RECORD OF PROCEEDINGS
PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXXX
CASE NUMBER: PD1200235
BOARD DATE: 20130221

BRANCH OF SERVICE: ARMY
SEPARATION DATE: 20040908

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SGT/E-5 (88M20/Motor Transport Operator) medically separated for bipolar disorder and chronic subjective back pain. The CI suffered a severe back injury when he was in a motor vehicle accident (MVA) with his truck in Iraq. This accident triggered a significant mood disturbance as well as exacerbated a history of intermittent explosive disorder-type symptoms. Despite medications, steroid injections, physical therapy (PT) for the back injury and intensive mental health treatment for the bipolar disorder, the CI failed to meet the physical requirements of his Military Occupational Specialty (MOS) or satisfy physical fitness standards. He was issued a permanent L3/S4 profile and referred for a Medical Evaluation Board (MEB). The MEB forwarded AXIS I: bipolar disorder not otherwise specified (NOS) and low back pain (LBP) secondary to L4-L5 disk herniation to the Informal Physical Evaluation Board (IPEB). The MEB forwarded no other conditions for IPEB adjudication. The IPEB adjudicated the bipolar disorder and chronic subjective back pain without neurological abnormality conditions as unfitting, rated 10% and 10%, with application of the Veteran's Affairs Schedule for Rating Disabilities (VASRD). The CI appealed to the Formal PEB (FPEB) that reaffirmed the IPEB's adjudication. The CI filed a Nonconcurrence to the FPEB findings and a Congressional Inquiry was initiated on his behalf. After review by the PEB and the US Army Physical Disability Agency (USAPDA), an Administrative Correction FPEB DA Form 199 was issued with no change in the disability ratings. The CI appealed to the Army Board for Correction of Military Records (ABCMR). The ABCMR denied the application and the CI was then medically separated with a combined 20% disability rating.

CI CONTENTION: "1. UNDERRATED ON THE FOLLOWING CONDITIONS: PTSD 10% AND BACK CONDITION 10%. 2. WHILE SERVING CONTINUOUS TREATMENT FOR MIGRAINES WAS PROVIDED BUT WAS NEVER RATED OR ADRESSED. 3. NOT RATED/TESTED FOR: SLEEP APNEA, TINNITUS AND TRAUMATIC BRAIN INJURY. DUE TO MY TBI I'M CURRENTLY FACING LOSS OF VISION THAT'S BEEN ADDRESSED BY THE VA."

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 mental health (bipolar disorder) and back conditions requested for consideration meet the criteria prescribed in DoDI 6040.44 for Board purview, and are accordingly addressed below. The requested conditions of posttraumatic stress disorder (PTSD), migraines, sleep apnea, tinnitus, traumatic brain injury (TBI), and vision problems are not within the Board's purview.

RATING COMPARISON:

Service FPEB – Dated 20040604			VA (6 Mos. Post-Separation) – All Effective Date 20040909			
Condition	**Code**	**Rating**	**Condition**	**Code**	**Rating**	**Exam**
Bipolar Disorder	9432	10%	Bipolar Disorder	9432	10%*	STR
Chronic Subjective Back Pain without Neurologic Abnormality	5299-5237	10%	Herniated Nucleus Pulposus, L4-5 and L5-S1	5299-5243	20%	STR
↓No Additional MEB/PEB Entries↓			0% X 1 / Not Service-Connected x 2			N/A
Combined: 20%			**Combined: 30%**			

*Bipolar D/O rating increased to 30% effective 20050208 based on first Mental Health C&P exam 20050328. Previous rating was based on service treatment record (STR). Later changed to bipolar D/O and PTSD and increased to 50% effective 20080229 based on VA treatment records and a C&P examination from 20080829.

ANALYSIS SUMMARY: The Board's authority as defined in DoDI 6040.44, resides in evaluating the fairness of Disability Evaluation System (DES) fitness determinations and rating decisions for disability at the time of separation. 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. Post-separation evidence is probative only to the extent that it reasonably reflects the disability and fitness implications at the time of separation.

