RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: marine corps

CASE NUMBER: PD1100596 SEPARATION DATE: 20040831

BOARD DATE: 20120319

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty LCpl/E-3 (9971 / Basic Marine), medically separated for mild cognitive dysfunction. His symptoms, which included short term memory loss, headaches, dizziness, syncopal episodes, nausea, and insomnia, began after an un-witnessed assault in August 2002 in which he sustained a head injury and lost consciousness for approximately 15-20 minutes. MRI was normal except for an incidental pineal cyst and a questionable sellar mass. His treatment included activity modifications, vestibular rehabilitation, and medications. He did not respond adequately to treatment and was unable to perform within his Military Occupational Specialty (MOS) or meet physical fitness standards. He was placed on limited duty and underwent a Medical Evaluation Board (MEB). Six head injury-related diagnoses were forwarded to the Physical Evaluation Board (PEB) IAW SECNAVINST 1850.4: “moderate closed head injury with associated grade three concussion; post-concussive syndrome; chronic, daily, constant headache, primarily of tension type with superimposed headaches with more migrainous features; mild cognitive dysfunction secondary to one and part of #2; central vestibulopathy, manifesting as intermittent vertigo, secondary to #1 and part of #2; and status post several episodes of syncope, likely manifestations of #2.” No other conditions appeared on the MEB’s submission. Other conditions included in the Disability Evaluation System (DES) file are discussed below. The PEB adjudicated the mild cognitive dysfunction condition as unfitting, rated 10%; with application of the Veterans Administration Schedule for Rating Disabilities (VASRD). The CI did not appeal and was medically separated with a 10% disability rating.

CI CONTENTION: “I firmly believe that my condition has only deteriorated since I was discharged from active duty. Since my medical separation from the Marine Corps, my cognitive and physical abilities have continued to deteriorate. My mental and physical limitations have become even more profound and the struggles of daily living, including work are extremely difficult. Please see the attached personal statement as Enclosure (1).” His attached statement elaborates his 70% VA rating and his symptoms. All service conditions are reviewed by the Board for their potential contribution to its rating recommendations.

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service PEB – Dated 20040610** | **VA (7 yrs. After Separation\*) – All Effective Date 20100730** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Mild Cognitive Dysfunction | 8045-9304 | 10% | Mild Cognitive Disorder | 8045-9304 | 30% | 20101029 + |
| Chronic,… Headache,… | Category 2 | Migraine Headaches | 8100 | 30% | 20101029 |
| Postconcussive Syndrome | Category 2 | TBI | 8045 | 70% | 20110106 |
| Central Vestibulopathy,… |
| S/P Several … Syncope |
| History of Disrupted Sleep |
| Moderate Closed Head Injury… |
| Pineal Cyst | Not Unfitting | No VA Entry |
| ↓No Additional MEB/PEB Entries↓ | Tinnitus | 6260 | 10% | 20101018 |
| PTSD  | 8045-9411 | NSC | 20101029 |
| 0% x 0/Not Service Connected x 6 (incl PTSD) | 20101018 |
| **Combined: 10%** | **Combined: 90%** |

\* VA ratings based on changed TBI VASRD criteria not applicable at separation date

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impairment with which his service-aggravated condition continues to burden him. 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 resulting in medical separation. This role and authority is granted by Congress to the Department of Veterans’ Affairs (DVA). The DVA, operating under a different set of laws (Title 38, United States Code), 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. The Board utilizes VA evidence proximate 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 6040.44; however, resides in evaluating the fairness of DES fitness determinations and rating decisions for disability at the time of separation, and using the VASRD in effect 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.

Mild Cognitive Dysfunction and Category Two Conditions (Headache; Post Concussive Syndrome; Vestibulopathy; Syncope; Disrupted Sleep; and Moderate Closed Head Injury with Associated Grade Three Concussion). The CI experienced multiple sequelae of a traumatic brain injury (TBI) resulting from a grade three concussion (with loss of consciousness), including both objective and subjective manifestations. It is noted that the VASRD in effect at the time of separation preceded the contemporary rating scheme for TBI or additional interim VA guidance on rating TBI (Training and FAST letters in 2006 and 2007); the Board is obligated to apply the VASRD in effect at the time of separation in its rating recommendation. The 2004 VASRD criteria for brain disease due to trauma, 8045, stipulated:

Purely neurological disabilities, such as hemiplegia, epileptiform seizures, facial nerve paralysis, etc., following trauma to the brain, will be rated under the diagnostic codes specifically dealing with such disabilities, with citation of a hyphenated diagnostic code (e.g., 8045–8207). Purely subjective complaints such as headache, dizziness, insomnia, etc., recognized as symptomatic of brain trauma, will be rated 10 percent and no more under diagnostic code 9304. This 10 percent rating will not be combined with any other rating for a disability due to brain trauma. Ratings in excess of 10 percent for brain disease due to trauma under diagnostic code 9304 are not assignable in the absence of a diagnosis of multi-infarct dementia associated with brain trauma.

