RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1200163 SEPARATION DATE: 20060721

BOARD DATE: 20121005

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SGT/E-5 (11B, Infantry), medically separated for a headache condition from post head trauma and a chronic pain condition from multiple retained shrapnel fragments. The CI sustained multiple blast injuries to include: shrapnel wounds to his face; throat; neck; arms and hands; and a closed head injury to include a skull fracture, broken jaw, broken teeth, and a ruptured eardrum. These injuries occurred while he was deployed to Iraq from an improvised explosive device explosion in January 2004. After a 2 week intensive care unit (ICU) treatment requiring a tracheotomy, feeding tube, chest tube and multiple drainage tubes in his face and neck, the CI was stabilized and transferred for further operative and rehabilitative care. He was hospitalized for 2 more months, and then received extensive outpatient treatment for greater than 2 years. He did not improve adequately with this treatment to meet the physical requirements of his Military Occupational Specialty (MOS) or satisfy physical fitness standards. He was issued a permanent P3/L3/S2 profile and referred for a Medical Evaluation Board (MEB). Persistent left arm weakness and paresthesias/ulnar neuropathy; status post (s/p) large soft tissue injury with forearm tendon repair; chronic debilitating migraine headaches and multiple fragments of retained shrapnel with mild persistent pain were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable. Two other conditions, as identified in the rating chart below, were forwarded on the MEB submission as medically acceptable conditions. The PEB adjudicated debilitating headache post head trauma and bundled the left arm condition with the pain from multiple retained shrapnel fragments conditions as unfitting, rated 10% and 10% respectively, with application of the US Army Physical Disability Agency (USAPDA) pain policy. The remaining conditions were determined to be not unfitting. The CI made no appeals, and was medically separated with a 20% disability rating.

CI CONTENTION: “The disability rating by the Army PEB conflicts significantly with the disability ratings issued by the Department of Veteran Affairs for the same conditions”.

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 conditions posttraumatic stress disorder (PTSD) and mild cognitive deficit 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 conditions. 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 Admin PEB – Dated 20060620** | | | **VA (2 Mos. Pre-separation) – All Effective Date 20060722** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Debilitating Headaches Post Head Trauma Secondary to IED Blast | 8045-9304 | 10% | Migraine Headaches S/P Head Injury | 8100 | 30% | 20060531 |
| Chronic Pain from Multiple Retained Shrapnel Fragments in Multiple Body Locations | 5099-5003 | 10% | Scar, Left Distal Forearm | 5228 | 20% | 20060531 |
| Ulnar Neuropathy, Left Upper Extremity | 8516 | 10% | 20060531 |
| Retained Conjunctival Foreign Body and Corneal Scar  S/P Shrapnel Injury, Right Eye | 6009 | 10% | 20060531 |
| Facial Scar with Shrapnel Fragments | 7800 | 10% | 20060531 |
| Scars, Neck S/P Tracheostomy with Shrapnel Fragments in Neck | 7800 | 10% | 20060531 |
| Scars, Right Hand with Loss of Motion of Thumb | 5228 | 10% | 20060531 |
| Shrapnel Fragments with Scar Formation of the Chest, Upper Extremities and Lower Extremities | 7805 | 0% | 20060531 |
| Scar, Waist | 7805 | 0% | 20060531 |
| Healed Jaw Fracture with Residual Shrapnel | 9999-9904 | 0% | 20060608 |
| Dental Trauma Tooth #7, S/P Shrapnel | 9913 | 0% | 20060608 |
| PTSD | Not Unfitting | | PTSD (Also Claimed as Cognitive Disorder) | 9411 | 30% | 20060531 |
| Mild Cognitive Deficit Secondary to Right Hemisphere Dysfunctions, S/P IED Blast | Not Unfitting | |
| No Additional MEB/PEB Entries | | | Constant Tinnitus, Right Ear | 6260 | 10% | 20060531 |
| Not Service-Connected x 3 | | | 20060531 |
| **Combined: 20%** | | | **Combined: 80%** | | | |

ANALYSIS SUMMARY: 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 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. 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.

