RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: AIR FORCE

CASE NUMBER: PD0900364 BOARD DATE: 20091223

SEPARATION DATE: 20070709

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SUMMARY OF CASE: This covered individual (CI) was a Staff Sergeant Pharmacy Technician who was medically separated from the Air Force in 2007 after more than 18.5 years of service. The medical basis for the separation was bilateral knee pain. The condition was determined to be medically unacceptable, the CI was referred to the PEB, found unfit for continued military service and separated at 20% disability using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable USAF and Department of Defense regulations.

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CI CONTENTION: The CI states: ‘While going through the MEB Process, I had additional conditions (diabetes, depression) which were not listed on the MEB Summary. Both conditions were discovered during the VA rating process. I spent 18 yrs and 7 months in the military and only received 20% for arthritic knees. I would like the board to consider the new information obtained through the VA process with my military career to receive a medical retirement.’

Continued: ‘In regards to my knees, both are are [sic] becoming degenerative each day. My orthopedic surgeon informed me while in the military that both my knees will eventually need replacing. I value the treatment which is received through the VA however I would like to have additional options thru Tri-Care to access medical care under the title of AF retiree when additional care becomes apparent. I understand the board is to rate on the disability rating which deemed me unfit however I hope the compassionate side of the board factors in all the information discussed plus the longevity of my military career before rendering a decision. As I mentioned earlier, I gave the military nearly 19 years of my life only to be separated without being medically retired. All members of my chain of command including my orthopedic doctor was astonished with the results from the MEB finding. Everyone believed a medical retirement was warranted. I did not seek a formal board hearing to dispute the findings due to lack of faith in the system. I had lost rank due to failing to meet the physical fitness standards without my chain of command considering my disabilities and any options which would have allowed me to retain my rank while slowly progressing to meet standards. When the final MEB decision came down, I had lost all faith in judicial fairness of the United States Air Force. I now know this was a mistake but my faith in the system at that time was very negative. I am very hopeful that the hoard will find a way to allow me to be medically retired. I'm very appreciative of the time the board is taking to reconsider my separation.’

Item 5 continued: ‘I was diagnosed with depression while stationed at Malmstrom Air Force Base around 2000 and the condition only accelerated over the years in the military. The stress placed upon me to meeting physical fitness standards with two deteriorating knees kept me in a state of hopelessness. This condition was not entered in my MEB summary therefore a rating wasn't determined or factored in the final decision. I was diabetic while on active duty and was not informed of the diagnosis until several months after my military career was over. I should have been placed on some type of diabetic therapy while on active duty but my diagnosis was confirmed until being rushed to Wilford Hall Medical Center with a glucose level of over 600.’

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RATING COMPARISON:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Service PEB** | | | | **VA (5 Mo. after Separation)** | | | | |
| **Condition** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| No corresponding MEB or PEB entry. | | |  | Major Depression | 9434 | 30% | 20071219 | 20070710 |
| No corresponding MEB or PEB entry. | | |  | Diabetes | 7913 | 20% | 20071205 | 20070710 |
| Bilateral Knee Pain Due to Osteoarthritis | 5003 | 20 | 20070501 | Osteoarthritis, Claimed as Left Knee Dysfunction | 5003 | 10% | 20071205 | 20070710 |
| Osteoarthritis, Claimed as Right Knee Dysfunction, Status Post Operative Meniscectomy Times 2 | 5010 | 10% | 20071205 | 20070710 |
| Hypertension | CATEGORY II -Conditions that can be Un-fitting but are not Currently Compensable or Ratable | |  | Hypertension | 7101 | 0% | 20071205 | 20070710 |
| Gout |  | Gout, Right Great Toe | 5002 | 0% | 20071205 | 20070710 |
| Obesity | CATEGORY Ill - Conditions that are not Separately Unfitting and not Compensable or ratable: | |  |  |  |  |  |  |
| Hyperlipidemia |  |  |  |  |  |  |
|  |  |  |  | Degenerative Arthritis, Claimed As Left Ankle  Dysfunction | 5010 | 0% |  |  |
|  |  |  |  | Pseudofolliculitis Barbae | 7813 | 0% |  |  |
|  | | | | NSC X 1 OSA | | |  |  |
| **TOTAL Combined: 20%** | | | | **TOTAL Combined (*Includes Non-PEB Conditions*):**  **60% from 20070710** | | | | |
|  | | | |  | | | | |

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ANALYSIS SUMMARY:

Condition 1: Bilateral Knee pain

CI had long history of bilateral knee problems and multiple sport and traumatic injuries of both knees. The NARSUM and VA C&P exam report two arthroscopic surgeries of the right knee and none on the left. However, the STR contains only one operative report and it discusses a left knee meniscal repair on 19921203. There are multiple references to a right knee arthroscopy in June 2004 for a meniscal tear and MRI of May 2004 documented a meniscal tear. It is possible the CI had two arthroscopic surgeries of the right knee and one on the left knee but he definitely had at least one arthroscopy in each knee.

Right knee

Osteoarthritis was documented on X-Rays. The right knee was status post meniscal repair with intermittent locking, pain, and swelling documented in NARSUM. Instability was not present on exam but orthopedic surgeon stated intermittent locking was a problem. ROM was limited to 110 degrees of flexion but this is not compensable. MRI prior to surgery documented a meniscal tear but no study was done after surgery. VA exam documented painful motion only; ROM was decreased to 110 degrees of flexion but this is not compensable. The CI did not complain of locking at this examination. There is no information in the STR concerning the frequency of locking.

The Board considered rating as 5258 Cartilage, semilunar, dislocated, with frequent episodes of ‘locking’, pain, and effusion into the joint at 20% because he had repair of a meniscal tear and continues to have locking, pain, and swelling. However, it is not clear that the locking of his right knee occurred frequently and therefore the criteria for VASRD 5258 are not met. This condition could therefore be rated as 5259, 5003, or 5010 and would rate at 10% under any of these codes.

Left knee

Osteoarthritis was documented on X-rays. The left knee was status post meniscal repair with pain and swelling. Subsequent MRI showed surgical changes and osteoarthritis. ROM was limited to 100 degrees of flexion but this is not compensable. No instability was documented. CI had pain and swelling but no locking and therefore 5258 cannot be applied. VASRD 5259 Cartilage, semilunar, removal of, symptomatic can be applied with a 10% rating. Codes 5003 and 5010 could also be applied and the same rating would be warranted. Rating of 10% is warranted under code 5259, 5010, or 5003.

|  |  |  |  |
| --- | --- | --- | --- |
| **Movement** | **Normal Range of Motion**  **(ROM)** | **ROM Mil**  **20070222** | **ROM VA**  **20071205**  **(pain)** |
| **Left Knee** |  |  |  |
| Flex | 140 | 0-100 | 130 (90) |
| Ext | 0 |  | 0 |
| **Right Knee** |  |  |  |
| Flex | 140 | 0-110 | 140 (110) |
| Ext | 0 |  | 0 |
|  |  |  |  |
| Notes |  | Left Knee: walks slowly and with guarded gait and posturing |  |
|  |  | Right Knee: No subluxation or lateral instability of knees, locks intermittently |  |

Condition 2: Depression

This condition was not addressed by the PEB but was listed as diagnosis in the NARSUM. Diagnoses of major depressive disorder and bulimia are clearly documented in the chart multiple times in 2001 and 2002. In June of 2002 he was admitted for suicidal ideation. He had depression and an eating disorder with a GAF of 50 and was given an S4 profile prior to admission. At discharge his GAF was 55 and at follow-up after admission GAF was 70. He remained on medication throughout rest of service but no significant mental health issues are documented. No ER visits or admissions. No mention of mental health issues in Commander’s letter. VA C&P stated MDD (Major Depressive Disorder), recurrent, moderate with GAF of 48. The CI definitely had a mental health condition while on active duty but there is insufficient evidence to conclude it was unfitting.

Condition 3: Other Conditions

Left ankle arthritis, Gout, Hypertension, Pseudofolliculitis Barbae were also rated by the VA but there is no evidence that supports concluding these conditions were unfitting. All were mentioned in the PEB, the NARSUM, the ETS physical, or the separation physical.

Condition 4: Type II Diabetes

This condition was not addressed by the PEB or anywhere in the DES package and it therefore outside the scope of this Board. However, type II diabetes more likely than not existed prior to separation on 20070709. This condition does not have an acute onset. Not having the condition on July 9 but having it on August 22 is not possible given the nature of the condition, the history of elevated serum glucose levels, and the presence of multiple risk factors for the disease. The CI required oral medication and diabetes that was not controlled by diet alone is considered unfitting.

There are multiple elevated serum glucose levels in chart, at least one of which was documented as being fasting. Near the time of separation the CI was seeing an allergist who noted an elevated non-fasting glucose, ordered a fasting level, and requested a consult to Internal Medicine (IM) for the elevated glucose and hard to control hypertension. The IM provider never addressed the fasting glucose level of 128 and did not repeat the test or request a glucose tolerance test. No further visits to IM are documented in the chart. The CI had almost every risk factor for diabetes type II: obesity (BMI near 40), family history of diabetes (mother), hypertension, HDL cholesterol under 35, and habitual inactivity (due to knee problems). The IM provider should have been aware of the increased risk of diabetes and should have completed a diagnostic work-up for diabetes or documented why one was not necessary.

The condition of hyperglycemia was listed in the AHLTA master problem list and appears to have first been applied in March or April 2007. In August 2007, one month after separation, CI was admitted to the ICU with a glucose reading over 600. At hospital discharge he was on metformin. If the IM provider had completed the diagnostic work-up prior to separation, the CI most likely would have been diagnosed with diabetes type II, would have been started on either diet modification or medication (or both), and more likely than not would not have ever experienced a blood sugar of over 600 or needed an ICU admission.

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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. After careful consideration of all available information, the Board unanimously concluded that the CI’s condition is appropriately rated at a combined 20% for right and left knee osteoarthritis and no recharacterization of the CI’s disability and separation determination is warranted.

Osteoarthritis and a history of meniscal repair were present in both knees. The CI had pain and swelling in both knees and intermittent locking of the right knee. Both knees had pain limited motion that did not reach the minimum criteria for rating based on limited range of motion. These conditions could be rated under VASRD 5003, 5010, or 5259 at 10%. The Air Force PEB rated under VASRD 5003 and the Board finds this code and rating is appropriate. The Board found no evidence to support a higher rating for either knee.

The Board considered the conditions of Major Depression, Left Ankle Arthritis, Gout, Hypertension, and Pseudofolliculitis Barbae which were rated by the VA and unanimously determined there is no evidence to support concluding these conditions were unfitting at the time of separation.

Type II diabetes was rated by the VA but was not mentioned in the Disability Evaluation System (DES) package and is therefore outside the scope of the Board. The CI retains the right to request his service Board of Correction for Military Records (BCMR) consider adding this condition as unfitting.

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RECOMMENDATION: The Board therefore recommends that there be no recharacterization of the CI’s disability and separation determination.

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090521, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

President

Physical Disability Board of Review

SAF/MRB

1535 Command Drive, Suite E-302

Andrews AFB MD 20762-7002

Reference your application submitted under the provisions of DoDI 6040.44 (Section 1554, 10 USC), PDBR Case Number PD-2009-00364.

After careful consideration of your application and treatment records, the Physical Disability Board of Review determined that the rating assigned at the time of final disposition of your disability evaluation system processing was appropriate. Accordingly, the Board recommended no re-characterization or modification of your separation with severance pay.

I have carefully reviewed the evidence of record and the recommendation of the Board. I concur with that finding and their conclusion that re-characterization of your separation is not warranted. Accordingly, I accept their recommendation that your application be denied.

Sincerely

Director

Air Force Review Boards Agency

Attachment:

Record of Proceedings

cc:

SAF/MRBR