The cognitive deficits described in this case are the main substrate for coding under the PEB’s 8045-9304 approach. On at least three occasions after his injury, the CI underwent an extensive battery of neurocognitive testing (month of injury, nine months post-injury [15 months prior to separation], and 19 months after injury [five months prior to separation]). All three objective test batteries demonstrated significant cognitive impairment, and the CI had an axis I diagnosis of “cognitive disorder NOS.” The test battery most proximate to separation (five months prior to separation) would ordinarily have the highest probative value in rating the CI’s condition at separation. However, the CI had not slept the night before that session, demonstrated obvious tiredness and slowed responses, and fell asleep twice during computer tasks; the examiner noted evidence of less than optimal effort, which reduced the validity of this evaluation. Nevertheless, there were deficits found on this evaluation that were consistent with prior evaluations. The tests and conclusions are summarized in this excerpt from the psychologist’s report:

“At this time, the test results suggest continued mild to severe deficits in delayed recall, both verbal and nonverbal, divided attention, verbal fluency, and bilateral fine motor coordination. The patient has shown improvements in some areas, such as immediate verbal memory, naming, and simple fine motor speed; however, he has also shown declines in some test scores. This may be due to circumstances surrounding the testing; the patient was extremely tired, falling asleep at a couple points during the session, and test results of some tests suggest less than optimal effort. Thus, the results of this evaluation are of questionable validity. Decreases in test scores can also occur as the result of depression; however, the patient reported his current mood as fine.”

For comparison, neuropsychological testing by the Defense Veterans Brain Injury Center (DVBIC), 15 months prior to separation (nine months after injury; in the initial narrative summary (NARSUM)), noted, as summarized in the neuropsychological addendum, “severe impairment on tests of complex attention and psychomotor speed, moderate impairment in naming, letter fluency, and fine motor coordination, bilaterally, and mild impairment in simple attention span and complex verbal memory.” The NARSUM examiner further summarized:

“There was notation that there was a significant difference between verbal intelligence quotient (61st percentile) and performance intelligence quotient (10th percentile representing moderately impaired). This was felt to be atypical in a neurologically intact population and felt to indicate that the patient sustained a significant decline in cognitive and intellectual functioning. Furthermore, his performances on those tests most sensitive to brain injury were severely impaired (digit symbol was less than 1st percentile). The patient also showed evidence of significant impairment of attention and concentration, with even poor simple immediate attention span (in the 16th percentile), while his performance was severely impaired on more complex attentional tasks (less than the 1st percentile). He additionally showed difficulties with fine motor coordination bilaterally (less than 5th percentile).

The NARSUM, 5 months prior to separation, was an update of a NARSUM done 12 months prior to separation, at the request of the PEB. The case was returned to the MTF with request for three items: (1) original neuropsychiatric testing which was summarized on the prior MEB submission, (2) repeat neuropsychiatric testing, and (3) an otolaryngologic addendum. The examiner reported the CI reported no significant improvement in his symptoms over the seven-month interval: his cognitive difficulties were unchanged; his headaches (with incapacitation four days per week, symptoms precipitated by exertion or stress) were unchanged; and the CI reported mild improvement in his vestibular symptoms, which were intermittent and did “not contribute any significant functional limitations.” The non-medical assessment (NMA) stated the CI missed 8 hours per week for treatment/evaluation/recuperation. The CI reported his insomnia persisted, and he experienced one additional syncopal event over the seven month interval (two events reported on prior NARSUM). Regarding the CI’s dizziness, the NARSUM noted vestibular balance testing revealed the CI had a chronic central vestibular deficit compatible with his closed head injury. Vestibular testing performed through the DoD vestibular balance laboratory one month after injury (23 months prior to separation), showed “a chronic central oculomotor deficit [central vestibulo-cerebellar finding] characterized by diplopia, abnormal slow horizontal and vertical saccadic eye movements and poor smooth pursuit.” Follow-up otolaryngologic reevaluation four months prior to separation stated the CI’s closed head injury-induced vertigo had improved, and recommended continued vestibular rehabilitation.

In addition to the aforementioned cognitive and oculo-vestibular deficits, the neuropsychology addendum to the MEB, dated 5 months prior to separation (9 days after the NARSUM), reported the CI experienced increased irritability (without overt violence) than prior to the assault, anxiety in crowds, insomnia (two to three hours of sleep per night), dizziness, and daily headaches. The CI was assigned administrative duties, “supervising disbursements and doing minor repairs” applying his background in carpentry. Mental status exam (MSE) was essentially normal; with mood “OK” and affect “appropriate but somewhat subdued.” Global Assessment of Functioning (GAF) was 65, indicating some mild symptoms or some difficulty in social or occupational functioning, but generally functioning pretty well, having some meaningful interpersonal relationships. The CI’s only axis I diagnosis was cognitive disorder NOS.

Although the CI apparently did not apply for VA compensation until 2010, there were three VA Compensation and Pension (C&P) exams, in the nine to 10 months prior to separation timeframe; these provide some additional information, and are discussed below.

A general C&P exam 10 months prior to separation, stated that in addition to his daily headaches and dizziness, the CI had experienced ten episodes of syncope over the past year, had not been able to work since the head injury, and had “significant functional impairment as he cannot concentrate,” although he was “working a desk job” at the time. The examiner reported the CI had difficulty with activities of daily living, as he could not cook, do any kind of shopping or gardening, drive a car, or push a lawnmower.

An ophthalmologic C&P exam, the same month (ten months prior to separation) evaluated the CI’s complaints of blurred vision in the right eye and sensitivity to light. The examiner noted profound subjective constriction of the visual fields, right eye greater than left eye; these were inexplicable and not consistent with head injury. The examiner also found right facial hypoplasia and right eye hyperopia, which he attributed to a congenital syndrome.

A psychiatric C&P exam, 9 months prior to separation, reported symptoms of irritability, memory loss, headaches and depression. The CI had been treated with psychotherapy and psychotropic medications, but his symptoms persisted. The CI also endorsed a history of alcohol abuse. Social and occupational difficulties were not specified, and the examiner stated the CI “gets along with his family, friends, and neighbors,” and was “able to focus on his daily activities.” MSE was significant for anxious mood and decreased concentration, but was otherwise normal. No GAF was provided. The examiner diagnosed mood disorder due to general medical condition. Although remote from separation, the Board noted that the CI underwent a series of C&P exams 74-77 months after separation. These exams indicated the CI’s symptoms of headaches, dizziness, memory loss (especially short term), irritability, and insomnia had persisted. The CI was married, had one child, and was employed full time as a farmer for the past two years. His only work limitation noted was an inability to stand for long periods. Physical exam including neurological evaluation was essentially normal (executive function “grossly normal but slow”), and the examiner diagnosed mild TBI with some residual posttraumatic headache, attributing the subjective memory disturbance to psychiatric issues and medications rather than to TBI. This was considered an improvement, not indicative of the CI’s condition at separation. The VA assigned a 70% rating to the CI’s TBI condition, through application of the new TBI rating criteria. A psychiatric C&P exam at 74 months after separation diagnosed PTSD (and mild cognitive disorder improving; GAF 57) based on a detailed history of combat experiences which were not verified in the record, and not possible, given the CI’s history of injury during advanced training. The Board therefore assigned minimal probative value to that exam.

The Board directed its attention to its rating recommendations based on the evidence described above with the VASRD in effect at the time. The Board clearly noted that current VASRD criteria would provide a higher rating, and that the VA ratings in 2010 were based on the newer VASRD. However, the newer rating criteria are not applicable to the Board adjudication given the CI’s date of separation.

The Board first addressed determining the most appropriate coding criteria and rating for the CI’s unfitting condition and if the restrictions of VASRD §4.124a code 8045 for “purely subjective complaints” was applicable, or if the criteria for VASRD §4.130 were applicable. The CI had an axis I diagnosis of cognitive disorder, NOS. The CI’s cognitive and vestibular complaints were documented in objective tests of performance; therefore his TBI picture consisted of more than the “purely subjective complaints” with the 8045 restriction of rating at no greater than 10% under 9304. The Board therefore considered the rating under the VASRD §4.130 criteria for its rating recommendation. The CI’s subjective complaints of headache and sleep disturbance were considered “purely subjective complaints” and coding under §4.130 criteria for the cognitive disorder was predominant. The Board applied the tenants of VASRD §4.126, evaluation of disability from mental disorders, for assigning an evaluation based on all the evidence of record that bears on occupational and social impairment. The Board next considered whether the CI’s diagnosis was the result of a “highly stressful event,” IAW §4.129 (mental disorders due to traumatic stress). The stressor, in this case was the assault that caused the CI’s injuries. The CI’s brain injury; however, and subsequent cognitive impairment were clearly related to trauma, and not to stress. The Board adjudged that the provisions of VASRD §4.129 were not appropriate to apply in this case.

The Board considered separately rating the CI’s syncopal episodes, analogous to 8100, migraine (headaches), with characteristic prostrating attacks; or analogous to 8911, epilepsy, petit mal, at 20% for “at least two minor seizures in the last 6 months” as the NARSUM and PEB worksheet (JDETS) noted headaches with incapacitation four days per week and episodes of loss of consciousness with effort and headache preceding the syncope (attributed to vagal response). Although the PEB conceded the syncopal episodes, they were adjudged by the PEB as a related category II condition, considered with the primary unfitting cognitive disorder. There was not a preponderance of evidence supporting separately unfitting findings for the headaches and/or syncopal episodes. Therefore the headaches and syncopal episodes were most appropriately considered as manifestations of the CI’s head injury, and any resultant functional impairment was considered under the CI’s unfitting mental health rating.

The Board also considered separately rating the central vestibulopathy, manifesting as intermittent vertigo (dizziness) as it was considered an objective finding; however, the NARSUM indicated there was no functional impairment and this was adjudicated be the PEB as category two. Independently, the intermittent vertigo was not considered to be at the level of being unfitting, therefore, any occupational and functional impairment was considered under the CI’s unfitting mental health rating. The Board also considered separately rating the CI’s visual field deficits, documented in the VA exam 10 months prior to separation; however, this was also inappropriate, given the pattern of visual field deficit being inconsistent with head injury, and given the lack of corroborating evidence, or evidence of functional impairment.

The exams and evidence proximate to separation best matched the VASRD §4.130 criteria at the 30% rating. The record provided conflicting evidence as to the CI’s occupational and social functioning, but the evidence supported the 30% description of “occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal).” After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a separation rating of 30% for cognitive disorder with headache, post-concussive syndrome, vestibulopathy and syncope condition coded 8045-9304 using the criteria of §4.130.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as “related category II” conditions by the PEB were: chronic, daily, constant headache, primarily of tension type with superimposed headaches with more migrainous features; post-concussive syndrome; central vestibulopathy manifesting as intermittent vertigo; status post several episodes of syncope; history of disrupted sleep; and moderate closed head injury with associated grade three concussion. These conditions were discussed above with the CI’s TBI and rated only as they impacted the CI’s mental condition and occupational and social impairment. The other condition forwarded by the MEB and adjudicated as category III (not unfitting) by the PEB was pineal cyst. This condition was not profiled, implicated in the non-medical assessment (NMA), or noted as failing retention standards. It was reviewed by the action officer and considered by the Board. There was no indication from the record that this condition significantly interfered with satisfactory duty performance. All evidence considered, there is not a preponderance of evidence in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the pineal cyst condition.

Remaining Conditions. Other conditions identified in the DES file were scars on bilateral arms, history of appendicitis, and neck and back pain. Several additional non-acute conditions or medical complaints were also documented. None of these conditions were occupationally significant during the MEB period, none carried attached duty limitations, 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. No other conditions were service-connected with a compensable rating by the VA within twelve months of separation or contended by the CI. 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 mild cognitive dysfunction condition, the Board unanimously recommends a rating of 30% coded 8045-9304 IAW VASRD §4.124a and §4.130.

In the matter of the headaches, post concussive syndrome, central vestibulopathy, syncope, disrupted sleep, and moderate closed head injury conditions, the Board unanimously recommends no change from the PEB adjudications as category two. In the matter of the pineal cyst condition, the Board unanimously recommends no change from the PEB adjudication as not unfitting. In the matter of any other medical conditions 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 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** |
| Cognitive Disorder with Headache, Post Concussive Syndrome, Vestibulopathy and Syncope | 8045-9304 | 30% |
| **COMBINED** | **30%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110713, 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 26 Mar 12 ICO

 (c) PDBR ltr dtd 4 Apr 12 ICO

 (d) PDBR ltr dtd 27 Mar 12 ICO

 (e) PDBR ltr dtd 4 Apr 12 ICO

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. Placement on the Permanent Disability Retired List with a 30 percent disability rating effective 31 August 2004.

 b. Disability separation with entitlement to disability severance pay with a rating of 20 percent (increased from zero percent) effective 31 October 2004.

 c. Placement on the Permanent Disability Retired List with a 30 percent disability rating effective 2 February 2002.

 d. Disability separation with entitlement to disability severance pay with a rating of 10 percent (increased from zero percent) effective 15 December 2006.

3. Please ensure all necessary actions are taken to implement these decisions, including 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)