RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: xxxxxxxxxxxxxxxxxxxx BRANCH OF SERVICE: MARINE CORPS

CASE NUMBER: PD11-00248 SEPARATION DATE: 20060415

BOARD DATE: 20120605

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 (3521/Organizational Automotive Mechanic), medically separated for memory dysfunction due to a shrapnel head injury incurred while deployed in November 2004. He did not respond adequately to treatment to perform within his Military Occupational Specialty (MOS) or to meet physical fitness standards. He was placed on limited duty and underwent a Medical Evaluation Board (MEB). “Intracranial injury of other and unspecified nature without mention of open intracranial wound; other general symptoms; disturbance of skin sensation; other closed skull fracture without mention of intracranial injury and unspecified concussion” were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW SECNAVINST 1850.4E. The MEB forwarded no other conditions for PEB adjudication. The PEB adjudicated the memory dysfunction condition as unfitting, rated 10%; with application of the Veterans Administration Schedule for Rating Disabilities (VASRD); “traumatic brain injury (TBI); penetrating brain injury, skull fracture; injury due to mortar blast and hypesthesia” as related category II diagnoses and obesity as a category IV condition (does not constitute a physical disability). The CI made no appeals, and was medically separated with a 10% combined disability rating.

CI CONTENTION: The CI states: “Due to the DOD changes written into the National Defense Authorization Act regarding combat related PTSD/TBI.”

SCOPE OF REVIEW: The Board wishes to clarify that the scope of its review as defined in DoDI 6040.44, Enclosure 3, paragraph 5.e.(2) is limited to those conditions which were determined by the PEB to be specifically unfitting for continued military service; or, when requested by the CI, those condition(s) “identified but not determined to be unfitting by the PEB.” The ratings for unfitting conditions will be reviewed in all cases. The requested PTSD condition is not within the Board’s purview. Any conditions or contention not requested in this application, or otherwise outside the Board’s defined scope of review, remain eligible for future consideration by the Board for Correction of Naval Records (BCNR).

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service PEB – Dated 20060208** | **VA (16 Mos. Post –Separation\*) – All Effective Date 20060416** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Memory Dysfunction | 8045-9304 | 10% | PTSD, Chronic Cognitive Disorder NOS, Alcohol Dependence | 8045-9411 | 100% | 20070815 |
| Traumatic Brain Injury | Cat 2 |  | Headaches Assoc. w/ SFW\*\* | 8199-8100 | 30% | 20071023 |
| Penetrating Brain Injury | Cat 2 |  | Monocular Vertical Diplopia | 6090-6080 | 10% | 20071023 |
| Injury Due to Mortar Blast | Cat 2 |  | Tinnitus | 6260 | 10% | 20070822 |
| Hypesthesia  | Cat 2 |  | SFW s/p Craniotomy; Scars | 7800 | 30% | 20071023 |
| Obesity | Cat 4 |  | No VA Entry | 20071023 |
| ↓No Additional MEB/PEB Entries↓ | Residual Scars Anterior Chest | 7804 | 10% | 20071023 |
| 0% X 1 / Not Service-Connected x 1 | 20071023 |
| **Combined: 10%** | **Combined: 100%** |

\*The CI filed his claim with the VA over one year after separation.

\*\*SFW means “Shrapnel Fragment Wounds.”

ANALYSIS SUMMARY: The Disability Evaluation System (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 service member’s career, and then only to the degree of severity present at the time of final disposition. 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 nor for conditions determined to be service-connected by the Department of Veterans’ Affairs (DVA), but not determined to be unfitting by the PEB. However, the DVA, operating under a different set of laws (Title 38, United States Code), is empowered to compensate all 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. 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 VASRD standards, based on severity at the time of separation. The CI filed a claim for DVA benefits over a year after separation and the DVA Compensation and Pension examinations were not performed until 18 months after separation. The Board utilizes DVA evidence proximal to separation in arriving at its recommendations; and, DoDI 6040.44 defines a 12-month interval for special consideration to post-separation evidence. The Board’s authority as defined in DoDI 6044.40, however, resides in evaluating the fairness of DES fitness determinations and rating decisions for disability at the time of separation. Post-separation evidence therefore is probative only to the extent that it reasonably reflects the disability and fitness implications at the time of separation. As an implied extension of the DoDI 6040.44 and NDAA 2008 mandates, the Board will comply with applicable DVA disability rating policy changes issued via “FAST” or training letters effective at the time of separation. The DVA training letter, TL06-03 (dated 13 February 2006), in effect at the time of the CI’s separation, specifically addressed the complexity of TBI and recommended coding “outside” of 8045 when a more favorable rating could be achieved under an alternate code; e.g., analogous to migraines 8100 versus 8045-9304 if headache was present.

