RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: ARMY

CASE NUMBER: PD0900233 BOARD DATE: 20100325

SEPARATION DATE: 20041218

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SUMMARY OF CASE: This covered individual (CI) was a Guard SSG (Supply) medically separated from the Army in 2004 after 11 years of combined service (8 years active duty). The medical bases for the separation were obstructive sleep apnea (OSA), a neck condition and a right great toe condition. He developed the onset of OSA in 2002, requiring continuous positive airway pressure (CPAP)--nocturnal breathing device. The condition improved with CPAP, but he continued to complain of fatigue and daytime somnolence. He developed neck pain after a motor vehicle accident in 2002. A Magnetic Resonance Imaging (MRI) diagnosed disc herniation at C5/6 and C6/7. He experienced occasional radiating pain into the left arm, but did not have a clinical radiculopathy and was not a surgical candidate. Despite conservative management, including epidural injections, he continued to have pain with lifting and wearing Kevlar. His toe condition was secondary to a comminuted fracture of the distal phalanx sustained in 2003. He suffered persistent osteoarthritis which interfered with basic soldiering and Army Physical Fitness Test (APFT) requirements. He was placed on a permanent P3/U3/L3 profile for the three conditions and underwent a Medical Evaluation Board (MEB). All three conditions were judged by the MEB to be medically unacceptable IAW AR-40-501 and forwarded to the Physical Evaluation Board (PEB). Additional conditions supported in the Disability Evaluation System (DES) packet are discussed below, but were not forwarded for PEB adjudication on the DA Form 3947. The PEB found the CI unfit for OSA, the neck condition and the toe condition. Each was rated 0%. These findings were upheld by the U.S. Army Physical Disability Agency (USAPDA) on appeal and the CI was separated with a 0% disability rating.

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CI CONTENTION: The CI’s application simply states: ‘Level of sleep apnea & disc herniation anxiety award (subsequent)’. He does not elaborate specific contentions

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RATING COMPARISON:

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| **Service PEB** | **VA (~1 Mo. after Separation) – All Effective 20041219** |
| **Condition** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** |
| OSA | 6847 | 0% | 20040917 | OSA | 6847 | 50% | 20050127 |
| Chronic Neck Pain | 5243 | 0% | 20040917 | Cervical Spine, Herniation… | 5237 | 10% | 20050127 |
| Right Great Toe Pain… | 5299-5281 | 0% | 20040917 | S/P Fx…Right Great Toe | 5199-5171 | 0% | 20050127 |
| No Additional DA Form 3947 Entries. | Non-PEB X 3 / NSC X 4 | 20050127 |
| **TOTAL Combined: 0%** | **TOTAL Combined (*Includes Non-PEB Conditions*): 60%**   |

ANALYSIS SUMMARY:

OSA Requiring CPAP. The PEB rating was based on provisions of DoDI 1332.39 (E2.A1.2.21). The rating IAW VASRD §4.100 is 50%, as applied by the VA. If in agreement with the PEB conclusion that OSA was indeed unfitting, the Board must base its rating recommendation on the VASRD standard (IAW DoDI 6040.44). This case, however, precipitated an extended Board discussion regarding the issue of fitness. The approach to OSA fitness adjudications by PEB’s across the services has evolved since the PEB adjudication of this case. Members are no longer considered unfit solely on the basis of the need for CPAP, since it has been demonstrated that the electrical and maintenance requirements can be met even in austere deployment environments. The standard for fitness adjudication has rather become whether or not the symptoms of OSA are adequately controlled so as not to impair Military Occupational Specialty (MOS) performance to an unfitting extent (independently of CPAP requirement). The Board is supportive of this approach since it allows many members to continue in service who would have otherwise been medically discharged, and there has been no evidence that it places members at medical risk. The Board also strives to establish uniformity in its recommendations for similar cases regardless of the applicant’s separation date. Disparate rating recommendations are sometimes forced by changes in the VASRD over time, but the decision at hand does not involve rating. In a case such as this one with other unfitting conditions as well as OSA, the historical variance in the PEB’s fitness adjudications for OSA creates a 50% rating gulf between applicants with the same severity of OSA but different separation dates. The Board believes that the same ‘ruler’ should be used for all applicants and that it is unreasonable to default to the outdated practice of finding CPAP, not OSA, unfitting. It would be a violation of DoDI 6040.4 4, however, for the Board to defend this principle at the expense of a lower combined disability rating than that already granted by the PEB. That is not a prohibitive constraint in this case.

