Social Security Administration
Compassionate Allowance Outreach Hearing on Traumatic Brain Injury and Stroke
Tuesday, November 18, 2008

Panel I: **TBI and PTSD: As Seen from Different Perspectives**

Speaker: Carla Sarno, MD

Chief Psychiatric Consultant, State of Maryland Disability Determination Service

Biography:

Dr. Sarno is the Chief Psychiatric Consultant for the State of Maryland Disability Determination Services. She has been with the agency for 9 years. She obtained her medical degree from St. George's University School of Medicine, completed her adult psychiatry training through Beth Israel Medical Center in New York City, and her Child and Adolescent Psychiatry fellowship through the Medical University of South Carolina. She has been in practice since 1987. She is Board Certified by the American Board of Psychiatry and Neurology in General Psychiatry and in Adolescent and Child Psychiatry. She has held various positions through the years including working as an outpatient clinical psychiatrist in the VA Hospital in Charleston, South Carolina and as Medical Director of the Child and Adolescent Outpatient clinic at the University of Maryland Medical Systems. She has been a member of the American Academy of Child and Adolescent Psychiatry and is currently a member of the American Medical Association. Dr. Sarno is employed on a part-time basis by the Sheppard Pratt Health Systems in Baltimore, MD and performs after hour crisis evaluations. She is employed full-time by the Maryland DDS and supervises fifteen psychiatric and psychological consultants who all review and render decisions on psychiatric disability claims per SSA regulations. Most recently Dr. Sarno has consulted with SSA's Military Casualty Team and has written an in-service training video on "Post-traumatic Stress Disorder in Military Casualty Claims." She has also lectured on mild TBI and PTSD in Wounded Warriors for the agency.

Testimony of Carla Sarno, MD
Chief Psychiatric Consultant
State of Maryland
Disability Determination Service

My name is Dr. Carla Sarno I am the Chief Psychiatric Consultant with the Maryland Dept. of Disability Determination Services and have been with the agency going on 10 years. I review and render medical decisions on psychiatric claims which include Military Casualty cases. These decisions are based on the medical evidence gathered by the Disability Examiner. Maryland is in a unique position, in that; we are in close proximity to Walter Reed and Bethesda Naval Hospitals. Since January 2006, we have received 347 Military Casualty claims which include OIF/OEF claimants. Out of the 347 cases we transferred 56 cases to other DDS agencies across the country due to the fact the soldiers/vets were transferred to other hospitals outside of our jurisdiction and further development was required in those cases. We currently have 37 Military Casualty cases pending in our agency.

"Military Service Casualty Cases" are flagged as such by our Field Office representatives and are forwarded to our agency. Once in our agency the case is developed and decided following Terminal Illness or procedures, which means they are given the highest priority and expedited through the system. The Military Casualty cases are assigned, developed and maintained by a designated unit of disability examiners and one supervisor in the Maryland agency. When a Military Casualty case is to be reviewed due to psychiatric allegations, these cases are assigned either to a psychiatrist or psychologist who has experience working in the VA system / have had specific training in Trauma disorders. Decisions are typically completed based on the medical evidence in the file. Rarely do we send these claimants to outside providers for psychiatric or psychological consults. Every bit of medical information is used in the file to make a determination. Notes from the neurologist, psychiatrist, psychologist, nurses and social workers are all considered in the assessment of the claimant.

Currently we are now seeing more TBI pre-screening tests / cognitive assessments as part of the record (such as the Brief Test of Attention, Trail making Test, and subscales from the Wechsler Adult Intelligence Scale–III and Wechsler memory Scale-III) which has been invaluable. In addition, information from family members has been essential. Sometimes this information is part of the VA MER and other times we have had to request that the disability examiner obtain this information. Family members/friends often pick up a problem before the claimant. In cases involving PTSD, the soldier can minimize the difficulties they are experiencing or may not pursue treatment because they are concerned about how this condition will impact their military career. Family and friends provide crucial information regarding daily functioning. This third party source often documents in the mild TBI and PTSD cases, irritability, isolation, nightmares, avoidance behaviors, sleep difficulties, excessive alcohol use / illegal drug use, domestic violence, and poor ability to persist or complete tasks.

There are times when decisions by our agency can be delayed. Decisions can be delayed because records are slow to reach our agency. Examiners report it is very difficult to obtain current inpatient / outpatient records from Bethesda Naval Hospital. 2-3 attempts are often required. Walter Reed has been a bit faster, but response time has not been consistent. Despite having FO representatives and liaison contacts in Bethesda and Walter Reed, records are still difficult to obtain. Decisions can also be delayed due to SSA policy requirements, in particular, if a claimant has experienced a traumatic brain injury, and the claimant is not severe enough to meet our listings or disability criteria requirements, the case needs to be held for a total of 6 months and reassessed at the end of that time. If the claimant has gotten worse the case will usually be allowed or if the claimant continues to progress the case will be denied. Traumatic brain injury cases can either be allowed under the neurological listings, 11.00, Epilepsy / CNS vascular accident (impacting speech) or the psychiatric listing, 12.02, Organic Mental Disorders. The neurological listings are very specific and require seizures be present more frequently than once a month, in spite of at least 3 months of prescribed treatment, significant and persistent disorganization of motor function in 2 extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station, or sensory or motor aphasia resulting in effective speech or communication be present. If the medical consultants cannot allow per the neurological listings, these cases (usually mild TBI) come to the psychiatric side of the agency to be reviewed under the Organic Mental Disorders.

