RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXXXXXX BRANCH OF SERVICE: marine corps

CASE NUMBER: PD201000712 SEPARATION DATE: 20031130

BOARD DATE: 20120424 TDRL Exit Date: 20081130

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty, LCPL/E3, 0600, Basic Command and Control Systems, medically separated for epilepsy. Medical history was significant for head trauma with loss of consciousness occurring several months prior to the first seizure. In November 2002, the CI experienced a seizure. After evaluation, he was returned to duty until a second seizure in March 2003. At that time, he was placed on medication and underwent a Medical Evaluation Board (MEB) for epilepsy. “Epilepsy, idiopathic, generalized” was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW SECNAVINST 1850.4E. No other conditions appeared on the MEB’s submission. Other conditions included in the Disability Evaluation System (DES) packet will be discussed below. The PEB adjudicated the “epilepsy, idiopathic, generalized” condition as unfitting, rated 40%, with application of the Veterans’ Administration Schedule for Rating Disabilities (VASRD) and recommended that he be placed on Temporary Disability Retired List (TDRL) status. The CI underwent a periodic TDRL evaluation in 2006 and was retained on TDRL. In 2008, the PEB recommended removal from the TDRL with a 10% disability rating. The CI requested the PEB reconsider the findings based upon additional information. The Reconsideration upheld the 10% rating. The CI then underwent a Formal PEB (FPEB) which adjudicated a 20% disability rating. The CI made no further appeals and was then medically separated with a 20% disability rating.

CI CONTENTION: “I have continued to have seizures and evidence of a learning difficulty, due to my service-connected injury. has [sic] been found by a neurologist after conduction of a neuro-psych test.” He elaborates no specific contentions regarding rating or coding and mentions no additionally contended conditions.

RATING COMPARISON:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Final Service FPEB – Dated 20081106** | | | | **VA** | | | | |
| **On TDRL – 20031201** |  | **TDRL** | **PDRL** | **Condition** | **Code** | **Rating** | **Effective Date** | **Exam** |
| Epilepsy, Idiopathic | 8910 | 40% | 20% | Grand Mal Seizure Disorder | 8910 | 60% | 20031201 | 20031023\* |
| ↓No Additional MEB/PEB Entries↓ | | | | Grand Mal Seizure Disorder | 8910 | 100% | 20070209 | 20070227\*\* |
| Complex Partial Seizure Disorder | 8910 | 100% | 20070209 | 20090720\*\*\* |
| 0% x 0/Not Service-Connected x 0 | | | |  |
| **Final Combined: 20%** | | | | **Total Combined: 60%/100%** | | | | |

\* 1 week prior to TDRL entrance.

\*\*21 months prior to separation from TDRL.

\*\*\*8 months after separation from TDRL. Diagnosis changed at this time.

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impairment with which his service-incurred condition continues to burden him. The Board wishes to clarify that it is subject to the same laws for disability entitlements as those under which the DES operates. The DES has neither the role nor the authority to compensate service members for anticipated future severity or potential complications of conditions resulting in medical separation. That role and authority is granted by Congress to the Department of Veterans’ Affairs (DVA), operating under a different set of laws (Title 38, United States Code). The Board evaluates VA evidence proximal to separation in arriving at its recommendations, but its authority resides in evaluating the fairness of DES fitness decisions and rating determinations for disability at the time of separation. The Board also acknowledges the CI’s contention suggesting that ratings should have been conferred for other conditions documented at the time of separation. While the DES considers all of the service member's medical conditions, compensation can only be offered for those medical conditions that cut short a service member’s career, and then only to the degree of severity present at the time of final disposition. The DVA, however, is empowered to compensate service-connected conditions and to periodically re-evaluate said conditions for the purpose of adjusting the Veteran’s disability rating should the degree of impairment vary over time.

