RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: marine corps

CASE NUMBER: PD1100184 SEPARATION DATE: 20080715

BOARD DATE: 20120130

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty member, Cpl/E-4 (0311, Rifleman), medically separated for post-concussive syndrome. He did not respond adequately to treatment and was unable to perform within his Military Occupational Specialty (MOS) or meet physical fitness standards and underwent MEB. Posttraumatic stress disorder (PTSD), post-concussive syndrome and major depressive disorder (MDD), single episode, were forwarded to the Informal Physical Evaluation Board (IPEB) IAW SECNAVINST 1850.4E on the NAVMED 6100\_1. An MEB addendum, submitted on behalf of the request of the CI dated 3 April 2008, added migraine associated dizziness, dizziness, vertigo, migraine headaches, hearing loss and tinnitus. Other conditions included in the Disability Evaluation System (DES) packet will be discussed below. The IPEB adjudicated the post-concussive syndrome as unfitting, rated 10%, with likely application of SECNAVINST 1850.4E and DoDI 1332.39 (E2.A1.5). The IPEB determined that PTSD, in partial remission; cognitive disorder, NOS; multiple grade II and III concussions; major depression; standard assessment of concussion score 24 out of 30; multiple IED exposures; personality change due to a medical condition; and, post-traumatic headache were Category II conditions, related to the unfitting diagnosis, but not separately unfitting. Alcohol dependence, in sustained partial remission, was determined to be a Category IV condition, one which does not constitute a physical disability. The CI made no appeals and was medically separated with a 10% disability rating.

CI CONTENTION: “Due to the changes in the NDAA 2008, I am respectfully requesting a review of my medical records. I was diagnosed with sever (sic) Post Traumatic Stress Disorder (PTSD) from my combat experiences in Iraq. During my medical board, I was not looked at for PTSD and several other medical conditions”. He elaborates no specific contentions regarding rating or coding and mentions no additionally contended conditions.

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service IPEB – Dated 20080414** | **VA (1/6 Mo. After Separation) – All Effective Date 20080716** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Post-Concussive Syndrome | 8045-9304 | 10% | Post-Concussive Syndrome | 8045 | NSC | 20090225 |
| Cognitive Disorder | Cat II |
| Multiple Grade Two and Three Concussions | Cat II |
| Personality Change Due to a Medical Condition | Cat II |
| Post-Traumatic Headache | Cat II | Migraine | 8199-8100 | 50%\* | 20090225 |
| PTSD | Cat II | PTSD | 9411 | 30%\*\* | 20080809 |
| MDD | Cat II |
| Alcohol Dependence | Cat IV | No VA entry |
| ↓No Additional MEB/PEB Entries↓ | Tinnitus | 6260 | 10% | 20090225 |
| Mild Low Back Strain | 5237 | 10% | 20080809 |
| Right Knee PFS | 5299-5260 | 10% | 20080809 |
| Left Knee PFS | 5299-5260 | 10% | 20080809 |
| 0% x 1/Not Service Connected x 2 | 20080809 |
| **Combined: 10%** | **Combined: 80%** |

\*Initially deferred, rated 50% on 20090325, retroactive to separation;

\*\* Rating increased from 30% to 50% on 20090325, retroactive to separation.

ANALYSIS SUMMARY: The DES is responsible for maintaining a fit and vital fighting force. 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 career, and then only to the degree of severity present at the time of final disposition. The Board acknowledges the sentiments expressed or implied in the CI’s application, i.e., that there should be additional disability assigned for his PTSD condition and for the significant impairment from his service-incurred musculoskeletal conditions which have worsened over time. It is a fact, however, that the DES has neither the role nor the authority to compensate Service members for anticipated future severity or potential complications of conditions incurred in service or resulting in medical separation. The Board’s authority resides in evaluating the fairness of DES fitness decisions and rating determinations for disability at the time of separation and, for PTSD, at six months after separation. Moreover, the Board notes that the mere presence of a diagnosis is not sufficient to render the condition unfitting. While the DES considers all of the medical conditions, compensation can only be offered for those medical conditions that cut short a career, and then only to the degree of severity present at the time of final disposition. However, the Department of Veterans’ Affairs (DVA), operating under a different set of laws (Title 38, United States Code), is empowered to periodically re-evaluate Veterans for the purpose of adjusting the disability rating should the degree of impairment vary over time. It is noted for the record that the Board has neither the jurisdiction nor authority to scrutinize or render opinions in reference to the CI’s statements in the application regarding medical care or suspected DES improprieties in the processing of his case. However, the Board notes that, contrary to the contention, the IPEB did specifically consider and adjudicate the PTSD condition.