Several examples mild TBI cases and the importance of 3rd party information are as follows:

I reviewed a case of a 23 year old man with the allegation of TBI, hearing loss, chronic neck pain. The Filed Office representative noted the claimant was anxious, he had a difficult time reading the forms, questions needed to be repeated over and over due to hearing difficulty, and he was very distracted by any movement in the office. This clamant had a history of completing one year of college and was in the U.S. Military as a Marine from 11/03-10/07. He was assigned to an explosives unit and it was this unit's job to remove explosives found in the road or from any location. Per the military hospital records, the claimant was reportedly exposed to over 300 IED blasts. In 4/07, he was exposed to a 100 lb blast which threw his vehicle 45 meters and he experienced loss of consciousness. He recalls vomiting an hour after the incident for 20 minutes. He was returned to the US in 6/07. On return, the claimant complained of significant difficulty with memory loss, he was unable to retain detailed information beyond 24 hours. On psychological testing his response time was extremely delayed. In 9/07 he was diagnosed with Cognitive disorder, nos; head injury; Post-Concussive syndrome; hearing loss and Torticolis; Visual impairment and Adjustment disorder with anxious Mood. Third party Activities of Daily Living indicated the claimant had difficulty recalling information after a half hour, needed "Post-It Notes" to prompt him to do an activity, he was nervous, anxious, loud noises made him freeze, he experienced occasional angry outbursts over insignificant things, he continued to experience nightmares and the family needed to manage his money. He was allowed under our psychiatric listing of 12.02, Organic Mental Disorders.

Another example of how general observations from medical personnel and family members are extremely helpful is as follows:

I reviewed a case of a 21 year old man with the allegation of a Gun Shot Wound to the left eye, Post traumatic Stress Disorder, TBI, problems walking and memory difficulties. This young man had completed 12th grade and was employed by the U.S. Military from 6/04-7/07, he was an infantry soldier. While in Iraq, he sustained a GSW to the head and was exposed to an IED in early 4/07. The evacuation report noted the claimant was extremely anxious during the exam; he apologized repeatedly for his perceived poor performance on preliminary psychological testing. The results of the psych testing indicated the claimant was functioning in the impaired range in the areas of language, auditory and verbal memory, and short and long term delayed recall. The psychiatric notes reported short term memory loss, he displayed somewhat evasive behaviors, apathetic mood, blunted affected, unable to remember what he did yesterday. However, he still had good insight into his condition and his judgment was intact. A full neuropsychiatric evaluation was recommended in 3 months.

The claimant has sustained an intracranial hemorrhage and subarachnoid hemorrhage and the records further indicated he had been exposed to frequent blasts while in Bagdad from motors / IEDs. The claimant was transferred to the VAMC for acute rehab in late 4/07. What is interesting to note the claimant denied or minimized his symptoms, in particular anything that potentially implied a psychiatric component. In fact, it was difficult for the psychiatrist to see this claimant since family would block access to the patient, reporting he was asleep. The claimant denied to the staff nightmares, disturbing dreams or flashbacks of any of the attacks. But the nursing staff on the unit noted the claimant was having difficulty falling, staying asleep, took frequent naps, was taking longer to remember things that he had done in the recent past, had poor eye contact and could not recall what he had yesterday.

The family was advised and educated regarding Post Traumatic Stress Disorder. The VA notes in 6/07 documented claimants reports of occasional irritability and feeling annoyed. The parents reported to our examiner via phone contact they do all the cooking and cleaning and assist with managing his money. They acknowledged their son's difficulty with short-term memory and provided a great deal of structure for their son on a daily basis. This particular case was allowed, with a short diary of 18 months. Although the medical evidence was just short of the 12 month requirement of a Medically Determinable Impairment, an allowance was determined based on a combination of factors, short term memory deficits and the need for on-going supports from family members. His condition was also listed under 12.02, Organic mental Disorder.

Third party ADLS can describe claimants with mild TBI as needing reminders, they take longer to do things, easily confused, irritable, they get easily frustrated or agitated, they have difficulty organizing themselves and their surroundings and they can be impulsive.

With Post Traumatic Stress Disorder claimants are reported to have difficulty with driving or going to crowded areas, such as the mall or the grocery store, they have an exaggerated startle response, cannot sleep or stay asleep, claimants can have difficulty trusting people, or that symptoms are brought on by certain triggers, such as, smells, sounds or visual cues. Often times the problems are very similar in both types of cases.

In summary, when our examiners in our agency were asked what improvements they would like to see in Military Casualty cases the overwhelming response was to be able to obtain records with more ease and efficiency. A case worker's name /number from the inpatient unit / outpatient department would be helpful so the examiner can have an actual contact person to follow-up with, if more evidence was needed or if evidence was not received. In addition, any input from the case manager regarding functioning while the claimant is still in the hospital or residential program would be helpful.

The psychiatric and psychological consultants find the pre-screening measures for TBI valuable, although certainly not complete; provides us some sense of the claimant's cognitive functioning along with serial mental status exams. What are very important in disability case development are the psychiatric longitudinal history and third party activities of daily functioning. There are times when conditions do not necessarily meet our minimum time requirement of 12 months, but based on the overall information received by the agency and severity of the condition we are able to make educated decisions that are fair and in the best interest of the claimant.