RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: air force

CASE NUMBER: PD0900164 COMPONENT: REGULAR

BOARD DATE: 20090806 SEPARATION DATE: 20060417

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SUMMARY OF CASE: This covered individual (CI) was a Security Forces Staff Sergeant medically separated from the Air Force in 2006 after more than eleven years of service. The medical basis for the separation was the totality of disability based on the presence of multiple medical conditions: Chronic low back pain associated with degenerative disc disease, Coronary artery disease, status post MI, New York Heart Association Class I, Hypertension, Obstructive sleep apnea (OSA) managed with continuous positive airway pressure (CPAP) machine, and Allergies stable on immunotherapy. The AF Informal PEB (IPEB) stated that while none of his medical conditions individually prevented him from reasonably performing the duties of his office, grade, rank, or rating, however, taken in totality, they made him unfit for continued military service. Therefore, they rated the condition that would be most advantageous to the CI: Chronic low back pain associated with degenerative disc disease 5243 at 10% using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Air Force and Department of Defense regulations.

The Department of Defense Instruction (DoDI) 1332.38 clearly states that a member may be determined unfit as a result of the overall effect of two or more impairments even though each of them, standing alone, would not cause the member to be referred into the Disability Evaluation System or be found unfit because of physical disability (E3.P3.4.4). However, no Department of Defense or Air Force regulatory guidance regarding the appropriate method of rating for this situation was available to the PDBR.

At the time of the rating DoDI 1332.39 was in effect and it stated that for Obstructive sleep apnea (OSA) the rating would be based on industrial impairment. According to the service treatment record (STR) and the Medical Evaluation Board (MEB) Narrative Summary (NARSUM), the CI’s OSA was well controlled with CPAP and therefore he would have received a 0% rating for mild industrial impairment. However, using the VASRD alone, this would rate 50%.

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CI CONTENTION: The CI appears to be asking to have sleep apnea and myocardial infarction added as unfitting conditions.

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RATING COMPARISON:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Previous Determinations** | | | | | | | | |
| **Service** | | | | **VA** | | | | |
| **PEB Condition** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam Date** | **Effective date** |
| Chronic low back pain assoc with degenerative disc disease | 5243 | 10 | 20060301 | Mechanical low back pain | 5237 | 10 | 200609 | 20060418 |
| Obstructive sleep apnea managed with CPAP | 6847 | Cat II | 20060301 | Obstructive sleep apnea | 6847 | 50 | 200609 | 20060418 |
| Coronary artery disease, s/p MI, NY Heart Assoc Class I | 7005-7006 | Cat II | 20060301 | Coronary Artery disease | 7005 | 10 | 200609 | 20060418 |
| Hypertension | 7101 | Cat II | 20060301 | Hypertension | 7101 | 10 | 200609 | 20060418 |
| Allergies, stable on immunotherapy | 7899-7825 | Cat II | 20060301 | Allergic rhinitis | 6522 | 0 |  | 20060418 |
| Overweight |  | Cat III | 20060301 | Tinnitus | 6260 | 10 | 200609 | 20060418 |
| Hyperlipidemia |  | Cat III | 20060301 | GERD | 7399-7307 | 10 | 200609 | 20060418 |
|  |  |  |  | TMJ | 9905 | 10 | 200609 | 20060418 |
|  |  |  |  | Headaches assoc with TMJ | 8100 | 0 | 200609 | 20060418 |
| **TOTAL Combined: 10%** | | | | **TOTAL Combined (*incl non-PEB Dxs*): 70% from 20060418** | | | | |

ANALYSIS SUMMARY:

Chronic low back pain associated with degenerative disc disease

It is unclear if the AF found this condition to be unfitting or not. The AF 356 form lists it as Category I Unfitting conditions which are compensable and ratable but the remarks in section 15 state that while none of his conditions were unfitting by themselves, together the totality of his conditions rendered him unfit.

The CI had low back pain radiating into his buttocks starting in November 2004 and continuing intermittently through the time of separation. No motor or sensory deficits were present. He frequently had muscles spasms and showed some improvement with conservative therapy including physical therapy and TENS. He was evaluated by an orthopedic surgeon who did not feel that surgery would be of any benefit. MRI showed bulging discs at L4-L5 and L5-S1 but there was no evidence of foraminal or central stenosis. Although the STR contains a request for range of motion (ROM) measurements, no measurements performed by the Air Force were found in the record.

The CI had a profile that included many restrictions that were most likely related to his back pain: no lifting, pushing, or pulling over 15 pounds; run, walk, cycle, swimming, elliptical machine, stationary bike, and treadmill at own pace and distance; and sit-ups and push-ups as tolerated. The profile also stated that he takes pain medication which might impair driving and judgment. With these restrictions, he would not be able to perform the duties of his AFSC. The profile does include suffix T with no deployments or TDY but does not specify which condition or combination of conditions were the reason for this restriction. The AF IPEB listed this condition as unfitting and rated it at 10%.