Memory Dysfunction due to Traumatic Brain Injury Condition. The CI was on his second deployment, when on November 25, 2004, shrapnel from a nearby mortar blast stuck him on the right side of his forehead, anterior chest and right thigh. Service treatment records (STRs) record only brief loss of consciousness at the time of shrapnel impact (10 seconds) without amnesia (able to recall the blast and another round that exploded nearby). He underwent neurosurgery to remove fractured skull fragments and shrapnel that penetrated his right frontal lobe. Post-operative CT scanning of the head and brain on December 2, 2004 demonstrated a small evolving contusion of the right frontal lobe and post-operative changes from a “small, right frontal craniectomy with malleable plate repair in a supraorbital location.” In the hospital he complained of seeing spots out of the right eye with bright light and seeing a reflection of the right eye with red and black circles surrounding the pupil when direct light is shined in the right eye. Evaluation by ophthalmology diagnosed posterior vitreous detachment. He was observed to be ambulating without difficulty on the hospital floor December 2, 2004.

The TBI screening performed on December 3, 2004 demonstrated immediate memory and language skills in the low average range. Delayed memory, attention, and visual-spatial skills were above average. Neurologic examination performed on December 3, 2004 was normal and he was ambulating without difficulty. There were no seizures or other complications of head injury. The CI was released from the hospital on convalescent leave December 3, 2004. He was seen at a VA primary care clinic near his home on December 9, 2004 to establish continuing care while on convalescent leave. The CI complained of pain in the right leg, some spots at certain visual angles in his right eye, numbness of the right forehead, numbness at the chest wound (shrapnel did not penetrate the chest wall and was removed), dull headache, and decreased hearing left ear. He was ambulating with a cane due to right thigh pain. The CI reported depressed mood, insomnia, and intrusive thoughts. The mood was somewhat depressed on examination. A mental health evaluation performed on December 21, 2004 noted anxiety and depressive symptoms with intrusive thoughts. There was decreased concentration on mental status examination (MSE). The examiner listed the diagnosis as posttraumatic stress disorder (PTSD) and STRs indicate treatment with medication (Celexa). At the time of neuropsychological testing June 17, 2005, the CI reported brief loss of consciousness at the time of injury and then feeling confused, “but now feels he has returned to his cognitive baseline.” He reported problems with little control over his temper (previously a problem but now much more so) and endorsed nightmares with decreasing frequency of three to four times per month, avoidance of reminders, and feeling watched. He also noted problems with planning and periods of increased energy. He denied feeling depressed, suicidal ideation, or abusing alcohol. A history of attention deficit hyperactivity disorder (ADHD) treated as a child, and two alcohol related non-judicial punishments early in his military career were noted. He also reported continued right frontal headache.

He also reported three seizures since the November 2004 head injury, but none since January 2005; however, this is not corroborated elsewhere in the STR. The CI had no difficulties with comprehension of instructions. During testing he was observed to be slightly irritable and occasionally responded impulsively. Test results were in the low average range. The neuropsychologist concluded that from a strictly cognitive perspective, the CI was considered fit for full duty. However, testing results also indicated reported symptoms suggesting of PTSD or bipolar disorder, and raised the concern the may have been fabricating psychiatric symptoms for secondary gain. Further psychological evaluation was recommended. Further evaluation with psychological testing onSeptember 8, 2005 concluded the CI was exaggerating psychiatric symptoms and that the testing profile was not similar to patients with PTSD and that it was unlikely the CI had PTSD at that time. Problems with coping skills, decision making, and social skills were identified. Poor attachment and interpersonal skills were stated to be consistent with his disclosure of his mother’s abandonment at a young age. Problems with alcohol abuse were also detected. During the evaluation, speech was observed to be fluent, of normal rate, rhythm and tone. The CI denied a history of seizure (previously reported by CI), or suicidal ideation. Neurology evaluation on October 6, 2005 noted complaint of memory dysfunction with unremarkable neuropsychological testing. The CI reported mild headache (ibuprofen was listed on his active medication list). Neurologic examination was normal including ocular movement. A CT scan of the head in September 2005 (when CI was hit by a car), noted post operative changes (a microplate and screws and underlying hypodensity). The CI also reported hypervigilance and dreams. Repeat neuropsychological testing performed on October 28, 2005 recorded CI complaint of decreased attention, concentration, irritability, and speech difficulties (stuttering and word finding not reported previously). He denied alcohol consumption for the prior 2 months. Testing reflected some symptom exaggeration but was not considered to be a degree to have invalidated testing. The CI reported he had discontinued his medications including Celexa 4 months before in June 2005, and there was evidence of anxiety and tension with testing. The examiner concluded that testing was consistent with the presence of “at Ieast mild cognitive deficits, which are likely secondary to traumatic brain injury.” Testing was noted for decreased verbal processing, attention, and concentration. Testing also noted somatic concerns and an affective component that were likely exacerbating the cognitive symptoms. The MEB NARSUM, dated December 14, 2005, lists final diagnoses of TBI, memory dysfunction, hypesthesia (disturbance of sensation about the scar), penetrating brain injury, skull fracture, and injury due to mortar blast. The commander’s non-medical assessment (NMA), dated January 25, 2006, reported significant problems performing duty in garrison due to problems with concentration, short term memory, and multitasking. The PEB adjudicated the CI’s traumatic brain injury as memory dysfunction appropriately coded 8045-9304 (dementia due to head trauma) consistent with VASRD guidelines in force at the time. The PEB’s 10% rating, was apparently based on an assessment of mild cognitive impairment reflected in neuropsychological testing performed in October 2005 which would be considered consistent with §4.130 guidelines (general rating formula for mental disorders). The CI was separated April 14, 2006. Four months after separation, the CI presented to the VA clinic with complaint of insomnia for 2 weeks. He did not show for an appointment in the mental health clinic on August 16, 2006. The next available record is a January 9, 2007 VA mental health clinic encounter which documents problems with alcohol abuse, and impulse control problems. The CI did not describe PTSD symptoms at that time. The CI filed a claim for VA benefits, July 2007, and VA ratings were based on C&P examinations performed over a year after separation and based on rating guidance not in effect at the time of separation (TL 07-05, 31 August 2007).

The Board directs attention to its rating recommendation based on the above evidence. The Board is required to adhere solely to the VA disability rating guidelines in effect at the time of separation (IAW DoDI 6040.44 and the NDAA 2008) which includes adherence to any concurrent applicable disability rating policy changes issued via “FAST” or training letters based on the CI’s separation date; in this case TL 06-03, February 2006. By precedent and legal opinion, the Board is obligated to comply with the Training Letters and “unbundle” the elements of TBI where that is to the member’s benefit. In this case that applies to other residuals of TBI including the CI’s headache, visual complaint, cognitive complaints, behavioral, and emotional dysfunction due to TBI. The CI manifested subjective symptoms of headache, right eye visual disturbance and hearing loss that would not otherwise attain a minimum rating under another diagnostic code at the time of separation. The CI reported headaches that were of mild severity and for which no medication was used except as needed ibuprofen. There were no prostrating attacks to support a minimum rating under VASRD diagnostic code 8100. The right eye visual symptoms were some spots at certain visual angles. There was no impairment of visual acuity, or oculomotor function, and the CI was able to complete extensive neuropsychological and psychological testing without visual complaints. Monocular diplopia was not documented prior to separation. Hearing loss was attributed to chronic long term career noise exposure and not due to TBI. An audiogram in January 2006 documents normal pure tone hearing thresholds except for slight decrease in high frequency hearing left greater than right. A complaint of tinnitus was not present in STRs prior to separation (CI checked “no” on DD Form 2807 regarding any ear trouble). The Board considered the cognitive, behavioral and emotional residuals of the CI’s TBI. The Board noted that there were symptoms suggestive of PTSD recorded in STRs; however results of neuropsychological and psychological testing did not support a conclusion that there were sufficient symptoms warranting a diagnosis separate from the residuals of TBI. The Board also noted the VA mental health encounter January 9, 2007 VA mental health clinic encounter, 9 months after separation, which did not record PTSD symptoms. Although PTSD as a separately unfitting diagnosis unrelated to TBI is not within the Board’s scope of review, emotional and behavioral symptoms attributed to TBI are. In accordance with §4.126 (evaluation of disability from mental disorders), cognitive disorders shall be evaluated under the general rating formula for mental disorders; neurologic deficits or other impairments stemming from the same etiology (e.g., a head injury) shall be evaluated separately and combined with the evaluation for delirium, dementia, or amnestic or other cognitive disorder. When a single disability has been diagnosed both as a physical condition and as a mental disorder, the rating agency shall evaluate it using a diagnostic code which represents the dominant (more disabling) aspect of the condition. The Board noted the impairing symptoms of irritability, anxiety, and cognitive problems, are overlapping symptoms of both TBI and PTSD or other psychological conditions. In accordance with VA rating guidance, more than one rating cannot be assigned for the same symptoms (i.e. a rating for PTSD and a rating for TBI that each are based on the same cognitive symptoms). Therefore, due to the overlapping and intertwined symptoms, the Board concluded that the symptoms of TBI, including cognitive, emotional and behavioral complaints were most appropriately rated in combination as a single evaluation for TBI (9411-8045) using the general rating formula for mental disorders. Any cognitive, emotional or behavioral complaints that may have been attributed to a posttraumatic stress condition are subsumed under the rating for TBI IAW §4.126 and §4.14 (avoidance of pyramiding).

The Board made note of neuropsychological testing in June 2005 concluding that from a cognitive perspective, the CI was fit for return to duty, and the neuropsychological testing in October 2005 that was consistent with mild cognitive impairment which supported the 10% rating adjudicated by the PEB. However, the Board also noted residuals of frontal lobe injury not merely restricted to mild memory dysfunction that included problems other cognitive functions (decreased verbal processing, attention, and concentration), irritability, anger, and problems with impulse control reflected in neuropsychological testing and the initial VA mental health clinic encounter 9 months after separation. The Board considered the nature of the brain injury affecting the right frontal lobe and considered the likelihood the CI’s right frontal lobe injury resulted in functional impairment that exceeded the 10% rating as suggested by the commander’s NMA which noted problems with forgetfulness, concentration and multi-tasking. The degree to which alcohol abuse or misuse contributed to the impairment was considered, but was not ascertainable and mitigated to some extent by the decrease in impulse control resulting from a frontal lobe injury. The Board also discussed the fact that the CI stopped taking Celexa in June 2005 and that the October 2005 neuropsychological testing noted contribution to impaired cognitive function due to symptoms treatable by Celexa. The Board discussed the problems with impulse control following separation documented in the January 2007 VA mental health clinic encounter and considered the extent to which they existed at the time of separation. The commander’s NMA clearly reflected symptoms of frontal lobe injury beyond memory that was productive of occupational impairment that more nearly approximated the 30% level. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a disability rating of 30% for the residuals of traumatic brain injury condition.

Other PEB Conditions. The MEB forwarded intracranial injury of other and unspecified nature without mention of open intracranial wound; other general symptoms; disturbance of skin sensation; other closed skull fracture without mention of intracranial injury and unspecified concussion. The PEB revised these conditions and adjudicated memory dysfunction as unfitting discussed above. TBI, penetrating brain injury, skull fracture; injury due to mortar blast and hypesthesia were adjudicated related category II diagnoses contributing to the primary unfitting condition, but not separately unfitting for rating. The Board’s first charge with respect to these conditions is an assessment of the appropriateness of the PEB’s fitness adjudications. The Board’s threshold for countering 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. TBI, penetrating brain injury, skull fracture, and injury due to mortar blast are subsumed under the rating for residuals of TBI above. The skull fracture itself was not a separately unfitting condition. Residual scar with hypesthesia (numbness/abnormal sensation over craniotomy scar) also were not separately unfitting conditions and there was no indication from the record that any of these conditions interfered with satisfactory duty performance. All were reviewed by the action officer and considered by the Board. After due deliberation in consideration of the preponderance of the evidence, the Board concluded that there was insufficient cause to recommend a change in the PEB fitness determination for the any of the additional PEB conditions, and, therefore, no additional disability ratings can be recommended.

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 residuals of TBI condition, the Board unanimously recommends a disability rating of 30% coded 8045-9304 IAW VASRD §4.130. In the matter of the PEB category II conditions the Board unanimously recommends no change from the PEB determinations as not separately unfitting. There were no other conditions within the Board’s scope of review for consideration.

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:

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Residuals of Traumatic Brain Injury | 8045-9304 | 30% |
| **COMBINED** | **30%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110330, 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

 (c) PDBR ltr dtd

 (d) PDBR ltr dtd

 (d) PDBR ltr dtd

1. Pursuant to reference (a) I approve the recommendations of the Physical Disability Board of Review 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. former USN: Placement on the Permanent Disability Retired List with a 30% disability rating effective 19 May 2004.

b. former USMC: Placement on the Permanent Disability Retired List with a 30% disability rating effective 15 April 2006.

 c. former USN: Disability separation with entitlement to disability severance pay with a rating of 20% (increased from 10%) effective 3 February 2005.

d. former USMC: Placement on the Permanent Disability Retired List with a 60% disability rating effective 30 January 2008.

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

 Assistant General Counsel

 (Manpower & Reserve Affairs)