Post Concussive Syndrome Condition with Posttraumatic Stress Disorder and Major Depressive Disorder. The PEB determined that post-concussive disorder was the primary unfitting condition and that PTSD, major depressive disorder, and cognitive disorder were category 2 conditions, conditions that are contributing to the unfitting condition (post-concussive syndrome), but not separately ratable. The conditions are discussed together due to the intertwined and overlapping nature of symptoms. The Board’s challenge was the overall approach to adjudicating this case. After careful consideration of the facts of the case the Board concluded that PTSD was the predominant unfitting condition and that the overlapping symptoms from post-concussive syndrome were appropriately subsumed in the rating for PTSD.

The CI was deployed to Iraq from 4 September 2005 until 29 March 2006. While in theater, he was reportedly exposed to several IED explosions. Medical care for one IED was present in the service treatment record. The CI was medically evaluated on 09 March 2006 when the vehicle he was driving was exposed to an IED blast. The record entry records he bounced his head off the steering wheel incurring a two to three inch “scratch” on the right forehead. He complained of a frontal headache and slight hearing loss of the right ear. He denied loss of consciousness, blurred vision, amnesia, nausea or vomiting. The neurologic examination was normal and he scored 30 on a Folstein mini mental status examination (30 is a perfect score, 25 and above is considered normal). The CI was return to duty with concussion precautions. On a post deployment health assessment dated 4 October 2006, he documented that he was dazed, confused or “seeing stars”, but indicated that there was no amnesia or loss of consciousness (LOC). He was first seen in the concussion clinic on 2 May 2007, over a year after the last IED exposure and over a year prior to separation. The CI reported numerous IED and RPG exposures but the incident for which medical care is documented was the primary significant event. He denied LOC with the event but stated he was disoriented for several minutes afterwards. He stated that the initial headaches after the IED blast had essentially resolved while he was on extended emergency family leave (several months), but following return to duty he experienced recurrent headache with putting on his military helmet. At that time, he noted that he had severe headaches 7/10 pain scale with nausea and dizziness when wearing a helmet or even a baseball cap. He also had sleep problems, feeling fatigued, tinnitus of the right ear, twitching of the left arm and hand, decrease cognition, slow thinking, short term memory (STM) loss, increase frustration, irritability, numerous stress symptoms and difficulties driving. The examiner noted “his symptoms had mainly resolved while he was on an eight month emergency leave and he was getting plenty of rest and sleep.”

The examiner also noted prior high risk activities to include boxing and skydiving. Subsequent treatment records recorded he suffered stars in seven of his fights but no knock-outs. His standardized assessment of concussion score was 25/30 consistent with his complaints. Thus began a thorough evaluation for postconcussive syndrome. This evaluation included vestibular, neuropsychology, neurology and psychiatry evaluations. While this evaluation was being completed the CI was placed on limited duty (LIMDU) restricting him from carrying a weapon, physical training to tolerance, no PFT, no field work and no shift work for six months with the following diagnoses: mild traumatic brain injury (TBI), PTSD, and major depressive disorder (MDD). Vestibular testing was normal and the examiner opined the dizziness was likely related to migraines. Three neuropsychological assessments were completed prior to separation collectively documented mild memory and processing deficits with an exam consistent with moderate major depression and PTSD. Global Assessment of Functioning (GAF) scores assigned during these evaluations were 60 and 65. At the time of initial neuropsychological testing, 25 July 2007, the neuropsychologist concluded “While the CI’s history of concussion cannot be ruled out as a possible contributor to his thinking difficulties, his prominent mood and PTSD concerns are the likely etiology for his memory and processing speed difficulties at this time.” Four months prior to separation and despite intervening psychiatric treatment the neuropsychologist commented “Due to significant psychiatric issues, difficult to determine if his problems on the cognitive evaluation are due to the history of blast or psychiatric issues.” Testing at that time, 13 March 2008, documented mildly impaired ability to learn and remember new information with mildly slowed processing speed. Earlier the neuropsychologist thought problems were primarily of attention and recommended ADHD medication. The Neurology assessment documented a normal exam, a normal brain MRI and assessed the CI with postconcussive syndrome, post-traumatic headaches, IED exposures, PTSD and major depression.

