RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXX BRANCH OF SERVICE: marine corps

CASE NUMBER: PD1000520 SEPARATION DATE: 20070731

BOARD DATE: 20110621

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was a Marine Corps Reserve member LCpl/E-3 (0331, Machine Gunner) medically separated for post-concussive syndrome and cervical dystonia. The CI sustained two concussions due to improvised explosive device (IED) blasts while deployed to Iraq in 2006. The cervical dystonia condition existed prior to deployment and was the reason he was medically evacuated from the theater of operations. He did not respond adequately to treatment and was unable to perform within his military occupational specialty (MOS) or meet physical fitness standards. He was placed on limited duty and underwent a Medical Evaluation Board (MEB). Post-concussive syndrome and spasmodic torticollis was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW SECNAVINST 1850.4E. Although no other conditions appeared on the MEB’s submission, the PEB also considered posttraumatic stress disorder (PTSD) and pain disorder associated with general medical condition. The Informal PEB (IPEB) adjudicated the post-concussive syndrome and cervical dystonia condition as unfitting, rated 10%, respectively with application of the DoDI 1332.39 and Veterans’ Administration Schedule for Rating Disabilities (VASRD). PTSD, pain disorder and cervical strain were determined to be conditions that were not separately unfitting and not ratable. Upon reconsideration at CI request, the PEB upheld its initial decision. He made no further appeals, and was medically separated with a 20% disability rating.

CI CONTENTION: “I feel as though my conditions warrant disability retirement do [sic] to the fact the PEB did not rate me appropriately for traumatic brain injury (TBI) and did not rate me at all for posttraumatic stress disorder (PTSD).”

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service ReCon PEB – Dated 20070612** | | | **VA (4 Mo. Pre-Separation) – All Effective 20070801** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Post-Concussion Syndrome | 8045-9304 | 10% | Post-Concussion Syndrome | 8045-9304 | 10% | 20070411 |
| Cervical Dystonia | 8199-8103 | 10% | Torticollis Neck Disability | 5237 | 10% | 20070411 |
| Cervical Strain | Cat II | |
| Pain Disorder | Cat III | |  | | | |
| PTSD | Cat III | | PTSD | 9411 | 50% | 20070416 |
| ↓No Additional MEB/PEB Entries↓ | | | Tinnitus | 6260 | 10% | 20070411 |
| 0% x 1 / Not Service Connected x 1 | | | 20070411 |
| **Combined: 20%** | | | **Combined: 60%** | | | |

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impact that his service-incurred conditions have had on his quality of life. However, the military services, by law, can only rate and compensate for those conditions that were found unfitting for continued military service based on the severity of the condition at the time of separation and not based on possible future changes. The VA, however, can rate and compensate all service connected conditions without regard to their impact on performance of military duties, including conditions developing after separation that are direct complications of a service connected condition. The VA can also increase or decrease ratings based on the changing severity of each condition over time. The Board’s role is confined to the review of medical records and all evidence at hand to assess the fairness of PEB rating determinations, compared to the VASRD standards, based on severity at the time of separation. It must also judge the fairness of PEB fitness adjudications based on the fitness consequences of conditions as they existed at the time of separation. The Board’s threshold for countering Disability Evaluation System (DES) fitness determinations is higher than the VASRD §4.3 reasonable doubt standard used for its rating recommendations but remains adherent to the DoDI 6040.44 “fair and equitable” standard. Any changes in the VASRD rating criteria following the CI’s separation are not applicable in this case (such as TBI TL07-05 [effective 31 August 2007] and the new TBI rating criteria of TBI FL08-36 [effective 23 October 2008]).

