Upper Extremity Pain with Mild Dysfunction”. The NARSUM included pain, sensory deficits in the radial nerve distribution and decreased muscle strength throughout the right forearm and presumably all of these findings were considered to be included. However, as mentioned above, impairment of the radial nerve alone could not cause the motor weakness and lack of endurance. A muscle injury code should be used to evaluate the weakness and lack of endurance or fatigue for the forearm. Both wrist flexors and extensors were affected at the VA Exam and the entire forearm was affected on the military exam. The VA used VASRD 5305 when evaluating the muscle injury. This code is for muscle group V, muscles that supinate and flex the elbow and the VA presumably used this code to include all of the affected muscles of the forearm.

The CI had deep penetrating wounds of short track from shrapnel fragments and compartment syndrome. He demonstrated fatigue after average use with lack of endurance and pain. He had weakness and multiple scars from the shrapnel fragments. His injuries clearly caused an inability to keep up with work requirements. The CI was returned to reserve status in March 2006 and at the time of the Psychiatric Addendum 20070109 he was still waiting to retire. After separation from active duty the CI was accepted to the Bloomington, IL police academy but was terminated during his training because of his inability to fire a pistol. He had decreased grip strength and numbness and stiffness in his thumb. He then worked as an iron worker in construction starting in February 2006 and duties included welding. He was much slower than his coworkers because of his pain. He could no longer do very heavy lifting and he will occasionally be slowed by headache and/or right arm pain. He did not have to multitask at work; just “stick a bolt in a beam.” He had to decline assigned duties on multiple occasions. His superiors were aware of his musculoskeletal problems and are supportive but he was counseled to find a new career. He had no difficulties with activities of daily living. However, he had difficulty coordinating a meal because he had difficulty with engaging in multiple activities simultaneously.

POST TRAUMATIC STRESS DISORDER (PTSD). During its review of the case, the PEB became aware of additional mental health conditions and requested additional mental health evaluations and testing. During his treatment phase and recovery from his wounds the CI began to experience symptoms of PTSD. The STR revealed an extended post deployment behavioral health history complicated early by alcohol abuse. His record revealed that the IED incident occurred during the CI’s second tour in Iraq. During the first deployment in 2003, two members of his unit drowned while crossing a river. This later affected the CI and upon return home he experienced symptoms of PTSD but refused behavioral health treatment. In February of 2005 the CI presented to the Illinois Family Medicine (IFM) Clinic complaining of difficult sleeping, decreased appetite, crying easily, and a loss of motivation. In follow-up visits he appeared to be doing better. During his third visit to IFM he complained of stress at work and stated he had been consuming a lot of alcohol. He was given seven days off. Upon his return from the days off, the CI related he did better, denied alcohol use, and said he was less stressed.

The CI was admitted for inpatient mental health evaluation and treatment on 20050425. The history and physical revealed two suicide attempts by overdose, and suicidal ideation about shooting himself with a gun. The evaluation also revealed alcohol abuse. The CI was discharged on 20050504 with the diagnosis of PTSD in remission; Mood Disorder in remission; and ETOH abuse, r/o dependence. His initial Global Assessment of Functioning (GAF) was 35 and upon discharge it was 70. The CI was admitted to the North Chicago VAMC from 20050425 to 20050504 for PTSD, depression, and two suicide attempts. He had previously attempted suicide twice by overdosing (January and February 2005) and had once considered shooting himself while cleaning a weapon. At the time of this admission he was not currently suicidal. In the weeks following the car bombing he developed symptoms of sad mood with decreased sleep and appetite, low energy and concentration and increasing anhedonia, helplessness, and hopelessness. He also had intrusive memories and nightmares, fear and avoidance of any driving or being close to cars, a sense that his life had forever changed and he would never be able to relate to people in a normal way, increased irritability and poor concentration. He began to drink heavily and experienced guilt, thinking it was his fault that he did not prevent the bombing. He was seen by a psychiatrist and started on Lexapro and Seroquel. The CI admitted to daily intoxication with six or more drinks per day and more on weekends. He had blackouts but no withdrawal or work impairment. The CI’s father stated he had been pulled over the previous week and almost got a DUI but the CI denied this. He minimized his drinking and thought he could stop whenever he wanted.