During this extensive postconcussive evaluation on 25 June 2007 the CI was emergently cared for an overdose after ingesting eight Vicodin pills combined with a large amount of beer and vodka. The CI attempted to manipulate his way out of substance abuse treatment, but reluctantly entered inpatient Substance Abuse Rehabilitation Program (SARP) in November 2007. The CI reported he “had experienced fifty hangovers and fifty alcohol related black-outs” since January 2007. He “rationalized and justified his drinking a method for controlling his anxiety and insomnia”. His first use of alcohol was at age 15 with a historical pattern of binge drinking two times per month from age 16-20. He successfully completed inpatient alcohol treatment and complied with follow-up in the outpatient setting during the MEB process. At the conclusion of his inpatient treatment the multiple clinical exams indicated the CI exhibited most of the symptoms of PTSD but also had troubling paranoid and narcissistic traits. Examiners commented: “However, it is unclear if his personality disturbance existed prior to entry or may reflect a personality change secondary to brain injury.” He was thought to remain at increased risk of relapse due to environmental concerns and the other psychiatric issues. He was assigned a GAF of 71 with a diagnosis of cognitive disorder not otherwise specified (NOS), PTSD, delayed in partial remission, and alcohol dependence, in sustained partial remission. The examiner opined the CI remained vulnerable to acute exacerbations of anxiety and agitation and appeared to be at a significant risk for relapse into alcohol dependence especially as he transitions out of the military and recommended continued psychological and psychiatric care through the VA.

The Board directs its attention to its rating recommendations based on the evidence just described. The IPEB adjudicated postconcussive syndrome as unfitting and rated it 10% IAW VARSD 8045-9304. The PEB determined the cognitive disorder; PTSD and MDD were contributing to this condition but not separately unfitting. The VA found postconcussive syndrome as not service connected citing no residuals after rating PTSD (claimed as depression) subsuming the overlapping symptoms of cognitive disorder and insomnia in the rating for PTSD and awarded separate ratings for migraines (subsuming dizziness), and tinnitus. The VA assigned a 30% rating for the PTSD condition based on §4.130 criteria without relying on the provisions of §4.129. The VA rater’s rationale for a 30% rating was well elucidated in the rating decision. The rating for PTSD was increased to 50% based on a decreasing GAF score of 45-50 at the six month interval with residual memory issues related to PTSD and insomnia not mild TBI. The VA also cited there was not enough evidence to determine if the personality disorder existed prior to service or was a direct result of the blast injury therefore did not rate. Finally, the VA cited the CI declined to undergo further neuropsychiatric testing and that his recent VA TBI assessment revealed a history of exposure to improvised explosives without traumatic brain injury.