Cervical Dystonia Condition. The CI experienced the onset of right sided neck pain associated with muscle spasm prior to deployment. He awoke one morning in late August 2006 with neck pain without history of specific injury that persisted despite treatment. He deployed to Iraq with his unit in September 2006, but due to persisting symptoms refractory to treatment in theater, he was medically evacuated in December for evaluation and treatment. Specialty evaluations (orthopedics, neurosurgery, physical medicine, anesthesia pain clinic) and imaging did not reveal a specific underlying cause and he was returned to the U.S. for MEB. Examinations documented muscle spasm of the right side neck muscles and decreased right lateral bending and right rotation. Although there was complaint of occasional pain radiation into the arm, neurologic examination found no evidence of radiculopathy (weakness, loss of sensation, change in reflexes). Magnetic resonance imaging (MRI) scanning revealed subtle degenerative disc changes, without bulging or herniation or evidence of neural compromise, that were not considered to have a causal relationship and his diagnosis was idiopathic cervical torsion dystonia (spasmodic torticollis). The neurology narrative summary (NARSUM), dated 21 December 2006, reflects limitation in performance of military tasks but no limitations in normal activities of daily living. However, the neurologist opined. “It is felt that his symptoms will impose some difficulty working at maximal-efficiency in his civilian capacity as an automotive mechanic, resulting in mild-moderate industrial impairment.” Treatments had included narcotic pain medication and botox injections. The PEB analogized the condition to tic, convulsive (8199-8103) and rated 10% for moderate. The VA coded the condition under cervical strain (5237), and rated under the general spine formula based on combined range of motion. Documented combined range of motions alone consistently do not exceed the 10% rating (documented cervical flexion does not attain the minimum rating). The Board considered both rating approaches reasonable and additionally considered whether a higher rating was warranted under the general formula for rating spinal conditions based on muscle spasm. Examinations documented muscle spasm, and imaging indicated some straightening of the cervical spinal contour. Clinical examinations through December 2006 recorded mild left rotation, mild tilt to left, and a depressed down sloping right shoulder (versus left shoulder held higher). The VA compensation and pension (C&P) exam on 11 April 2007 recorded normal posture, but also recorded that the CI held the neck in a right lateral position. The Board considered the neurologist’s opinion regarding the potential occupational impact and the CI’s memorandum requesting reconsideration detailing the condition’s impact on his ability to function in his job as an auto mechanic. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt) and §4.7 (higher of two evaluations), the Board recommends a separation rating of 20% for the neck condition (coded 5257, cervical strain) based on the persistent presence of muscle spasm resulting in abnormal cervical spine contour and posture.

