RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: xxxxxxxxxxxxxxxxxx BRANCH OF SERVICE: Army

CASE NUMBER: PD1100873 SEPARATION DATE: 20060724

BOARD DATE: 20120913

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was a mobilized National Guard 1LT/O-2 (92A00, Quartermaster) medically separated for cognitive disorder and migraine headaches. He suffered a serious heat stroke injury during a 2004 deployment to Iraq, requiring medical evacuation. Consequent to heat stroke, he was diagnosed with residual cognitive impairment, headaches, and psychiatric disturbance. These residual conditions did not improve sufficiently with treatment to satisfy the operational requirements of his Military Occupational Specialty (MOS). He was issued a permanent P3/S3 profile and referred for a Medical Evaluation Board (MEB). Three separate conditions, judged to be medically unacceptable IAW AR 40-501, were forwarded to the Physical Evaluation Board (PEB): cognitive disorder, migraine headache, and anxiety disorder. The PEB consolidated the cognitive and anxiety disorders as a single unfitting condition, rated 10%, citing criteria of Department of Defense Instruction (DoDI) 1332.39. The migraine condition was also determined to be unfitting, rated 0%, citing criteria of the Veterans Administration Schedule for Rating Disabilities (VASRD). The CI made no appeals, and was medically separated with a 10% combined disability rating.

CI CONTENTION: “I was given 10% for cognitive disorder and 0% for migraine headaches upon separation from the Army. I immediately applied to Dept of VA for compensation and was awarded 70% for PTSD [post-traumatic stress disorder] with panic disorder, major depressive disorder and cognitive disorder back to the date of my discharge from the Army, I then applied for an increase in my PTSD and was awarded 100% for this condition on 4/5/2007. I feel the Army should have rated me at least 70% at the time of my discharge due to the severity of my PTSD and cognitive disorder.” He does not elaborate further or specify a request for Board consideration of any additional conditions.

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.” All three of the MEB submitted conditions as identified above (with consolidation of two of them) were rated as unfitting by the service; thus, all are within the DoDI 6040.44-defined purview of the Board and are addressed below. Although the contended posttraumatic stress disorder (PTSD), panic disorder and major depressive disorder (MDD) were not identified by the PEB, and are thus not within the defined purview of the Board as distinct conditions per se; the disability associated with all psychiatric conditions, regardless of the diagnosis or multiple diagnoses, is subsumed under a single rating using the same criteria IAW VASRD §4.130. Therefore the CI’s disability rating recommendation from the Board will be unaffected by the specific psychiatric diagnosis determined to be unfitting by the service. 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 (ABCMR).

RATING COMPARISON:

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| --- | --- |
| **Service PEB – Dated 20060724** | **VA (2 Mo. Post-Separation) – Effective 20060725** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Cognitive Disorder, NOS 2⁰ to Heat Stroke | 9326 | 10% | PTSD … Alcohol Abuse … Anxiety Disorder… Cognitive Disorder  | 9411 | 70% | 20060925 |
| Migraine Headaches | 8100 | 0% | Migraine Headaches | 8100 | 0% | 20061005 |
| Anxiety Disorder, NOS | Subsumed in 9326 above. | Subsumed in 9411 above. | 20060925 |
| No Additional MEB/PEB Entries | Lumbar Strain  | 5237 | 20% | 20061005 |
| Diabetes Mellitus, Type II | 7913 | 20% | 20061005 |
| Osteoarthritis, Left Knee | 5260-5003 | 10% | 20061005 |
| Asthma | 6602 | 10% | 20061005 |
| Hypertension | 7101 | 10% | 20061005 |
| **Combined: 10%** | **Combined: 90%** |

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, and the progressively higher disability ratings from the Department of Veterans’ Affairs (DVA) which he has received. It must be noted, however, that the Disability Evaluation System (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 DVA; which operates under a different set of laws (Title 38, United States Code). The DVA is empowered to compensate all service-connected conditions; and, is obligated 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 DVA 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 6044.40, however, resides in evaluating the fairness of rating determinations for the disability existing 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.

