RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: marine corps

CASE NUMBER: PD201000286 SEPARATION DATE: 20060715

BOARD DATE: 20120216

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SSG/E-6 (2311/Ammunition Technician), medically separated for bipolar II disorder. He did not respond adequately to treatment and was unable to satisfactorily perform within his military occupation. He was placed on limited duty (LIMDU) and underwent a Medical Evaluation Board (MEB). Bipolar affective disorder, prolonged posttraumatic stress disorder (PTSD), and personality disorders were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW SECNAVINST 1850.4E. The PEB adjudicated the bipolar II disorder condition as unfitting, rated 10%, with application of SECNAVINST 1850.4E and Veterans’ Administration Schedule for Rating Disabilities (VASRD). The PTSD was determined to be a pre-existing condition and the personality disorder a category IV condition, not a physical disability. The CI made no appeals and was medically separated with a 10% disability rating.

CI CONTENTION: “MY DISCHARGE WAS 20%DUE TO ‘PERSONALITY DISORDER’ AND ‘BIPOLAR DISORDER’. BOTH OF WHICH WERE MISDIAGNOSED. THE VA HAS SINCE DIAGNOSED ME WITH PTSD COMBINED WITH A TRAUMATIC BRAIN INJURY. I FEEL AS THOUGH MY CONDITIONS WARRANT MILITARY RETIREMENT.” He also lists PTSD, TBI, major depressive disorder (MDD), bilateral knee pain and bilateral ankle pain in block 14.

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service IPEB – Dated 20060412** | | | **VA (9 Mo. After Separation) – Effective Date 20060716** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Bipolar II Disorder | 9432 | 10% | PTSD with dementia resulting from head trauma (formerly rated as Bipolar Disorder)\* | 9411 | 30%\*\* | 20070402 |
| PTSD, Childhood | Pre-existing Condition | |
| Personality Disorder | CAT IV | | Personality Disorder | 9999-9440 | NSC | 20070402 |
| ↓No Additional MEB/PEB Entries↓ | | | Post concussion headaches | 8045-8100 | 30%\*\* | 20070313 |
| Right ankle strain | 5271 | 10%\*\* | 20070313 |
| Tinnitus | 6260 | 10%\*\* | 20070329 |
| Right knee strain with limitation of extension | 5261 | 10%\*\*\* | 20070716 |
| 0% x 6/Not Service Connected x 4 | | | 20070313 |
| **Combined: 10%** | | | **Combined: 90%\*\*\*** | | | |

\*Initially rated at 10% for Bipolar Disorder (the only rated condition) coded 9342 on VARD 20061121; changed to PTSD retroactive to separation by DRO Decision due to a “clear and unmistakable error,” rated at 30% coded 9411. \*\*Later increased to 70% effective 20070913 on VARD 20071011. This is also when post concussion headaches, right ankle strain, and tinnitus ratings were added. \*\*\*Initially received an overall 10% rating at separation, raised retroactively to 60% by the 20070604 VARD, and then to 90% effective 20070913 by VARD 20071011. This is also when the right knee condition was added rated at 10% retroactive to separation.

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 service disability entitlements as those under which the Disability Evaluation System (DES) operates. The MDES 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 DVA 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 service 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 career, and then only to the degree of severity present at the time of final disposition. The DVA, however, is empowered to compensate all service-connected conditions without regard to fitness for military duties, 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 notes that the mere presence of a diagnosis is not sufficient to render the condition unfitting and subject to service disability compensation.

Bipolar II Disorder, PTSD, and Personality Disorder. The CI was treated in 2002-2003 for anxiety and depression. Symptoms of PTSD were noted to be due to a reported history of childhood sexual abuse (suicidal thoughts since age 12 are recorded). No references to in-service traumatic events are present. Over the next two years he received counseling and medication management and was medically cleared for full duty. The CI was deployed to Iraq from August 2004 to March 2005. His DD Form 214 lists two awards of the combat action ribbon. The Purple Heart medal is not listed on the DD Form 214 nor is there a citation for its award in the record. There are no combat injuries documented in the service treatment records (STR), the MEB NARSUM, or the MEB history and physical examination. Although the narrative summary (NARSUM) reports exacerbation of PTSD following return from his deployment to Iraq, mental health records following that deployment document depressive symptoms related to non-deployment stressors. Mental health treatment records reflect that symptoms of depression developed following return from deployment in the context of financial debts, marital conflict, divorce proceedings, and work related problems (the CI was pending administrative disciplinary action). After evaluation in June 2005, he was returned to duty while receiving treatment. Symptoms improved with treatment but recurred Thanksgiving 2005 when his new fiancé broke off the relationship, and suicidal thoughts prompted hospitalization. During that hospitalization, CI reports of combat trauma could not be verified by his operational unit command.