The language in the PEB’s DA Form 199 makes it clear that the limitations imposed by CPAP were the main basis for its fitness determination. It states, ‘Occasional daytime somnolence. CPAP requires reliable electric power source and regular technical maintenance. Proper operation of the machine cannot be achieved outside of a home or barracks environment. Rated for daytime impairment mild to none...’ A focus of Board deliberation was whether the severity of symptoms, not the need for CPAP, was unfitting in this case. Key evidence in support of a favorable decision for the CI was the opinion expressed by the MEB physician in the narrative summary (NARSUM). It states that OSA ‘...significantly affects his ability to do his job. It primarily affects his cognitive ability to do the administrative work required of his MOS. He is also unable to drive for long distances.’ Furthermore the Commander’s letter states ‘[CI’s name] inability to focus on tasks stemming from fatigue is not conducive to an environment that deals with sensitive items and inventories.’ Regarding the probative value of these statements, the following factors were discussed. The MEB physician was remote from the CI’s duty assignment and it is unlikely that the history was independently confirmed. In that regard, the history is suspect based on evidence that the CI’s account of his symptoms may have been overstated. A subsequent VA examiner’s note from a rating examination for the CI’s back condition stated, ‘The veteran's range of motion was very restricted and very guarded during range of motion trials. However, it is noted that following his range of motion trials he was able to bend fully forward to 90 degrees to tie his shoes to get redressed from the examination.’ The rating decision consequently discounted the exam. Such documentation cannot help but introduce a degree of skepticism in Board members for making a recommendation based solely on the CI’s statements to the MEB physician. Regarding the Commander’s statement, it is noted that it was perfunctory and written by a Human Resources Officer, then signed by a Warrant Officer, neither one of whom was the Commanding Officer signing the CI’s evaluations.

There is, conversely, persuasive evidence that the CI’s performance was not significantly impaired by diminished mental faculties or fatigue issues. Perhaps the most compelling is the VA rating examiner’s documentation that the CI was employed (commencing prior to separation) as an executive for the Department of Health and also doing PhD coursework toward a business degree. This is essentially *prima fascie* evidence that he was fit to perform in his Supply Specialist MOS. His NCO evaluations remained strong throughout the period after he was diagnosed with OSA and placed on CPAP. Reports in the pre-separation period contain such statements as ‘maintains without loss, accountability for over $774,000 worth of organizational and installation equipment’ and ‘meticulous attention to detail’. Additionally there is clinical evidence challenging the stated severity of OSA symptoms at the time of separation. A follow-up sleep study was performed two months prior to separation. This documented no awakenings, near normal sleep efficiency and REM pattern with ‘light’ snoring. The lowest oxygen saturation recorded was 92% (normal variance). It is difficult to reconcile these findings with such daytime symptoms as hypersomnolence, fatigue or inability to drive long distances. Although a sleep study cannot by any stretch be considered a ‘gold standard’ for predicting daytime symptoms, the average patient with these results would be considered well controlled.

After lengthy deliberation, the Board decided there was not convincing evidence that the CI was unfit for his MOS as a result of the medical consequences of OSA. As elaborated above, the Board cannot justify a recommendation that OSA is unfitting based solely on the need for CPAP. The Board, therefore, does not find reasonable doubt in the CI’s favor for supporting the PEB’s fitness adjudication for the OSA condition.

Cervical Condition. The NARSUM exam for the neck stated ‘Neck has full range of motion without any spinal tenderness.’ The PEB’s DA Form 199 quoted this exam in rationale for a 0% rating, stating ‘it does not meet the criteria for even the lowest rating provided in the VASRD.’ Although it referenced the VASRD and not the USAPDA pain policy for its decision, the PEB ignored the VASRD requirement for goniometric range-of-motion (ROM) measurements as well as consideration of VASRD §4.49 (painful motion). A full set of cervical ROM measurements was provided in an orthopedic evaluation for the MEB, however. Although titled ‘Fitness for Duty Evaluation’, the orthopedic evaluation was in the typical format for a specialty addendum to the NARSUM. This exam did not specify if the measurements were obtained by goniometry but included all six values required for rating under the spine formula. It is summarized along with the VA rating examination in the chart below.

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| Cervical ROM | MEB – 4/29/04 | VA C&P – 1/27/05 |
| Flexion | 40⁰ | 40⁰ |
| Combined | 270⁰  | ≥340⁰ |
| §4.71a Rating | 10% | 10% |

The service examinations did not document the presence or absence of painful motion regarding the cervical spine. The VA exam noted painful motion. The documented painful motion and/or the 40° flexion provides for a rating of 10% IAW VASRD §4.71a. All evidence considered, reasonable doubt is resolved in favor of the CI in recommending a separation rating of 10% for the cervical condition. VASRD code 5243, as applied by the PEB, is appropriate. There was no ratable peripheral nerve impairment in evidence.

Right Great Toe Condition. The degree of impairment expected from arthritis following a toe fracture is difficult to reconcile with the need for a U3 profile and as the basis for an unfitting disability. The profile stated and the NARSUM confirmed, for example, that the CI was unable to perform the bicycle alternative event for the APFT. Contiguous pain from the pedal pressure would not be expected to render an individual unable to complete the event. It was perhaps the aerobic limitations from the OSA that was the real culprit, although pulmonary function testing was normal. Referencing the toe condition, the VA examiner stated ‘He walks three-quarters of a mile twice a day while on break at work.’ The Board therefore questions the necessity for the profile and the appropriateness of the fitness adjudication for the toe condition. Both the Commander’s statement and the orthopedic consultant, however, noted specific impairments from the foot condition that could be considered unfitting. Reasonable doubt would therefore dictate that the PEB’s finding of unfit remain as adjudicated. Although under different codes, both the PEB and the VA found no compensable rating for the condition. Since there was no compensable ROM impairment and painful motion is speculative, the Board is in agreement with a 0% rating. Neither the VASRD code applied by the PEB, analogous to hallux rigidus (a frozen toe), nor the one applied by the VA, analogous to amputation, is a good fit with the condition or congruent with a 0% rating. The best fit is 5010 for traumatic arthritis, rated as degenerative arthritis. As a single minor joint without compensable ROM impairment or documented painful motion, it is appropriately rated 0% IAW §4.71a. This is the Board’s recommendation.

Other Conditions. The NARSUM addressed hypertension and gastroesophageal reflux disease (GERD) as additional medical conditions, but did not forward them on the DA Form 3947. The MEB physical also documented low back pain, knee pain and a history of anxiety. The hypertension was stable on medication and asymptomatic without complications. GERD was only occasionally symptomatic (VA exam states 3 - 4 episodes a year) and did not require daily medication. Neither hypertension nor GERD, therefore, are relevant for consideration as unfitting. The back condition was not noted in the physical profile or in the Commander’s statement. As noted above, doubt is cast on the degree of impairment associated with the condition. There is no significant evidence suggesting that the back condition could be considered unfitting. The CI noted ‘knee pain’ on his MEB physical without elaborating. The VA examiner related a complaint of bilateral knee pain but could only elicit a history of service connection for a right knee strain incurred in a training injury in 1997. This was not under active treatment or associated with documented abnormal exam findings at the time of separation. There is nothing in the physical profile, Commander’s statement or elsewhere in evidence which suggests any fitness implications of the knee condition. Thus there is no basis for a Board recommendation in that regard. The history of anxiety noted by the CI on the MEB physical and mentioned in his application was not a diagnosed or treated condition at the time separation. It was not initially service connected by the VA, although the CI subsequently received a compensable rating for it. There is no evidence that there was any mental impairment to military performance, as discussed in detail with the OSA condition.

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. As discussed above, PEB reliance on DoDI 1332.39 for rating obstructive sleep apnea was operant in this case, but is irrelevant since the Board is not rendering a rating recommendation for the condition. In the matter of the obstructive sleep apnea condition, the Board by a 2:1 vote recommends that it be recharacterized as not unfitting and therefore not rated. The single voter for dissent (who recommended characterization as unfitting and a rating of 50% IAW VASRD §4.100) submitted the addended minority opinion. In the matter of the cervical spine condition, the Board unanimously recommends a rating of 10% coded 5243 IAW VASRD §4.71a. In the matter of the right great toe condition and IAW VASRD §4.71, the Board unanimously recommends no change in the PEB rating of 0% but a change in VASRD code to 5010-5003. In the matter of the hypertension, gastroesophageal reflux disease, back condition, right knee condition, anxiety condition or any other medical conditions; the Board unanimously agrees that it cannot recommend any findings of unfit for additional rating at separation.

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

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Cervical Disc Disease | 5243 | 10% |
| Traumatic Arthritis Right Great Toe | 5010-5003 | 0% |
| Obstructive Sleep Apnea | Not Unfitting |
| **COMBINED** | **10%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090310, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

 MICHAEL F. LoGRANDE

 President

 Physical Disability Board of Review

MINORITY OPINION:

As the Action Officer, my initial opinion and draft narrative for the Board proposed a recommendation for unfitting OSA rated 50% IAW the VASRD. Although some parts are redundant with the contents of the Record of Proceedings, the original draft is excerpted below for balance.

The Board acknowledges that the PEB’s fitness adjudication occurred before the evolution of the current approach to OSA by all of the services. Members are not considered unfit solely on the basis of CPAP treatment, since the electrical and hygiene requirements can be met even in austere deployment environments. In select cases the Board may recommend a finding of fit even if contrary to the PEB’s adjudication at the time. Such a recommendation, however, must be based on evidence that the daytime OSA symptoms were improved on CPAP such that they no longer interfered with MOS performance. In this case there is clear evidence to the contrary. The NARSUM states that OSA ‘...significantly affects his ability to do his job. It primarily affects his cognitive ability to do the administrative work required of his MOS. He is also unable to drive for long distances.’ The Commander’s letter states ‘[CI’s name] inability to focus on tasks stemming from fatigue is not conducive to an environment that deals with sensitive items and inventories.’ The Board therefore recommends no change in the PEB’s fitness adjudication for OSA. It recommends a 50% rating as mandated by DoDI 6040.44.

The opinions expressed in the Record of Proceedings were also written by me, containing the pertinent evidence and arguments which surfaced during deliberation. These facts and opinions, now documented as rationales for the Board’s consensus decision, had been considered during my initial evaluation. I do not disagree with their accuracy or relevancy, and concede that they are persuasive as a reasonable basis for the Board’s considered opinion. This was not an easy vote for any Board members and was deliberated at length. Albeit with admitted ambivalence, I was not persuaded enough from my original opinion as Action Officer to change my vote. I maintain that although there was weighty evidence on both sides of this question, there remained enough reasonable doubt in favor of this applicant to find OSA unfitting and grant the rating. In support of my position, I offer the following arguments.

1) The most compelling fact that I could not overcome to cast a unanimous vote, and the one of most concern to the other voters as well, was the NARSUM opinion. The MEB physician was quite explicit that the symptoms of OSA, not the MOS implications of CPAP, were the cause of significant impairment. This was mitigated only by the Board’s conclusion that the medical opinion was premised on a history from the applicant of dubious accuracy. This suspected exaggeration of symptoms arose understandably from evidence that performance itself did not reflect impairment and from the incongruent sleep study; but, a significant source of Board skepticism was the documentation of fairly clear deception at the time of the VA back exam. I would not argue that this incident was an invalid observation by the VA physician. I do not believe it follows, however, that the applicant was deceptive or exaggerating regarding his account of symptoms to an Army medical officer months earlier for a different condition. Although it may be legitimately suspected, I cannot in good faith conclude that, more likely than not, it occurred. By extension I cannot conclude to a ‘more likely than not’ standard that significantly impairing symptoms were not present at the time of the MEB examination.

2) It is commonly asserted that, compared to the VASRD ratings for many other conditions and injuries, the 50% rating for OSA requiring CPAP is difficult to justify if the symptoms are not significantly incapacitating. This is relevant because I believe it cannot help but introduce a bias into the adjudication of OSA cases. Although not purporting to speak for others, there is a natural tendency to raise the fitness bar for OSA because of the high rating stakes. This engenders a perceived affront to veterans with more disabling conditions resulting in lower VASRD ratings. A ‘fair’ rating in this case, for example, might be considered 10%. If that were the rating, would the Board’s fitness scrutiny have reached beyond the statement in the NARSUM and the PEB’s decision as we did in this case? It must be said that the Board is routinely thorough in its investigation of all the evidence, more often than not to the advantage of the applicant. Even the possibility of an unavoidable negative bias, however, lends at least a small degree of additional reasonable doubt favoring the applicant in this case.

3) The Board must give extra pause to a decision which results in a recommendation contrary to the service adjudication and unfavorable to the applicant. This principle in itself confers yet another degree of unquantifiable, but relevant, reasonable doubt in favor of the applicant.

The Action Officer continues to support the initial recommendation preceding the Board’s deliberation, i.e., a VASRD §4.100 rating of 50% for OSA as an unfitting condition.

ACTION OFFICER POST-DATED ADDENDUM (20100428):

A premise of all Board members at the time of the decision reflected in this record was that the Board had the prerogative of recommending that OSA was not unfitting. Although contrary to the PEB’s fitness adjudication, the majority decision would not have lowered the CI’s overall rating and therefore not posed a direct violation of DoDI 6040.44. Subsequent to this Board, however, it was determined that the Board will not exercise the dubious authority to make unfavorable recommendations regarding PEB fitness determinations in OSA cases. This was decided in a joint meeting of the President and key members of the Physical Disability Board of Review with the lead agency’s legal advisor on April 21, 2010. On this basis alone, the minority opinion must be supported. The majority voters are aware and in agreement with the need to change our recommendation on this basis. In compliance with new policy, the Action Officer respectfully requests that the President uphold the Minority Opinion and change the Board’s final recommendation in this case to:

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** |
| Obstructive Sleep Apnea | 6847 | 50% |
| Cervical Disc Disease | 5243 | 10% |
| Traumatic Arthritis Right Great Toe | 5010-5003 | 0% |
| **COMBINED** | **60%** |