As noted above, the Board considered whether TBI or PTSD was the predominant unfitting condition and whether there was evidence the two diagnoses were separately unfitting and ratable conditions. There was a LIMDU prohibiting weapons use, three neuropsychological assessments concluding PTSD and MDD were significantly contributing to his cognitive disorder, SARP documenting alcohol dependence in remission with PTSD and the NMA’s statement noting thirty hours of work missed but otherwise work exceptional. The record available for review supports a single IED injury resulting in a return to duty status. Furthermore there was neither LOC nor amnesia with this injury. This event could be at most a Grade I concussion although not formally diagnosed. Typically individuals recover and are returned to duty or contact sports within a week of a Grade I concussion. The Board considered the abatement of his symptoms while on emergency leave and the resurgence of symptoms when returning to duty which is more suggestive of a psychiatric condition than post-concussive condition. The Board concluded that PTSD, not postconcussive syndrome was the predominant unfitting condition and that the most accurate way to capture the CI’s overall unfitting disability for rating was to rate his PTSD subsuming overlapping cognitive symptoms (IAW TL 07-05; “Symptoms of cognitive impairment and mental disorders such as depression and PTSD often overlap. In such cases, a single evaluation taking into account both conditions may be the most appropriate way to evaluate them”). Post-traumatic headache is discussed separately below.

The first charge before the Board was to determine if this case was a result of a “highly stressful event” (as per §4.129). IAW DoDI 6040.44 and DoD guidance (which applies current VASRD 4.129 to all Board cases), the Board is obligated to recommend a minimum 50% PTSD rating for a retroactive six-month period on the Temporary Disability Retired List (TDRL). The Board must then determine the most appropriate fit with VASRD 4.130 criteria at six months for its permanent rating recommendation. The service treatment evidence did show the CI suffering an IED blast injury, and an injury or death of his fellow Marine in this same incident which was related in later service treatment records. The CI received the combat action ribbon. Therefore the Board determined this case did meet the criteria for a “highly stressful event”. All members agreed that the §4.130 criteria for a rating higher than 50% were not met at the time of separation from active duty, and therefore the minimum 50% TDRL rating (as explained above) is applicable.

The most proximate source of comprehensive evidence on which to base the permanent rating recommendation in this case were VA psychiatric outpatient notes encompassing the targeted six-month interval and a VA TBI compensation and pension examination 25 February 2009, seven months after separation. An early December 2008 behavioral health note documented noncompliance with all his medications. A January 2009 speech pathology assessment noted difficulty with memory likely related to PTSD and insomnia with a normal speech evaluation. The speech pathologist opined that the memory problems were more likely due to PTSD and insomnia than to mild TBI. The CI scored in the average range on memory testing administered by the speech pathologist. In February 2009, a behavioral health addendum documented the patient likely has Axis II pathology, declined to undergo neuropsychiatric testing and did not comply with sending results of previous psychiatric testing. The VA TBI compensation exam in February 2009 documented the CI did not have symptoms of sleep disturbance, dizziness, vertigo, weakness or paralysis, fatigue, mobility issues, stagger or fall, attention, concentration nor decision making abilities. The CI was still having mild day to day short term memory issues. The examiner documented no overt psychiatric manifestations with his exam. In March 2009, eight months after separation he related symptoms of obsessive compulsive rituals, losing track of time, impulsivity with mood and money, nightmares, and difficulty with memory. He denied depression and had been happy since being the owner of a new puppy which he felt was therapeutic. He reinitiated driving in September 2008, started living with his girlfriend since December 2008 and was attending college as a full-time student pursuing pre-med course work. He was also working as a bouncer at a local college bar. His mental status exam (MSE) showed a blunted affect, but was otherwise normal. His GAF score was 50, connoting moderate impairment. The examiner noted the CI was smiling, and commented the CI appeared much more relaxed and was not on heightened alert as per prior visits.