Unfitting Condition: Epilepsy. In 2002, the CI fell and hit his head with a 15 minute loss of consciousness (LOC) while in boot camp. He was also noted to have several broken ribs and was given 5 days of light duty. He apparently responded well to conservative management. Several months later, he had a grand mal seizure in November 2002 with a witnessed LOC and generalized tonic-clonic movement. Computed tomography scan performed on 7 November 2002, was remarkable only for a 5 mm calcification in the posterior left occipital lobe which could have been physiologic. Magnetic resonance imaging done on 25 November 2002, was remarkable for slight size asymmetry between the left and right hippocampi. The 10 March 2003 neurology note documented that both tests were normal as were multiple electroencephalograms (EEGs). He had one additional seizure in March of 2003, was begun on Dilantin and referred to MEB.

The CI was placed on TDRL effective 1 December 2003. The MEB exam on 13 March 2003 documented two seizures, November 2002 and March 2003. The neurological examination was normal. The subsequent FPEB noted a third seizure in August 2003; however, the PEB JDETS only documents two. There is an emergency room report of a third seizure on 27 July 2003, though, the CI had stopped his Dilantin. The VA compensation and pension (C&P) exam dated 23 October 2003 was not available in the record. The PEB adjudicated the seizure disorder at a 40% rating and coded it 8999-8910, analogous to epilepsy. The VA awarded 60% for a history of three major seizures in the past year.

The Board first considered the TDRL entry rating. The medical record documents three major seizures in the first year of diagnosis, in November 2002, March 2003, and July 2003. These three seizures occurred within an 8-month period and support a 60% rating for “averaging at least one major seizure in 4 months over the last year.” After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends an initial TDRL rating of 60% for the epilepsy condition.

A periodic TDRL evaluation was accomplished 9 May 2006, 2 years after the CI entered the TDRL. It was noted that the CI had had no seizure activity since prior to the MEB on 13 March 2003. The CI stated that he was taking his Dilantin without side effects and had not had further seizures since the initial two while on active duty. The Board notes the inconsistency between the various histories documented and clear documentation elsewhere of the three seizures noted above. The neurological examination was normal as was the mental status exam. He was noted to be “currently fit for military service” and as a working as a truck driver. This is the only periodic TDRL evaluation available in the record.

The history obtained during a VA C&P exam on 27 February 2007 noted that the CI had about 10 seizures in a week, he reported he was told they were the partial complex type. He had been taking Dilantin. His last seizure was reportedly on 21 February 2007; it had lasted minutes and was accompanied by post-ictal confusion. The CI was unemployed as he could no longer work as truck driver. The VARD related to this exam also cites Memphis VAMC records from 16 January 2006 to 30 March 2007 and Little Rock/North Little Rock VAMC records from 15 June 2004 to 29 March 2006 and rateds based on the frequency of partial complex seizures reported in these records. These notes are not available in the record for review. The VARD noted continuous treatment for seizures, history of one generalized seizure in the past 2 years and complex partial (minor) seizures of about 9 to 10 per week. Although a 100% rating requires an average of one major seizure per month over the last year, the VA assigned a 100% rating. As there was likelihood of improvements, the rating was subject to a future review and examination.

Another VA C&P examination was completed on 20 July 2009, 8 months after separation from the TDRL. The VA continued the 100% rating citing the FPEB report on 10 January 2008, treatment reports from Little Rock VAMC from 20 January 2008 to 22 July 2009, and this C&P exam. The VA outpatient treatment notes are not in the record for review. The FPEB rationale report stated his last major seizure was March 2008, the one witnessed by his wife. VA treatment report on 20 November 2008, also stated last the major seizure was March 2008. The neurologic exam was normal and impression was a questionable seizure disorder but he was instructed to continue with Depakote. In June 2009 he had a possible seizure and his Depakote level was found to be low. At an outpatient visit In July 2009, the CI reported his last seizure was 3 days prior and he had been taking Depakote as prescribed. The examiner opined this might have been a pseudoseizure. The VA C&P exam noted two different types of seizures with the major type occurring once a week and the minor type occurring about twice a week according to the CI’s report. The neurologic exam was normal. The examiner noted a new diagnosis of partial complex seizure disorder. The examiner also noted a diagnosis of pseudoseizures was possible but this was not been confirmed by EEG. The 100% rating was continued for an average of at least one major seizure per month over the past year. As there was likelihood of improvements, the rating was subject to a future review examination.