Headache Condition Post Head Trauma. The CI sustained an IED blast 2 January 2004 which resulted in a closed head injury including a basilar skull fracture, a facial fracture with dental trauma, and a ruptured eardrum. The facial fracture and dental trauma required operative intervention and the remaining head injuries required conservative treatment with pain medications. After discontinuing the pain medication the CI noted the onset of chronic daily headaches and severe incapacitating headaches. The CI was evaluated by Neurology and was diagnosed and treated for chronic recurrent migraine without aura and chronic recurrent muscle contraction tension headaches. The CI responded to preventive treatment with the medication Nortriptyline and the abortive treatment with the medications Fioricet, Zomig and Midrin. The commander’s statement documented the CI had migraine headaches each week, with no set pattern and required him to leave his duty assignment, take the prescribed medications and rest.

At the MEB exam, the CI reported he continued to suffer from chronic daily headaches which were significant and had improved to some degree with medication, however he continued to have headaches on a frequent enough basis of several times a week. In the Neurology addendum for the MEB the CI reported the daily severe headache, which would reached a pain level of 3 of 10 in intensity, lasted 6-8 hours and responded to the medications Fiorcet and Zomig. The second, less intense headache responded to the medication Midrin. He started a trial of the preventive medication, Topamax, which decreased the frequency and intensity of the severe headache. The MEB physical exam demonstrated normal neuromuscular findings and a normal mini mental status exam. The Neurologist opined the severe headaches occurred at least 2-4 times a month and he will likely require continued pharmacotherapy for the remainder of his life. At the VA Compensation and Pension (C&P) exam, 2 months prior to separation, the CI reported no additional history already reported in the MEB exam. The C&P exam demonstrated no additional physical findings. The skull X-ray revealed evidence of old shrapnel wound with multiple scattered metallic fragments in the right facial structures and otherwise a normal skull series. The examiner diagnosed migraine headaches with a frequency of 4 times a month, responsive to therapy without complications and milder headaches of unspecified nature, managed with mild analgesics without complications.

The Board directs attention to its rating recommendation based on the above evidence. The PEB and VA chose different coding options for the condition, which had significant implications on the rating for the Board to consider. The PEB chose to code analogously to 8045 code (Residuals of Traumatic Brain Injury [TBI]) which falls under §4.124a—Schedule of Ratings–Neurological Conditions and Convulsive Disorders with the 9304 code (Dementia due to head trauma), which falls under §4.130 Schedule of Ratings-Mental Disorders. The Board agreed while the evidence clearly did not support dementia the evidence did support a significant head injury which clinically is synonymous to a TBI. Therefore the Board agreed the PEB was consistent with applying the 8045 code to classify the disabling migraine headaches and the Board notes that the maximum allowable for this code is 10% for the CI’s separation date. The VA coded 8100 (Migraine Headaches) and rated 30%. The Board’s rating recommendation for 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. Additionally, the VA Training letter TL07-05 (dated 31 August 2007) went further in recommending separate ratings under the applicable codes for each ratable component of TBI in evidence; e.g., headache, tinnitus, dizziness, etc. Therefore the Board agreed based on the CI’s date of separation (21 July 2006) that the 8045-9304 coding is correctly applied the 8100 code could not be considered for a higher rating. 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 post head trauma condition.

Chronic Pain from Multiple Retained Shrapnel Fragments. The PEB combined the chronic pain from multiple retained shrapnel fragments to include the left arm pain and weakness (left arm condition) as a single unfitting condition, coded analogously to 5003 and rated 0%, relying on the USAPDA pain policy for not applying separately compensable VASRD codes. The Board must apply separate codes and ratings in its recommendations if compensable ratings for each condition are achieved IAW VASRD §4.71a. As elaborated below, a separate compensable rating for the left arm condition is supported by the evidence in this case. Having determined that separate ratings are warranted; however, the Board must also satisfy the requirement that each ‘unbundled’ condition was unfitting in and of itself. Not uncommonly, this approach by the PEB reflects its judgment that the constellation of conditions was unfitting and that there was no need for separate fitness adjudications, not a judgment that each condition was independently unfitting. The Board therefore exercises the prerogative of separate fitness recommendations in this circumstance, with the caveat that its recommendations may not produce a lower combined rating than that of the PEB. In this case, the left arm condition was well supported as unfitting by evidence from the narrative summary (NARSUM) and service treatment record (STR). The other shrapnel injuries reflected pain from scars and foreign bodies and the Board specifically looked at all these. The Board agreed that separately none of the remaining shrapnel injuries were well supported as separately unfitting. After deliberation, all members agreed that (more likely than not) the left arm condition, in isolation, would have rendered the CI incapable of continued service within his MOS; and, accordingly merits a separate disability rating.