Cognitive Disorder with Subsumed Anxiety Disorder. The CI had no history of cognitive or psychiatric issues prior to the heat injury he suffered in Irag, August 2004. He was conducting operations with sustained physical exertion during casualty evacuations. He collapsed and was comatose for 6 hours, requiring immediate evacuation from theater. After redeployment he manifested clear signs of cognitive impairment, chiefly in the areas of executive functions and memory/attention. He was also emotionally labile, with easy frustration and anxiety over minimal stressors. He experienced intractable insomnia and frequent panic attacks. His cognitive and psychiatric symptoms responded favorably to (but did not resolve completely with) an extended trial of psychotherapy, behavioral therapy and medication. No inpatient treatment was required, and there were no features of suicidality or psychosis. The final neuropsychological testing was performed 8 months prior to separation. Results were as follows: speech - “little difficulty articulating his thoughts and feelings verbalizations were seen as basically relevant, coherent, and organized;” attention - “mild attentional difficulties periodically” (simple attention normal, sustained attention “average to low average”); intelligence - “average;” memory – “overall functioning falls close to the normal range on the majority of tasks;” motor coordination - “mild slowing” with combined fine motor/visual motor tasks (isolated fine motor and visual motor performance was normal); reasoning - “little evidence of impairment in patient’s abstract, conceptual reasoning abilities;” executive functioning - “low average range, which represents an improvement from the time of his previous neuropsychological evaluation;” social functioning - “little evidence of impairment in the patient's level of social or in his practical social skills socially alert, personable individual who is able to be quite sensitive to the needs and feelings of others as well as to his own social needs;” and, psychiatrically, “There has been some depression relating to the patient's heat stroke and its aftermath, but the patient appears to be coping relatively well with the help of supportive psychotherapy and medication.” The provider concluded with, “While not ready to return to combat, this soldier should be able to meet the demands of Quarter Master in the Army Reserves.” In response to this conclusion, however, the psychiatrist completing the narrative summary (NARSUM) opined the following.

Despite this recommendation by this civilian provider, there is evidence that this individual continues to have continued difficulty with his cognitive processing. His wife described the patient frequently losing things and forgetting things easily. … He gets frustrated easily when he has difficulty with simple motor tasks such as tying his shoes. This frustration often causes him to experience acute anxiety sometimes precipitating a headache, and after the fact, he tends to become very depressed and withdrawn from others for several days. Although he has been able to perform in a limited capacity at work, it is unlikely that he would be able to process larger amounts of complex formation to a degree necessary for a Military Officer.

The NARSUM stated that the panic attacks had resolved, that the insomnia persisted and was recalcitrant to multiple medications, that the CI still manifested some social avoidance, and that he still required memory aids (notes, cues, etc.) for daily functioning. At the time of separation he was maintained on two mood stabilizers (Wellbutrin, BusPar) and a sleep medication (Ambien). The mental status examination (MSE) and gross cognitive testing were normal. Two diagnoses were listed on axis I: cognitive disorder, not otherwise specified (NOS) and anxiety disorder, NOS. The DoDI 1332.39-defined social and industrial impairment for each diagnosis was “mild.” Specifically the examiner noted that criteria for PTSD were not met. The commander’s statement documented an assignment as assistant to the unit administrator with duties commiserate to rank; and, assessed performance as “satisfactory and within Army standards;” but, in a follow-up letter stated that his initial letter “may have been misconstrued;” and, clarified that the CI did not perform duties independently, but rather “assisted as much as he was able to considering the medications he was taking and the stress he was under dealing with his situation.”

At the VA psychiatric Compensation and Pension (C&P) exam, 2 months after separation, the CI was employed as a school teacher; although, he stated that his principal had “just given me the basic things to do mostly away from other people.” The memory issues and cognitive impediments reported at the VA exam were considerably more significant than those documented by the NARSUM, final neuropsychological testing, and other service treatment record (STR) entries during the MEB period. The severity of combat stressors and casualty exposures in Iraq recorded by the VA examiner were not consistent with the reports documented in service, and a 2 week period of unconsciousness was reported following the heat stroke. Symptoms more typical for PTSD (i.e., startle reflex, avoidance of crowds, hyperarousal, etc.) were recorded by the VA examiner, than were the symptoms recorded by the NARSUM psychiatrist and other providers. Additionally, a report of daily significant consumption of alcohol was forthcoming, including a history that that the CI had been drinking throughout the day “about a liter a day” prior to separation. Numerous negative entries, and no positive entries, for alcohol and substance abuse are evidenced in the STR. The psychotherapeutic medications noted in the C&P were Wellbutrin, Celexa and lorazepam. The MSE was normal, other than noting a “solemn” affect. Cognitive testing noted some impairment in “immediate and recent memory skills;” but, communication skills, logic/abstraction, and concentration were normal. The VA psychiatrist made axis I diagnoses of PTSD, MDD, cognitive disorder, and alcohol abuse; with a global assessment of functioning (GAF) assignment of 45 (consistent with major impairment). The action officer opines that a GAF score this low is incongruent with the objective occupational functioning and MSE, although it undoubtedly accounts for the escalation of symptoms and impairments recorded in the C&P history. No comparison GAF assignment is in evidence from the records.

The Board directs attention to its rating recommendation based on the above evidence. The Board first considered if application of VASRD §4.129 with a constructional 6-month period on the Temporary Disability Retirement List (TDRL) was indicated in this case. Although the heat stroke incident certainly constitutes a “highly stressful event” as referenced by §4.129; it must be recognized that the cognitive and psychiatric sequeale of a medical insult to the brain is more akin to traumatic brain injury, for which §4.129 is not applicable, than it is to PTSD and other purely psychologically mediated conditions for which §4.129 was promulgated. It is also relevant that the CI underwent an extensive period of rehabilitation prior to separation, and the cognitive/psychiatric residuals of heat stroke were stabilized to a point that TDRL was not medically indicated at separation. All members agreed, therefore, that application of §4.129 is not indicated in this case. The Board next deliberated the probative value assignment to the MEB/NARSUM evidence vs. the significantly disparate evidence from the VA C&P evaluation. It was considered that some of the historical details recorded by the VA psychiatrist were uncorroborated, if not refuted, by STR evidence; and, the history and reported acuity of symptoms as documented in the NARSUM were congruent with, and corroborated by, the outpatient entries in the STR over an extended period of time. It must also be considered that the linkage of monetary benefit to VA rating examinations render them inherently vulnerable to a secondary gain bias. Although the evidence from the C&P evaluation is not discounted on this basis, it is a factor which must go on the probative value scale. All members agreed, therefore, that the NARSUM and the STR during the MEB period were the more probative sources of evidence for assessing disability at separation; and, all agreed that the §4.130 threshold for a 50% rating was not approached and that the criteria for a 0% rating were exceeded.

The deliberation thus settled on arguments for a 30% versus a 10% rating recommendation. The §4.130 description for a 30% rating is “occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks;” while that for 10% is “occupational and social impairment due to mild or transient symptoms which decrease work efficiency only during periods of significant stress, or; symptoms controlled by continuous medication.” The purely objective performance and objective findings were the distinctly probative and comprehensive pre-separation neuropsychological evaluation, the serially normal (or nearly so) mental status examinations, the initial commander’s letter (the content of which was not easily “misconstrued”), and the CI’s ability to move promptly into the teaching profession at separation (conceding that the position may have been somewhat sheltered at that point). These objective measures, unbiased by any psychological overlay, are much better aligned with the 10% criteria quoted above. Conversely, it was argued that there were clearly some residual cognitive impairments (documented both in the neuropsychological testing and the NARSUM) which would clearly impart some “decrease in work efficiency” as per the 30% language; that the CI remained subject to bouts of anxiety that would surely disrupt his work day, that he remained dependent on multiple psychotherapeutic medications to maintain functionality; and, that some degree of social impairment (specifically avoidance) likely remained in play at separation. After considerable deliberation, considering the preponderance of the evidence and with full deference to VASRD §4.3 (reasonable doubt), the Board consensus was a 30% rating recommendation for the cognitive/anxiety disorder.

Migraine Condition. The CI’s headaches began concurrently with the heat stroke incident. Initially they were a feature of the panic attacks; and, even after resolution of the latter, the headaches were often triggered (or accompanied) by episodes of anxiety. Numerous treatment notes document near daily frequency of headache occurrence with duration of hours; and, little success with multiple trials of medications. Key passages from the neurology addendum to the NARSUM, relevant to VASRD §4.124a rating, are excerpted below.

[CI] has continued to experience chronic daily headaches, described as a gripping vise-like pain in the frontal region that may wax and wane from a baseline 3/10 up to episodes of 10/10 intensity. These severe episodes can occur on average 1-2 times per week, and are associated with nausea, photophobia, lightheadedness, blurred vision, and tingling in the distal extremities. They can last from 45 minutes up to several hours. … Severe headache episodes appear to be triggered by anxiety attacks, less severe headaches will often be triggered by emotional stress, fear or frustration, particularly any task that requires him to concentrate. On two occasions he presented to [local urgent care center] for acute treatment (08, 16 March 2006). Soldier also reports on two prior occasions in early June and September 2005 he had reported to local emergency room for similar episodes associated with transient confusion/disorientation.

The urgent care and emergency room visits referenced in this addendum (and quoted in the PEB’s DA Form 199 rating rationale) were confirmed in the record, and no additional encounters for rescue treatment of headache are in evidence. The VA C&P examiner, after separation, reported a headache frequency of “six times per week” with duration of “minutes to hours.” The VA rating decision referenced the CI’s failure to respond to a request for additional documentation of treatment for headache, and assigned a non-compensable rating for lack of “characteristic prostrating attacks.”

The Board directs attention to its rating recommendation based on the above evidence. The VASRD §4.124a rating schedule for code 8100 (migraine) rests heavily on the frequency of “characteristic prostrating attacks over last several months;” and, it is incumbent on the Board to apply DoDI 6040.44-compliant and uniform criteria which would define a recurrent migraine episode as ‘prostrating’ and ratable. Under DoDI 6040.44, the Board is directed to: “use the VASRD in arriving at its recommendations, along with all applicable statutes, and any directives in effect at the time of the contested separation (to the extent they do not conflict with the VASRD in effect at the time of the contested separation).” Since the VASRD does not provide a definition of ‘prostrating’, it can be argued that the Board is directed to apply the DoDI 1332.39 definition which requires evidence that medical treatment is sought for each rated episode. The Board, by precedence, has not required rigid proof of medical attention for each and every episode to characterize it as prostrating; but, does require reasonably convincing evidence that rated attacks force the abandonment of work or current activity to treat the migraine; although, self-management (medication and/or sleep) under outpatient monitoring and supervision has been accommodated within this threshold. The Board could not find any evidence that the CI was abandoning his duties or other pursuits in order to seek medical treatment or self-treat for any occurrence of migraine other than those associated with medical visits as documented above. During the year prior to the adjudication date (separation) there were three such visits. After due deliberation, considering all of the evidence and mindful of VASRD §4.3, the Board concluded that there was insufficient cause to recommend a change in the PEB adjudication of the headache condition.

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. As discussed above, PEB reliance on DoDI 1332.39 for rating cognitive/anxiety disorder was operant in this case and it was adjudicated independently of that policy by the Board. In the matter of the cognitive/anxiety disorder, the Board by a vote of 2:1 recommends a disability rating of 30%, coded 9413-9326, IAW VASRD §4.130. The single voter for dissent (who recommended no change from the rating of 10%) submitted the addended minority opinion. In the matter of the migraine headache condition and IAW VASRD §4.124a, the Board unanimously recommends no change in the PEB adjudication. 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.

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Cognitive Disorder and Anxiety Disorder due to Heat Stroke | 9413-9326 | 30% |
| Migraine Headache  | 8100 | 0% |
| **COMBINED** | **30%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20111006, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans’ Affairs Treatment Record

 XXXXXXXXXXXXXXXX

 President

 Physical Disability Board of Review

MINORITY OPINION:

The majority voters in this case shared my concern that there was a significant psychological overlay in this case compromising the probative value of the evidence on which much of the ratable criteria under §4.130 must rest. The sources of this impression are numerous, and significant ones are documented in these proceedings. There is a marked contrast between the objective evidence and the subjective evidence; and, the protracted course of treatment notes document a consistently improving psychiatric and cognitive course. I believe the CI’s disability rating criteria were accurately portrayed in the pre-separation neuropsychological testing and by his commander’s unequivocal statements prior to the follow-up letter (which raises contextual questions and itself elaborated situational problems rather than intrinsic disability). It does not make medical sense that the CI recovered steadily over a 1½ year period from his injury to the point accurately measured by the neuropsychological testing; and then regressed at the time of actual medical separation and follow on VA disability rating. I believe that a strong argument exists for a disability rating aligned with the objective evidence in this case, i.e., 10%; and, differ with the majority in finding adequate reasonable doubt to concede a higher rating. I therefore contend that the PEB rendered a fair rating decision in this case; and, respectfully urge the Secretary to consider the following minority recommendation with no recharacterization of the CI’s disability and separation determination:

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Cognitive Disorder and Anxiety Disorder due to Heat Stroke | 9326 | 10% |
| Migraine Headache  | 8100 | 0% |
| **COMBINED** | **10%** |

SFMR-RB

MEMORANDUM FOR Commander, US Army Physical Disability Agency

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

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation for XXXXXXXXXXXXXXXXXXX, AR20120016892, (PD201100873)

1. I have reviewed the enclosed Department of Defense Physical Disability Board of Review (DoD PDBR) recommendation and record of proceedings pertaining to the subject individual. Under the authority of Title 10, United States Code, section 1554a,

I reject the Board’s recommendation and accept the Board’s minority opinion as accurate that the applicant’s final Physical Evaluation Board disability rating remains unchanged. There is insufficient justification to support the Board’s recommendation in accordance with Army and Department of Defense regulations.

2. This decision is final. The individual concerned, counsel (if any), and any Members of Congress who have shown interest in this application have been notified of this decision by mail.

BY ORDER OF THE SECRETARY OF THE ARMY:

Encl XXXXXXXXXXXXXXXXX

 Deputy Assistant Secretary

 (Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA