RECORD OF PROCEEDINGS
PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXX
CASE NUMBER: PD1200369
BOARD DATE: 20121207

BRANCH OF SERVICE: ARMY
SEPARATION DATE: 20081018

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SGT/E-5 (13F/Fire Support Specialist), medically separated for chronic neck pain that began after a vehicle rollover in Afghanistan in March 2006; chronic upper back pain secondary to the same incident; and, anxiety disorder, not otherwise specified, associated with possible cognitive disorder following deployment to Afghanistan. The CI injured his back in a vehicle rollover while deployed to Afghanistan and his neck and back pain began in March 2006. He continued his duty in pain for the remainder of his deployment, and returned home in June of 2007. The CI was tried on various treatment modalities but continued to have neck and back pain daily without improvement. While deployed, the CI was very anxious and reportedly witnessed combat deaths. The CI self-referred to Combat Stress in November 2006 and he was diagnosed with anxiety disorder, not otherwise specified (NOS). He was allowed to finish the deployment in a limited position after reassignment to the forward operating base (FOB). After returning home in August 2007, he was referred to Army Substance Abuse Program (ASAP) due to alcohol issues and he underwent treatment for his mental health condition. The CI responded well to therapeutic interventions and reduction of alcohol consumption but his illness continued to affect his ability to perform military duties. The chronic neck pain that began after a vehicle rollover, chronic upper back pain secondary to the same incident, and anxiety disorder NOS associated with possible cognitive disorder conditions could not be adequately rehabilitated to meet the requirements of his Military Occupational Specialty (MOS) or satisfy physical fitness standards. He was issued a permanent U3/S3 profile and referred for a Medical Evaluation Board (MEB). The left and right shoulder pain, and alcohol abuse conditions identified in the rating chart below, were also identified and forwarded by the MEB as meeting retention standards. The Physical Evaluation Board (PEB) adjudicated the chronic neck pain that began after a vehicle rollover, chronic upper back pain secondary to the same incident, and anxiety disorder NOS associated with possible cognitive disorder conditions as unfitting, rated 10%, 10% and 0%, respectively, with application of Department of Defense Instruction (DoDI) 1332.39, and the Veteran's Affairs Schedule for Rating Disabilities (VASRD). The left and right shoulder pain condition was determined to be not unfitting; the alcohol abuse condition is not a physical disability and is not ratable per DoDI 1332.38. The CI made no appeals and was medically separated with a 20% disability rating.

CI CONTENTION: "I was discharged with a combined 20% rating from the Medical Board that included a 0% rating for Anxiety Disorder. I believe this violates VA Schedule of Rating Disabilities (VASRD) 4.129 which states that when a mental disorder that develops in service as a result of a highly stressful event is severe enough to bring about the veterans release from active military service, the rating agency shall assign an evaluation of not less than 50 percent and schedule an examination within the six month period following the veterans discharge to determine whether a change in evaluation is warranted. (Authority 38 USC 1155) DODI 1332.39 I was subsequently provided a 50% rating for PTSD from VA (see attached print out) providing diagnostic code 9411, PTSD, 50% rating from 10/19/2008. I believe the board erred in not providing the appropriate rating per VASRD and DODI 1332.39 and ask that consideration be granted to changing my disability separation to Disability Retirement."

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 unfitting anxiety disorder condition, as requested for consideration, meets the criteria prescribed in DoDI 6040.44 for Board purview and is addressed below, in addition to the unfitting conditions of chronic neck pain and chronic upper back pain. 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 20080805			VA (3 and 4 Days Post-Separation) – All Effective Date 20081019			
Condition	**Code**	**Rating**	**Condition**	**Code**	**Rating**	**Exam**
Chronic Neck Pain	5237	10%	Degenerative Disc Disease Cervical Spine	5237	10%	20081022
Chronic Upper Back Pain	5237	10%	Degenerative Disc Disease Thoracic Spine	5237	10%	20081022
Anxiety Disorder NOS Associated with Possible Cognitive Disorder	9413	0%	Post-Traumatic Stress Disorder to include Insomnia	9411	50%	20081021
Left and Right Shoulder Pain	Not unfitting		No VA Entry			
↓No Additional MEB/PEB Entries↓			Chondromalacia Right Knee	5099-5014	10%	20081022
			Pes Cavus	5278	10%	20081022
			Tinnitus	6260	10%*	20081022
			Traumatic Brain Injury with Headaches	8045	10%	20081022
			0% X 2 / Not Service-Connected x 3			20081022
Combined: 20%			**Combined: 80%** (Bilateral Factor 1.9)**			