An IPEB on 21 July 2008 recommended the CI be removed from the TDRL and separated with a 10% rating for epilepsy, idiopathic, generalized. The JDETs notes document the CI was still taking Depakote (valproic acid) and referenced multiple notes from March and April 2008. The CI requested reconsideration and on 15 August 2008 a Reconsideration PEB also determined the CI should be separated with a 10% rating. The record available for review contains the rationale for the decision of the FPEB dated 6 November 2008. The FPEB determined the CI’s final rating was 20%. This rationale refers to a “third periodic TDRL physical evaluation on 3 July 2008, at the Bayne Jones Army Community Hospital, Fort Polk, Louisiana.” This physical evaluation report is not available in the record and upon request, it could not be located.

The FPEB convened 6 November 2008, to determine the TDRL exit disability rating. It was noted that the CI had no seizures following TDRL entry in 2003 until January 2007. The CI also complained of occasional 10-60 minute spells of disorientation and confusion. A 5 day video EEG (VEEG), off medications, showed neither observed nor EEG evidence of epileptiform activity despite sleep deprivation, hyperventilation and photic stimulation in addition to stopping the anti-epileptic medication. The “spells” were determined to be probable pseudoseizures by multiple neurologists and emergency room physicians. The CI had a C&P exam on 27 February 2007. At that exam, he stated that he had had five seizures between the initial seizure and December 2006. The previous histories had been for either two or three seizures in this time frame. It was also noted that he was having 10 complex partial seizures per week. The neurological examination was normal. The examiner documented that the CI reported one generalized seizure with unconsciousness per month and 9 to 10 complex partial seizures per week. This was based on the history obtained from the CI and is not consistent with the reported histories in the treatment records available for Board review. The VA increased his rating to 100% based on this history. The FPEB noted that the CI had another seizure in March 2008. At the FPEB, the CI testified that he had suffered sequelae from the initial head injury which had been overlooked. This is discussed separately, below. The final VA C&P exam was accomplished on 20 July 2009, 8 months after separation. At this exam, the CI stated that he had weekly grand mal type seizures and a second type of “absence” seizure which was also accompanied by a post-ictal state. The latter type of seizure occurred twice a week. The C&P examiner determined that he most likely had complex partial seizures and generalized seizures. Again, the frequency of seizures was based on the history obtained from the CI and is not consistent with the histories reported by the CI in the treatment records available for Board review. The VA rating decision continued the 100% rating. The FPEB rated the single seizure disorder at 20% for the permanent separation rating.

The Board next considered the permanent disability rating at TDRL exit. The Board noted that the VA applied a 100% rating for multiple weekly complex partial seizures in 2007, during the TDRL period, and continued this rating in 2009, based on the 20 July 2009 C&P, for frequent complex partial seizures as well as one generalized seizure occurring weekly. The last clinic visit available in the record, done on 3 July 2008 was significant for pseudoseizures, but otherwise stated that he “denied any problems.”

The Board also noted that the CI had reported having had seizures for events potentially ascribed to other causes such as a 31 March 2008 use of Ativan. While the C&P examiners determined that the CI had complex partial seizures, none of the treating physicians gave the CI this diagnosis. It is also noted that the 5 day VEEG was entirely normal as were been all EEGs. However, to confirm pseudoseizures, the questionable seizure activity must occur during the EEG monitoring with the EEG failing to show epileptiform activity. This did not occur. The CI had no events during the video EEG hospitalization so no determination could be made. It is not uncommon to have normal EEGs when no seizure activity is present in patients with known seizure disorders. The Board notes that the FPEB concluded that the multiple “seizure” episodes represented pseudoseizures and finds no compelling evidence to dispute this finding, despite the opinions of the latter two C&P examiners. None of the available treatment notes from the TDRL time period document a diagnosis of complex partial seizures but some do reference events that were attributed to non-seizure type activity such as vertigo and possible or probable pseudoseizures. There is no clear evidence these frequently recurring events were actual seizure activity as diagnosed by a treating physician.