As regards to the permanent rating recommendation, all members agreed that the §4.130 threshold for a 70% rating was not approached. A 50% rating IAW §4.130 would rely on an inference that the acuity of reported symptoms could reasonably be expected to result in impaired occupational reliability and productivity, without objective confirmation this was not the case. The deliberation settled on arguments for a 30% versus a 10% permanent rating recommendation. The argument for a 10% permanent rating can be sustained by the §4.130 description for that rating, i.e., “occupational and social impairment due to mild or transient symptoms which decrease work efficiency… only during periods of significant stress; or symptoms controlled by continuous medication.” The VA C&P evidenced nodecreased work efficiency and nosocial impairment, without reference to periods of stress. Although symptoms were not fully controlled, the CI was noncompliant with medications, and this latter stipulation is preceded by “or” not “and.” The Board noted the GAF’s at the six month interval connoted moderate impairment yet the symptoms and social improvements supported the 10% argument. The Board noted that prior to entering the military, the CI was working as a bouncer (and reported that he drank all the time), and after separation at the six month interval, he not only was working as a bouncer, he was attending college, had a significant relationship with his girlfriend, and maintained sobriety from alcohol. The Board also noted the reports describing the CI’s clinical history were not supported by the primary service medical documentation and revealed conflicting symptom reporting. The Board is left to consider, therefore, that the CI’s accounts of his symptoms and their severity, which constitute most of the psychiatric evidence, are subject to probative value compromise. In such cases, the Board leans more heavily on the well-grounded evidence such as actual performance and functioning, objective elements of the mental status examination and symptoms which are consistently reported and compatible with clinical expectations. In so doing however, the Board remains cognizant of VASRD §4.3 (reasonable doubt) and favorably concedes matters which it cannot opine to a “more likely than not” standard. All of the evidence, bolstering and reducing support for the higher rating, was debated. The majority of the Board failed, on balance, to find adequate reasonable doubt favoring the CI in support of a recommendation for the higher rating. After due deliberation, considering the totality of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a permanent PTSD disability rating of 10% in this case.

Other PEB Conditions: The other conditions forwarded by the MEB and adjudicated as category 2 conditions by the PEB were cognitive disorder, post-traumatic headache, multiple grade two and three concussion, and personality change due to medical condition. Alcohol dependence in sustained partial remission was a category 4 condition, a condition which does not constitute a physical disability. Cognitive disorder, sleep disturbances, and personality change were subsumed under the §4.130 PTSD rating. After the CI’s blast injury he noted residual chronic headaches occurring daily 2/10 pain scale, then about one time per day he has a migraine-like headache which Maxalt immediately resolves. He noted nausea and vomiting with the wearing of a helmet and post exercise. He was seen by neurology, noted to have a normal exam and radiographs and diagnosed with migraines and recommended treatment. In follow-up the CI had improvement in headache frequency and lessening of severity, requiring abortive therapy two times per week. It is clear from the record that headaches prevented the wear of a helmet and thus, he could not meet MOS requirements. Therefore the Board concluded that the headaches were separately unfitting. Although the VASRD offers no specific definition for “prostrating,” in practice, the common dictionary definition is applied when rating headaches under the diagnostic code 8100 migraine headaches. The clear English definition of prostrating is “utter physical exhaustion or helplessness,” and does not indicate that seeking medical attention is required. There is no evidence that his headaches were prostrating in the record prior to separation. The VA rating was based on the 25 February 2009 C&P exam, over seven months after separation, which documented historical multiple episodes of exercised induced fainting and headaches lasting several hours, three days a week. The fainting spells were documented as occurring while in Marine Special Forces training which he abandoned, yet was not symptomatic enough to deem him unfit and he subsequently deployed. Furthermore these fainting spells were not objectively documented prior to separation or in the VA C&P two weeks after separation. The Board considered that while the CI did not have prostrating attacks prior to separation if he did not wear his helmet (or sometimes service cover); he was prevented from participating in military duties. After due consideration, the Board determined that the headache condition be rated at 0% and coded 8199-8100, analogous to migraine headaches at separation and permanently. The personality change due to a medical condition was adjudicated by the IPEB as a not unfitting Category II condition. The MEB psychiatric addendum dated 22 May 2007, over one year prior to separation, noted paranoid and narcissistic traits. It was unclear if these were pre-existing, secondary to brain injury, or PTSD. Regardless, his commander did not indicate that his work performance was impaired and any personality change related to mild TBI and PTSD is considered in the rating for PTSD. The history of concussion and cognitive disorder, are discussed above under TBI and PTSD and any related impairments are subsumed under the rating for PTSD. In the matter of personality change condition, the Board unanimously recommends no change from the PEB adjudications as, Category II, contributing to but not separately unfitting. Alcohol abuse is not a separately ratable condition.