Bipolar Disorder Condition. The CI was first evaluated by combat stress in theater after the MVA triggered significant mood disturbance. In May 2003, the mental health screener noted the CI had moderate symptoms and further psychological evaluation was indicated. The MEB narrative summary (NARSUM), completed 7 months prior to separation, documented that the CI was referred for psychiatric evaluation during the medical processing that occurred when he was evacuated to Fort Campbell KY for this back condition. The CI was first seen by mental health in October 2003. He first saw the provider that completed the MEB NARSUM on 10 November 2003 and endorsed mood swings. The CI was seen for follow-up 4 days later and although his judgment and insight appeared appropriate, the examiner diagnosed "mood and anxiety disorder not otherwise specified with elements of Post-Traumatic Stress Disorder (PTSD) and then again his history probably consistent with intermittent explosive disorder." He was eventually diagnosed with bipolar disorder. Although the NARSUM does not state when Lithium was started, the CI had a therapeutic level on 3 December 2003. The CI was issued a permanent S4 profile by psychiatry in November 2003 and the MEB was initiated. The profile was combined with the permanent L3 profile for back pain in late December 2003.

In mid-December 2003, the CI continued to endorse feelings of anxiety and fatigue; however, on follow-up with the psychiatrist he seemed to be responding to a trial of Lithium. He had also started Gabapentin for his chronic pain and this may have benefitted his mental health condition. The MEB NARSUM mental status examination (MSE) was completed on 26 January 2004, approximately 7 months prior to separation. At that time, the CI reported he was still depressed and it had been a difficult month because he had re-injured his back. He also described an incident where his dog acted out and he thought he would have killed the dog if his wife had not been there. He thought the Lithium was helping and wanted to continue taking it along with his gabapentin. He was also taking Seroquel to help with insomnia. At the time of the MEB, the MSE noted a tired or depressed mood and his affect was both tired and restricted. He admitted to feeling being watched and denied auditory or visual hallucinations but at times heard weird noises. He was considered a highly reliable historian and his history was corroborated by his wife. The diagnosis was bipolar disorder NOS, moderate, with elements of intermittent explosive disorder and PTSD subsumed under the bipolar disorder and not warranting a separate diagnosis. The condition was considered to have marked impairment for military duty and definite impairment for social and industrial adaptability. The condition was manifested by persistent irritable moods states sometimes associated with high energy and

high activities level suggestive of hypomania as well as depressed and tired states where he would spend most of the day inactive with difficulty concentrating, difficulty sleeping, and difficulty with goal directed activity. He also noted grossly disproportionate responses to minor irritations to which he has insight. The examiner also noted anti-social traits, but doubted the presence of a true antisocial personality disorder. The overall Global Assessment of Functioning (GAF) was 55, in the range of moderate symptoms.

A VA mental health clinic note in January 2005 noted that the CI had just been released from a 6-day inpatient stay at Cumberland Hall for depression and suicidal ideations. At the clinic visit, the CI endorsed symptoms of paranoia, sleep disturbances, nightmares, exaggerated startle responses, self-isolation, waking up from sleep fighting-causing him to hit the wall and punch his wife, and decreased appetite. The examiner diagnosed major depressive disorder (MDD), severe and recurrent, without psychotic features and PTSD. The GAF was 50--in the range of serious symptoms. A VA psychiatric treatment note from 4 March 2005 documented significant symptoms of both bipolar disorder and PTSD. The MSE noted a dysphoric mood and a blunted flat affect. He continued to have feelings of mild paranoia thinking people were watching him or looking at him. No GAF was noted but at the time of this examination, the CI was pursuing a degree in nursing, attending school at night, and he reported he was doing very well in his academic work. He also reported he was going to start working full time at a Wal-Mart distribution center. He had been working with his friends doing various odd jobs.

