RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1100847 SEPARATION DATE: 20080809

BOARD DATE: 20120717

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SPC/E-4 (68W10/Combat Medic), medically separated for brain disease due to trauma. 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 issued a permanent P4 profile and underwent a Medical Evaluation Board (MEB). Post-concussive syndrome manifested by frequent headaches was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Three other conditions, as identified in the rating chart below, were forwarded on the MEB submission as medically acceptable conditions. The PEB adjudicated the brain disease due to trauma condition as unfitting, rated 10% with application of the Veterans Administration Schedule for Rating Disabilities (VASRD), respectively. The CI made no appeals, and was medically separated with a 10% combined disability rating.

CI CONTENTION: “During the MEB process which took longer than it was supposed to, being evaluated by several doctors I feel that I was given unfair treatment during the entire process. Doctors refused to diagnose me with PTSD after several complaints they would keep telling me that I am exaggerating symptoms. I received a diagnosis of anxiety disorder, NOS (which the VA ended up diagnosing me with PTSD my first mental health evaluation). I complained about issues with my lower back and hip which still gives me trouble to this day (for some reason that did not make me fall below retention standards even though it was unbearable for me to perform the physically demanding tasks and the injury was service connected). There are days where I feel that I need medication stronger than the 800 mg Motrin that I have been taking but when I see the VA doctor about it he says that I need to lose weight and all my problems will be solved. I am very limited on physical activity due to the pain it causes in my back and hip. I just want to be treated fairly and I do not feel like that I have. If you have any questions or need anything else please inform me so that I can get it.”

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 conditions anxiety disorder, low back pain (LBP), and shrapnel injury left hip, as requested for consideration, meet the criteria prescribed in DoDI 6040.44 for Board purview and are addressed below, in addition to a review of the ratings for the unfitting condition of brain disease due to trauma. 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 Army Board for the Correction of Military Records (BCMR).

RATING COMPARISON:

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| --- | --- |
| **Service PEB – Dated 20080430** | **VA (~1 Mo. After Separation) – All Effective Date 20080810** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Brain Disease due to Trauma | 8045-9304 | 10% | Post Concussive Syndrome | 8045 | 10% | 20081208 |
| Migraines | 8100 | 10% | 20081208 |
| Anxiety Disorder, NOS | Not Unfitting | PTSD | 9411 | 30% | 20081124 |
| Episodic Low Back Pain | Not Unfitting | Chronic Lower Back Condition | 5237 | 10% | 20081208 |
| Shrapnel Injury, Left Hip | Not Unfitting | Residuals, Shrapnel Injury, Left Hip | 5316 | 10% | 20081208 |
| ↓No Additional MEB/PEB Entries↓ | Right Shoulder Condition | 5203 | 10% | 20081208 |
| Bilateral Tinnitus | 6260 | 10% | 20081201 |
| Not Service-Connected x 2 | 20081208 |
| **Combined: 10%** | **Combined: 60%** |

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 acknowledges the CI’s contention that suggests ratings should have been conferred for other conditions documented at the time of separation. The Board wishes to clarify that it is subject to the same laws for disability entitlements as those under which the Disability Evaluation System (DES) operates. 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. However, the Department of Veterans’ Affairs (DVA), operating under a different set of laws (Title 38, United States Code), is empowered to compensate all service-connected conditions and to periodically reevaluate said conditions for the purpose of adjusting the Veteran’s disability rating should the degree of impairment vary over time. 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 6040.44, however, resides in evaluating the fairness of DES fitness determinations and rating decisions for disability at the time of separation and is limited to conditions adjudicated by the PEB as either unfitting or not unfitting. Post-separation evidence therefore is probative only to the extent that it reasonably reflects the disability and fitness implications at the time of separation.