The MEB NARSUM, dated 7 March 2006, approximately six weeks after release from the hospital and four months prior to separation, documents three psychiatric diagnoses. Bipolar II disorder was manifested by periods of poorly regulated mood, irritability, periods of expansive mood and decreased need for sleep, with the current episode manifested by depressed mood, poor energy, poor sleep, intermittent suicidal ideation, and generalized sadness. Chronic PTSD was manifested by social isolation, hyperarousability, and disturbing recollections of childhood traumatic experiences. Personality disorder not otherwise specified (NOS) with anti-social and borderline features was manifested by mood liability, chronic suicidal ideations, poor coping mechanisms, and difficulties with authority. At the time of discharge from the hospital, the CI’s mood was characterized as neutral, and he was observed to have eaten and slept well while hospitalized without suicidal ideation. It is unclear if the mental status examination (MSE) documented in the NARSUM is the hospital admission examination or a subsequent examination close to the time the summary was prepared. In the examination recorded in the NARSUM, the CI’s mood was dysphoric, with full and congruent affect. The CI denied suicidal ideation unless he had to return to his command. There was no homicidal ideation or evidence of psychosis. Memory, judgment and cognition were intact. Insight was limited. The bipolar II disorder was moderate and did not meet full criteria for mania. The chronic PTSD was determined to have a childhood onset and to be an “existed prior to service” (EPTS) condition. He was also noted to have an EPTS personality disorder NOS with antisocial and borderline features. The diagnosis of personality disorder was based a long term pattern of thinking and behavior (including suspensions from high school for menacing teachers and getting into fights; being disruptive to his unit, and multiple disciplinary infractions) and extended inpatient observation, and was considered to be a “significant” contributor to the CI’s social and occupational impairments. Elsewhere in the record, it was documented that CI had run away from home twice and had suffered incest with his mother. The Global Assessment of Functioning (GAF) was 60, consistent with moderate symptoms or moderate difficulty in social, occupational, or school functioning. The impairment for social and industrial adaptability was estimated as definite for the bipolar II disorder and moderate for PTSD.

The VA Compensation and Pension (C&P) examination was on 2 April 2007, over eight months after separation. The CI reported he was a scout sniper in Iraq with many “confirmed kills” (reported by him variously as 67 and 36; the Board notes that either number would place him among the elite snipers of the war in Iraq). However, his DD Form 214 does not reflect a secondary MOS for marine scout sniper. This MOS, 8541, is awarded only after special training and is required before operating as a scout sniper. The USMC sniper school required pre-requisites include that scout sniper candidates already have an infantry MOS (03XX), are currently serving in or are designated for assignment to a scout sniper billet, and have no history of mental illness. The CI’s DD Form 214 did not reflect any scout sniper training or MOS, and with his lack of an infantry MOS, and history of mental illness, it is highly unlikely that he would have been qualified for training and/or employed as a scout sniper.