Using an evaluation performed five months after separation the VA rated this disability as 5237 Mechanical low back pain at 10%. The VA examination showed greater than normal ROM but the CI had pain on motion which can be rated at 10% IAW paragraph 4.59 and VASRD code 5003. The VA examination documented no further impairment with repetitive motion and no tenderness to palpation or spasm,

Obstructive sleep apnea managed with CPAP

It is unclear if the AF found this condition to be unfitting or not. The AF 356 form lists it as Category II but in the remarks section states that while none of his conditions were unfitting by themselves, together the totality of his conditions rendered him unfit. At the time of his separation, the AF PEB did sometimes determine that members were unfit for continued service because they were not deployable secondary to their requirement to use CPAP machines. However, in 2006 95% of servicemembers were presented to the AF PEB were found to be fit and returned to duty.

The CI’s profile does not list any restrictions that appear to be specific to this condition. It does include suffix T with no deployments or TDY but does not specify which condition or combination of conditions were the reason for this restriction.

The diagnosis actually was UARS (upper airway resistance syndrome), not OSA, according to the consults from the sleep clinic in the STR. However, UARS would be rated under the same rating criteria as OSA. He presented in Dec 2004 for loud snoring, excessive daytime sleepiness, and concerns about sleep apnea. Sleep studies showed he had UARS and that CPAP was tolerated reasonably well and controlled his symptoms. The AF IPEB did not rate this condition.

A VA evaluation five months after separation is consistent with the Air Force exam and the VA also used the diagnosis 6847 OSA. They rated him at 50% because CPAP was required to control his symptoms.

Coronary artery disease status post myocardial infarction, New York Heart Association Class I

It is unclear if the AF found this to be unfitting or not. The AF 356 form lists it as Category II but in the remarks section states that while none of his conditions were unfitting by themselves, together the totality of his conditions rendered him unfit.

The CI’s profile does list restrictions that appear to be specific to this condition including run, walk, cycle, swimming, elliptical machine, stationary bike, and treadmill at own pace and distance. With these restrictions, he would not be able to perform the duties of his AFSC. The profile does include suffix T with no deployments or TDY but does not specify which condition or combination of conditions were the reason for this restriction.

The CI first had symptoms of chest pain in early 2003. A Thallium stress test in March 2003 showed a subtle area of inferior hypoperfusion with normal left ventricular function (LV) and a cardiac catheterization was performed. This showed normal LV function (ejection fraction (EF) 76%), normal hemodynamics, and diffuse atherosclerotic heart disease without any significant high grade blockages. The cardiologist recommended aggressive management of elevated cholesterol and other risk factors. The CI continued to have chest pain and fatigue out of proportion to his daily activities and a second stress thallium was done in Oct 2004. This showed a previous inferior wall infarct with peri-infarct ischemia. The cardiologist felt this was new. The CI was then able to quit smoking and was exercising 30 minutes every day. A third thallium stress test was done in December 2005 as part of an evaluation requested for the MEB. The CI was able to complete nine minutes on a Bruce protocol and the test was stopped secondary to fatigue. This is equivalent to 10.1 METs. Maximum heart rate was 156, 82% of predicted maximum and maximum blood pressure was 160/78. There were no symptoms of angina and no EKG changes consistent with ischemia. A small area of scarring was noted at the posterior basilar segment but systolic function was preserved and EF was 61%. No ischemia was present clinically, on EKG, or scintigraphically. The AF IPEB did not rate this condition.

A VA evaluation five months after separation noted the CI was walking one to three miles a day and would occasionally have very mild angina symptoms. The VA examiner stated the CI had increased his exercise tolerance over the past few months. The VA rated this condition as 7005 Arteriosclerotic (atherosclerotic) heart disease (Coronary artery disease, CAD) at 10% based on the CI’s ability to achieve 10 METs without symptoms and the requirement for continuous medications.

Hypertension

It is unclear if the AF found this to be unfitting or not. The AF 356 form lists it as Cat II but in the remarks section states that while none of his conditions were unfitting by themselves, together the totality of his conditions rendered him unfit.

The CI’s profile does not list any restrictions that appear to be specific to this condition. It does include suffix T with no deployments or TDY but does not specify which condition or combination of conditions were the reason for this restriction. Historically, the AF has not considered members with controlled hypertension as unfit.

The CI’s blood pressure was controlled with medications and this diagnosis is not specifically addressed in the NARSUM. The STR documents the diagnosis and need for medication. The AF IPEB did not rate this condition.

A VA evaluation performed five months after separation was consistent with the information in the STR. The exam revealed slightly elevated diastolic measurements: 120/90, 124/88, and 128/90 and a history of elevated BPs. They rated this condition at 10% because medication is required.

Allergies, stable on immunotherapy

It is unclear if the AF found this to be unfitting or not. The AF 356 form lists it as Cat II but in the remarks section states that while none of his conditions were unfitting by themselves, together the totality of his conditions rendered him unfit.

The CI’s profile does not list any restrictions that appear to be specific to this condition. It does include suffix T with no deployments or TDY but does not specify which condition or combination of conditions were the reason for this restriction.

A RILO (review in lieu of MEB) was done for this condition because the CI had previously had an MEB and a subsequent RILO for this condition. An August 2002 MEB for allergies, hives, and anaphylaxis determined he was fit for duty with limitation code C. A September 2003 RILO after 2 years of immunotherapy determined he was fit fir continued service with no limitations. He had previously had unexplained hives and episodes of anaphylaxis. He received two years of immunotherapy and at the time of this RILO he no longer had any problems related to this. He had no episodes in the past twelve months. The AF IPEB did not rate this condition.

A VA evaluation five months after separation was consistent with the AF evaluation. They rated condition at 0% because he has no current issues. However, the VA used the allergic rhinitis code, 6522.

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BOARD FINDINGS: IAW DoDI 6040.44, the PDBR used the Veteran’s Affairs Schedule of Rating Disabilities (VASRD) as the most favorable basis for rating. After careful consideration of all available information, the Board determined by simple majority that the CI’s condition is appropriately rated at 10% for Chronic low back pain and 10% for Coronary artery disease for a combined total of 20%.

The contradictory nature of the information documented on the AF 356 form obscured the IPEB’s determination of fitness. The Board identified three methods for rating this CI’s disability which the AF IPEB stated resulted from the overall effect of two or more impairments even though each of them, standing alone, would not cause the member to be found unfit because of physical disability.

1. Use the same method the IPEB used, rate the one condition that would be most advantageous to the CI. According to the Board’s rating parameters (VASRD) this would result in rating OSA and the rating would be 50%.
2. Consider all conditions that contributed to the CI’s unfitness according to the remarks of the IPEB as unfitting and rate them. Applying the VASRD to these conditions would result in a 60% combined rating (6847 OSA at 50%, 5243 Back pain at 10%, 7005 Coronary artery disease at 10%, 7101 Hypertension at 10%, and 7899-7825 Allergies at 0%).
3. Evaluate each condition to determine fitness and rate those conditions considered unfitting.

Method 1 has no regulatory basis and the Board unanimously determined it was not appropriate. In Method 2 the Board assumes the IPEB meant all category II conditions were unfitting but were not currently compensable or ratable. However, the IPEB specifically stated that none of the conditions were individually unfitting, including the one they considered category I and rated. The fact that the IPEB applied the method of selecting the one most advantageous condition to rate implies they did not consider all the conditions to be unfitting. If they had determined all the conditions were unfitting, they would have rated all of them. Therefore, it is not reasonable to rate each of the conditions as unfitting.

If the Board cannot assume the IPEB meant all category II conditions were unfitting the Board must determine which of the conditions were unfitting and rate those considered to be unfitting. It is within the purview of the PDBR to add unfitting conditions and rate them appropriately as long as the condition is mentioned somewhere in the Disability Evaluation System (DES) documents. Therefore, Method 3 is the most appropriate way to determine the CI’s disability rating.

The fact that the IPEB stated the CI’s back pain was category I and rated it implies they considered this condition to be unfitting. Yet the remarks section states this condition (along with all of the other conditions) is not individually unfitting. However, as the Board determined this condition is independently unfitting this is a moot discussion.

The Board determined both low back pain and coronary artery disease were unfitting and OSA, hypertension, and allergies were not unfitting. Specific restrictions related to back pain and coronary artery disease that would prevent the CI from reasonably performing his duties as a Security Forces NCO were delineated on the CI’s profile. Therefore, the Board determined these conditions were unfitting. The AF and VA evaluations of both conditions were similar and yielded the same 10% rating for low back pain. This rating is based on painful motion IAW paragraph4.59 and VASRD 5003. The AF IPEB did not rate coronary artery disease but the NARSUM and the STR support the VA’s rating of 10%. This rating is based on the ability to achieve 10 METs without symptoms and the requirement for continuous medication.

Both hypertension and allergies were controlled on medication and were not considered to be unfitting. No restrictions were required and these conditions did not interfere with the CI’s ability to perform the duties of his position.

The CI’s symptoms of snoring and excessive daytime sleepiness were controlled with CPAP. No restrictions specifically related to OSA were delineated in the CI’s profile and the Commander’s letter did not mention any job performance or deployment issues related to excessive sleepiness or the use of CPAP. There is no clear evidence that his condition interfered with CI’s ability to perform the duties of his office, grade, rank, or rating and therefore this condition cannot be considered unfitting.

The single voter for dissent (who recommended applying Method 2) submitted the attached minority opinion.

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RECOMMENDATION: The Board recommends that the CI’s prior determination be modified as follows, effective as of the date of the CI’s prior medical separation.

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| --- | --- | --- |
| Unfitting Condition | VASRD Code | Rating |
| Chronic low back pain assoc with degenerative disc disease | 5243 | 10 |
| Coronary artery disease, s/p MI, NY Heart Assoc Class I | 7005-7006 | 10 |
| Combined | 20% |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090210, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