*Original VARD of 20090203 deferred Tinnitus; combined rating was 70%. VARD of 20090324 added Tinnitus @ 10% and raised the combined rating to 80%.
**Individual Unemployability effective 20090418

ANALYSIS SUMMARY: The Board utilizes VA 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 Disability Evaluation System (DES) fitness determinations and rating decisions for disability 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.

Anxiety Disorder, Not Otherwise Specified (NOS), Associated with Possible Cognitive Disorder Condition. A psychiatric addendum to the MEB narrative summary (NARSUM) was completed by a psychiatrist in May 2008. The CI was deployed to Afghanistan from February 2006 to June 2007 and earned a combat action ribbon. The addendum refers to mental health treatment before, during, and after deployment but none of the records alluded to are available for the Board to review. The CI had been very anxious prior to the deployment and he reported daily alcohol use for the 6 months prior to deployment apparently as a self-treatment. He reported traumatic events occurred during his deployment and that he had sought care with combat stress in November 2006. The CI was not redeployed early but he was reassigned to FOB security and he reported "being away from the commotion helped him." He was able to complete his full deployment but began mental health treatment shortly after his return home. He was treated for anxiety disorder NOS and for posttraumatic stress disorder (PTSD) and was referred by psychiatry for alcohol abuse treatment in August 2007. He reported the therapy had helped him gain control over his anger. He also reported that he had had some difficulty with short-term memory after returning home. At the time of the addendum, he noted his

memory had been a lot better in the previous 3 months and he denied a persistent depressed mood. He still had restless sleep, nightmares, and flashbacks of combat every now and then and had lost interest in things that reminded him of Afghanistan, but he was interested in video games and a new relationship with a girlfriend of 8 months. The addendum reports a progress note from psychology in April 2008 indicated the CI's PTSD had essentially resolved with some minor symptoms periodically. The source document is not available for Board review. The CI also reported a significant decrease in alcohol intake. A mental status examination (MSE) was essentially normal with euthymic mood and an affect that was full ranging, reactive, and appropriate to content. Neuropsychological testing performed by a civilian provider in November 2007 documented mild deficits but review of the results by a Walter Reed neuropsychologist noted some of the tests used were outdated and considered substandard. Testing that was considered valid reflected mild memory impairment and moderate impairments of visuospatial and processing speed. However, it was unclear if these were new findings. Pharmacy records reveal previous treatment with Trazodone but the CI was not taking that at the time of the addendum. He was taking an anti-depressant but that was for his chronic pain. Although the examining psychiatrist noted a history of treatment for PTSD, he opined that the CI did not meet full Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) criteria for the diagnosis at the time of his evaluation. He noted that while the PTSD had responded well to treatment and reduction in alcohol consumption, the CI had a history of dissociative symptoms and did not recommend continuation on active duty. While the description provided appears consistent with very limited symptoms and the examining psychiatrist noted a Global Assessment of Functioning (GAF) of 62, which is evidence of some mild symptoms, the psychiatrist also specifically stated the CI had moderate military and psychiatric impairment and that deployment and injury were external precipitating conditions. Prior to his mental health condition, the CI had no difficulties performing any required occupational tasks. At the time of the MEB evaluation, the CI was assigned to the Warrior Transition Unit and had no occupational responsibilities. The MEB psychiatrist opined the CI was currently capable of working full time in civilian employment in a position with salary commensurate with his current military pay grade. However, he did not recommend positions requiring the operation of a motor vehicle or heavy machinery or carrying a weapon/firearm. He also recommended the CI remain within 50 miles of a facility with behavioral health care services. Additionally, the CI was assigned a permanent S3 profile by two other independent physicians. An S3 profile is indicative of more significant mental health issues that are incompatible with military service. The CI had been awarded social security disability (SSD) for inability to work in a civilian job on 15 April 2008.