The CI stated “he was involved in multiple firefights in Kosovo as part of the First Marine Expeditionary Unit in country.” The 26th Marine Expeditionary Unit from Camp Lejeune, NC, deployed to Kosovo in June and July 1999 and was among the first U.S. peacekeeping forces in country. The CI was assigned to the 2d Supply Battalion, Camp Lejeune, as an ammunition technician and deployed in support of the peacekeeping mission. The CI reported his most traumatic event in service was while in a guard tower on 2 April 2005 at the Abu Ghraib prison in Iraq when a suicide bomber breached the barriers and blew the tower up killing all five of his fellow marines in the tower. Records of U.S. casualties for that day, 2 April 2005, and the days around that time, do not corroborate the deaths of five marines at Abu Ghraib. There was one marine death on 2 April 2005 in Haditha. There was one marine death on 1 April 2005 in Ramadi. There were no further marine deaths until 20 April 2005 in Ramadi. Historical accounts document that the Abu Ghraib prison complex was attacked by insurgents on 2 April 2005. The US Marine Corps' Echo Company 2nd Battalion, 10th Marines, was stationed at Abu Ghraib and tasked with perimeter defense. A vehicle born IED was detonated outside the front wall after Marines fired on it, but it did not breach the wall. Tower 4 was the focus of attack and several injuries from hand grenades are reported in references, but the tower was not destroyed and no U.S. military deaths were reported. Approximately 44 U.S. personnel were injured, some seriously. Also, medical records indicate that the CI left the AOR on 28 March 2005 and did not return. The CI also reported he fell 40 feet that day (2 April 2005) injuring his head, neck and back, requiring five days of hospitalization in Iraq with subsequent medical evacuation to Germany. Service treatment records do not corroborate this history. They reflect that he tripped on the stairs and fell, or fell through a trap door, on 28 March 2005 injuring his knee and was placed in a knee brace and evacuated to Germany for orthopedic evaluation. An MRI report documents the MRI examination was performed at Landstuhl Regional Medical Center in Germany on 30 March 2005. A patient movement request dated 31 March 2005 (Julian date 090) reflects planned medical evacuation to Camp Lejuene; flight surgeon notes indicate the CI would be traveling commercial air. There are no aero-medical records showing the CI returned to Iraq. There is no evidence the CI was in Iraq on 2 April 2005 and substantial evidence that he was in Germany or en route to the U.S. on that day. Therefore, it is very unlikely he was present in Abu Ghraib on 2 April 2005. The only injury documented from CI’s fall was a mild knee medial collateral ligament sprain (by MRI). He also reported difficulties due to traumatic brain injuries from combat. Service treatment records document the following non-combat head injuries: in 1996 incurred in a fight on a weekend night at a club (hit by a bottle; loss of consciousness and hospitalized); December 2004 in a motor vehicle accident [MVA] while deployed; and in September 2005 in a mountain biking accident. No treatment records from the CI’s Iraq deployment are available; however, there are no references to hospitalization or injuries while deployed other than the knee injury in medical documentation in the months immediately following return from that deployment.

The C&P examiner noted that CI had nightmares, sleep disturbances, hypervigilance, detachment and impaired short-term memory and mood changes. The CI stated that the PTSD symptoms were so severe that he checked into a local hospital. The Board notes that the MEB narrative states that he was self-admitted for depression after his fiancé broke off their engagement. The C&P also noted a history of poor grades in high school, fighting in school, and failing the 11th grade. CI dropped out of school and later obtained his GED. Mental status examination showed logical, linear goal oriented thought processes. Concentration and memory were adequate, but some anomia was noted. Mood was irritable. CI denied any current suicidal or homicidal thoughts. The examiner diagnosed PTSD based on the CI’s subjectively reported symptoms and traumatic stressors. The examiner did not make an Axis II diagnosis based on this interview and concluded the CI did not meet the criteria for bipolar disorder. The examiner estimated CI’s GAF at 45, indicative of serious symptoms or serious impairment in social, occupational, or school functioning.

The Board first considered whether the CI’s psychiatric condition meets the §4.129 definition of “a mental disorder that develops in service as a result of a highly stressful event [that] is severe enough to bring about the Veteran’s release from active military service.” Should the Board decide that §4.129 is applicable in this case, then, IAW DoDI 6040.44 and DoD guidance, 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 Board noted that the stresses of deployment to a combat zone, although considerable under the best of circumstances, do not automatically equate to the §4.129 standard of “a highly stressful event” or to Criterion A stressors for PTSD – a typical mental disorder for which the provisions of §4.129 would apply. Although the CI deployed to a combat zone and the NARSUM reported exacerbation of PTSD symptoms following return from deployment, mental health records following deployment document depressive symptoms related to non-deployment stressors of marital discord secondary to the infidelity of his spouse, debt, and work stressors. CI reports of combat trauma during his hospitalization leading to the MEB could not be verified by command. Similarly, post-separation VA records document CI report of traumatic combat stressors which are not corroborated by the evidence of primary service records. The CI’s PTSD diagnosis was based on childhood traumatic stressors. The Board could not confidently identify any “highly stressful” event while on active duty and notes that the preponderance of professional opinion favored that the §4.129 threshold was not met and that the application of §4.129 is not appropriate in this case.

The Board next considered the rating at separation from military service. The PEB determined the bipolar disorder to be unfitting and rated it at 10%. The PTSD was adjudicated as an EPTS condition and the personality disorder non-compensable. The VA initially rated the bipolar disorder at 10% based on service records, but after the C&P examination performed eight months after separation, changed the diagnosis to PTSD and adjudicated a 30% rating.

The CI asserts military psychiatrists erred in diagnosis. The Board notes that the MEB diagnosis was made by military psychiatrists after an extensive hospitalization and outpatient follow-up with the benefit of external the VA examiner was significantly different from that in the MEB NARSUM and that it corroborative sources, whereas the VA examiner discounted the bipolar disorder and attributed the symptoms solely to PTSD based on a single examination without benefit of historical corroboration. The Board also noted that the history given to was not supported by any treatment notes in the service records or the historical record. The CI was noted to be untruthful during his hospitalization and subsequent VA examiners also noted inconsistencies in his history.

The Board then considered the rating assigned by the PEB for the bipolar disorder and the EPTS adjudication for the PTSD. The CI was noted to have moderate impairment from the PTSD which was determined to have a childhood onset. Although the NARSUM reported exacerbation of PTSD following return from deployment, mental health records following deployment document depressive symptoms related to non-deployment stressors of marital discord, debt, and work stressors. He was also noted to have a personality disorder with anti-social and borderline features manifested by chronic suicidal ideation (since age 12), labile mood, poor coping skills and difficulties with authority.

Although the PTSD was considered EPTS due to the pre-service childhood trauma underpinning this diagnosis, the CI did not receive care for mental illness until late 2002, after serving six years on active duty. At the time of the MEB, he had served over eight years, the threshold at which pre-existing conditions can be considered in the military disability system. There is no indication that the PEB made any EPTS deduction or failed to include symptoms from PTSD in the overall §4.130 rating. In accordance with VASRD principles (§4.126, Evaluation of disability from mental disorders), mental health diagnoses are rated together as one condition under the primary diagnosis due to overlapping symptoms and impairments. The Board considered impairments attributed to the CI’s PTSD in its overall §4.130 rating recommendation for bipolar disorder.

Also relevant to its recommendation, the Board considered the impact on service rating of the significant contribution from an underlying and appropriately un-ratable personality disorder (with borderline and anti-social traits). It was quite clear to all members that this carried significant psychopathology independent of the bipolar disorder and PTSD. The Board considered a recommendation for a formal deduction, but it was concluded that an accurate degree of contribution was unascertainable and therefore the rating would be based on the totality of the evidence. The contribution from un-ratable impairment was considered in this case, with regard to reduced probative value of symptoms reported. The Board also noted that the commander stated: the CI “cannot be trusted;” he displays an “inability to effectively carry out his duties;” his “behavior off duty has led to several disciplinary infractions;” and, he “maintains somewhat of an apathetic attitude and will only achieve the bare minimum to avoid further disciplinary action.” These behavioral issues reflect the underlying personality disorder rather than the PTSD or bipolar II conditions. It was ultimately concluded that this factor was justly relevant to the Board’s recommendations, independently of the VASRD §4.130 criteria in evidence, and IAW the “fair and equitable” standard promulgated in DoDI 6040.44.

The Board cannot weigh as heavily any medical opinions premised on the conflicting history. It likewise cannot give full weight to the subjective elements of evaluations relative to the severity of conditions supported by contradictory history such as were evident in the C&P examination. Furthermore, the MEB exam is also more proximate to separation (four vice eight months). The Board therefore assigned a higher probative value to the MEB evaluation and retains the PEB diagnoses.

All Board members agreed that the evidence of the NARSUM examination did not approach the 50% rating; therefore, the Board deliberations centered on a 10% versus a 30% rating at separation. Social and occupational impairment consistent with a 30% evaluation (“occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks…”) could be surmised from some of the documented symptoms at the time of the MEB exam, including dysphoric mood and a history of marital and occupational difficulties. However, the Board noted that many of the issues the CI had with his command could be directly attributed to the borderline and anti-social traits of his personality disorder. There were no psychomotor abnormalities, his speech was normal, affect full and congruent, and his memory, cognition and judgment were intact. Insight was considered limited. The Board is left to consider 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 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.

The Board discussed the occupational and social impairment evidenced in the pre-separation documentation. There are significant probative value concerns related to the CI’s personality disorder as regards his reporting of symptoms. There was a clear pattern of documented transiently increased symptoms that were tightly linked to acute external stressors of marital and occupational difficulties. With relief of occupational stressors while hospitalized, the CI was described as largely asymptomatic, which was consistent with his personality disorder diagnosis. The Board also noted that the duty impairment cited by the commander is typical compared to that seen in a maladaptive personality disorder, and consistent with the pre-service dysfunction reported by the CI to multiple examiners. After due deliberation, in consideration of the totality of the evidence, and IAW §4.3 (reasonable doubt), the Board concluded that there was insufficient cause to recommend a change from the PEB fitness adjudication for the bipolar disorder condition, PTSD condition or the personality disorder.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were prolonged PTSD, determined to exist prior to service, and personality disorders, adjudicated as a category IV condition. Both were discussed above.

Other Contended Conditions. The CI’s application asserts that compensable ratings should be considered for PTSD, MDD, TBI, bilateral knee pain and bilateral ankle pain. PTSD and MDD are discussed above. Head trauma while on active duty was noted (1996 off duty fight, December 2004 MVA, and September 2005 mountain biking accident). No chronic residuals of TBI or post-concussive syndrome were diagnosed or determined to have unfitting symptoms. A 1997 audiology evaluation records complaint of decreased hearing in the right ear after the 1996 head injury. Audiogram results met retention standards. The CI injured his right knee in Iraq in March 2005. An MRI showed a mild sprain of the medial collateral ligament with otherwise intact knee structures. Upon return to his home base, he was placed on limited duty while recovering and returned to full duty in July 2005. By September 2005, he was mountain biking. There were no further clinic entries for knee pain until April 2006 (injured running) following the PEB. Bilateral knee MRIs were normal after discharge. Although the CI was treated for ankle injuries while on active duty, there is no record of treatment for the ankles during the last two years of active duty. These conditions were reviewed by the action officer and considered by the Board. There was no evidence for concluding that any of the conditions interfered with duty performance to a degree that could be argued as unfitting. The Board determined therefore that none of the stated conditions were subject to service disability rating.

Remaining Conditions. Other conditions identified in the DES file were right hearing loss, migraines, and bilateral temporal artery pseudoaneurysm status post surgery, epididymal cyst, claw toe, pes cavus, and status post appendectomy. 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 non-medical assessment. 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. Additionally tinnitus was noted in the VA rating decision proximal to separation, but was not documented in the DES file. The Board does not have the authority under DoDI 6040.44 to render fitness or rating recommendations for any conditions not considered by the DES. The 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. The Board did not surmise from the record or PEB ruling in this case that any prerogatives outside the VASRD were exercised. In the matter of the bipolar II disorder, PTSD, and personality disorder conditions, the Board unanimously recommends no change from the PEB adjudication. In the matter of the TBI, MDD, bilateral knee pain and bilateral ankle pain, right hearing loss, migraines, bilateral temporal artery pseudoaneurysms status post surgery, epididymal cyst, claw toe, pes cavus and status post appendectomy, 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, therefore, recommends that there be no recharacterization of the CI’s disability and separation determination, as follows:

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Bipolar II disorder | 9342 | 10% |
| Posttraumatic stress disorder, Childhood (EPTS) | Category I | N/A |
| **COMBINED** | **10** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20100330, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans' Affairs Treatment Record

President

Physical Disability Board of Review

MEMORANDUM FOR DIRECTOR, SECRETARY OF THE NAVY COUNCIL OF REVIEW

BOARDS

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATIONS

Ref: (a) DoDI 6040.44

(b) CORB letter dtd 6 Mar 12

In accordance with reference (a), I have reviewed the cases forwarded by reference (b), and, for the reasons provided in their forwarding memorandum, approve the recommendations of the PDBR the following individuals’ records not be corrected to reflect a change in either characterization of separation or in the disability rating previously assigned by the Department of the Navy’s Physical Evaluation Board:

Assistant General Counsel

(Manpower & Reserve Affairs)