The CI’s hospital course was not included on the discharge summary but was included in his VA C&P exam of 20051208. “The medications that the patient was on were continued including Lexapro 20 mg p.o. q.a.m., quetiapine 100 mg p.o. q.h.s. for insomnia. Multivitamins, thiamine 100 mg p.o. daily and folic acid 1 mg p.o. daily were given to the patient as well in light of his alcoholism. The patient was doing well and tolerating all the medications without any side effects. Two days after admission, as he was fully stable with euthymic mood and no psychiatric symptoms or complaints, the patient was moved to Medical Hold to await alcohol rehabilitation evaluation. The patient minimized all of his symptoms including posttraumatic stress disorder, major depressive disorder symptoms and alcoholism symptoms. He seemed to believe that he was perfectly fine, that everything was in the past and that he wanted to go back to active duty. He was still talking a lot about the guilt he felt in the past, about the symptoms he had in the past, but he was reporting these symptoms as being greatly improved at this time. As mentioned above, a significant amount of denial was identified as a major coping mechanism for this patient. The patient was evaluated by Alcohol Rehabilitation program at Great Lakes Naval Hospital and initially minimized everything so much that they could not diagnose alcoholic problems. His command wanted him re-evaluated again, and eventually, he gave enough symptoms to be recommended for outpatient treatment. Throughout his hospitalization, he continued to deny any symptoms, to deny any suicidal or homicidal thoughts or any kind of physical or psychiatric discomfort. He was eating and sleeping well. He was interacting very well with staff and peers and participating in all group activities.”

Hospital discharge plans included going home with his parents to Peoria and then to his Command in Peoria by 20050506. He was to follow-up for substance abuse treatment on 20050509. On 20050511 the CI entered into a Substance Abuse Rehabilitation Program for alcohol abuse. He did not meet diagnostic criteria for alcohol dependence. This was a structured intensive outpatient program. While he did have tolerance, he did not have withdrawal symptoms. He achieved the goals of treatment and completed the program successfully and was discharged on 20050526. A continuing care plan for this and PTSD was arranged by a social worker. The CI enrolled in treatment with psychology at the VA Illiana Clinic in May 2006. In June 2006 his care was transferred back to BAMC. At that time he was experiencing repetitive nightmares 2-3 times a week and was having trouble with short term memory. He was having difficulty sleeping and had taken all of his Ambien and Seroquel. The psychologist felt he would respond well to treatment at BAMC and the transfer of care was arranged. However one month later he was released from treatment at Community Behavioral Health, BAMC on 20050705 and instructed to follow-up at the VA. On 20051018 a memo from the VA psychologist to the CI’s commanding officer (CO) related that it was thought that the CI would “effect a full recovery emotionally and intellectually”. He was cleared for all activities but physical.

The VA C&P Psychiatry Evaluation on 20051208 (more than twelve months pre-separation) noted your current symptoms as: intense but vaguely vacant eye contact, mildly dysthymic mood, masked anxiety, difficulty concentrating, limited insight, severe depression, two suicide attempts, nightmares, sad mood, decreased sleep, increased anhedonia, intrusive memories, avoidance, not able to relate to people, irritability, and feeling extremely guilty. The CI admitted nightmares approximately four nights a week. Frequently he had been told by others that he had a 1,000 mile stare and during these episodes he would be thinking about Iraq. He had intrusive memories and triggers. He no longer owned or shot guns, he got rid of all his. He would respond unthinkingly and involuntarily to loud or unexpected noises and admitted to inordinate rage. Mental status examination noted meticulous grooming, intense but vaguely vacant eye contact. Speech had normal rate, rhythm, and volume but was sparse and he offered little spontaneous information. His mood was mildly dysthymic and his uncomfortable response to queries and tentativeness of verbalizations were indicative of masked anxiety. He had no current suicidal ideation or intent. No specific cognitive defects were noted on exam or detected on the mini-mental status exam. Intellectual capacity appeared to be average but was not specifically tested. His insight was limited by defensive strategies, specifically denial. The examiner noted that he would not concede that his aversion to firearms would preclude continuing his service in the military. He unquestionably met the diagnostic criteria for PTSD and the assault that resulted in his injuries appeared to be at the heart of his re-experiencing, avoidance, and hyper-reactivity that he reluctantly reported. The examiner noted the CI used alcohol excessively in an attempt to diminish the anguish associated with his combat experiences and that maladaptive pattern became severe enough to require treatment for alcohol abuse. The examiner also noted the CI continued to minimize both his PTSD and alcohol abuse. This was also noted while he was an inpatient and during his alcohol abuse treatment. The examiner opined the degree of improvement in PTSD symptoms and his seemingly total remission of alcohol abuse were highly suspect. He also opined there was a high probability that the CI was far more emotionally distressed and far less abstinent that he admitted. He stated, “It is highly likely that Mr. \*\* veneer of normalcy is exceedingly thin, however, and comes at a substantial emotional price he may not be able to continue to pay. It is not at all certain that Mr. \*\*, despite his psychologically healthy façade, will make a smooth or problem-free transition to a civilian lifestyle or continue to interact appropriately with the world around him.” The CI’s PTSD was considered moderately severe and his alcohol abuse was secondary to his PTSD. The GAF score was 51, which reflects moderate difficulties in most areas of functioning. No subsequent psychiatric C&P examinations were performed.

The VA initially evaluated the CI’s PTSD as 50%. However, the VA later revised this rating to 70% with the same effective date. The later VA rating decision specifically noted the CI’s admission in May 2005 and history of suicide attempts and ideation. This was not mentioned in the initial VA rating decision but it was mentioned in the VA Psychiatric C&P 20051208 that was considered in the initial rating decision. The NARSUM Psychiatric Addendum dated 20070109 included neuropsychological testing results. “The patient continues to experience symptoms of Post Traumatic Stress Disorder including the experience of a traumatic event, recurrent and intrusive distressing recollections of the event including images and thoughts of the event, recurrent distressing dreams of the event, intense psychological distress at exposure to internal or external cues that resemble all aspect of the traumatic event and physiological reactivity or anxiety when experiencing aspects of the traumatic event. In addition, he continues to avoid stimuli that are associated with the event (specific racial groups and cars that are white). He continues to have difficulty recalling important aspects of the trauma and continues to experience increased arousal as evidenced by hyper-vigilance and difficulty concentrating. The patient denies that his is drinking alcohol, but results of the Personality Assessment Inventory (PAI) suggest this might not be the case.” The PAI is a computerized self-report inventory. While the CI did not portray himself in either a positive or a negative way, certain aspects of the profile raise the possibility of denial of problems with drinking or drug use. The profile was also consistent with experiencing a disturbing traumatic event that continues to cause distress and produce recurrent episodes of anxiety. However, he reported relatively little distress from relationships or lack of social supports. The profile suggests he is “satisfied with himself as he is, is not in marked distress and does not see a need to change his behavior.” This is highly consistent with the VA Psychiatric C&P exam and hospital course from April 2005 that noted significant use of denial as a defensive mechanism. The examiner noted that despite his psychiatric symptoms, the CI appeared to have adjusted to his psychiatric and cognitive problems. While his physical symptoms alone would prevent further military service, his psychiatric symptoms would likely interfere with his ability to function in combat. After two years of treatment, the condition was considered stable and not likely to improve. No GAF was reported but the examiner recommended the CI be medically retired and placed on the TDRL. The PEB determined the PTSD was not unfitting.

Work/School History. At the time of the VA C&P in December 2005, the CI reported he was still technically enrolled in Illinois State University. He had been taking classes prior to deployment and had been doing well in Criminal Justice. He reportedly was no longer interested in law enforcement because he abhorred firearms. At that time he intended to go to Law School instead. After separation the CI was working as an ironworker with some difficulties secondary to his right forearm injury. He had enrolled in four Criminal Justice classes at Illinois State University in September 2005. However, he dropped out of school after a month because of memory problems. Since September 2006 he had been taking apprenticeship classes in ironworking. He reported that he took voluminous notes, and was successful because the course content is easier. At the time of the Psychiatric Addendum in January 2007, the patient lived in his own home in Bloomington, IL and rented space to two other vets. The patient states that he was entirely responsible for maintaining the household. However, his roommates maintained his bills and organized a filing system for him. He stated he has difficulty coordinating a meal because he had difficulty engaging in multiple activities simultaneously. The patient jogged, lifted weights, hunted, fished and rode a motorcycle for recreation. He had been dating a woman for the previous year and a half. The patient denied having any previous difficulty learning. He graduated High School on time and immediately enlisted. He reported that he earned a 3.9 GPA in high school where he participated in football, scholastic bowl, and Spanish Club, and was both a Peer Advisor and a Peer Intern. In high school he describes himself as the "class clown" and a "nerd". The patient reported that prior to his injury he completed three years at Illinois State University, Normal, IL where he majored in Criminal Justice and earned a 3.3 Average. He earned an ASVAB AFQT score of 74.

OTHER CONDITIONS:

Cognitive Disorder. The neuropsychiatry evaluation reported as part of the MEB Psychiatric Addendum did not provide reliable results and the effort expended by the CI was questionable. The CI complained of problems with his memory and stated that for two years he could not recall anything orally delivered including instructions, movies, or television shows. He misplaced objects frequently and used post-it notes to improve his recall. His roommates had to help him set up a filing system so he would remember to pay his bills on time. Based on the neuropsychiatry evaluation the PEB determined the Cognitive Disorder NOS was not unfitting. The VA did not address this condition separately from PTSD. No further neuropsychiatric testing was performed.

Post-Concussive Headaches. This condition does not appear to have been unfitting at the time of separation from service. The Psychiatric Addendum to the MEB stated the CI had headaches at least once a week since his injury. His headaches would generally appear in the morning and despite taking two Extra Strength Tylenols, it would persist throughout the day. He rated his pain as an 8. He had been given Imitrex and some anti-seizure medications but none of these had helped. He only had to leave work on two occasions during the two year period and he would normally continue to work throughout the day regardless of his level of pain.

Other Conditions not in the Disability Evaluation System (DES): Right upper extremity with retained fragments, right upper extremity fracture, left arm scar associated with left hand burn, left lower extremity scar, left hand burn scar, and tympanic membrane perforation

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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 unanimously determined that the CI’s right arm condition was appropriately evaluated as Right Forearm Muscle Injury with Retained Foreign Body, VASRD Code 5305, and rated at 30%. The CI had a lengthy treatment regimen for his right forearm injury which included shrapnel wounds and compartment syndrome. After all the interventions in May 2006 he still had worsening pain and continued numbness in the superficial branch of the radial nerve distribution. He also had significant weakness and lack of endurance which caused an inability to perform required tasks.

The Board considered the condition of Post-Traumatic Stress Disorder (PTSD) and unanimously determined that while this condition was present, it was not unfitting at the time of separation from service and therefore no disability rating is applied. There was no evidence of occupational or social impairment. The examiners opined that he did not appear to be in a significant amount of stress and that he had made a good adjustment to both his psychiatric and cognitive problems. While the CI did have difficulty taking four college classes simultaneously in September 2005, a year later he was working and taking apprenticeship classes in ironworking. He owned his own home and rented rooms to two other veterans. He had maintained a relationship with a woman the previous year and a half.

The Board considered the condition of Cognitive Disorder and unanimously determined this condition was not unfitting. Neuropsychological testing was not valid due to questionable effort and the examining neuropsychologist and psychiatrist were not able to determine the extent of the CI’s cognitive difficulties. However, the CI was working and taking apprenticeship classes and he owned his own home and rented rooms to two roommates. The examiners opined he had made a good adjustment to both his psychiatric and cognitive problems. There is no evidence of functional impairment. While the PEB did not address Headaches, the Psychiatric Addendum and the MEB History and Physical both included this condition. The Board unanimously determined this condition was not unfitting at the time of separation and therefore no disability rating is applied. There is no evidence this condition interfered with performance of any required duties and no duty restrictions can be attributed to this condition.

The other conditions rated by the VA (Right upper extremity with retained fragments, right upper extremity fracture, left arm scar associated with left hand burn, left lower extremity scar, left hand burn scar, tinnitus, and tympanic membrane perforation) 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 Naval Records (BCNR) to consider adding these conditions as unfitting.

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Board Recommendations: The Board recommends that the CI’s prior determination be modified as follows and that the discharge with severance pay be recharacterized to reflect permanent disability retirement, effective as of the date of his prior medical separation.

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Right Forearm Muscle Injury with Retained Foreign Body  | 5305 | 30% |
| **COMBINED** | **30%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20091028, 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 XXXXX, FORMER USMC, XXX XX XXXX

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. Effective the date of discharge (3 March 2006), placement on the Permanent Disability Retired List with a disability rating of 30 percent.

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)