At the MEB exam, the CI marked the following items as yes: nervous trouble of any type (anxiety or panic attacks), loss of memory or amnesia or neurological symptoms, frequent trouble sleeping, received counseling of any type, and having been evaluated or treated for a mental condition. The MEB physical exam completed in April 2008 noted the diagnoses of PTSD, traumatic brain injury (TBI), and depression and recommended further follow-up with psychiatry. The examiner who performed this examination also completed the MEB NARSUM approximately a week later.

The VA Compensation and Pension (C&P) exam was completed at the time of separation, approximately 5 months after the psychiatric addendum. The CI reported that he had taken Trazodone for this PTSD and had stopped taking it because it had not helped him. He was not employed but he was looking for a part time job as allowed by his SSD. The CI had been in treatment for PTSD for 12 weeks prior to separating, including group psychotherapy and initially did well, however his symptoms had returned with "full force" and were causing significant disruption. At the time of the C&P exam he had been informally dropping in to talk to a counselor at a Veteran's Center in Watertown, NY. The MSE documented an overtly and noticeably anxious mood that resulted in shaky speech and some difficulties with word finding and articulation. The CI was "quite tremulous and shaky." His affect was noted to be full range

and appropriate. He had nightmares two to three times a week on average, chronically and severely disrupted sleep, agitation, hyperarousal, had daily intrusive thoughts and flashbacks, and moderate to severe social anxiety and social avoidance. He was quite tense, anxious, and hypervigilant in any public situation and avoided them at all costs. He was also hypervigilant at home, making frequent security checks of windows and doors, especially at night. He also had an exaggerated startle response. He was living with his girlfriend and their two children but he was not engaged in any social activities. The examiner opined his personal and social adjustment was moderately to severely impaired. He also opined that the CI's symptoms of PTSD were sufficiently severe enough to significantly impair his ability to maintain appropriate behavioral and emotional stability in work situations. The CI reported he would occasionally have a good day but the examiner doubted this would allow him to be successfully employed. He diagnosed PTSD and assigned a GAF of 50, indicative of serious symptoms and/or any serious impairment in social, occupational, or school functioning. The examiner also personally escorted the CI to the Operation Iraqi Freedom/Operation Enduring Freedom (OIF-OEF) transition office to ensure the CI was immediately enrolled in the VA and into treatment as quickly as possible.

The initial VA rating decision (VARD) dated February 2009 included evidence from VA outpatient treatment records (from October 2008 through January 2009) that the CI was receiving ongoing mental health treatment and a record from December 2008 noted that he had recently started working. The actual treatment records are not available for review. This VARD also reported the CI was receiving SSD benefits due to multiple medical and mental health problems and that the CI was going to seek part-time employment to the limit allowed relative to his SSD benefits. A later VARD from August 2009 that granted individual unemployability also included evidence from VA outpatient treatment records from April through July 2009. These treatment records are also unavailable. The CI reported he had worked part time at HGA but had to leave his job due to his disability and his back, knees, PTSD, and TBI prevented him from following substantially gainful employment. He reported that he had "bad headaches on busy days with [his] post-traumatic stress disorder, [he] had to go home early." HGA confirmed that he had worked there from November 2008 to 17 April 2009, working from 4 to 8 hours a day for a total of 18 to 24 hours per week. Social security reports verified he was receiving SSD due to an anxiety related disorder.