The Board also noted that the CI had a low Dilantin level prior to the seizure in June 2009 and that he was seizure free in all accounts between separation in November 2003 and early January 2007, a period of over 3 years. There is documentation of a grand mal seizure on 31 March 2008. This represents one major seizure in the prior 12 months. The VA rating decision of 1 August 2009 references a major seizure June 2009, more than 12 months after March 2008, supporting a rating of 20%. While the VA C&P examiner diagnosed partial complex seizure activity, none of the CI’s treating physicians made this diagnosis and none considered these events to be seizures. While the VA rating for seizures is based on the Veteran’s report of frequency of events, the diagnosis must first be made by a treating physician. After due deliberation, in consideration of the totality of the evidence, the Board concluded that there was insufficient cause to recommend a change from the PEB fitness adjudication for the seizure condition at TDRL exit.

Other Contended Conditions. The CI contends for additional rating of a learning difficulty condition. The Board notes that the TDRL entry MEB exam documented “loss of consciousness on the order of minutes. No evident adverse sequelae thereafter.” No comment was made on the non-medical assessment (NMA) of cognitive impairment. The Board notes the March 16, 2010 neuropsychology evaluation documented impairment but was completed more than a year after TDRL exit. While the traumatic brain injury (TBI) could have contributed, the examiner noted that this is confounded by history of seizures, anti-epileptic medications, and possible long-standing attention deficit hyperactivity disorder (ADHD). The CI was also noted to score in the severe depressive range. There is no evidence that the “learning difficulty” was clinically active or significant while on active duty if it was present. Moreover, no learning difficulty condition was noted in the DES. 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.

Remaining Conditions. An acute episode of bronchitis was identified in the DES file. This condition was not clinically active during the MEB period, was not the basis for limited duty, and was not implicated in the NMA. It was also noted that he had fractured his arm as a child. These conditions were reviewed by the action officer and considered by the Board. It was determined that neither could be argued as unfitting and subject to separation rating. Additionally, no other conditions were noted in the VA rating decision proximal to separation. The Board, therefore, has no reasonable basis for recommending any additional unfitting conditions for separation rating.

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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. In the matter of the epilepsy condition, the Board unanimously recommends a TDRL disability rating of 60%, coded 8910 and a permanent separation rating of 20%, both IAW VASRD §4.124a. In the matter of the bronchitis and the history of a fractured arm condition, 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, effective as of the date of his prior medical separation:

|  |  |  |  |
| --- | --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** | |
| **TDRL** | **PERMANENT** |
| Epilepsy, idiopathic, generalized | 8910 | 60% | 20% |
| **COMBINED** | **60%** | **20%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20100525, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans' Affairs Treatment Record

President

Physical Disability Board of Review

MEMORANDUM FOR DEPUTY COMMANDANT, MANPOWER & RESERVE AFFAIRS

COMMANDER, NAVY PERSONNEL COMMAND

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATIONS

Ref: (a) DoDI 6040.44

(b) PDBR ltr dtd 7 May 12 ICO XXXXXXXXXXXXXXX

(c) PDBR ltr dtd 22 May 12 ICO XXXXXXXXXXXXXXX

(d) PDBR ltr dtd 10 May 12 ICO XXXXXXXXXXXXXXX

(e) PDBR ltr dtd 3 May 12 ICO XXXXXXXXXXXXXXX

1. Pursuant to reference (a) I approve the recommendations of the PDBR set forth in references (b) through (e).

2. The official records of the following individuals are to be corrected to reflect the stated disposition:

a. former USMC: Placement on the Temporary Disability Retired List for the period 1 December 2003 through 30 November 2008 with a 60 percent disability rating (increased from 40 percent) with final disability separation on 1 December 2008 with a 20 percent disability rating.

b. former USN,: Placement on the Permanent Disability Retired List with a 30 percent disability rating (increased from 20 percent) effective 31 October 2001.

c. former USMC: Placement on the Permanent Disability Retired List with 30 percent disability rating (increased from 10 percent) effective 30 August 2009 .

d. former USMC: Disability separation with entitlement to disability severance pay with a rating of 20 percent (increased from 10 percent) effective 31 October 2006.

3. Please ensure all necessary actions are taken to implement these decisions, included the recoupment of disability severance pay if warranted, and notification to the subject members once those actions are completed.

Assistant General Counsel

(Manpower & Reserve Affairs)