Post-Concussive Syndrome. The Board’s rating recommendation for 8045, TBI is directly impacted in this case by the following policy established by firm precedent and prior legal opinion. As an implied extension of the DoDI 6040.44 and the National Defense Authorization Act 2008 mandates, the Board will comply with applicable VA disability rating policy changes issued via “FAST” or Training Letters (TL) effective at the time of separation. The Board considered the rating for TBI IAW VASRD criteria in effect at the time of separation which includes TL 06-03 (February 2006). Both the PEB and VA rated the CI’s post-concussive syndrome 10% code 8045-9304 IAW VASRD guidelines (8045 residuals of TBI; 9304 dementia due to head trauma). The CI deployed in September 2006 and sustained two concussions: grade III concussion on 28 October 2006 and grade II concussion on 21 November 2006 as a result of IED blast exposures. He was evacuated from theater due to his chronic neck pain which began prior to deployment, and not due to symptoms related to TBI. While undergoing evaluation of his neck condition at Landstuhl Regional Medical Center, a routine TBI screen on 18 December 2006 was positive for symptoms of headache, memory problems, sleep disturbance, and ringing in the ears. In addition, there was occasional dizziness and nausea. An anesthesia evaluation of the CI’s neck condition on 20 December 2006 also noted the post-concussive syndrome with complaint of occasional frontal headache, one to three times per week, without photophobia or phonophobia, and occasional nausea, dizziness and tinnitus. Neurologic examinations and imaging of brain were normal, and he was advised to follow up with neurobehavioral health upon return to his home base. Upon return he was referred for formal neuropsychological (NP) testing performed on 21 March 2007. At the time of NP testing, the CI reported first noticing problems with short term memory and attention. NP testing revealed symptoms of PTSD discussed below. On formal NP testing the CI failed formal measure of motivation and effort, but passed other embedded measures; therefore, the testing was interpreted with caution due to notable fluctuations in effort. The difficulties with effort were thought to be related to discomfort from his chronic neck pain and psychological symptoms consistent with PTSD. The neuropsychologist felt that it did not appear that the CI was attempting to embellish or exaggerate his symptoms, but that testing under represented his true ability. Visual memory recall was severely impaired, but he performed well on other visual tasks using a model. There was mild impairment in verbal fluency that improved with coaching. The neuropsychologist concluded that the etiology of the cognitive deficits was difficult to ascertain and “the true level of cognitive impairment is difficult to assess at this time due to the involvement of his physical and psychiatric symptoms.” The neuropsychologist’s diagnoses included pain disorder associated with both psychological factors and a general medical condition, chronic, and ruled out PTSD. The neuropsychologist estimated a global assessment of functioning (GAF) at 60 for moderate symptoms (at the milder end of the moderate range). The 3 April 2007 psychiatry MEB NARSUM documented CI complaint of sleep disruption and anxiety following closed head injury. He complained of being more easily distracted and noted slow thinking and short term memory impairment. The mental status examination was otherwise normal. The psychiatrist recorded a few symptoms consistent with PTSD but did not render a diagnosis of PTSD (due to described symptoms not meeting full criteria, including lack of clinically significant distress or impairment from the reported symptoms). Formal diagnoses included cognitive disorder and post-concussive syndrome. The psychiatrist estimated the GAF at 70 for some mild symptoms (at the milder end of mild). Two weeks after the military psychiatry evaluation, the CI underwent VA psychiatry C&P examination, 16 April 2007 (three months before separation) for claimed PTSD and TBI. On mental status examination, memory was mild to moderately abnormal. The C&P psychiatrist assigned a GAF of 63 for mild symptoms (including PTSD symptoms and TBI symptoms combined; “The concussion condition due to IED blasts is part and parcel of posttraumatic stress disorder. It is not a separate diagnosis”). IAW with VASRD guidance and TL 06-03 in effect at the time of separation, the CI’s post-concussive syndrome symptoms are rated 10%, which is the maximum permissible rating. The CI manifested subjective symptoms that would not otherwise warrant rating under another diagnostic code. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s 10% rating decision for post-concussive syndrome/residuals of TBI (8045-9304).