Brain Disease Due To Trauma. The CI’s commander stated that while deployed to Iraq, the CI was “involved in a catastrophic improvised explosive device (IED) explosion that destroyed his Humvee” Other evidence in the record states this occurred in January 2006 and that the CI was also involved in multiple other IED attacks that were less serious. There is conflicting evidence as to whether the CI lost consciousness or not. However, loss of consciousness is not required for the diagnosis of a concussion and post-concussive effects may occur with any level of severity of traumatic brain injury (TBI), including mild. The Board’s rating recommendation for code 8045, TBI, in this case is subject to the following policy (established by precedent and prior legal opinion). As an implied extension of the DoDI 6040.44 and NDAA 2008 mandates, the Board will comply with applicable VA disability rating policy changes issued via “FAST” or Training Letters effective at the time of separation. The VA Training Letter, TL06-03 (dated 13 February 2006), 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. TL 07-05 (dated 31 August 2007) went further in recommending separate ratings under the applicable codes for each ratable component of TBI in evidence in addition to the rating under 8045 for subjective symptoms that did not warrant separate ratings under another code; e.g. headache, nausea, vomiting, dizziness, blurred vision, sleep disturbance, weakness, paralysis, sensory loss, spasticity, aphasia (language disorder resulting in difficulty communicating), dysphagia (difficulty swallowing), apraxia (loss of the ability to carry out learned purposeful movements, despite having normal motor function), balance disorders, disorders of coordination, seizure disorder, attention, concentration, memory, speed of processing, new learning, planning, reasoning, judgment, executive control, self-awareness, language, abstract thinking, depression, anxiety, agitation, irritability, impulsivity, and aggression. In this case the letter allows separate ratings for 1) post-concussive syndrome with subjective dizziness and memory and concentration problems; 2) headaches due to TBI; and 3) anxiety and depression due to TBI; rendering each in effect as separately unfitting conditions for purposes of the combined disability rating. The current TBI rating criteria became effective on 23 October 2008.

Traumatic Brain Injury/Post-Concussive Syndrome Condition. The PEB adjudicated this case independently of TL 07-05 and utilized the previous VASRD rating criteria which stated that subjective complaints such as headache, dizziness, insomnia, etc., recognized as symptomatic of brain trauma, will be rated 10%, and no more, under diagnostic code 9304 in the mental disorders section of the rating schedule. It also said that this ten% rating would not be combined with any other rating for a disability due to brain trauma and that ratings in excess of ten percent for brain disease due to trauma under diagnostic code 9304 were not assignable in the absence of a diagnosis of multi-infarct dementia associated with brain trauma. The PEB applied a 10% rating for brain disease due to trauma IAW these rating criteria. However, the training letter altered the methodology for rating TBI and its sequelae and the Board will utilize the methodology of VA Training Letter 07-05 as described above as the VA did in their rating of the CI’s disability due to TBI.

The VA did not initially apply a rating for 8045 post-concussive syndrome but applied separate ratings for migraines, PTSD, and tinnitus. However, the VA did not initially have access to all of the CI’s medical records. After the VA reviewed additional service treatment records (STR), in addition to the information from the partial STR and the results of the VA Compensation and Pension (C&P) examination completed in December 2008, approximately 4 months after separation, the VA determined a rating for post-concussive syndrome was warranted. This was based on the subjective symptoms of dizziness and memory loss which were consistent with post-concussive syndrome but had not been attributed to any other etiology. A 10% rating for code 8045 was effective the day after the CI separated from service.

As described above, the CI was subjected to multiple IED blasts with one in January 2006 that was much more significant than the others. In addition to the headaches, anxiety, and depression that developed secondary to the CI’s TBI, the CI also had subjective short term memory difficulties, difficulty concentrating, and dizziness. Neuropsychological testing documented a mild cognitive disorder, not otherwise specified (NOS) and the administering psychologist stated the CI continued to demonstrate marginal to minimal memory deficits which could be readily compensated for. He stated the CI was functioning as an individual with mild residuals of TBI. Therefore, the CI did not meet the criteria for a separate rating for cognitive disorder under the VASRD general formula for rating mental illness. However, subjective complaints such as mild loss of memory and concentration problems without objective evidence on testing warrants a 10% rating under code 8045. In agreement with the approach outlined in TL 07-05 and applied by the VA in its rating, the Board also determined a 10% rating for 8045 TBI was warranted based on the CI’s subjective symptoms. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a disability rating of 10% for the TBI condition.

