RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD11-01004 SEPARATION DATE: 20080623

BOARD DATE: 20121003

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SGT/E-5 (19K20/M1 Armor Crewman), medically separated for chronic headaches which did not improve adequately with treatment to meet the physical requirements of his Military Occupational Specialty (MOS) or satisfy physical fitness standards. He was issued a permanent P3 profile and referred for a Medical Evaluation Board (MEB). Sleep apnea, history of traumatic brain injury (TBI), high frequency hearing loss (HFHL), mild elevation of triglycerides, intermittent paresthesias of right hand, incidental finding of cervical disc disease, alcohol (in remission), and anxiety disorder, as identified in the rating chart below, were also identified and forwarded by the MEB. The Physical Evaluation Board (PEB) adjudicated the chronic headaches condition as unfitting, rated 0% with application of the Veteran’s Affairs Schedule for Rating Disabilities (VASRD). The CI made no appeals, and was medically separated with a 0% disability rating.

CI CONTENTION: "VA assigned ratings of 50% for migraine headaches, 10% for post concussion syndrome with memory loss, 10% for right hand paresthesias, 30% for PTSD, 10% for a cervical spine condition, 10% right knee retropatellar pain syndrome and 10% for tinnitus. A rating of 0% was assigned for shrapnel wound, right elbow. The shrapnel was never removed and continues to cause problems. I continue to suffer from all of these conditions. I had surgery on my right knee on 19 Oct 2010, at the St Louis VA. The surgery was not a success. I was injured in an IED explosion on 26 Aug 2006, and was awarded a purple heart for wounds in which I took shrapnel in my right elbow in three places. Over the course of one deployment in support of OIF4, I was directly involved in 11 IED explosions which resulted in migraines and memory loss. During the deployment I witness numerous dead and injured US soldiers and Iraqi nationals. I was also involved in numerous mounted and dismounted firefights. All of these situations continue to affect me and aggravate my PTSD.”

SCOPE OF REVIEW: The Board wishes to clarify that the scope of its review as defined in the Department of Defense Instruction (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 TBI, HFHL, intermittent paresthesias of right hand, and cervical disc disease, as requested for consideration, meet the criteria prescribed in DoDI 6040.44 for Board purview. These are addressed below, in addition to a review of the rating for the unfitting condition. The Board noted that the CI contended for PTSD. PTSD was not a specific diagnosis forwarded to the PEB, however anxiety disorder was determined to be not unfitting by the PEB. Following separation the VA examiner changed the diagnosis to PTSD which was rated by the VA. The Board therefore considered contended mental health condition regardless of specific diagnostic label did fall within the purview of the Board and is discussed under the contended conditions paragraph below. The remaining conditions listed on the DD Form 294 application are not within the Board’s purview even though rated by the VA at separation. 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 Correction of Military Records.

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service IPEB – Dated 20080325** | | | **VA (<1 Mo. Post-Separation) – All Effective Date 20080624** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Headaches | 8199-8100 | 0% | Migraine Headaches | 8100 | 50% | 20080617 |
| Sleep Apnea | Not Unfitting | | OSA | 6847 | 50% | 20080617 |
| Anxiety Disorder | Not Unfitting | | PTSD | 9411 | 30% | 20080617 |
| R Hand Int Paresthesias | Not Unfitting | | Right Hand Paresthesias | 8515 | 10% | 20080611 |
| History of TBI | Not Unfitting | | Post Concussion Syndrome | 8045 | 10% | 20080617 |
| HFHL | Not Unfitting | | Tinnitus | 6260 | 10% | 20080617 |
| Triglyceride elevation | Not Unfitting | | No VA Entry | | | 20080617 |
| Alcohol (in remission) | Not Unfitting | | No VA Entry | | | 20080617 |
| No Additional MEB/PEB Entries | | | Cervical Spine Condition | 5242 | 10% | 20080611 |
| Right Knee RPPS | 5003 | 10% | 20080611 |
| 0% X 2 / Not Service-Connected x 4 | | | |
| **Combined: 0%** | | | **Combined: 90%** | | | |

ANALYSIS SUMMARY: The Disability Evaluation System (DES) is responsible for maintaining a fit and vital fighting force. While the DES considers all of the member's medical conditions, compensation can only be offered for those medical conditions that cut short a member’s career, and then only to the degree of severity present at the time of final disposition. The DES has neither the role nor the authority to compensate service members for anticipated future severity or potential complications of conditions resulting in medical separation nor for conditions determined to be service-connected by the Department of Veteran Affairs (DVA) but not determined to be unfitting by the PEB. However the DVA, operating under a different set of laws (Title 38, United States Code), is empowered to compensate all service-connected conditions and to periodically re-evaluate said conditions for the purpose of adjusting the Veteran’s disability rating should the degree of impairment vary over time. The Board’s role is confined to the review of medical records and all evidence at hand to assess the fairness of PEB rating determinations, compared to VASRD standards, based on severity at the time of separation.

Chronic Headache Condition. On 26 August 2006, the CI was injured by an improvised explosive device (IED) and sustained shrapnel to the right elbow. A Glasgow Coma Scale (GCS) test administered that same day was normal with 15/15 criteria correct. A post-deployment health history, taken one month later and while still in theater, noted that he had previously had symptoms of headache, difficulty remembering and ringing in his ears, but that these had resolved. Over the next few months, he endorsed symptoms of fatigue and sleep disturbance, but denied headache, impaired memory and cognitive difficulties. At a neurology evaluation at performed on 8 December 2006, he reported a period of confusion after the explosion and was thought to have post-concussive syndrome. However the CI denied headache (HA) as well as memory loss or cognitive issues at that visit. The neurology evaluation was for a transient episode of right sided numbness and difficulty moving the right leg associated with headache that had occurred a few days before. The episode could not be explained by the neurologist. Magnetic resonance imaging (MRI) of the brain performed in February 2007 was normal (including MR angiography). He was seen by his primary care manager on 21 February 2007 and complained of both HAs and memory impairment. This is the first time cognitive complaints appeared in the service treatment record since the IED incident 6 months before. Two days later, he also complained of poor concentration, but was noted to have normal thought processes on examination. A neurologist noted subjective complaints of memory issues and HAs when seen on 18 March 2007 during a follow up visit after the imaging. Four days later, at a Soldier Readiness Program (SRP) visit, the examiner documented mild to occasional HA rated at 8/10 for pain which responded well to over the counter (OTC) medications. The CI endorsed weekly problems with short-term recall and attention span. However, at another SRP visit on 4 April 2007, he denied HA or problems with either concentration or memory. The NCO evaluation which covered from 1 May 2006 to 30 April 2007, encompassing 4 months prior to the IED blast on 26 Aug 2006 and 8 months afterwards including the onset of the HAs and memory/cognitive issues, was very strong. He was ranked among the best and given “1”s for success and potential, the highest rating possible. In June 2007, the neurologist noted that his HAs were better, but that he still had issues with memory and concentration. The neurologist also annotated that there was possible benefit from treatment with a medication indicated for memory improvement and cognitive rehabilitation. The CI had run out of his medications, though he was treated with medications for HAs over the next few months with good results. A traumatic brain injury (TBI) assessment on 11 September 2007 documented that he still endorsed HAs, forgetfulness, poor decision making as well as dizziness, poor balance and irritability. There are three commander’s statements in the record. The first was written on 14 September 2007 by the officer who had been his commander since July 2006, over 14 months. In it he wrote:

He is a competent and motivated Soldier with superior leadership and organization skills...I have not been able to discern a difference in performance between the time prior to deployment to Iraq and the present…His condition is unlikely to change and while I have not witnessed any inability to perform his job, it is obvious that he is struggling with his condition.

The succeeding commander wrote the next two commander’s statements utilizing the above report as a template, keeping much of the original language, but adding contradictory statements. The first of these, on 2 October 2007, noted both that the CI “performed all duties commensurate with his position superbly” and “SGT Atley’s performance has significantly decreased since return from OIF IV.” This same commander wrote an additional commander’s statement, the final of the three total reports, in which he kept the contradictory language in his first report. He commented that the CI was working as CQ NOCIC 40-45 hours a week, but noted that “due to his TBI, he often forgets what tasks he is given if not directly supervised by a peer or superior.” It also noted that his duties included typing. There is significant disparity between these reports, all of which were written within a 4 week period. The Board notes that the first was written by the officer who had been in command both before and after the deployment and TBI and who had observed the CI over a 14+ month period of time. Also, this report is consistent with the strong NCOER written a few months earlier. The second and third commander’s statements are internally contradictory, written by an officer who apparently only recently had taken command and were written after the CI was in the DES process. Between these statements and separation, there were numerous service treatment record entries which commented on the status of the HAs. The majority of these documented that the CI either had no complaints or had benefited from the medications if he had suffered from a HA. On 13 December 2007, it was noted that compliance with medical therapy was questionable as the CI had not refilled the Topamax, a medication given for HA prophylaxis, for three months and that it was dispensed in a 30 day supply. There were neither records indicating that the CI had been placed on quarters for his HAs nor were there records showing that he had left work early due to his HAs. During the DES process, the CI was diagnosed with severe obstructive sleep apnea (OSA) for which he was given both CPAP (continuous positive airway pressure) and then BiPAP (bi-level positive airway pressure) with good control of his OSA. However, measured compliance was sub-optimal (63% usage from December 2007 to February 2008). In the narrative summary (NARSUM), the CI reported that his high school girl friend told him he stopped breathing while sleeping, suggesting that the condition existed prior to entry.The Board notes that aside from daytime drowsiness, symptoms of OSA include HA, cognitive impairment and difficulty with memory. The Board also noted that the CI was near his maximum weight in February 2007 at 235 pounds and had gained an additional 25 pounds by the time of DES entry in September 2007. Being overweight is strongly linked with OSA.