Left Arm Condition. The CI is right-hand dominant who sustained multiple shrapnel wounds, multiple blast injuries from an IED explosion to include a flesh wound ( a soft tissue injury of his left forearm) measuring 8 cm x 8cm with flexor tendon, ulnar artery and radial nerve damage for which he underwent a protracted operative repair. The flesh wound required multiple procedures for irrigation and debridement of the volar (anterior) aspect of the forearm, and then required a skin graft (a groin flap transfer) attaching his left wrist to his left hip. This remained in place for 3 weeks after which it was operatively divided with success. In March 2004 an occupational therapy found in the STR documented the CI had difficulties with his basic activities of daily living (ADL’s) and lack of sensation of the flap. A March 2004 electromyogram (EMG) of the left hand revealed severe demyelinating and axonal median nerve neuropathy, which was followed conservatively per Orthopedics. Due to persistent pain another EMG in July 2004 revealed normal sensory conduction of his ulnar nerve, severe demyelinating and axonal median nerve neuropathy with significant clinical and electrodiagnostic resolution since his prior study in March 2004. The CI continued to have surgery on the left hand for foreign body removal with the last one in evidence in October 2004. In January 2005 he was noted to have adhesions and subjective ulnar neuropathy and underwent a recommended flap defattening and tenolysis with ulnar neurolysis procedure with noted improvement in his ulnar neuropathy and marked improvement in his range-of-motion (ROM). He underwent a similar procedure for the radial side of the flap (flap defattening and tenolysis with median neurolysis) in June 2005. However he continued to have persistent pain. His profile specifically listed left arm pain and weakness s/pshrapnel injury with tendon damage and included the following limitations: no lifting greater than two pounds left hand, unable to construct an individual fighting position and no pushups. The commander’s statement documented due to the CI’s injuries he has nerve damage, loss of strength and immobility causing him extreme pain and frustration. He has been compliant with treatment and “the Physician Assistant at Robinson Health Clinic” expressed concern that the mobility in his hands may never be fully restored.

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.

|  |  |  |
| --- | --- | --- |
| Left Wrist ROM | Ortho ~11 Mo. Pre-Sep | OT for MEB ~8 Mo. Pre-Sep |
| Dorsiflexion (0-70⁰) | 45⁰ | 45⁰/45⁰/50⁰ |
| Palmar Flexion (0-80⁰) | 55⁰ | 50⁰/55⁰/55⁰ |
| Ulnar Deviation (0-45⁰) | 15⁰ | 12⁰/15⁰/12⁰ |
| Radial Deviation (0-20⁰) | 15⁰ | 10⁰/5⁰/10⁰ |
| Comment |  |  |
| §4.71a Rating | 10%\* | 10%\* |

\*Conceding §4.59 painful motion

At the MEB exam, 4 months prior to separation, the CI reported significant weakness with respect to left as opposed to right-sided forearm strength, which limited him in doing many of his normal functions. The MEB physical exam demonstrated a visible surgical scar to the volar aspect of the left forearm with hypothesia to the distal hand in an ulnar distribution, grip strength testing displayed clear weakness on the left relative to the right side. Additionally, ROM testing appeared to be relatively recovered s/p tendon transfer. The photographs in evidence depicted a residual large oval shaped scar on the volar aspect of his left forearm proximal to his wrist. The occupation therapy medical evaluation for the MEB, eight months prior to separation, demonstrated supination and pronation of the right wrist 85/80 respectively. The left side showed supination and pronation of 65/42 respectively, grip strength showed the most significant disparity, right 100 pounds and left 58 pounds; and pincher pincher strength averaged of 14.3 pounds on the right and 7 pounds on the left. The occupational therapy examiner opined the patient, although having made significant improvement, still had weakness in the left hand compared to the right. The CI also had problems with hypo-anesthesia of areas of the flap and the distal hand that significantly impair his ability to perform simple working tasks. The orthopedic addendum completed for the MEB, 10 months prior to separation, documented the CI’s postoperative rehabilitation and recovery was dramatic for excellent function and restoration. On his last examination performed in August 2005 there were very minimal proximal forearm adhesions in his remaining proximal scars, but no adhesions under the well-contoured volar forearm flap, which had an excellent contour and viability. The median nerve and ulnar nerve functions were normal. He had full pronation and supination. The orthopedic examiner opined the CI was doing well after left volar forearm flap, excellent cosmetic appearance of his scars and function on the left with no pain or soft tissue swelling and that he was neurovascularly intact. The examiner further recommended continued occupational therapy and rehabilitation and that he be referred to TDRL status as his present condition was likely to improve even farther. At the C&P exam 2 months prior to separation, the CI reported no new additional history. He reported enjoying fishing, lawn work, football, baseball and basketball and could sustain heavy physical activity without immediate distress. The C&P exam demonstrated multiple shrapnel scars over the chest, upper and lower extremities, and the face and head and surgical scars of the left forearm, left waist and right hand that were healthy in appearance and texture. There were sensory deficits of the left forearm extending to his left hand and there was loss of movement of both thumbs so that the right and left thumb could not reach the base of the fifth finger, only reaching half the distance and without Deluca observations. However the actual ROM measurements of the right and left thumb were documented as normal. There was loss of strength in the left forearm and the left hand had a motor deficit, 3 of 5, with motor testing. X-rays of the right and left hand revealed scattered metallic fragments status post old shrapnel wound.

The Board directs attention to its rating recommendations based on the above evidence which includes consideration of functional loss lAW VASRD §4.10, §4.40, §4.45 and §4.59. The Board notes that the MEB was complete, well documented, and compliant with VASRD §4.46 (accurate measurement). The exam was similar in terms to the ratable data in the occupational therapy exam completed for the MEB, consistent with corroborating evidence, consistent with the other collateral physical findings, consistent with the diagnostic and clinical pathology in evidence and more complete than the VA exam. While the orthopedic exam cited excellent postsurgical results, the Board notes the limited wrist ROM’s documented in the orthopedic exam corroborated with the OT MEB exam and further the orthopedic examiner opined the injury needed more time to recover and recommended the CI be placed on a TDRL. Therefore, based on all evidence and associated conclusions just elaborated, the Board is assigning preponderant probative value to the MEB evaluation. The PEB and VA chose different coding options for the multiple retained shrapnel injuries condition. The PEB bundled the shrapnel conditions, rated 10% and coded with the 5003 code (Arthritis, degenerative) which included the left forearm condition IAW VASRD §4.71a—Schedule of Ratings–Musculoskeletal System. The VA coded and rated each shrapnel injury. The Board notes the VA unbundled each system impacting the left forearm condition to maximize the rating for the CI. The VA first rated scar, left distal forearm 20% with code 5228 (Thumb, limitation of motion) IAW §4.71a—Schedule of ratings–musculoskeletal system. While the decision cited the residual scar limiting motion with an area or areas exceeding 12 square inches IAW §4.118—Schedule of ratings–skin, the VA chose to use the musculoskeletal code for the disabling effect the scar caused, limitation of motion of the thumb, likely for the higher rating. The VA next rated ulnar neuropathy left upper extremity 10% with code 8516 (Ulnar nerve, paralysis of) IAW §4.124a—Schedule of ratings–neurological conditions and convulsive disorders for a §4.25 combined rating of 30%. The Board deliberated on how best to code the CI’s left forearm condition. By precedent, the Board does not recommend separation rating for scars unless their presence imposes a direct on limitation on fitness. There was clear evidence that the functional impairments from the left forearm injury were pain, weakness of the forearm, weakness of the hand affecting grip strength, non compensable limited ROM of the left wrist and sensory deficits specifically in the ulnar nerve distribution. The Board agreed the 5307 muscle code (Group VII Function: Flexion of wrist and fingers) IAW §4.73—Schedule of Ratings–Muscle Injuries best captures the weak flexion injuries of the wrist and fingers and limitation of motion; therefore, IAW §4.14, (avoidance of pyramiding) the Board did not consider a scar code. When considering the application of §4.56—evaluation of muscle disabilities, the Board notes in this case the type of injury, the extensive, prolonged treatment of the left forearm, the CI’s inability to function within his MOS, and the objective findings of pain, decreased strength, as well as noncompensable ROM loss best fit the moderately severe disability of muscles. Additionally, the Board considered VASRD §4.55 principles of combined ratings for muscle injuries specifically; however, “(a) A muscle injury rating will not be combined with a peripheral nerve paralysis rating of the same body part, unless the injuries affect entirely different functions.” The Board agreed the residual median nerve impairments (sensory, pain and weakness) affected similar functions of muscle Group VII and therefore the Board could not invoke §4.55 for additional rating. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a combined disability rating of 20% for the left forearm condition.

Contended PEB Conditions. The contended conditions adjudicated as not unfitting by the PEB were PTSD and cognitive deficit. 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 MEB forwarded PTSD as not disqualifying and the PEB adjudicated as not unfitting. The condition was profiled as an S2 not an S3 profile. An S3 profile per AR-40-501 allows the utilization of a service member under specific conditions after a remission from a psychiatric illness. The Board looked for evidence to support an S3 profile and found the profile did limit him from being unable to carry and fire a weapon however there is speculation if this was due to his multiple shrapnel wounds or his mental health condition or both. The Board did not find any other evidence that prevented the CI from certain duties or citation of duty assignments where outpatient psychiatric treatment was required. The CI was diagnosed with PTSD in December 2004 by psychiatry and there are no further STR’s in evidence after this intake until the MEB exam. The commander’s statement documented according to the division mental health provider the CI will suffer from PTSD for an uncertain amount of time and that he was taking mental health medications for this condition. The commander further documented that the CI was currently attached to Bravo Company, but could not perform duties for the company “because of the constant fast paced physical and mental stress…day in and day out”. The MEB documented the CI had been under consistent psychiatric care and was under both medical therapy and psychotherapy and that care would be ongoing. The MEB physical exam demonstrated a well adjusted CI without evidence of a MSE. The neuropsychiatry consult completed in October 2005, nine months prior to separation, documented symptoms of; intrusive recollections, detachment from others, avoidant behaviors, foreshortened future, sleep problems, irritability and acts of hypervigilance. The neuropsychiatrist opined technically he did not meet boardable criteria; he had a significant case of PTSD, required medications for sleep and for his secondary mood disorder and likely needed continued ongoing therapy. The Board looked for evidence to support interference of his duty from this condition, outside the reference in the commander’s statement, and did not find any. This condition was reviewed by the action officer and carefully considered by the Board. After due deliberation in consideration of the preponderance of the evidence and weighing higher than reasonable doubt, VASRD §4.3, the Board majority concluded that there was insufficient cause to recommend a change in the PEB fitness determination for the contended PTSD condition. The mild cognitive deficit secondary to right hemisphere dysfunctions, s/p IED blast condition was not profiled; was not implicated in the commander’s statement; and, was not 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. 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 PTSD and cognitive deficit; therefore, no additional disability rating can be recommended.

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. As discussed above, PEB reliance on the USAPDA pain policy for rating headache condition and chronic pain from multiple retained shrapnel condition was operant in this case and the condition was adjudicated independently of that policy by the Board. In the matter of the headache condition and IAW the VASRD at the time of separation with consideration of the VA Training and Fast letters, the Board unanimously recommends no change in the PEB adjudication. In the matter of the left arm condition, the Board unanimously recommends a disability rating of 20%, coded 5307 IAW VASRD §4.73. In the matter of the chronic pain multiple shrapnel condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the contended PTSD condition, the Board by a vote of 2:1 recommends no change in the PEB adjudication. The single voter for dissent (who recommended there was sufficient cause to recommend a change in the PEB fitness determination for the PTSD condition and further recommended a TDRL rating of 50% IAW §4.129 and a permanent rating of 30%, coded 9411 IAW VASRD §4.130). The single voter did not elect to submit a minority opinion. In the matter of the contended mild cognitive deficit condition, the Board unanimously recommends no change from the PEB determination as not unfitting. 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** |
| Chronic Debilitating Headaches Post Head Trauma Secondary to IED Blast Condition | 8045-9304 | 10% |
| Persistent Left Arm Weakness S/P Large Soft Tissue Injury from IED Injury with S/P Forearm Tendon Transfer | 5307 | 20% |
| Chronic Pain from Multiple Retained Shrapnel Fragments in Multiple Body Locations | 5099-5003 | 10% |
| **COMBINED** | **40%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20120320, 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, AR20120019887 (PD201200163)

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 40% 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 40% 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 XXXXXXXXXXXXXXXXXX

Deputy Assistant Secretary

(Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA