RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXXX BRANCH OF SERVICE: ARMY

CASE NUMBER: PD201000129 SEPARATION DATE: 20071025

BOARD DATE: 20110204

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SUMMARY OF CASE: This covered individual (CI) was an active duty SPC (21B10, Combat Engineer) medically separated from the Army in 2007 after nine years of service. The medical basis for the separation was left foot pain, following fractures of the 1st through 3rd metatarsals. The CI was initially injured in October 2001 when a steel beam fell on his left foot. He underwent surgery the next day. He had persistent pain after surgery, and a Military Occupational Specialty (MOS) Medical Review Board found him fit for duty and issued a permanent L-2 profile for no running. He subsequently deployed three times to Iraq and had two additional foot surgeries in October 2005 and February 2007, including a prosthetic metatarsophalangeal implant. This final procedure improved his range of motion; but despite post-operative orthotics and medications, his pain persisted such that he could not perform within his MOS or deploy. The CI was also evaluated for mild Post-concussive Syndrome (PCS) with headaches and memory loss, Dysthymic Disorder, Anxiety Disorder, Attention Deficit/Hyperactivity Disorder (ADHD), and intermittent tinnitus. The CI was issued a permanent L-3/S-2 profile and referred to a Medical Evaluation Board (MEB). Chronic left foot pain was addressed in the narrative summary (NARSUM) and forwarded to the Informal Physical Evaluation Board (IPEB) as medically unacceptable IAW AR 40-501. The other conditions were considered medically acceptable. The IPEB adjudicated the left foot pain, status post fractures of the 1st-3rd metatarsals as the only unfitting condition, rated 10% with likely application of the US Army Physical Disability Agency (USAPDA) pain policy. The CI did not appeal and was medically separated with a 10% disability rating.

CI CONTENTION: “Rated at 100% by the VA.” He elaborates no specific contentions regarding rating or coding and mentions no additionally contended conditions. As a matter of policy, all service conditions are reviewed by the Board for their potential contribution to its rating recommendations.

The Rating Comparison Chart is found on page 2.RATING COMPARISON:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Service IPEB – Dated 20070820** | | | | **VA (1 Day after Separation) – All Effective 20071026** | | | |
| **Condition** | **Code** | | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Left Foot Pain, S/P Fx of 1st - 3rd Metatarsals | 5299-5279 | | 10% | Traumatic Fx L 2nd and 3rd Metatarsals Distally w/Pinned & Later Fusion w/ OA and Scars | 5010-5284 | 20% | 20071026 |
| Mild PCS w/ Headaches and Memory Loss | | Not Unfitting | | TBI w/PCS, PTSD & Major Depressive Disorder | 8045-9411 | 100%\* | 20071026 |
| Dysthymic Disorder | | Not Unfitting | |
| Anxiety Disorder | | Not Unfitting | |
| ADHD (EPTS) | | Not Unfitting | |
| *(w/above)* | | | | Migraine Headaches | 8045-8100 | 30% | 20071026 |
| Intermittent Tinnitus | | Not Unfitting | | Tinnitus | 6260 | 10% | 20071115 |
| ↓No Additional MEB/PEB Entries↓ | | | | Residual Fx Left 4th (Ring) Finger | 5230 | 0% | STR |
| Hearing Loss, L. Ear … | 6100 | 0% | 20071115 |
| L Shoulder, R Arm, R Elbow, R Wrist, Low Back, R Knee, L Knee, R Ankle, Bil Pes Planus, R. Hearing, Inabil. to Reg. Body Temp | | NSC | |
| **TOTAL Combined: 10%** | | | | **TOTAL Combined (*Includes Non-PEB Conditions*): 100%** | | | |

\*Diplopia (claimed as Double Vision) assoc w/TBI w/PCS, PTSD and Major Depressive Disorder (previously evaluated under §4.28-Pre-stabilization), 6090-6065 at 80%, added effective 20090910

ANALYSIS SUMMARY:

Left Foot Condition. As noted above, the PEB rated the left foot condition at 10%, coded analogously to 5279, metatarsalgia, anterior (Morton’s disease), with likely application of the USAPDA pain policy for rating. The CI sustained a new fracture of the left foot (5th metatarsal head in August 07 (after the MEB exam and NARSUM but prior to the PEB) when he was involved in an accident when his scooter was struck by a car. Of note, the VA exam was performed one day post-separation and two months after the traumatic foot re-injury. The military exam and service treatment record did not indicate that the CI’s gait was abnormal at the time of the MEB; however, the CI was noted to be wearing a fracture boot and using a cane at separation. He did not require a cane or crutches prior to his scooter crash. The CI did not have foot drop. Pre-scooter-crash, the range of motion of the toes was impaired: dorsiflexion to 10° and “minimal plantar flexion” of the 2nd through 4th toes in unison, all limited by pain; the surgical scar was not described as painful or otherwise interfering with duty. The MEB examiner noted an episode of plantar fasciitis of the left foot in 2005 that had resolved. At the VA exam, the CI was still wearing a fracture boot (there were problems with compliance wearing the fracture boot due to discomfort), and he was experiencing pain, resulting in the need for an assistive device (a cane). The VA examiner noted the CI’s gait was “stable but wearing a cam walking boot,” and he was “not able to walk with normal flexion of toes.” The VA examiner also noted there was pain with manipulation and at rest, and there was “no pain with motion or any limitation due to weakness, incoordination, fatigability or repetitive use.” The VA C&P exam noted loss of flexion of the left 2nd and 3rd digits, and the 2nd metatarsal was “rigid no flexion and extension; no flexion with walking.” The VA examiner omitted reference to the 1st metatarsal fracture, and felt there was a fusion of the 2nd (and possibly the 3rd) metatarsophalangeal joint, although the CI had no history of fusion. This suggests several possibilities: (1) examiner error, (2) malfunction of the prosthetic joint, or (3) growth of bone spurs limiting joint motion. A VA podiatry outpatient note one month after the C&P exam (three months post-re-injury), found the fracture not completely healed. The CI was still wearing a fracture boot and using a cane to ambulate, but reported no pain at the 5th metatarsal, only at the 2nd metatarsal with weight bearing and weather changes. On exam, there was minimal tenderness at the 2nd metatarsophalangeal joint, and no tenderness at the 5th metatarsal. No information in the file provides insight into the CI’s condition after the 5th metatarsal fracture had completely healed. The Board considered the CI’s overall foot condition, including residual impairment resulting from the 5th metatarsal fracture at the time of the C&P exam and, with the proviso that the injury was not yet completely healed (potentially transient), considered the subsequent outpatient evaluations. There were several diagnoses that may have contributed to the CI’s left foot pain, and the Board considered the total disability of the left foot in its rating recommendation. Multiple examiners and radiographs noted osteoarthritis of the foot, the presence of mild hallux valgus with bunion, and pes planus (flat feet). The Board determined that the CI did not meet the criteria for §4.63 (loss of use) and that pain was a significant component of the CI’s condition. The Board agreed that the most appropriate coding option in this case is 5010-5284, foot injuries, other (due to trauma), and the severity is best described as “moderately severe.” After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a separation rating of 20% for the left foot condition.

Other DA Form 3947 Conditions (Mild PCS w/ Headaches and Memory Loss, Dysthymic Disorder, Anxiety Disorder, ADHD (EPTS), Intermittent Tinnitus). The MEB listed these conditions on the DA Form 3947 as meeting AR 40-501 retention standards and the Board agreed that these were likely not unfitting. However, there is sufficient evidence suggesting that these conditions (absent pre-existing ADHD) resulted from a Traumatic Brain Injury (TBI) condition, which worsened prior to separation such that that they would have interfered significantly with military job performance. The DES file, service treatment record, post-separation VA C&P exams, VA outpatient treatment records, and VA contact reports provided evidence of physical (headache, nausea, vomiting, sleep disturbance, balance disorder), cognitive (memory, concentration, speed of processing), and possibly behavioral (depression, anxiety, irritability, impulsivity) residuals of TBI that at the time of separation were significantly worse than the information available to the PEB indicated. Although ADHD was EPTS and the CI had a pre-service episode of major head trauma with unconsciousness for one and a half days and hospitalization for 12 days (vehicle crash as suicide attempt), the CI had no evidence of any pre-deployment ratable level of impairment. The CI additionally had over eight years of service. The mental health-related diagnoses did not appear to have been clearly unfitting absent the symptoms attributable to cognitive disorder attributable to TBI, which appeared predominate. The CI was exposed to numerous (at least 23) explosions while in Iraq. He did not lose consciousness but was “dazed for 15 minutes” after at least one explosion. TBI symptoms and exposure to explosions were corroborated. The NARSUM noted these exposures to IED explosions and suggested they were the cause of possible PCS, stating, “Since at least April 2004, the Soldier has had some memory loss, intermittent headaches, and occasional tinnitus…” The CI’s permanent profile included an S-2 designation, and stated, "needs intermittent psychiatric follow-up," but contained no restrictions beyond those attributed to the chronic left foot pain. Although the Commander’s statement noted the foot condition only, it stated the CI was assigned to the rear-detachment company for the Battalion when it is deployed. There was no evidence in the record whether or not the CI had any significant job responsibilities in Golf Company and there is no way to gauge his job performance at that time. The NARSUM stated that neuropsychiatric testing in July 2007 showed “intermediate memory standard score was 65, in the extremely low range,” and “the language score was 85 within the low average range.” Although the neuropsychiatric evaluator suggested the low memory score was “impacted by” the CI’s ADHD, he did not comment on the potential contribution of TBI. Several record entries noted the Army had issued the CI a Personal Digital Assistant prior to separation, apparently to help with cognitive difficulties.

There is significant evidence that the TBI condition worsened after the time of the PEB, but prior to separation. Two-week pre-separation VA psychiatric outpatient notes described memory impairment and impulsivity and diagnosed Cognitive Disorder, NOS. In June 2007, while still on active duty, the CI began working as a greeter at Walgreens, with no reports of difficulties; however, a VA Report of Contact (nine days pre-separation) notes he was having significant difficulties in attempting to work in the Walgreens photo lab, stating, “His memory problems prevent him from correctly filling customers' orders, and complaints had been made against him.” The report further noted:

“He said he is only able to get to and from work because he has a GPS system that is programmed to tell him directions. He uses a PDA to remind him of appointments and tasks because he forgets them otherwise. He tries to write down all important conversations because he will forget.”

At the VA C&P exam, one day after separation, the examiner reported the CI was working at Walgreens but performing so poorly due to cognitive difficulties (mixed pictures from different rolls in the photo lab; not able to work as cashier because of numbers and low frustration threshold) that he had lost wages and feared losing his job. The CI terminated his employment five days post-separation due to inability to drive, as noted below. The examiner identified the CI’s TBI, and found “slow thoughts, confused easily/loss attention, difficult concentration, difficulty following directions (fold paper and place on table)…delayed reaction time…speech is slow…,” and “cognitive impairment is problematic with loss memory, cognition, concentration, attention, information processing.” The examiner was unsure as to whether the CI was competent to handle his own funds due to impulsive spending, which required that his wife control financial matters. Within the week following separation, the VA noted the CI could no longer drive safely due to “blackouts” (waking up finding himself driving the wrong way against traffic) and confusion (getting lost while driving). An EEG three months post-separation (January 2008) demonstrated “intermixed slowing which was thought to be consistent with a mild degree of diffuse cerebral dysfunction.” Subsequent neuropsychiatric testing eight months post-separation (June 2008) revealed “very mild cerebral dysfunction primarily affecting speed of information processing and working memory.” The VA rated TBI w/PCS, PTSD & Major Depressive Disorder (also claimed as Dysthymic Disorder, Anxiety, ADD & Memory Loss), at 100% (pre-stabilization rating), effective the day after separation. The NARSUM attributed the CI’s headaches to PCS resulting from exposure to IED explosions in Iraq, and suggested they were mild. They did not require the use of specific prescribed anti-migraine medication and noted, “have never been incapacitating or prostrating, and they have never resulted in limitations in his ability to function at work.” The post-separation VA exam noted the CI was experiencing weekly or less often migraine headaches, which were “controlled with medications.” The examiner did not describe the characteristic prostrating attacks, stated the headaches lasted for one hour, and, although there was mention of nausea and vomiting, there was no mention of impact on functioning due to the headaches. Any functional impairment appeared to result from the cognitive impairments described above. The CI’s behavioral dysfunctions were well documented, but did not appear to be unfitting at the time of separation. There is no evidence in the record that the CI was hospitalized in the military or the VA for psychiatric illness, had psychiatric-related “limitations of duty or duty in a protected environment,” or that his psychiatric symptoms interfered with effective military performance. The NARSUM noted the CI was diagnosed with Anxiety Disorder and Depression, and was taking an antidepressant medication. Pre-separation psychiatry notes suggest the CI had PTSD symptoms, scoring 55 on his PTSD Checklist in January 2007. The CI had reportedly been treated for PTSD during his second deployment, and in June 2007 attempted suicide by huffing Endust®. He was not hospitalized but was treated in the Army Substance Abuse Program. Pre-separation symptoms included irritability, insomnia, “jittering,” impulsivity, chronic relationship problems, decreased concentration, nightmares, flashbacks, avoidance, hypervigilance, and detachment. Mental Status Exam (MSE) showed him to be depressed, anxious, angry, labile, and restricted affect, with a depressed mood and “jittery psychomotor activity.” Global Assessment of Functioning (GAF) was rated at 55, corresponding to moderate symptoms or moderate difficulty in social or occupational functioning. Pre-separation VA psychiatric outpatient notes appear to corroborate pre-separation military psychiatry notes. The VA identified Major Depressive Disorder (MDD); Cognitive Disorder, NOS; and “Rule-Out” or “History of” PTSD as Axis I diagnoses. The two VA providers rated the CI’s GAF as 60, in the same range as the military mental health providers. The post-separation VA psychiatric C&P exam diagnosed PTSD and MDD, with the MDD being “related not only to his PTSD but also to the consequences of his…brain injury.” Symptoms were the same as pre-separation, plus emotional volatility and suspiciousness. Mental Status Exam (MSE) reported “he is quite depressed and anxious,” had a history of suicidal ideation with intent (loading weapon with intent of killing himself; date unspecified), and endorsed visual hallucinations, “seeing things out of the corner of his eye when there is nothing or no one there.” GAF was 53, the same range as pre-separation exams. Taken together, the pre- and post-separation psychiatric evaluations suggest the CI’s behavioral level of functioning was potentially unfitting at the time of separation when considered in conjunction with overlapping symptoms of TBI.

If the foregoing evidence of post-MEB worsening of the CI’s conditions had been available to the PEB, they would most likely have judged the TBI condition to be unfitting. After due deliberation, the Board majority agreed, that the preponderance of evidence with regard to the functional impairment of the TBI favors its recommendation as an additionally unfitting condition for separation rating. The Board cannot find reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudications for the Dysthymic Disorder and Anxiety Disorder, and cannot find evidence supporting addition of MDD or PTSD as unfitting conditions for separation rating once the symptoms most likely attributable to TBI are removed from consideration. Although the VA linked these conditions to the TBI, the Board agreed that they likely resulted from the same trauma (Iraq deployment with IED exposures), but were unlikely due to the TBI pathology. The Board majority recommends that the residuals of TBI be separately rated IAW VA Training Letter 07-05 (TL 07-05), with the TBI-related cognitive disorder rated as 8045-9304 (brain disease due to trauma – dementia due to head trauma) at 10% under the VASRD in effect at the time of separation. The Board majority further advises that the TBI-related tinnitus condition be rated under 8045-6260 at 10%, and that the TBI-related headache condition be rated as 8045-8100, at 0%.

Other Conditions. The NARSUM noted left knee arthroscopy, and the MEB physical noted chronic bilateral foot pain (since 2006), rib contusion (2003), ankle sprain (2000), right knee pain with retro patellar pain syndrome (1999), and hematuria (2007). In addition to those addressed above, the DES documents noted several other relatively minor conditions with no potential link to fitness. In addition to the conditions noted in the preceding paragraph, the VA also rated migraine headaches at 30% within 12 months of separation. The Board considered the CI’s overall headache condition and disability, regardless of the specific diagnosis, and that analysis and rating is included in the TBI discussion above. No other conditions were service connected with a compensable rating by the VA within twelve months of separation. Diplopia, was noted in the VA rating decisions after the 12-month period of special consideration post- separation and is therefore ineligible for Board consideration. The Board does not have the authority under DoDI 6040.44 to render fitness or rating recommendations for any conditions not considered by the DES. The Diplopia and any contended conditions not covered above remain eligible for Army Board for Correction of Military Records (ABCMR) consideration. Neither the physical profile nor the Commander’s statement identified any conditions other than the left foot pain and profiled psychiatric conditions noted above. No link to fitness is in evidence for any of these other conditions. The Board, therefore, has no reasonable basis for recommending any additional unfitting conditions for separation rating.

BOARD FINDINGS: IAW DoDI 6040.44, provisions of DoD or Military Department regulations or guidelines relied upon by the PEB will not be considered by the Board to the extent they were inconsistent with the VASRD in effect at the time of the adjudication. As discussed above, PEB reliance on the USAPDA pain policy for rating the left foot pain was operant in this case and the condition was adjudicated independently of that policy by the Board. As discussed above, some Board recommendations in this case are IAW application of TL07-05, effective 20070831, to rating under VASRD code 8045 prior to promulgation of the current TBI standards (effective 20081023). In the matter of the left foot pain condition, the Board unanimously recommends a rating of 20% coded 5010-5284 IAW VASRD §4.71a. In the matter of the mild PCS w/headaches and memory loss, and intermittent tinnitus conditions, the Board recommends, by a vote of 2:1, that it be added as an additionally unfitting condition for separation rating; coded as Traumatic Brain Injury, and its residuals rated separately IAW TL07-05 and the VASRD in effect at the time of separation; Brain Disease due to trauma – Dementia due to head trauma, 8045-9304, at 10%; TBI-related tinnitus, 8045-6260, at 10%; and TBI-related headaches, 8045-8100 at 0%. The single voter for dissent (who recommended no recharactarization of the PEB adjudications as not unfitting for mild PCS w/headaches and memory Loss, and intermittent tinnitus) did not elect to submit a minority opinion. In the matter of the Dysthymic Disorder and Anxiety Disorder, the Board unanimously recommends no recharacterization of the PEB adjudications as not unfitting. In the matter of the Attention Deficit/Hyperactivity Disorder, the Board unanimously concurs that it existed prior to service (designated EPTS) and was not permanently service aggravated and is thereby not eligible for separation rating. In the matter of the MDD, PTSD, right knee pain with retropatellar pain syndrome, or any other medical conditions eligible for Board consideration, the Board unanimously agrees that it cannot recommend any findings of unfit for additional rating at separation.

RECOMMENDATION: 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** |
| Left Foot Pain, S/P Fractures of the 1st-3rd Metatarsals | 5010-5284 | 20% |
| Brain Disease Due to Trauma – Dementia due to Head Trauma | 8045-9304 | 10% |
| TBI-related Tinnitus | 8045-6260 | 10% |
| TBI-related Headaches | 8045-8100 | 0% |
| **COMBINED** | **40%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20100212, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

Deputy Director

Physical Disability Board of Review