Headaches due to Traumatic Brain Injury Condition. The CI developed chronic headaches after experiencing multiple IED explosions including a significant explosion in January 2006. No records of care immediately after any IED explosion are available for review. An in-theater outpatient visit note dated 18 August 2006, documents the earliest record of a headache available for review. There are earlier notes related to the left hip shrapnel injury from January and April 2006, but these do not include any information about headaches. The CI did not indicate any problems with headaches on his post deployment health assessment (PDHA) on 25 September 2006. However, in April 2007 he was referred to a neurologist for treatment of chronic headaches. An outpatient visit on 23 April 2007, documented a history of headaches for about one year after IED exposure. The headaches had been once a month but were then increasing in frequency. The headaches were in the frontal area and the CI had been seen in the emergency room the previous weekend for a headache. MRI studies of both the cervical spine and brain were normal in April 2007. In May 2007 a neurology note documented several headaches per day which were accompanied by ataxia, blurry vision, anisocoria, nausea, and occasional vomiting. The headaches were secondary to post-concussive syndrome and the CI was given Gabapentin and Maxalt. The neurologist cleared the CI to try deploying to the National Training Center (NTC) with his unit but noted he might have to return early. The CI was also taking Tramadol for acute headaches. A follow-up visit in June 2007 noted prophylaxis was not effective and his medications were changed to Propranolol and Tramadol. He continued taking Gabapentin. The record contains multiple follow-up visits that mention headaches but few mention the frequency of the headaches. In October 2007 the frequency was decreased to three times per week. A more detailed history is documented in an outpatient visit note dated 24 March 2008. This note documents persistent chronic headaches despite trail of multiple medications. The CI was having severe headaches three to four times a week. They started in the AM and lasted all day. He had gone to the ER several times in the past for treatment but the most recent time was 3 months ago. He was currently taking Neurontin and Fioricet for the headaches. The physician stated the CI had persistent severe headaches that continued after adequate treatment and interfered with his performance of duty.

The MEB narrative summary (NARSUM) completed in January 2008, approximately 8 months prior to separation, noted the headaches occurred approximately three times a week at that time. There were sharp, throbbing, bifrontal headaches accompanied by some light sensitivity. The clinical history and diagnosis of headache due to postconcussive syndrome as described above were also documented. A permanent profile was issued in August 2007 and the CI as referred to the MEB for this condition. No physical examination was included and the provider referred to the MEB History and Physical (H&P) completed in August 2007. This examination consisted of a checklist with everything marked normal and no additional comments.

A VA C&P examination completed on 8 December 2008, approximately 4 months after separation, documented a headache frequency of seven times per week. He was unable to go to work with these headaches but could perform some household chores. The CI reported good response from the gabapentin but he had twitching as a side effect. The neurologic exam was within normal limits. He reported he had not lost any time from work due to headaches.

The PEB determined the CI was unfit due to brain disease due to trauma on 30 April 2008 and applied a 10% disability rating for code 8045-9304. It appears they rated the CI solely on the headache manifestations of his TBI. The PEB applied the DoDI 1332.39 definition of prostrating when rating this condition. This DoDI was in effect at the time but has since been rescinded. It was never used by the VA and is not used by this Board. The DoDI defines prostrating as “the service member must stop what he or she is doing and seek medical attention.” The PEB stated: “the soldier developed chronic headaches after exposure to several IED blasts in 2006 in Iraq, which were near enough to cause shrapnel wounding, but did not cause loss of consciousness (10 A/C, Purple Heart). Imaging, neuropsychological testing and neurology exams are normal. Headaches are not prostrating but frequent and severe enough to interfere with duty.” The VA also rated the headaches at 10% but utilized VASRD code 8100 and rated the headaches due to TBI separately IAW VA TL 07-05. VA guidance uses the clear English definition of prostrating and significantly differs in that seeking medical attention is not required. The VA rating decision noted the CI did not have prostrating headaches at least once a month and assigned the 10% rating for prostrating headaches occurring once every 2 months on average over the last several months.