Remaining conditions. Other conditions identified in the DES include blurred vision, right hand pain, bilateral knee pain, and low back pain. Several additional non-acute conditions or medical complaints were also documented. None of these conditions were clinically significant during the MEB period, none were the basis for limited duty and none were implicated in the NMA. 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. Tinnitus was rated by the VA within twelve months of separation. This was in the DES file but there was no documentation in the record that it impaired duty. 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. In the matter of the PTSD, the Board by a vote of 2:1 recommends that the CI’s prior separation be modified to reflect that the CI was placed on the TDRL at 50% for a period of six months (PTSD at 50% IAW §4.129 and DoD direction) and then permanently separated with severance pay by reason of physical disability with a final 10% rating as indicated below. The single voter for dissent (who recommended TDRL at 50% for a period of six months (PTSD at 50% [IAW §4.129 and DoD direction] and then permanent 30% disability and retirement) submitted the addended minority opinion. In the matter of the posttraumatic headache condition, the Board unanimously recommends that it be added as an additionally unfitting condition for separation rating; coded 8199-8100 analogous to migraine and rated 0% IAW VASRD §4.124a. In the matter of the blurred vision, right hand pain, bilateral knee pain, and low back pain, tinnitus or any other condition 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; TDRL at 50% for 6 months following CI’s prior medical separation (PTSD at minimum of 50% IAW §4.129 and DoD direction) and then a permanent separation with a 10% disability rating as indicated below.

|  |  |  |  |
| --- | --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **TDRL RATING** | **PERMANENT****RATING** |
| PTSD | 9411 | 50% | 10% |
| Migraine Headaches | 8199-8100 | 0% | 0% |
| **COMBINED** | **50%** | **10%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294 dated 200110308, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans' Affairs Treatment Record

 President

 Physical Disability Board of Review

MINORITY OPINION:

The minority voter concludes a 30% permanent rating for PTSD at the end of the six month constructive TDRL period is appropriate in this case based on the evidence of the record and application of VASRD §4.3 (reasonable doubt) and §4.7 (higher of two evaluations). The post separation examinations document CI report of continued symptoms of PTSD including sleep disturbance, hypervigilance, irritability, and mood swings. Although going to college and working in the same occupation he had prior to entering military service, the VA neurology encounter 14 January 2009 documents CI report of difficulties with school due to memory and concentration problems. The comments and Global Assessment of Functioning ratings by the examining psychiatrists also indicate their assessment of moderate impairment that more nearly approximates the 30% rating. VA treatment records up to a year after separation do not reflect improvement. The minority voter acknowledges that there was scant direct evidence regarding occupational functioning at the time of permanent rating requiring an assessment based on symptom report. When speculation is required, reasonable doubt should weigh heavily in Board deliberations. The minority voter concludes that considering the evidence and mindful of VASRD §4.3 (reasonable doubt), a permanent disability rating of 30% for PTSD in this case is appropriate, fair and equitable.

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 22 Feb 12 ICO

 (c) PDBR ltr dtd 28 Feb 12 ICO

 (d) PDBR ltr dtd 24 Feb 12 ICO

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

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

 a. XXXXXX, former USN, : Placement on the Temporary Disability Retired List (TDRL) with a 50 percent disability rating for the period 26 October 2006 through 25 April 2007 followed by disability separation with a final rating of 10 percent effective 26 April 2007.

 b. XXXXX, former USMC: Placement on Permanent Disability Retired List with a 30 percent disability rating effective 30 June 2008.

 c. XXXXXX, former USMC: Placement on the TDRL with a 50 percent disability rating for the period 15 July 2008 through 14 January 2009, followed by disability separation with a final rating of 10 percent effective 15 January 2009.

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

 Assistant General Counsel

 (Manpower & Reserve Affairs)