The VA mental health Compensation & Pension (C&P) examination approximately 7 months after separation noted a significant inpatient hospitalization that took place 28 April 2000 through 3 January 2005 for depression and suicidal ideations. The MSE documented a depressed mood and a dysphoric affect. The CI had difficulty recalling historic events and his thought content was significant for some paranoia with thoughts that people are out to get him. He also reported he had been involved in almost ten physically violent altercations after he had been discharged from the military. Additionally, the CI reported feelings of depressed mood, dysphoric affect, paranoia, mood swings, nightmares, loss of appetite, loss of interest, irritability and anger, nervousness, autonomic hyperarousal, feelings of detachment from others, feelings of internal numbness, feelings of nervousness, and feelings of elevated mood at times. A Personality Assessment Inventory (PAI) was completed and while there was some evidence the CI did not answer in a completely forthright manner and that could lead to inaccurate impressions, there was no evidence he attempted to either exaggerate or minimize his symptoms. The results appeared to be congruent with other information from the available record, including problems with depression, isolation, insomnia, interpersonal relationships, ability to control his own impulses, and fairly rapid and extreme mood swings. The examiner noted a diagnosis of AXIS I bipolar II disorder, most recent episode depressed, moderate but previously severe with psychotic features. He also noted a second AXIS I diagnosis of PTSD, mild, and an AXIS IV diagnosis of marital problems, inadequate social support, and difficulty maintaining employment. The overall GAF was 55 in the range of moderate symptoms. The C&P examination noted the CI had begun working as a security guard in January 2005, but was fired for being late multiple times. Two weeks prior to the examination, he had started working at a Wal-Mart distribution center. He also reported working on his RN degree. There is no information on how the CI was performing either at work or at school. The CI was married but had marital difficulties and he reported he had a few friends. The next C&P examination was completed in August 2008 and it included documentation of a second hospitalization for suicidal ideation in 2007. He reported he had depressed moods that lasted a few weeks and stated he typically did not go to work or would leave early during these periods. Occupation was listed as full time clerical for the last one to 2 years with at least 12 weeks of work lost due to psychiatric problems. The exam also noted the CI was going to college, one class at a time, for human services to work with veterans. There was no mention of a nursing degree.

The Board directs its attention to the question of applicability of §4.129, mental disorders due to traumatic stress, and the rating recommendation based on the evidence just described. The PEB rating, as described above, was derived from DoDI 1332.39 and preceded the promulgation of the National Defense Authorization Act (NDAA) 2008 mandate for DoD adherence to VASRD §4.129. The Board noted that psychiatric NARSUM stated the CI's bipolar disorder was triggered by the MVA in Iraq. While the MEB psychiatrist opined a separate diagnosis of PTSD was not warranted, the PEB included this diagnosis along with bipolar disorder as the CI's unfitting condition. At the C&P examination, a moderate bipolar disorder was diagnosed along with mild PTSD. However, a diagnosis of PTSD is not required for application of VASRD §4.129. The VASRD states, "When a 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, the rating agency shall assign an evaluation of not less than 50 percent and schedule an examination within the six month period following the veteran's discharge to determine whether a change in evaluation is warranted." IAW DoDI 6040.44 and VASRD §4.129, the Board is obligated to recommend a minimum 50% rating for a retroactive 6-month period on the Temporary Disability Retired List (TDRL). Whether or not the CI is considered to have had PTSD as a separate diagnosis at the time of separation, the Board determined that §4.129 should be applied. The psychiatric MEB NARSUM does not support a rating greater than 50% at the time of separation and therefore, an initial 50% disability rating for code 9432 (Bipolar disorder) is recommended.

The Board must then determine the most appropriate fit with VASRD 4.130 criteria at 6 months for its permanent rating recommendation. The proximate source of comprehensive evidence on which to base the permanent rating recommendation in this case is the C&P examination performed approximately 7 months after separation. The Board directs attention to its permanent rating recommendation based on the above evidence. The VA chose the same disability code as the PEB, 9432 (Bipolar D/O). The VA initially rated the bipolar disorder condition 10% based on the service treatment record (STR), however the 5 May 2005 VARD increased the rating to 30% effective 8 February 2005 based on the initial C&P mental health examination completed in March 2005, approximately 7 months after separation.

The Board agreed that the mental health C&P examination from March 2005 was closest to the 6-month point after separation and therefore this examination is assigned the greatest probative value in determining the permanent rating recommendation. Based on this examination and VA treatment records from December 2004 to January 2005 (3 to 4 months after separation), the VA assigned a 30% disability rating for 9432 (bipolar disorder). The rating decision noted a moderate impairment in the vocational arena and a mild to moderate impairment in the social arena.

All Board members agreed that the 50% threshold was not approached. The Board then considered the criteria of the 30% rating [Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal)] versus the 10% rating (occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or; symptoms controlled by continuous medication). The C&P examiner had opined the CI's post-military psychosocial functioning seemed fair to poor as evidenced by the fact that the CI had problems containing his anger in public, he had lost interest in activities, had some difficulty maintaining employment, and had marital difficulties. The CI also had continued symptoms of depression, paranoia, mood swings, nightmares, loss of appetite, loss of interest in activities, irritability and anger, nervousness, autonomic hyperarousal, detachment from others, internal numbness, nervousness, and elevated mood at times. There is no evidence of any symptom free periods and his symptoms were neither mild nor transient. While the record does show employment and attendance at school, the available

facts suggest he was not successful in either endeavor. He was not able to maintain employment at any one place. It also appears that he was not able to maintain any significant load of coursework and changed from studying nursing to human services, a much less intellectually challenging major. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a permanent disability rating of 30% for the bipolar disorder condition.

Chronic Subjective Back Pain Condition. There were two 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 ~8 Months Pre-Separation	VA C&P ~45 Months Post-Separation
Flexion (90º Normal)	35º	60º
Ext (0-30)	10º	15º
R Lat Flex (0-30)	15º with pain	30º
L Lat Flex 0-30)	10º with pain	30º
R Rotation (0-30)	30° (45º) with pain	30º
L Rotation (0-30)	30° (45º)	30º
Combined (240º)	140º	195º
Comment	PT exam: Measured with inclinometer; slow antalgic gait with cane; cogwheel movements with extension; pain 10/10. NARSUM: "constant moderate pain with occasional episodes marked pain"	Cane; guarding; pain with motion tenderness; antalgic gait;
§4.71a Rating	20% (PEB 10%)	20%

The CI's back pain is well documented in the numerous entries in the STR dated from June 1999 through August 2006. After the accident in Iraq, the CI was evaluated in theater by Neurology in May 2003 for right lower extremity radicular symptoms. He was then evacuated to Fort Campbell for further evaluation. Magnetic resonance imaging (MRI) in June 2003 revealed abnormal disc herniations with broad based disc bulges at L4-5 level and L5-S1, along with mild bilateral foraminal stenosis and ventral thecal sac effacement, but without significant spinal stenosis at L4-5 and L5-S1. The orthopedics evaluation in June 2003 noted normal motor and sensory exams and the CI was referred to physical therapy and pain management. A repeat MRI in September 2003 was unchanged from the initial exam. A third MRI in May 2004 also documented right paracentral herniated disks at L4 and L5. Lumbar X-rays from May 2004 were normal with a questionable narrowing of the L5 disk space. The CI continued with complaints of severe LBP shooting down to the lower extremities greater on the right with tingling, numbness, and weakness in the legs. An electromyogram and nerve conduction study (EMG/NCS) study of bilateral lower extremities in September 2003 demonstrated no evidence of radiculopathy from L2 to S1 and no evidence of bilateral lower extremity peripheral sensory motor neuropathy, peroneal neuropathy, or tibial neuropathy. A repeat EMG/NCS in October 2003 was also normal. A neurologic evaluation in October 2003 documented a normal base and antalgic baseline gait with careful but symmetric step length and arm swing, and normal turn. The CI was able to toe, heel, and tandem walk. Straight leg raise (SLR) testing produced low back discomfort without radiation at 80 degrees bilaterally. Reflexes were symmetric bilaterally with lower extremities 2+ and 3 and upper extremities 1+ and 2. Sensory exam of the lower extremities was normal except pinprick sensation decreased over the right foot, in the medial and lateral surfaces, medial malleolus, and sole. Motor exam was 5/5 bilaterally except 4/5 for the right quadriceps and 5-/5 for the right hamstring and ankle eversion.

The MEB NARSUM completed 7 months prior to separation documented that the CI had severe pain with numbness and tingling that radiated down the left side of his body when he walked and that he required a cane to help support the left side of his body while he walked. At the time of this NARSUM, the CI had tried and failed extensive rehabilitation, traction, electrical

stimulation epidural steroid blocks, and multiple nonsteroidal anti-inflammatory drugs (NSAIDS). The MEB NARSUM reported exam findings from a physical therapy evaluation on 26 January 2004 and the information from the source document are summarized in the chart above. These ROM measurements were made with an inclinometer, not a goniometer. The CI was evaluated by the VA to establish care in December 2004 but no C&P exam was completed until June 2008. The examiner in December 2004 noted complaints of radicular symptoms however, gait, reflexes, motor, and sensory findings were normal. A repeat EMG done in January 2005 revealed normal findings in the left lower extremity (the right lower extremity was not tested).

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. There was no motor impairment in this case and the CI underwent multiple EMGs before and after separation that were all normal. Since no evidence of functional impairment exists in this case, the Board cannot support a recommendation for additional rating based on peripheral nerve impairment.

The Board directs attention to its rating recommendation based on the above evidence. The FPEB coded the chronic subjective back pain condition analogous to 5237 (Lumbosacral or cervical strain) and rated 10%. The VA coded the back condition analogous to 5243 (Intervertebral disc syndrome) and rated 20% based on information from the STR. With the constructed TDRL period required by VASRD §4.129, the Board must determine disability ratings relevant for the time of separation and entrance onto the constructed TDRL period and for the time at the end of this constructed TDRL. The General Rating Formula for Diseases and Injuries of the Spine considers the CI's pain symptoms "With or without symptoms such as pain (whether or not it radiates), stiffness, or aching in the area of the spine affected by residuals of injury or disease." The MEB NARSUM examination met the 20% criteria "Forward flexion of the thoracolumbar spine greater than 30 degrees but not greater than 60 degrees." While the NARSUM ROM measurements were made with an inclinometer and not a goniometer, the record supports the finding that the CI had severely limited ROM on flexion with an antalgic gait and he required the use of a cane to help support the left side of his body when walking. An antalgic gait due to muscle spasm or guarding also warrants a 20% rating. While there is no evidence of muscle spasm, the CI did have painful motion and guarding can be assumed to have been present. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (Reasonable doubt), the Board recommends a disability rating of 20% for the chronic subjective back pain condition without neurologic abnormality at the time of entrance into the constructed TDRL period.

Although the first C&P examination was not completed until June 2008, the VA treatment record documents a continuous history treatment for significant of back pain. The 2008 C&P examination ROM measurements were made with a goniometer and they support a 20% rating. This examination also documents a persistent antalgic gait. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a permanent disability rating of 20% for the chronic subjective back pain condition without neurologic abnormality.

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 bipolar disorder condition, the Board unanimously

recommends a TDRL disability rating of 50%, IAW with VASRD §4.129 and unanimously recommends a permanent disability rating of 30%, coded 9432 IAW VASRD §4.130. In the matter of the chronic subjective back pain condition, the Board unanimously recommends a 20% disability rating for both the TDRL and the permanent disability ratings, with both coded 5299-5237 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
Bipolar Disorder	9432	50%	30%
Chronic Subjective Back Pain without Neurologic Abnormality	5299-5237	20%	20%
	COMBINED	**60%**	**40%**

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 2010307
Exhibit B. Service Treatment Record
Exhibit C. Department of Veterans' Affairs Treatment Record

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Acting Director
Physical Disability Board of Review

SFMR-RB

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

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation for xxxxxxxxxxxxxxxxxxxxxxx, AR20130003762 (PD201200235)

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

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Deputy Assistant Secretary
(Army Review Boards)