The PEB rating, as described above, was derived from DoDI 1332.39 and while it did not precede the promulgation of the National Defense Authorization Act (NDAA) 2008 mandate for DoD adherence to Veterans Administration Schedule for Rating Disabilities (VASRD) §4.129, it did not comply with that requirement. The Board notes that while §4.129 is generally applied to PTSD cases, the paragraph is not limited to this particular diagnosis but is applicable when any "mental disorder that develops in service as a result of a highly stressful event is severe enough to bring about the veteran's release from active military service." While the CI had received treatment for PTSD, the psychiatric addendum stated he did not meet the criteria for PTSD and anxiety disorder, NOS was diagnosed. However, the examining psychiatrist did relate the CI's mental health condition to "alleged combat-related trauma" and noted the deployment was a precipitating condition. The CI was awarded a combat action ribbon. The VA examiner diagnosed PTSD. However, regardless of which diagnosis, anxiety disorder or PTSD, is assigned, §4.129 is applicable. IAW DoDI 6040.44 and DoD guidance (which applies current VASRD 4.129 to all Board cases), the Board is obligated to recommend a minimum 50% rating for a retroactive six-month period on the Temporary Disability Retired List (TDRL). The Board must then determine the most appropriate fit with VASRD 4.130 criteria at six months (April 2009) for its permanent rating recommendation. The psychiatric addendum to the NARSUM was completed 5 months prior to separation and the C&P was completed 4 days after separation. Therefore, both of these examinations will be used to determine the TDRL entrance rating. All VARDs in evidence document a future mental health C&P examination was planned for January 2011. However, there is no evidence of this examination in the record and the most recent

VARD is dated February 2010. While there are no further examinations available to determine the permanent rating at TDRL exit in April 2009, the August 2009 VARD that granted entitlement to individual unemployability contains evidence of employment history and VA treatment records that can be used to determine the permanent rating recommendation.

The Board directs its attention to its rating recommendations based on the evidence above. The VA assigned a 50% rating for PTSD based the examination at the time of initial separation and IAW VASRD §4.130 criteria without relying on the provisions of §4.129. A follow-up mental health examination was planned but there is no evidence it ever occurred. All members agreed that the §4.130 criteria for a rating higher than 50% were not met at the time of separation, and therefore the minimum 50% TDRL rating (as explained above) is applicable. As regards the permanent rating recommendation, all members agreed that with an inability to maintain even part time employment, the §4.130 threshold for a 10% rating were well exceeded but that the criteria for a 70% rating was not approached. The deliberation settled on arguments for a 30% versus a 50% permanent rating recommendation. With no new information about the CI's symptoms, the Board can only assume the frequency and severity of symptoms described in the October 2008 VA C&P examination continued. Although the CI was not able to maintain sustained employment, he was employed part time for several months. There is no information about the quality of his work when he was present and his physical disabilities contributed to his inability to maintain employment. Therefore, it is difficult for the Board to support a finding of continuously reduced reliability and productivity, even with the application of reasonable doubt. However, the CI's employment history is consistent with occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks. After due deliberation, considering the totality of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a permanent disability rating of 30% for the mental health condition.

Chronic Neck Pain Condition. There were two goniometric range-of-motion (ROM) evaluations in evidence, with documentation of additional ratable criteria, which the Board weighed in arriving at its rating recommendation as summarized in the chart below.

Cervical ROM	MEB ~6 Months Pre-Separation	VA C&P At Separation
Flex (45° Normal)	45°	45°
Ext (0-45)	35° (Pain at 30)	45°
R Lat Flex (0-45)	35°	45°
L Lat Flex (0-45)	40°	45°
R Rotation (0-80)	50°	80°
L Rotation (0-80)	60°	80°
COMBINED (340°)	265°	340°
Comment	PT: Measured with a standard goniometer. Tenderness to lower c-spine muscles; no guarding or spasm; no abnormal spinal contour. No change in ROM after 3 repetitions. MEB: Increased pain, fatigue, weakness, fatigue, and lack of endurance after three repetitions. No neurologic examination.	No objective pain on motion. No guarding, spasm, or tenderness; motor, sensory (pin prick, vibration, light touch, and position), and reflex exams; Normal neurologic examination and motor 5/5 bilaterally.
§4.71a Rating	10%	10%

The MEB NARSUM was completed approximately 6 months prior to separation and slightly more than 2 years after he was injured in Afghanistan. The CI reported baseline pain at 3/10 with flare-ups up to 4 times per day with pain rated at 8/10 during a flare-up. Magnetic resonance imaging (MRI) of the cervical spine obtained in September 2007 documented minimal degenerative disc bulge in appearance with relatively mild crowding of the thecal sac at C3-4 and C4-5. Neural foramina were patent in all visualized levels. No significant focal disc herniation was seen. Abnormal spinal contour with straightening of his cervical lordosis was

noted but as noted above, in April 2008 the curvature of the cervical spine was normal. Surgery was not recommended. At the MEB exam performed in April 2008, the CI reported numbness and tingling and cervical radiculopathy was included as a diagnosis. Although no neurologic examination was completed for the MEB NARSUM, a normal examination in both upper and lower extremities was documented by a neurologist in February 2008. While the MEB physical exam noted an abnormal spinal exam, it did not elaborate on what abnormalities were present. The C&P exam at the time of separation noted a similar history of injury and failure to respond to conservative therapy. The CI reported intermittent paresthesias and numbness in his left upper extremity, particularly in the ulnar nerve distribution. However, the neurologic examination was completely normal.

A later VARD from August 2009 that granted individual unemployability also included evidence from VA outpatient treatment records from April through July 2009. These treatment records are unavailable. This VARD states that in May 2009, it was noted that the CI's musculoskeletal complaints were much improved since quitting smoking and losing weight. He had good ROM noted in his joints at that time; however, he reported having continued back and neck pain.

The Board directs attention to its rating recommendation based on the above evidence. Both the PEB and the VA rated the chronic neck pain condition at 10% using 5237 at the time of separation from service. This is also the time of entry into the constructed TDRL. While no formal examination was completed at the time of the TDRL exit in April 2009, the VARD from August 2009 reports outpatient VA medical records from April through July 2009 document continued neck pain. There is no indication the chronic neck pain condition either improved or degenerated significantly. 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 chronic neck pain condition at both the time of entry into the constructed TDRL entry in October 2008 and at the time of exit in April 2009.

Board precedent is that a functional impairment tied to fitness is required to support a recommendation for addition of a peripheral nerve rating at separation. The pain component of a radiculopathy is subsumed under the general spine rating as specified in §4.71a. The sensory component in this case has no functional implications. No motor related symptoms were reported and all neurologic examinations were within normal limits. As no evidence of functional impairment exists in this case, the Board cannot support a recommendation for additional rating based on peripheral nerve impairment.

Chronic Upper Back Pain Condition. There were two goniometric ROM evaluations in evidence, with documentation of additional ratable criteria, which the Board weighed in arriving at its rating recommendation as summarized in the chart below.

Thoracolumbar ROM	MEB ~6 Months Pre-Separation	VA C&P At Separation
Flexion (90º Normal)	90º (100)	90º
Ext (0-30)	25º	20º
R Lat Flex (0-30)	25º (Pain at 25)	30º (35)
L Lat Flex 0-30)	25º	30º (35)
R Rotation (0-30)	30º (Pain at 20)	30º
L Rotation (0-30)	30º	30º
Combined (240º)	225º	230º
Comment	PT: Measured with a standard goniometer. No tenderness, guarding, spasm, abnormal spinal contour. No change in ROM after 3 repetitions. MEB: Increased pain, fatigue, weakness, fatigue, and lack of endurance after three repetitions. No neurologic or gait exam.	No objective pain on motion. No guarding, spasm, or tenderness; motor, sensory (pin prick, vibration, light touch, and position), and reflex exams; motor 5/5 bilaterally. Negative straight leg raise.
§4.71a Rating	10%	10%

The MEB NARSUM) was completed approximately 6 months prior to separation and slightly more than 2 years after he was injured in Afghanistan. The CI reported baseline pain at 3/10 with flare-ups as often as four times per day with pain rated at 8/10 during a flare-up. An MRI of the thoracic spine obtained in September 2007 documented degenerative discs with small disc herniations and annulus tears more evident in T7-8 and T8-9. There was slight flattening of the ventral cord but no cord edema. Spinal canal and neural foramina were all patent in all visualized levels. Mild exaggerated thoracic kyphosis was noted. Surgery was not recommended. Although no neurologic examination was completed for the MEB NARSUM, a normal examination in both upper and lower extremities and normal gait was documented by a neurologist in February 2008. In addition, an electromyogram (EMG) and nerve conduction studies were performed on both lower extremities in March 2008 and the results were normal. At the MEB exam, the CI marked yes to: recurrent back pain or any back problems and numbness and tingling. While the MEB physical exam noted an abnormal spinal exam, it did not elaborate on what abnormalities were present. The C&P exam at the time of separation noted a similar history of injury and failure to respond to conservative therapy. The CI reported intermittent paresthesias and dysthesias in both lower extremities that occurred with walking.

A later VARD from August 2009 that granted individual unemployability also included evidence from VA outpatient treatment records from April through July 2009. These treatment records are unavailable. This VARD states that in May 2009, it was noted that the CI's musculoskeletal complaints were much improved since quitting smoking and losing weight. He had good ROM noted in his joints at that time; however, he reported having continued back and neck pain.

The Board directs attention to its rating recommendation based on the above evidence. Both the PEB and the VA rated the chronic upper back pain condition at 10% using 5237 at the time of separation and from service. This is also the time of entry into the constructed TDRL. While no formal examination was completed at the time of the TDRL exit in April 2009, the VARD from August 2009 reports outpatient VA medical records from April through July 2009 document continued back pain. There is no indication the chronic upper back pain condition either improved or degenerated significantly. 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 chronic upper back pain condition at both the time of entry into the constructed TDRL entry in October 2008 and at the time of exit in April 2009.

Board precedent is that a functional impairment tied to fitness is required to support a recommendation for addition of a peripheral nerve rating at separation. The pain component of a radiculopathy is subsumed under the general spine rating as specified in §4.71a. The sensory component in this case has no functional implications. No motor related symptoms were reported and all neurologic examinations were within normal limits. Additionally EMG and nerve conduction testing was normal. As no evidence of functional impairment exists in this case, the Board cannot support a recommendation for additional rating based on peripheral nerve impairment.

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 the anxiety disorder, NOS, associated with possible cognitive disorder condition was operant in this case and the condition was adjudicated independently of that instruction by the Board. The PEB also did not apply VASRD §4.129 to the CI's anxiety disorder NOS condition adjudication, for which the Board also provides remedy. In the matter of the anxiety disorder, NOS, associated with possible cognitive disorder condition, the Board unanimously recommends an initial TDRL rating of 50% and a 30% permanent rating

at 6 months, coded 9413 IAW VASRD §4.130. In the matter of the chronic neck pain condition, the Board unanimously recommends an initial TDRL rating of 10% and a 10% permanent rating at 6 months, coded 5237 IAW VASRD §4.71a. In the matter of the chronic upper back pain condition, the Board unanimously recommends an initial TDRL rating of 10% and a 10% permanent rating at 6 months, coded 5237 IAW VASRD §4.71a. 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	
		TDRL	PERMANENT
Anxiety Disorder NOS Associated with Possible Cognitive Disorder	9413	50%	30%
Chronic Neck Pain	5237	10%	10%
Chronic Upper Back Pain	5237	10%	10%
	COMBINED	**60%**	**40%**

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20120417, w/atchs
Exhibit B. Service Treatment Record
Exhibit C. Department of Veterans' Affairs Treatment Record

XXXXXXXXX, DAF
President
Physical Disability Board of Review

SFMR-RB

MEMORANDUM FOR Commander, US Army Physical Disability Agency
(TAPD-ZB / XXXXXXX), 2900 Crystal Drive, Suite 300, Arlington, VA 22202-3557

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation for XXXXXXXXXXXXXXXXXX, AR20120022689 (PD201200369)

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 constructively place the individual on the Temporary Disability Retired List (TDRL) at

60% disability for six months effective the date of the individual's original medical separation for disability with severance pay and then following this six month period recharacterize the individual's separation as a permanent disability retirement with the combined disability rating of 40%.

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 temporary disability 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 day following the six month TDRL period.

c. Adjusting pay and allowances accordingly. Pay and allowance adjustment will account for recoupment of severance pay, provide 60% retired pay for the constructive temporary disability retired six month period effective the date of the individual's original medical separation and then payment of permanent disability retired pay at 40% effective the day following the constructive six month TDRL period.

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

XXXXXXXXXXXX
Deputy Assistant Secretary
(Army Review Boards)

CF:
( ) DoD PDBR
( ) DVA