Although the condition is outside the Board Scope of Review, it nonetheless could exacerbate or even be causal for the symptoms attributed to post-concussive syndrome. The MEB NARSUM was dictated 4 February 2008, just over 4 months prior to separation. The CI reported that he was taking Topamax twice a day and was averaging a headache every day or every other day averaging 5/10 in intensity; he also noted sensitivity to light, but without nausea or vomiting and that loud noises and physical activity triggered the HAs. He also reported that several times a week he stopped what he was doing and would lie down in a dark room after taking the Zomig; the HA resolved over the course of several hours, but that he would often need to take another Zomig four to five hours after the first Zomig. However, the Board noted the PEB annotation performed on 25 March 2008 that there was no record that the CI had refilled his medication since September 2007 and that he had not gone to the emergency room (ER) for his HAs. The VA Compensation and Pension (C&P) examination performed on   
17 June 2008, 6 days prior to separation. The CI stated that the HAs ranged from 3-4/10 to 10/10 and were triggered by loud noises or when startled as well as physical exertion. The HAs could last up to 24 hours, but generally lasted 6 hours. These improved with Zomig and a nap, but generally he needed to be in a dark, quiet room. These were associated with nausea, vomiting, photophobia and phonophobia. He stated that he could have HAs several times a day, but could also go weeks without a HA. He had not been taking his medications. He was thought to have migraine HAs and the examiner attributed these to the TBI. The Board directs attention to its rating recommendation based on the above evidence. The PEB coded the headache condition as 8199-8100, analogous to migraine headaches, and rated it at 0% citing that the CI had not refilled his medications for the HAs since September 2007, 7 months earlier, and that there had been “no documentation of prostration or any significant industrial impairment in a garrison environment.” The VA also coded for migraine HAs as 8100, but rated the condition at 50% citing “daily and often incapacitating and associated with nausea, vomiting, photophonia and phonophobia” as reported by the CI to the C&P examiner.

The Board considered both ratings. A search of the records did not show any evidence for prostrating headaches, placement on quarters, or ER visits for his headaches. Numerous records showed that he enjoyed good relief of his headaches when he was compliant with his medications and also that he remained HA free on numerous visits long after he had last refilled his Topamax, inconsistent with the VA determination that he had daily headaches. There was no record of lost duty time, other than for clinical visits, outside of the history provided to the MEB and C&P examiners. None of the commander’s statements in evidence indicated a loss of duty time from the headaches and the final statement on 10 October 2007 documented that he was working “40-45 hours a week.” The Board first considered the coding option for 8100, migraine headaches. The Board observed that while the CI endorsed prostrating headaches, the service treatment record (STR) does not support this and that the rating best fits the 0% description. The Board also considered rating the headaches under code 8045, residuals of TBI, but noted that neither the PEB nor the VA rated the CI for post-traumatic headaches and that the physician who dictated the NARSUM opined that these did not fit the description of post-traumatic headaches. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board concluded that there was insufficient cause to recommend a change in the PEB adjudication for the headache condition.

Contended PEB Conditions. The contended conditions adjudicated as not unfitting by the PEB were TBI with memory impairment, HFHL left ear, right hand paresthesias, cervical disc disease, and mental health condition diagnosed as anxiety disorder prior to separation and PTSD after separation. Although the CI contended for PTSD which was diagnosed by the VA after separation, but not explicitly considered by the PEB, the Board concluded this fell within the purview of the Board as the manifestations of the mental disorder diagnosed as anxiety disorder are the same used to support the later diagnosis of PTSD. The Board then considered each of these conditions for fitness. 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.

The PEB determined the TBI with memory impairment to be not unfitting and it was noted to meet retention standards by the MEB. It was part of the P3 profile issued for DES entry, but not on the final permanent profile. It was noted in the record that the CI had no LOC during the TBI in service, but that he had suffered LOC prior to enlistment after a car accident and had academic difficulties in high school, prior to enlistment. This information was not disclosed at accession and revealed to the MEB examiner when the NARSUM was prepared. The Board noted that he denied memory or cognitive impairment for several months after the TBI while deployed and that the initial commander’s statement did not document these difficulties. Moreover, this commander specifically noted that he could still meet his job requirements, although the subsequent commander documented that the CI required oversight on a third commander’s statement. The MEB NARSUM examiner noted that the mini mental status examination was normal (30/30), memory intact for immediate, intermediate and long-term recall as well as normal cognitive function. He also noted that testing (records not available for review) indicated some exaggeration of his memory deficits. The C&P examiner noted that the CI had a good accounting of events and scored 29/30 on the mini mental status examination, opining that his deficit might be too subtle for the screen. The Board observed that a normal score is 25 or above. The examiner did not request additional neurocognitive screening as the CI informed him that he had this testing four times already. However, the VA examiner did not have this information available for review. After due deliberation in consideration of the preponderance of the evidence, the Board concluded that there was insufficient cause to recommend a change in the PEB fitness determination for the TBI with memory impairment condition.

The Board noted that the HFHL of the left ear met retention standards. The profile remained H-1 throughout his service. The C&P examination showed a mild sensorineural loss between 3000 and 4000 Hz on the left which was non-compensable, although he was granted 10% for intermittent tinnitus on the left. There is no evidence that the tinnitus interfered with the performance of his military duties. After due deliberation in consideration of the preponderance of the evidence, the Board concluded that there was insufficient cause to recommend a change in the PEB fitness determination for the HFHL condition.

The PEB determined that the right hand paresthesias were not unfitting and the MEB noted that this met retention standards. No profile was given. In the third commander’s letter, it was noted that the in garrison duties of the CI included typing and there was no indication that he had difficulty with this task. The neurologist noted a normal motor examination and that testing was normal other than an artifact observed on nerve conduction testing from a small fragment of retained shrapnel. At the C&P examination, the CI complained of numbness and tingling several times a day with use, but had a normal sensory examination. The motor examination was normal other than the ADQ (abductor digiti quinti, a muscle which primarily moves the little finger away from the hand) which was 5-/5. A general C&P examination that same day did not note any motor or sensory deficit. After due deliberation in consideration of the preponderance of the evidence, the Board concluded that there was insufficient cause to recommend a change in the PEB fitness determination for the right hand condition.

The cervical disc disease was an incidental finding during the evaluation of the right hand paresthesias. There is no evidence in the record that the CI was treated for neck pain; the condition was neither profiled nor noted by the commanders as interfering with duty. The CI did not mention neck pain on the separation history. After due deliberation in consideration of the preponderance of the evidence, the Board concluded that there was insufficient cause to recommend a change in the PEB fitness determination for the cervical disc condition.

The Board then considered the anxiety disorder/PTSD disorder condition. It noted that PTSD was not diagnosed prior to the C&P examination 6 days prior to separation although there were some symptoms documented on the TBI screens. The CI maintained a S1 profile and was noted by the MEB examiner to have no unfitting mental health conditions. The MEB determined that the anxiety disorder met retention standards and the PEB noted that it was not unfitting. No mental health condition was noted by either commander as interfering with duty performance. The Board found no evidence to support the contention that an unfitting mental health condition was present prior to separation. None of these conditions were profiled; none were implicated in the commander’s statement; and, none were judged to fail retention standards. All were reviewed by the action officer and considered by the Board. There was no indication from the record that any of these conditions significantly interfered with satisfactory duty performance. The Board concluded therefore that none of these conditions could be recommended for additional disability 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 headache condition, by a 2:1 vote, the Board recommends no change in the PEB adjudication. The single voter for dissent (who recommended adopting the VA rating 8045 at 10%) did not elect to submit a minority opinion. In the matter of the contended TBI, HFHL, right hand paresthesias, cervical disc and mental health conditions the Board unanimously recommends no change in the PEB adjudication as not unfitting. There were no other conditions within the Board’s scope of review for consideration.

RECOMMENDATION: The Board recommends that there be no recharacterization of the CI’s disability and separation determination as follows:

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| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Chronic Headaches | 8199-8100 | 0% |
| **COMBINED** | **0%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20101026, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans’ Affairs Treatment Record

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President

Physical Disability Board of Review

SFMR-RB

MEMORANDUM FOR Commander, US Army Physical Disability Agency

(TAPD-ZB / ), 2900 Crystal Drive, Suite 300, Arlington, VA 22202-3557

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation for XXXXXXXXXXXXXXXXX, AR20120019101 (PD201101004)

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 accept the Board’s recommendation and hereby deny the individual’s application.

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 XXXXXXXXXXXXXXX

Deputy Assistant Secretary

(Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA