RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: ARMY

CASE NUMBER: PD0900079 BOARD DATE: 20100304

SEPARATION DATE: 20060209

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SUMMARY OF CASE: This covered individual (CI) was an active duty Captain (pilot) medically separated from the Army in 2006 after 5 years of service. The medical basis for the separation was neurovascular syncope. In early 2001 he was grounded from flight status for recurrent episodes of syncope and vertigo. He underwent neurology and cardiology consultations and his diagnosis was confirmed by formal tilt table methodology. He was tried on various treatment regimens with little success and continued to experience abrupt episodes of vertigo and/or syncope. In late 2001, he was placed on Temporary Disability Retired List (TDRL) with a rating of 30% under 8299-8210. In 2003 he was re-evaluated and it was determined that his condition was not improved. He continued on TDRL at 30%. His final TDRL evaluation was in 2006 and included repeat evaluations by a neurologist and cardiologist. An Informal Physical Evaluation Board (IPEB) at that time determined that he had improved and recommended medical separation. His rating was dropped to 10%. This adjudication was upheld by a Formal Physical Evaluation Board (FPEB) and by the US Army Physical Disability Agency (USAPDA) on appeal. The CI was medically separated with a 10% disability rating. There are no other medical conditions relevant to the case.

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CI CONTENTION: The CI contends that his TDRL rating of 30% was unfairly dropped to 10% at medical separation. He states ‘As nothing had changed, with the rating of 30% in the two prior boards, there was no ground to decrease my rating and state that my condition had improved.’ He references a supporting opinion from his primary care physician (an Army physician) and states, ‘For this TDRL follow up, I was examined by a neurologist for approximately 60 minutes and a cardiologist for approximately 30 minutes.’

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RATING COMPARISON:

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Service PEB** | | | | **VA** | | | |
| **Condition** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Effective** |
| **On TDRL:** |  |  |  | No VA exam at time of TDRL. Rating based on STR. | | | |
| Neurovascular Syncope | 8299-8210 | 30% | 20011029 | Neurovascular Syncope | 8299-8210 | 30% | 20020228 |
| **Off TDRL:** |  |  |  |  | | | |
| Neurovascular Syncope | 8299-8210 | 10% | 20060208 | VA re-evaluation at time of final separation was 30% per CI’s application, although that VARD and exam is not in evidence. | | | |
| No Additional DA 3947 Entries. | | | | No Additional VA Codes or Ratings. | | | |
| **TOTAL Combined (Off TDRL): 10%** | | | | **TOTAL Combined (*Includes Non-PEB Conditions*): 30%** | | | |

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ANALYSIS SUMMARY:

Neurovascular Syncope Condition. The CI’s opinion that he had not improved over the course of his TDRL period can be both supported and questioned by various provider notes. The Board takes the position that subjective improvement or worsening should not influence its coding and rating recommendation at the time of separation. It is recognized, in fact, that Physical Evaluation Boards (PEBs) across the services sometimes apply an overly generous initial rating in order to meet the requirement of 30% disability for placement on TDRL. This is in the member’s best interest at the time and does not mean that a final lower rating is unfair, even if the applicant does not perceive any improvement. The sole basis for the Board’s recommendation is the optimal Veterans Administration Schedule for Rating Disabilities (VASRD) rating for disability at separation.

The following serial excerpts provide a good overview of the clinical course and severity in this case.

Narrative Summary (NARSUM)at placement on TDRL: ...he still has syncope two to three times a month. Another two to three times a month he has six or eight hour periods of time where he is unable to even sit up in a chair because he has so much vertigo.

1st TDRL Re-evaluation: He continues to have daily episodes of lightheadedness or dizziness without vertigo. He has had syncope about once a month, not requiring hospitalization.

End-TDRL Neurologist: ...persistent episodes of both daily presyncope...compensated...by changing positions slowly and...daily episodes of ‘spins’...will require him to take a knee, does not improve with eye closure.

End-TDRL Cardiologist: Subsequently, he has continued to have his pre-syncopal symptoms every 2-3 days at random. While sitting or standing he suddenly feels lightheaded, but can abort an actual syncopal episode by lying down. Returns to normal quickly. In addition, he continues to have brief episodes of vertigo daily. No other cardiovascular symptoms. Otherwise feels fine and able to exercise. Good appetite with stable weight.

Army Primary Care Provider: [CI name] is a patient under my care and this memorandum is based on my history and physical exam and review of his medical records to include his most recent Cardiology and Neurology evaluations at Walter-Reed Army Medical Center (WRAMC) in June and September 2005 respectively. I am writing this memorandum in full support of [CI name]'s appeal to the Physical Evaluation Board (PEB) board regarding the reduction in disability...To date, his syncopal episodes have continued at the same frequency and intensity since time of initial diagnosis. Of note, his vertigo episodes have become more frequent since his initial board in 2001.

The Board first examined the various coding options for this case. The PEB’s 8299-8210 analogous code for vasovagal nerve impairment is commonly applied and is recommended in the Army’s Table of Analogous Codes. This is a clinical fit with the CI’s formal diagnosis of neurovascularly-mediated syncopal or near-syncopal events. It does, however, leave a lot of latitude for the rater’s opinion regarding the threshold for ‘severe’ vs. ‘moderate’. Analogous rating to the 6204 vestibular code could be supported on the basis of the vertiginous-like episodes. A 30% rating for 6204 (the highest under the code) is defined as ‘dizziness and occasional staggering’. Frequent vertigo and intermittent ataxia was documented in support of the 30% criteria throughout the clinical course. Finally, analogous rating under 8911 for petit mal seizures is also a practical fit with the actual disability and supplies an objective scale for rating. This analogous rating code has been employed by the VA for similar cases. The §4.124a definition for minor seizure ‘a brief interruption in consciousness or conscious control’ is not a bad descriptor for either the syncopal/presyncopal or vertiginous type episodes. If each episode is counted as a minor seizure, the NARSUM description would provide for a 20% rating at TDRL placement and all of the end-TDRL descriptions would provide for a 40% rating at separation. The Board feels constrained in applying 8999-8911, however. It would be incongruent to apply different codes at TDRL placement and at separation for the same condition, and the Board’s purview for recommending a 20% rating onto TDRL is questionable. After discussion, the Board also rejected the 6299-6204 approach since the supported diagnosis in this case is not vestibular and VASRD authority for applying it is open to challenge. Especially since 8299-8210 was the PEB’s and the VA’s choice in this case, the Board opted to remain consistent. That choice entails more of a judgment call as to whether the final PEB’s determination was justified by the clinical evidence available to it. The formal PEB’s DA Form 199, which refers to CI testimony not otherwise in evidence, is excerpted.

History of neurovascular syncope. Rated as mild because the Soldier's symptoms of feeling as though he is going to faint (presyncopal symptoms) resolve quickly once the Soldier lies down and because Soldier has infrequent syncopal episodes (every 6-8 weeks according to Soldier testimony). Presyncopal symptoms occur every 2-3 days at random (TDRL exam; Formal Testimony). The present PEB rating of 10% more accurately reflects the current degree of severity of your condition. The PEB considers your condition to have improved so as to be ratable at less than 30%.

The PEB’s stated facts are accurate. There are, however, unstated facts which are quite relevant. The PEB assessment disregards the vertiginous type episodes. The DA Form 199 for the initial PEB stated ‘episodes of syncope and vertigo in excess of 2-3 times per month’. It is incongruent to then eliminate episodes of vertigo from the subsequent rating. The neurology and cardiology notes document at least daily frequency for vertiginous events. The neurologist’s note that they would force the CI to kneel would argue against them being trivial enough to ignore. The primary care physician, from a vantage of overall better familiarity with the clinical course, states the vertiginous episodes were worsening over time. She also did not believe there was clinical improvement in the strictly presyncopal events. As stated in his USAPDA appeal, the CI had simply learned compensatory measures to avoid complete syncope. How much this subtracts from the disability itself is open to question. All evidence considered, the Board cannot find enough strength in the PEB position to overcome a good deal of reasonable doubt in the CI’s favor regarding the final disability rating. It therefore recommends a disability rating of 30% at the time of medical separation.

Other Conditions. There were no additional medical conditions identified in the Disability Evaluation System (DES) packet or service treatment record (STR) which are relevant for Board consideration as potentially unfitting. Some prior minor injuries, since resolved, were mentioned in the NARSUM and/or MEB physical. No other conditions were noted on the physical profile or in the Commander’s statement. The VA evaluation did not identify any other conditions, nor does the CI contend for any. The Board, therefore, has no reasonable basis for recommending any additional unfitting conditions for separation rating.

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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 neurovascular syncope condition, the Board unanimously recommends a separation rating after TDRL of 30% coded 8299-8210 IAW VASRD §4.124a. The Board unanimously agrees that there were no other conditions in evidence relevant for consideration as additionally unfitting.

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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** |
| Neurovascular Syncope with Vertigo | 8299-8210 | 30% |
| **COMBINED** | **30%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090127, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

