RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXX BRANCH OF SERVICE: MARINE CORPS

CASE NUMBER: PD0900376 BOARD DATE: 20100512

SEPARATION DATE: 20080111

 TDRL 20030331

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUMMARY OF CASE: This covered individual (CI) was a Sergeant, Warehouseman medically separated from the Marine Corps in 2008 after more than three years of service. The medical basis for the separation was Type 1 Diabetes. After an initial eight month limited duty, the CI underwent a Medical Evaluation Board (MEB) and was placed on the Temporary Disability Retired List (TDRL) with a 40% rating for diabetes mellitus. After three TDRL periodic re-evaluations an Informal Physical Evaluation Board (PEB) on 20070801 determined he was fit for continued naval service. This determination was reconsidered on 20070904 and no change was made. The CI then demanded a formal hearing. A Formal PEB hearing conducted on 20071114 considered testimony and new medical evidence and this board determined the CI was unfit for continued naval service. He was then separated with a 20% disability using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Navy and Department of Defense regulations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CI CONTENTION: ‘I believe that my disability should have been rated as 40% disabling and not 20% as the PEB showed in 2007. My Diabetes Mellitus met the 40% disabling requirement when it was evaluated by the PEB in 2007 and it still meets the 40% disabling requirements. I would like to add that I suffer from peripheral neuropathy on my left and right lower extremities as a result of my Diabetes Mellitus. Please review the medical evidence previously submitted in 2007 (please obtain from the PEB, since I do not have copies of those records) and the medical evidence submitted with this application. Please grant me a 40% disability for my Diabetes Mellitus and a 10% disability for my right lower extremity and a 10% disability for my left lower extremity peripheral neuropathy, since my Diabetes Mellitus has caused these conditions. Please note that I'm willing to be reexamined by a medical doctor for the purpose of this evaluation.’

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service PEB** | **VA (3 months prior to TDRL, 5 years prior to Separation)** |
| **Unfitting Conditions** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| Diabetes Type 1 | 7913 | 20% | 20071114 | Diabetes Mellitus (Type 1) | 7909 | 60% | 20030117 | 20030401 |
|  |  | Not in DES | Residuals, Right Shoulder Strain w/bony OS Acromially | 5299-5203 | 10% | 20030117 | 20030401 |
|  |  | Not in DES | Residuals, Left Shoulder Strain w/bony OS Acromially | 5299-5203 | 10% | 20030117 | 20030401 |
|  |  | Not in DES | Residual Left Ankle Sprain | 5299-5271 | 10% | 20030117 | 20030401 |
|  |  | Not in DES | Residuals Right Ankle Sprain | 5299-5271 | 10% | 20030117 | 20030401 |
|  |  | Not in DES | Residuals Lumbar Spine Strain | 5295 | 10% | 20030117 | 20030401 |
|  |  | Not in DES | Tinnitus | 6260 | 10% | 20030117 | 20030401 |
|  |  | Not in DES | Lattice Degeneration with Peripheral Retinal Holes, Left Eye | 6099-6008 | 10% | 20030128 | 20030411 |
|  |  | Not in DES | Lattice Degeneration with Peripheral Retinal Hole, Right Eye | 6099-6008 | 10% | 20030128 | 20030401 |
| **TOTAL Combined: 20%** | **TOTAL Combined (*Includes Non-PEB Conditions*):** **80% from 20030401 (with Bilateral Factor 3.4 %)** |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ANALYSIS SUMMARY:

Diabetes Mellitus Type 1

The CI was diagnosed with Diabetes Mellitus (Probable Type I) in September 2002. While he was hospitalized for three (3) days secondary to his presentation as a new diabetic, the medical record clearly documents that he did not have diabetic ketoacidosis. His hospitalization was for the purpose of insulin initiation and diabetic education. Laboratory values were suggestive of diabetes mellitus type 1 as the member had a C-peptide level of 0.8, an insulin level of less than 2 and Islet cell antibodies of 1:2. With initiation of insulin treatment, the CI's blood sugar levels were 90's to 160's with no episodes of hypoglycemia, as per medical record documentation immediately prior to placement on TDRL.

At time of entry onto TDRL the CI was on insulin, an oral hypoglycemic agent, and restricted diet but there was no evidence of any:

* Regulation of activities
* Ketoacidosis
* Any complications of diabetes--the lattice degeneration of the retinas bilaterally is not related to diabetes. No diabetic retinopathy was noted on the Compensation and Pension (C&P) exam of 20030128
* Hospitalizations except one in 2002 when diagnosis was made (no ketoacidosis was present then either)
* Hypoglycemic episodes
* Need for twice monthly visits to provider
* Progressive weight loss

While on TDRL the CI was followed from Nov 2003 until Jul 2007 by Internal Medicine. Clinical notes and intermittent summary letters, prepared for the purpose of TDRL periodic reviews in Mar 2004 and Aug 2006, provided detailed information of the CI's clinical course and laboratory assessment. Although there was some consideration of whether the CI's Diabetes Mellitus should be considered Type I or Type II, the member always was insulin requiring, with stable HbA1C levels in the low 6 range (barely above normal). The CI's weight steadily increased from 175 pounds at time of placement on the TDRL to a high of 220 pounds. The CI was regularly followed every 6 months with no hospitalizations, no ER visits, and no severe hypoglycemic episodes documented. The CI testified that he informed his provider that he was moving to Waco, Texas and would need to change providers. Throughout the member's ongoing care he remained on insulin, Lantus at bedtime, Humalog (sliding scale), and metformin.

New medical information provided for the Formal PEB review included a "new patient" clinical evaluation that was performed on 26 Sep 2007 in Waco, Texas. The provider initiated adjustment of the CI's insulin regimen based upon the four times daily accucheck of blood sugar values. She also discussed a possible insulin pump for improved glucose control. On the follow-up appointment on 7 Oct 2007, the provider note describes the labs as "benign" and reviewed the CI's blood sugar log in order to make medication and dosage modifications. The blood sugar log documented fluctuations in blood sugar values in response to medication adjustments, as would be expected during this period of insulin dosage modification.

Finally, the CI sought evaluation at Fort Hood on 9 Oct 2007 to obtain additional information for the Formal PEB consideration and discussing the possibility of an insulin pump. Lab values at Fort Hood on 9 Oct 2007 document a Hemoglobin A1c of 6.40 and a glucose level of 240. Fort Hood Internal Medicine note specifically states that the member's insulin requirements are increasing and finds this incongruent with return to active service.

In summary, the Formal PEB found the CI unfit for return to naval service. Although the member's military occupational specialty is a Supply and Administration Warehouse Clerk, his insulin dosing regimen and accucheck blood sugar surveillance were performed four times per day. The Formal PEB found these requirements likely to interfere with the CI's ability to perform his required duties as a Marine Sergeant, even in a warehouse setting.

Because the CI had recently changed providers and was undergoing medication adjustment, his blood sugar logs revealed some minor fluctuations concurrent with clinical modification of his medications. However, the CI had not been hospitalized, never had diabetic ketoacidosis, and had regular ongoing care since Nov 2003 by a single Internist who repeatedly documented the member's reasonable control. There is no documentation of significant, activity-limiting episodes of hypoglycemia. The member was not hospitalized, nor had he required emergency room evaluation, since his initial diagnosis in Sep 2002.

At the time he separated from the TDRL in 2008, the CI had peripheral neuropathy in both lower extremities. He was taking Lyrica with some relief of his burning pain. However, only conditions present at the time of entry onto the TDRL can be evaluated and this condition was not present when he entered the TDRL in 2001. Also these conditions are not mentioned anywhere in the Disability Evaluation System (DES) package. Therefore, even though the CI had bilateral peripheral neuropathy when he separated from the TDRL; this was a complication from his diabetes; no rating can be applied for peripheral neuropathy.

The VA rated the CI’s diabetes mellitus under code 7909, Diabetes Insipidus. However, the CI had diabetes mellitus, and it is unclear why the VA used 7909 instead of 7913 Diabetes Mellitus.

At the time of separation from the TDRL, the CI followed a restricted diet and was taking insulin and an oral hypoglycemic agent. No regulation of activities had been prescribed by a health care provider and there is no evidence that it should have been prescribed.

Other conditions (not in the DES):

Bilateral Lower Extremity Peripheral Neuropathy; Residuals, Right Shoulder Strain with Bony OS Acromially; Residual Left Ankle Sprain; Residuals Right Ankle Sprain; Residuals Lumbar Spine Strain; Tinnitus; Lattice Degeneration w/Peripheral Retinal Holes, Left Eye; and Lattice Degeneration w/Peripheral Retinal Hole, Right Eye

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 determined that the Ci’s condition is most appropriately rated as Diabetes Mellitus 7913 at 20%.

A disability rating for Diabetes Mellitus greater than 20% requires regulation of activities. For rating purposes regulation of activities is defined as avoidance of strenuous occupational and recreational activities. There is no evidence of any regulation of activities in any of the available records. The CI had diabetes mellitus required insulin and a restricted diet and this warrants a 20% rating.

The Board also considered the condition of Bilateral Lower Extremity Peripheral Neuropathy at the CI’s request. When determining the final and permanent disability rating, the Board must evaluate the CI’s condition at the time of separation from the TDRL in 2008. However, the Board can only evaluate conditions that were present at the time the CI entered the TDRL and were mentioned in the DES package. This condition was not mentioned in the DES package and is therefore outside the scope of the Board. The CI retains the right to request his service Board of Correction for Naval Records (BCNR) consider adding these conditions as unfitting.

The other diagnoses rated by the VA (Residuals, Right Shoulder Strain with Bony OS Acromially; Residual Left Ankle Sprain; Residuals Right Ankle Sprain; Residuals Lumbar Spine Strain; Tinnitus; Lattice Degeneration w/Peripheral Retinal Holes, Left Eye; and Lattice Degeneration w/Peripheral Retinal Hole, Right Eye) were not mentioned in the DES package and are therefore outside the scope of the Board. The CI retains the right to request his service BCNR consider adding these conditions as unfitting.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090520, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

 President

 Physical Disability Board of Review

MEMORANDUM FOR DIRECTOR, SECRETARY OF THE NAVY COUNCIL OF REVIEW

 BOARDS

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATION

 ICO XXXXXX

Ref: (a) DoDI 6040.44

 (b) PDBR ltr dtd 20 May 10

 I have reviewed the subject case pursuant to reference (a) and approve the recommendation of the Physical Disability Board of Review (reference (b)) that Mr. XXXX’s records not be corrected to reflect a change in either his characterization of separation, or in the disability rating previously assigned by the Department of the Navy’s Physical Evaluation Board.

 Principal Deputy

 Assistant Secretary of the Navy

 (Manpower & Reserve Affairs)