Contended PTSD. The CI contends he should have received a disability rating and compensation for PTSD. To be ratable and compensable by the DES, a condition must be unfitting for continued military service. While undergoing evaluation for his neck pain in Germany, a physical medicine and rehabilitation evaluation on 15 December 2006 indicated no psychological symptoms on review of systems. At the time of NP testing on 21 March 2007, the CI endorsed some symptoms consistent with a diagnosis of PTSD including hypervigilance, increased startle response, combat nightmares, distress at loud noises, ruminating thoughts and sleep problems. He denied suicidal and homicidal ideation and significant depressive symptoms. Other than the sleep problems, he denied interference of these symptoms in his everyday life; the CI “…currently denied any negative affect of symptoms of PTSD on his everyday functioning.” The neuropsychologist was concerned that he was using alcohol to self-medicate but military and VA psychiatry examinations did not elicit a similar concern. Mental status examination was unremarkable. The neuropsychologist’s diagnoses included pain disorder associated with both psychological factors and a general medical condition, chronic, and ruled out PTSD (the term “rule out” indicated a possible diagnosis warranting follow up, not a firm diagnosis). The neuropsychologist estimated a GAF at 60 for moderate symptoms (at the milder end of the moderate range). The 3 April 2007 psychiatry NARSUM documented CI complaint of sleep disruption and anxiety following closed head injury. He reporting having nightmares two to three times per week but denied intrusive thoughts or re-experiencing symptoms. He was easily startled by loud noises, without experiencing any impairment. He complained of being more easily distracted and noted slow thinking and short term memory impairment. His mood was generally bored and somewhat irritable, but he denied significant depressive symptoms, impulsive behavior (spending, pleasure seeking), or alcohol abuse. The mental status examination otherwise normal and there was no suicidal or homicidal ideation. Formal diagnoses included cognitive disorder and post-concussive syndrome, but not PTSD (due to described symptoms not meeting full criteria, including lack of clinically significant distress or impairment from the reported symptoms). The psychiatrist estimated the GAF at 70 for some mild symptoms (at the milder end of mild). Two weeks after the military psychiatry evaluation, the CI underwent VA psychiatry C&P examination, 16 April 2007 (three months before separation) for claimed PTSD and TBI. The CI reported that more prominent symptoms of PTSD and TBI that began several months before and were constant every day. He reported feelings of helplessness, hopelessness, anger and irritability with outbursts of anger, frequent recollections of the events, nightmares, flashbacks, and recurrent distressing dreams. He reported sleep disturbance with difficulty falling and staying asleep. He tried to avoid feelings, thoughts, conversations about the trauma, and war movies which aroused bad memories of the Iraq war. He reported an exaggerated startle response and was disturbed by loud noise, thinking it was an IED. There was no detailed information regarding occupational functioning. He was in a stable relationship with his girlfriend for one and half years. He denied abuse of alcohol. According to the examiner, other than PTSD, there were no other mental symptoms. The CI was not on medication or in treatment for PTSD. On mental status examination he was anxious and depressed. His speech was normal with intact thought processes, judgment and insight and his memory was mild to moderately abnormal. There were no panic attacks, delusions, hallucinations, ritualistic obsessions, or suicidal/homicidal ideation. The C&P psychiatrist diagnosed PTSD and commented, “The concussion condition due to IED blasts is part and parcel of PTSD. It is not a separate diagnosis.” Assigning a GAF of 63 for some mild symptoms, the psychiatrist summarized, “He has occasional difficulty performing activities of daily living. His psychiatric symptoms are mild to moderate. He has difficulty establishing and maintaining work and social relationships and decrease in work efficiency, especially during periods of significant stress.” The IPEB on May 17, 2007 determined that PTSD was not separately unfitting. In his 3 June 2007 letter requesting reconsideration of the PEB rating, the CI focused on his neck condition and made no mention of PTSD or residuals of TBI. Four months after separation, the CI underwent another VA C&P examination for PTSD. The CI was employed in a similar field he worked prior to entering the military and remained in a stable relationship with his girlfriend, with plans to marry. He was not being treated for his symptoms of PTSD. Except for some increased depressive features, symptoms were essentially unchanged and included continued problems with memory and forgetfulness. He reported some difficulties getting along with co-workers. The examiner assigned a GAF of 55 for moderate symptoms.

The Board notes that the CI was exposed to Criterion A stressors, and reported symptoms of PTSD. Although not formally diagnosed by the MEB psychiatrist, the PEB considered PTSD that was listed by the neuropsychologist as a possible diagnosis. Although there is no direct evidence that these symptoms affected the CI’s duty performance, there limited evidence regarding occupational functioning. The commander’s February 2007 non-medical assessment referred only to concussions. The CI was evaluated by military psychiatrists who were aware of PTSD symptoms, but concluded criteria for diagnosis were not met, including absence of clinically significant distress or impairment based on clinical history, and estimated the functional impairment of his symptoms as mild. During the NP testing and psychiatry evaluation, the CI indicated that these symptoms were not functionally impairing and the CI did not seek or receive treatment for PTSD. Although the C&P examiner opined there was decrease in work efficiency he did not document any evidence in support of that conclusion. Also he stated the symptoms of post-concussive syndrome and PTSD were inextricably intertwined and estimated a GAF in the mild range. Board members agreed the severity of PTSD symptoms reported at the time of the C&P examination did not arise to the level for being unfitting. There were no duty limitations related to PTSD and in his later correspondence to the PEB the CI made no mention of PTSD or symptoms of PTSD. After due deliberation, and in consideration of the totality of the evidence, the Board cannot find adequate justification for recharacterization of the PEB fitness adjudication for the PTSD condition or recommending PTSD as additionally unfitting for separate rating.

Remaining Conditions. Other conditions identified in the DES file were pain disorder associated with general medical condition, right knee pain, hearing loss, and tinnitus. The pain disorder diagnosis rendered by the neuropsychologist refers to the cervical dystonia condition. Any potential contribution of the neck pain condition on cognitive functioning is subsumed under post-concussive syndrome, and is not separately unfitting or ratable. The pre-separation C&P examination records complaint of right knee pain since 2003 in boot camp. The pain was reported to be intermittent and daily, usually with activity, running, and stairs. The examination was unremarkable and an x-ray of the knee was normal. Service treatment records document a clinic visit for left knee pain in 2003. The MEB history and physical examination records a history of knee pain from July 2003 to the end of 2003. There were no other records showing complaint of knee pain. The CI experienced decreased high frequency hearing and tinnitus following IED blast exposures. By the time of the 11 April 2007 VA audiology C&P examination, his hearing and speech recognition were normal. There was continued complaint of tinnitus in the left ear. Several additional non-acute conditions or medical complaints were also documented. None of these conditions were clinically or occupationally significant during the MEB period, none were the basis for limited duty and none were implicated in the commander’s statement. These conditions were reviewed by the action officer and considered by the Board. It was determined that none could be argued as unfitting and subject to 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. In the matter of the cervical dystonia condition, the Board, by a vote of 2:1, recommends a rating of 20% coded 5237 IAW VASRD §4.71a. The single voter for dissent (who recommended no recharacterization) submitted the addended minority opinion. In the matter of the post-concussive syndrome and IAW VASRD §4.124a and TL 06-03 (February 2006), the Board unanimously recommends no change in the PEB adjudication at separation. In the matter of PTSD or any other medical conditions eligible for Board consideration, the Board unanimously agrees that it cannot recommend a finding 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** |
| Cervical Dystonia | 5237 | 20% |
| Post-Concussive Syndrome | 8045-9304 | 10% |
| COMBINED | 30% |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20100401 w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

Deputy Director

Physical Disability Board of Review

MINORITY OPINION:

I do not agree with the majority regarding the coding and rating of the CI’s neck condition, coded under cervical strain (5237), and rated under the general spine formula at a higher rating based on muscle spasm.

There was no evidence of injury or strain. An evaluating head and neck surgeon (ENT) noted the absence of other specific cause consistent with a diagnosis of torticollis (also termed spasmodic torticollis and cervical dystonia) and cited accepted medical principles noting the condition is most common in the CI’s age group, and is often precipitated by stressful circumstances. Furthermore, there was a history of similar episode of neck spasm pre-service indicating a predisposition to the condition.

Although muscle spasm was well documented, it did not, in my opinion, approach the degree described in the general rating formula for spine diseases for the 20% rating , muscle spasm or guarding severe enough to result in an abnormal gait or abnormal spinal contour such as scoliosis, reversed lordosis, or abnormal kyphosis. Motion was limited only in right sided motion, but movement in all other planes was essentially normal. Based on this, the VA adjudicated a 10% rating. A cervical spine x-ray on 21 September 2006 was reported by the radiologist to show normal alignment. The neurosurgeon evaluating the CI in December 2006 concluded imaging studies showed “slight straightening” of the cervical spine. “Normal alignment” and “slight straightening” do not more nearly approach the abnormal spinal contour described in the criteria for the 20% rating under the general rating formula for spine diseases.

The PEB’s coding of the cervical dystonia condition analogized to tic, convulsive (8199-8103) and rated 10% for moderate is, in my opinion, an accurate description of the CI’s neck disability.

All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s 10% rating decision for the CI’s neck condition (coded 8199-8103).

I recommend no recharacterization as shown in the chart below:

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| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Cervical Dystonia | 8199-8103 | 10% |
| Post Concussive Syndrome | 8045-9304 | 10% |
| COMBINED | 20% |

: MEMORANDUM FOR DIRECTOR, SECRETARY OF THE NAVY COUNCIL OF REVIEW

BOARDS

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATION

ICO XXXXX, FORMER USMC, XXX XX XXXXX

Ref: (a) DoDI 6040.44

(b) PDBR ltr dtd 23 Aug 11

I have reviewed the subject case pursuant to reference (a) and non-concur with the recommendation of the Physical Disability Board of Review as set forth in reference (b). Therefore, Mr. XXX’s records will not be corrected to reflect a change in either his characterization of separation or in the disability rating previously assigned by the Department of the Navy’s Physical Evaluation Board.

Principal Deputy

Assistant Secretary of the Navy

(Manpower & Reserve Affairs)