The headache frequency of three times per week reported on the MEB NARSUM is corroborated by the outpatient note from 24 February 2008 which stated severe headaches that interfered with performance of duty occurred three to four times per week. The CI did have multiple follow-up visits for medication management as well as multiple trips to the emergency room for treatment. Additionally outpatient notes from June 2007 through June 2008 document 14 separate days with a headache present. This corroborates a frequency of a minimum of once a month on average. The CI did not seek care for every headache. By precedence the Board requires evidence that an attack requires abandonment of work or activity at hand to seek treatment (which includes self-medication and/or sleep), or to escape noxious stimuli in the immediate environment, in order for it to be characterized as prostrating. The frequency and severity of headaches characterized in the STR support a finding of prostrating headaches occurring at least once a month over the several months prior to separation. However, the VA C&P examination presents a different clinical picture and it is not clear that the CI had monthly prostrating headaches. While the VA exam is after separation it is actually closer in time to the date of separation and it contains more detailed information about the nature of the headaches. It appears that, in general, most of the CI’s headaches were not prostrating. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a disability rating of 10% for the headaches due to TBI condition.

Anxiety and Depression due to Traumatic Brain Injury Condition. On a PDHA completed on 5 September 2006, the CI marked that he was currently interested in receiving help for a stress, emotional, alcohol or family problem. He also annotated that he had difficulty remembering, ringing of the ears, nightmares about and thought about an experience when he did not want to, and was constantly on guard, watchful, or easily startled. Responses such as these should have resulted in a referral to mental health. However, the PDHA was signed by a nurse (not a physician, physician assistant, or a nurse practitioner as required) and no mental health referral was recommended. The CI was instead told to follow-up at his TMC as needed. While no records from the time the CI was deployed are available in the record available for review, the CI’s commander in theater signed two statements in August 2007 which stated the CI had a TBI and mental illness after a catastrophic IED explosion and that these conditions prevented satisfactory performance of his required duties. One statement mentions PTSD and one mentions PTSD, depression, and anxiety. While no profile from August 2007 is available in the record, the commander states the CI was not able to be around or fire his individually assigned weapon and this profile restriction is generally recommended only for PTSD or seizure disorder. The only profile available for review is dated 23 January 2008 and line 5.a. Able to carry and fire assigned weapon is not marked either yes or no.

A memorandum from the Warrior Transition Unit (WTU) commander dated 31 January 2008, states the CI was in the WTU for PTSD, TBI, anxiety disorder, and hip injuries from an IED. Multiple outpatient treatment notes refer to treatment by a psychiatrist but no actual psychiatric treatment notes are available for review. There is evidence for multiple and frequent visits for individual and group psychiatric treatment appointments from 29 March 2007 to 16 October 2007 and a final visit on 10 April 2008 for a neurobehavioral status exam. Additionally there is no formal psychiatric addendum to the MEB NARSUM available in the record. There are a few notes from psychology appointments including one referring to psychotherapy. The CI was treated with Fluoxetine, Alprazolam, Trazodone, Mirtazapine, and Bupropion. Prazosin was also used to treat nightmares during a hospitalization for a suicide attempt in August 2007. However it was stopped during that hospitalization due to side effects. At a VA outpatient visit in February 2009, 6 months after separation, his medication was changed to Citalopram from Fluoxetine and Bupropion; and, Brazodone was continued.

An outpatient visit note dated 17 May 2007 and from the soldier readiness program noted the CI had previously been seen by psychiatry for depression and alcohol problems and had received counseling from psychology but had had been cleared by psychology to deploy to the national training center (NTC). His current medication was Fluoxetine which had recently been increased and Restoril. The CI reported he thought he would be able to perform at NTC and wanted to go. It is not clear if he deployed to NTC or not. However, he was admitted for inpatient psychiatric care at a civilian hospital from 9 August 2007 to 14 August 2007 after a suicide attempt; he took a “bunch of pills” while intoxicated. On admission his Global Assessment of Functioning (GAF) was 35 and his diagnosis was anxiety disorder, NOS; depression disorder, NOS; rule out PTSD; and ethanol abuse. He was treated with medication and therapy and medication on discharge was Fluoxetine, Mirtazapine, and Antabuse. He responded well to treatment and his GAF at discharge was 61. His discharge diagnoses were: anxiety NOS; depression, NOS; and alcohol abuse. An appointment with psychology noted a scheduled follow-up with psychiatry on 6 September 2007 and a separate outpatient note referenced a psychiatric appointment on 4 October 2007, but as stated above no psychiatric treatment notes are available for review. While depression, anxiety, alcohol abuse, and alcohol dependence in remission were included in the master problem list noted in autocites section of multiple outpatient notes, the diagnosis of PTSD was not included in any outpatient note. However, if the psychiatrist was not using the electronic medical record to document psychiatric care, the diagnosis would not be present in the master problem list even if the psychiatrist was treating that condition. While there is a significant amount of indirect evidence for the diagnosis of PTSD while on active duty, there is no direct evidence.

Neuropsychiatric testing was completed sometime prior to 16 October 2007. Although the test results are not available in the record, the psychologist authored an outpatient note on 16 October 2007 discussing some of the results. The CI reported a chief complain of memory problems but stated the nightmares were not as bad. This visit also documents symptoms of decreased concentrating ability, memory lapses or loss, daytime somnolence, difficulty falling asleep, middle-night awakening, early morning awakening, morning grogginess, non-restorative sleep, talking while asleep, nightmares, screaming in the middle of the night, sleep apnea, loss of interest in activities, anhedonia, social withdrawal, loss of interest in friends and family, a previous suicide attempt, fear of loss of control of emotions, violent behavior, emotional problems/concerns, disturbing or unusual thoughts, feelings, or sensations, sexual behavior loss of libido, personality change, character deficiency, interpersonal relationship problems, no energy, a desire for health recovery, a desire to continue living, and no homicidal thoughts. The psychologist stated the neuropsychiatric screening showed symptom exaggeration and artificially depressed results. He also stated the CI’s memory problems were primarily psychogenic and there was no need to follow-up with him. However, he included anxiety disorder NOS and depression in the assessment and provided 45-50 minutes of individual therapy at that visit. The psychologist also stated the CI was deployable from a neuropsychological perspective.

This same provider evaluated the CI for the PEB on 10 April 2008 and referenced the previous neuropsychological testing at this visit. The CI reported his memory was about the same as it had been but that he was irritable and the anxiety and possibly the depression were worse than before. The psychologist noted that upon review of the previous testing, the CI’s memory appeared to be mildly impaired from a psychometric perspective. He also reported the testing showed a pronounced tendency to amplify his symptoms with a SIMS score of 28 (cut off was reported as >14). He cited the WTU commander’s statement that the CI could function independently and that he had been an outstanding soldier in the WTU. There were two statements from this commander dated 31 January 2008 and 19 March 2008 and both stated the CI had been working in a clerical job on a hospital ward and his hours were limited to 15 hours per week. The psychologist concluded the CI had mild residuals of TBI with regards to marginal to mild memory deficits. He also noted mild decreased concentrating ability. Additionally the psychologist noted significant symptoms related to anxiety and depression with persistent worry, high irritability, hostility, depression (more dysphoria than anything else), sleep disturbances, anhedonia, social withdrawal, no loss of Interest in friends and family, no energy, no dangerous thoughts reported, a desire for health recovery, a desire to continue living, not thinking about suicide, no stated intent to commit suicide, no previous suicide attempt (this is incorrect as discussed above), homicidal thoughts, fear of loss of control of emotions, no violent behavior, emotional problems/concerns, sexual behavior loss of interest but no performance problems, superficial/shallow, overly passive in a relationship, and overly dependent in a relationship, no marital problems, no problems with one's peer group, and no behavioral complaints. His assessment was post-concussion syndrome: cognitive disorder NOS, mild.

There was a telephone consult with a psychiatrist on 8 January 2008 with “requesting a narrative for his MEB” listed as the reason. The assessment was depression and alcohol abuse and the plan included continuing medications and following-up with this psychiatrist. A warrior transition clinic primary care physician had been providing some of the refills of psychiatric medications. This psychiatrist stated the CI’s depression did not cause him to fall below retention criteria for psychiatry. There was no mention of the anxiety disorder or PTSD. Also, as stated above there is no psychiatric addendum to the MEB NARSUM available for review.

The MEB NARSUM completed in January 2008, 7 months prior to separation, stated the CI was taking Fluoxetine and Trazodone. It refers to the 16 October 2007 outpatient note from the psychologist discussed above but does not include any reference to note from 10 April 2008 also discussed above, any psychiatric addendum, or any mental status examination (MSE). There is no MSE available it the STR for review. A memorandum from the PEB dated 13 March 2008 requested a comprehensive psychiatric reevaluation with results expressed in axial format as per DSM IV, to include a full analysis on the extent of memory loss as a result of the TBI. There is no record of any such evaluation in the STR. However, on 30 April 2008 a PEB determined the CI was unfit for continued service due to “brain disease due to trauma.” The PEB also determined anxiety disorder, NOS; episodic LBP; and shrapnel injury, left hip were not unfitting. There is no mention of depression; PTSD; or cognitive disorder NOS, mild. The commander’s statement from the CI’s operational unit states the CI cannot perform the duties required of a combat medic due to his PTSD and TBI and specifically mentions a profile restricting the CI from carrying or firing his weapon. He also states the CI exhibited signs of “great distress, depression and anger issues.” The WTU commander stated the CI was able to successfully work 15 hours per week on a hospital ward performing administrative and support functions.

A VA C&P examination for mental illness was completed on 24 November 2008, approximately 4 months after the CI separated from service. The examiner stated the CI met the DSM IV criteria for PTSD and also had a diagnosis of MDD. He stated the symptoms of each mental disorder could be delineated from each other. The PTSD was an anxiety disorder manifested with nightmares, intrusive thoughts, and flashbacks. The MDD was a mood disorder characterized as having depressed mood, generalized loss of interest, low libido, no appetite, insomnia, and low energy. The examiner noted the CI had been treated with daily medications and psychotherapy as often as twice a month. He also noted the one hospitalization discussed above. The CI reported multiple symptoms of PTSD, anxiety, and depression. The VA C&P MSE is the only such examination available for review. The CI’s affect and mood showed a disturbance of motivation and mood. The CI was only motivated to go to work and it was difficult for him to help his wife with simple tasks around the house. After leaving the service, the CI worked at the Logan County Jail. He was working there at the time of the C&P examination and reported he had not had to miss any work due to his mental health condition. He had a good relationship with his supervisor and with his co-workers. He also had a good relationship with his wife and parents but had few other friends. The examiner estimated a GAF of 68 indicative of some mild symptoms or some difficulty in social, occupational, or school functioning, but generally functioning pretty well, and having some meaningful interpersonal relationships.

The VA rated PTSD at 30% based on a review of his STR and the C&P examination. They noted the presence 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), due to such symptoms as: depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often); chronic sleep impairment; mild memory loss (such as forgetting names; directions, recent events).

While it is likely the CI did have PTSD while he was in service, there is no direct evidence in the record available for review of any treatment for this diagnosis while on active duty. However, all mental illness is rated together IAW the general rating formula for mental disorders in VASRD §4.130 and the presence or absence of the diagnosis of PTSD does not affect the rating for mental illness due to TBI. There is a large amount of evidence in the record that supports the diagnosis of anxiety and depression due to TBI and in accordance with the VA Training Letter 07-05 dated 31 August 2007, this condition is rated separately. Although the CI does have symptoms supportive of the 30% rating there is no evidence of any significant occupational impairment. He has some meaningful relationships and appears to function well at work. Without any significant occupational impairment, a rating higher than 10% cannot be justified. Although not all of the CI’s symptoms were controlled with medication, there was no evidence of any decrease in work efficiency or intermittent periods of inability to perform occupational tasks in his job at the jail. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a disability rating of 10% for the anxiety and depression due to TBI condition.

Contended PEB Conditions. The contended conditions adjudicated as not unfitting by the PEB were episodic LBP and shrapnel injury, left hip. 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.

Episodic Low Back Pain Condition. This condition was not significantly clinically or occupationally active during the MEB period, did not carry any attached profile, and was not implicated in the commander’s statement. This condition was 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 this contended conditions; and, therefore, no additional disability rating can be recommended.

Shrapnel Injury, Left Hip Condition. Although this condition is not mentioned in the medical condition portion of the CI’s permanent P4 profile, several of the limitations of the profile are specifically attributable to this condition and cannot be due to the CI’s post-concussive syndrome. This also includes restrictions on running, doing three to five second rushes under direct and indirect fire, constructing and individual fighting position, and ability to move with a fighting load at least two miles. The CI’s operational unit commander’s statement specifically mentions shrapnel injuries to the left hip and thigh. He stated that with these physical limitations and inability to physically exert himself, the CI was combat ineffective and would be a risk to both himself and others in a combat environment.

As noted in the operational unit commander’s statement, the CI was not able to perform the required duties of his MOS or those required of all soldiers due to the limitations caused by this shrapnel injury. While this condition is not mentioned on the profile, there are restrictions on the profile which cannot be attributed to post-concussive syndrome or any other condition. The preponderance of evidence supports a determination that this condition rendered the CI unfit for continued military service.

During the IED explosion in January 2006, the CI received shrapnel wounds to the left thigh and hip area. On 14 January 2006, he was noted to have antalgic gait but was ambulating on his own. He was treated with antibiotics and nonsteroidal anti-inflammatory (NSAID) medication, instructed to watch for signs of infection, and returned to duty with a limitations. Two weeks later he was referred to higher level of care in theater with increasing pain after prolonged walking. The provider felt there was no active infection but the CI had bursitis due to the irritation from the shrapnel and administered a steroid injection. A follow-up visit to another provider in April 2006 notes continued bursitis and absence of active infection. Medication was changed to a different NSAID. No records of any further visits from theater are available for review and the next visit documented was at Fort Carson in January 2007. He continued to have pain and was referred to orthopedics for shrapnel removal. The shrapnel was surgically removed in March 2007. At a physical therapy (PT) appointment, 5 days post-op, the CI was doing well and able to run and he was given a home exercise program by a PT assistant. However, the CI was seen by a physical therapist 2 days later. He continued to have intermittent pain but had no more visits to orthopedics or PT appointments. In January 2008, the CI accidently stabbed himself in the left thigh while closing a knife and was treated in the emergency room. A visit with his WTU case manager on 28 January 2008, documented 4/10 dull pain in the left hip. He had remained on a profile from at least August 2007 and was assigned to the WTU in September 2007 for this and other conditions.

The MEB NARSUM performed on 24 January 2008 does not include any physical exam findings and refers to the MEB H&P completed on 27 August 2007. The lower extremity examination is marked as normal on this form as is every area except anus and rectum which were not examined. However it is known from other examinations that the CI had a scar on his left thigh from the shrapnel wound but this exam did not annotate this on the skin exam as is routinely done. Also this examination stated the CI’s feet had a normal arch but he had previously been treated for pes planus with inserts. There appear to be several inconsistencies in this physical examination. The VA C&P examination performed on 8 December 2008, 4 months after separation, includes the same clinical history annotated above and includes a complete examination of the hip and thigh. The CI reported flares of left hip pain that occurred 6 times per week and lasted 2 hours. The pain was localized to the area of the shrapnel injury and was 7/10 at its worst. It was elicited by physical activity and relieved by pain medication and rest. The CI had easy fatigability and pain and he was unable to perform prolonged walking or heavy lifting without fatigue and pain. He had bursitis as a complication of this injury and was treated with steroid injections. He did return to duty after this injury but was on modified duty with the restrictions described above. Examination noted normal posture and gait. A muscle wound was noted at the left hip. There was no adherence to underlying structures or adhesion to bone. Motor strength was 5/5 and sensory and reflex exams were normal. The range of motion of the left hip was full and equal to that of the right hip. With repetitive use, the left hip was additionally limited by pain.

The cardinal signs and symptoms of muscle disability are loss of power, weakness, lowered threshold of fatigue, fatigue-pain, impairment of coordination, and uncertainty of movement. The record demonstrates the CI had a lowered threshold of fatigue and fatigue pain after a deep penetrating wound of a short track from a shrapnel fragment that did not demonstrate an explosive effect of a high velocity missile, residuals of debridement, or prolonged infection. A small linear entrance wound was noted as was a lowered threshold of fatigue and fatigue-pain. This supports a 10% rating for moderate injury of the Group XVI muscle group. After due deliberation, the Board agreed that the preponderance of the evidence with regard to the functional impairment of shrapnel injury, left hip favors its recommendation as an additionally unfitting condition for separation rating. It is appropriately coded 5316 and meets the VASRD §4.73 criteria for a 10% rating.

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BOARD FINDINGS: IAW DoDI 6040.44, provisions of DoD or Military Department regulations or guidelines relied upon by the PEB will not be considered by the Board to the extent they were inconsistent with the VASRD in effect at the time of the adjudication. While the PEB did not utilize VA TL 07-05 dated 31 August 2007, the Board applied the directives of this letter in making its rating recommendation in compliance with applicable VA disability rating policy changes issued via “FAST” or Training Letters effective at the time of separation. In the matter of the TBI condition, the Board unanimously recommends a disability rating of 10%, coded 8045 IAW VASRD §4.124a. In the matter of the headaches due to TBI condition, the Board unanimously recommends a disability rating of 10%, coded 8045-8100 IAW VASRD §4.124a. In the matter of the anxiety and depression due to TBI condition, the Board unanimously recommends a disability rating of 10%, coded 8045-9413IAW VASRD §4.130. In the matter of the contended episodic LBP condition, the Board unanimously recommends no change from the PEB determination as not unfitting. In the matter of the contended shrapnel injury, left hip condition, the Board unanimously agrees that it was unfitting; and, unanimously recommends a disability rating of 10%, coded 5316 IAW VASRD §4.73. 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** |
| Traumatic Brain Injury | 8045 | 10% |
| Headaches due to Traumatic Brain Injury | 8045-8100 | 10% |
| Anxiety and Depression due to Traumatic Brain Injury | 8045-9413 | 10% |
| Shrapnel Injury, Left Hip | 5316 | 10% |
| **COMBINED** | **30%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110916, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans’ Affairs Treatment Record

 XXXXXXXXXXXXXXXXXX

 President

 Physical Disability Board of Review

SFMR-RB

MEMORANDUM FOR Commander, US Army Physical Disability Agency

(TAPD-ZB / ), WRAMC, 2900 Crystal Drive, Suite 300, Arlington, VA 22202

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation

for XXXXXXXXXXXXXXXXXXXXXX, AR20120013617 (PD201100847)

1. Under the authority of Title 10, United States Code, section 1554(a), I approve the enclosed recommendation of the Department of Defense Physical Disability Board of Review (DoD PDBR) pertaining to the individual named in the subject line above to recharacterize the individual’s separation as a permanent disability retirement with the combined disability rating of 30% effective the date of the individual’s original medical separation for disability with severance pay.

2. I direct that all the Department of the Army records of the individual concerned be corrected accordingly no later than 120 days from the date of this memorandum:

 a. Providing a correction to the individual’s separation document showing that the individual was separated by reason of permanent disability retirement effective the date of the original medical separation for disability with severance pay.

 b. Providing orders showing that the individual was retired with permanent disability effective the date of the original medical separation for disability with severance pay.

 c. Adjusting pay and allowances accordingly. Pay and allowance adjustment will account for recoupment of severance pay, and payment of permanent retired pay at 30% effective the date of the original medical separation for disability with severance pay.

 d. Affording the individual the opportunity to elect Survivor Benefit Plan (SBP) and medical TRICARE retiree options.

3. I request that a copy of the corrections and any related correspondence be provided to the individual concerned, counsel (if any), any Members of Congress who have shown interest, and to the Army Review Boards Agency with a copy of this memorandum without enclosures.

BY ORDER OF THE SECRETARY OF THE ARMY:

Encl XXXXXXXXXXXXXXXXXXXX

 Deputy Assistant Secretary

 (Army Review Boards)