RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: AIR FORCE

CASE NUMBER: PD0900630 SEPARATION DATE: 20070702

BOARD DATE: 20101209

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SUMMARY OF CASE: This covered individual (CI) was an active duty SSgt (E-5), (3S0X1, Personnel Journeyman), medically separated from the Air Force in 2007 after 12 years of service. The medical basis for the separation was Diabetes Mellitus (DM) Type II in Poor Control with Nephropathy. The CI was diagnosed with DM in 1996 and had been previously considered by a Medical Evaluation Board (MEB) in 2001 after a single episode of diabetes ketoacidosis (DKA) secondary to oral steroids and was returned to duty on oral hypoglycemic medications. Compliance with recommended treatment was an issue and DM control deteriorated over the next few years. The CI was C-coded (deployment limited: ALC-C) for her DM. The CI was performing all duties of her Air Force Specialty Code (AFSC), but did not respond adequately to treatment to be able to deploy within her AFSC. Following a Review In-Lieu of MEB (RILO) for ALC-C re-evaluation, a complete MEB was directed. The CI was issued a temporary P-4 profile and underwent a MEB. The MEB forwarded “Type II Diabetes Mellitus Complicated by Nephropathy, Uncontrolled” to the informal Physical Evaluation Board (IPEB) as the only listed condition and as not meeting retention standards. The IPEB determined “Diabetes Mellitus Type II in Poor Control with Neuropathy” as unfitting at 20% disability using the Veterans Administration Schedule for Ratings Disabilities (VASRD) and applicable Air Force and Department of Defense regulations. The IPEB added Seasonal Allergic Rhinitis and Migraine Headaches as not unfitting (Category II), and Hypertriglyceridemia as not unfitting (Category III) conditions. The CI appealed to the Formal PEB (FPEB) with a contention for return to duty. The FPEB changed the diagnosis to “Diabetes Mellitus Type II complicated by Nephropathy, uncontrolled” with the same IPEB rating coding and 20% disability level. The CI appealed the FPEB determination to the Secretary of the Air Force Personnel Council (SAF/MRBP) requesting an increased disability rating of 30%. The FPEB’s determination was upheld, the CI made no further appeals and was therefore separated at 20% disability.

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CI CONTENTION: The CI states: “The ratings for the condition(s) which rendered me unfit should be changed because they were not correctly rated prior to separation from the Air Force. I have additional issues that were not considered service acceptable that are associated with the condition that determined me to be unfit. I request they be considered for a higher rating because the VA rating, upon review, has been determined as 70% for service connected compensation for diabetes related issues. A further review was conducted, and subsequent to that review, a total award of 100%was granted for service connected disabilities. I am requesting a 70% rating from the Air Force for retirement purposes.”

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RATING COMPARISON:

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| --- | --- |
| **Service FPEB (20070413)** | **VA (3 Mo after separation) All Effective 20070703** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| DM Type II Complicated by Nephropathy, Uncontrolled | 7913 | 20% | Nephropathy with Hypertension (HTN) Associated with DM  | 7541 | 60% | 20071009 |
| Type II DM Type II | 7913 | 20% | 20071009 |
| Allergic Rhinitis (SAR) | Category II | Allergic Rhinitis (AR) | 6522 | 10% | 20071009 |
| Migraine … (HA) | Migraine headaches  | 8100 | 30% | 20071009 |
| Hypertriglyceridemia | Category III  | Hypertriglyceridemia | 7099-7000 | NSC |
| ↓No Additional MEB/PEB Entries↓ | L Hip … Arthritis (DJD) | 5003 | 10% | 20071009 |
| R Hip DJD | 5003 | 10% | 20071009 |
| R Knee … (PFS) | 5019 | 10% | 20071009 |
| L Knee PFS | 5019 | 10% | 20071009 |
| R Tennis Elbow | 5024 | 10% | 20071009 |
| R Shoulder  | 5024 | 10% | 20071009 |
| Lumbar Strain | 5237 | 10% | 20071009 |
| Sinusitis | 6512 | 10% | 20071009 |
| Bronchitis | 6600 | 10% | 20071009 |
| R Breast Scar | 7626-7804 | 10% | 20071009 |
| Hemorrhoids; Cholecystectomy Scar | 0% | 20071009 |
| Lymphadenitis; Seborrheic Keratosis and Axillary Dermatitis; Gyn Disorders; Hypertriglyceridemia; Pes Planus; and Bilateral Foot Conditions  | NSC |
| **TOTAL Combined: 20%** | **TOTAL Combined (*Includes Non-PEB Conditions*): 90%\*** |

\*Peripheral Neuropathy L & R LE; 10% each, added effective 20090403 (combined 100%)

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ANALYSIS SUMMARY: The review by the SAF/MRBP specifically addressed the CI’s unfitness for duty and the stability of her medical condition in response to the request by the CI to remain on active duty:

“However, in the case under review, the member's medical condition has not been optimally controlled under its currently prescribed treatment. Although it has been implicit that the member's failure to fully comply with therapy has been due to unpleasant side effects of her medications, the fact remains that her poorly controlled Diabetes poses an unreasonable risk to the member's long and near-term health and for degradation of her unit's mission. The Board found this factor particularly relevant in the context of the austere operational environments and physical stressors confronting *all* members of today's Air and Space Expeditionary Force. Addressing the member's disability rating award and the decision to separate versus retire her, the Board is aware that terms such as "uncontrolled" or "poorly controlled" may depict a level of instability that could warrant consideration for either continued care and observation or placement on the Temporary Disability Retired List. However, based upon the member's established track record of poor control of her Diabetes Mellitus, as reflected through long standing fluctuations in her glycosylated hemoglobin levels, the Board was not optimistic for the achievement of a durable level of control of her medical condition through any further adjustments in her current treatment regimen. Further, since the member's medical care has been managed with oral agents alone and her physical activities have not been restricted, or *regulated,* due to her Diabetes, the member's medical condition does not reach the threshold for the higher disability rating that she desires, under criteria listed for her medical condition in the Veterans Administration Schedule for Rating Disabilities, code 7913.”

For the sake of clarity, after the history, the nephropathy and hypertension will be discussed independently from the DM. All three conditions will be considered together for the rating recommendation as the PEB linked the DM and nephropathy and the VASRD considers the linkages between Hypertension (HTN) and renal disease for rating consideration. IAW VASRD §4.115: “Separate ratings are not to be assigned for disability from disease of the heart and any form of nephritis, on account of the close interrelationships of cardiovascular disabilities.”

History of Conditions (DM, Nephropathy and HTN): The CI was diagnosed with Type II DM in or about 1996 and was managed with diet and exercise (source records were not available for review). In 2001, the CI’s DM condition worsened following a short burst of steroids (prednisone) given for an unrelated dermatologic condition. The CI was hospitalized with DKA and treated acutely with insulin with transition to oral medications (hypoglycemic) for DM control. A MEB determination in 2001 was for return to duty. No records were available for review after the 2001 MEB until email traffic in 2004/5 which documented non-compliance with prescribed diet, exercise and medications. During a dental pre-surgery evaluation (20041018), the CI’s glycosylated hemoglobin level (HA1C) and blood glucose were determined to be high and the procedure was cancelled. The record indicated the CI was not taking all of her medications. The next visit in the record is for the 20050718 MEB exam (two years prior to separation). At that visit, the CI’s fasting blood sugar (FBS) and HA1C were again elevated. Urinalysis for microalbumin was within normal limits (WNL). In Aug 2006, continued non-compliance was noted as well as microalbuminuria (an indicator of renal dysfunction). Her blood pressure (BP) was 136/93. On 20061027 (8 months prior to separation), the albumin/creatinine ratio (ACR) was 38 (30 is the upper limit of normal), Glucose 333 (elevated), BUN 4 (normal), Cr 0.5 (normal) and BP 133/92 (elevated). Urinalysis was abnormal for 3+ sugar, but otherwise negative. The flow chart mentioned above annotates an elevated ACR on multiple occasions in 2006. The assessment was DM Type II complicated by nephropathy, uncontrolled. The CI was noted to have a BP of 109/71 during a dental appointment five weeks before separation. Although no treatment record diagnosis of hypertension (HTN) was found in the records available to the Board, the MEB physical note indicated medication for blood pressure and the VA records indicated a diagnosis of HTN while in service in 2006 while on active duty. There are post-separation notes from military clinics indicating labile HTN or “white coat HTN” with indicators on the automated problem list (AHLTA).

Diabetes Mellitus Type II: It is clear from the record that the CI had DM poorly controlled while on active duty despite diet, exercise and oral hypoglycemic medications. Poor compliance was frequently noted. As stated by SAF/MRBP, the CI never had regulation of her activities as a result of this condition. The CI had only one documented episode of ketoacidosis (DKA) or hypoglycemic reaction requiring hospitalization six years prior to separation, and was not having more than monthly visits to a diabetic care provider. Continued poor control was noted at the last visit on active duty, four days before separation. The VA examination three months after separation substantiated the CI’s history of DM and level of disability noted in the service exams and the VA granted a 20% rating for DM based on their exam. Records indicate the CI started insulin (in addition to oral medications) within 4 months of separation. The VA exam of 20090513 indicated “ongoing DKA or hypoglycemic reactions that require 1 visit(s) to a diabetic care provider per month” and the Veterans Administration Rating Decision (VARD) referenced additional medical information from 20090521 (WHMC) that indicated reasonable control. The VA continued the CI’s 20% rating for DM. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s rating decision of 20% for the DM condition.

Hypertension: The PEB determination of “DM Type II Complicated by Nephropathy, Uncontrolled” as unfitting indicted that Nephropathy was part of the unfitting condition. In order to rate Nephropathy, the level of ratable HTN must first be considered (for application of the VASRD Nephropathy rating), even though HTN is not separately unfitting. Hypertension is considered under the CI’s unfitting renal condition IAW VASRD §4.115. While there are recordings of elevated BP while on AD [labile HTN as discussed above], the preponderance of measurements are normal including those closest to separation. The average of the BP measurements obtained the final two months on active duty (AD-medical and dental appointments) was 123.6/82 (normal), and there was no evidence that the CI was on continuous HTN medications. There was no indication that the CI had “diastolic pressure predominantly 100 or more, or; systolic pressure predominantly 160 or more” prior to separation. At the 20071009 VA exam (three months after separation), the CI’s BP was noted to be elevated:

“The three blood pressure readings are 142/102,140/102, and 154/100. On 10/9//2007 her blood pressure readings were 142/102, 140/102, and 154/100. On 10/9/2007 her blood pressure readings were 142/92, 136/88, and 134/82.”

All readings were accomplished on the same day, which is not per protocol of VASRD 7101 Note 1: “… readings taken two or more times on at least three different days. …” Two sets were exactly the same for all readings and may indicate duplication rather than a third set of measurements. Regardless, these measurements could, at most, be interpreted to indicate “diastolic pressure predominantly 100 or more on average.” The CI was diagnosed with HTN at the C&P and the examiner stated “The claimant has: essential hypertension and it is not a secondary complication of diabetes.” It is unclear how the VA nephropathy rating was derived from this exam as the VARD stated “based on the objective evidence we have granted a 60 percent evaluation for hypertension with diastolic pressure predominantly 120 or more and moderately severe symptoms” which did not appear justified by the examination findings or the record. The Board deliberated what the CI’s HTN would rate under code 7101 (required for consideration in rating renal disease) and considered the evidence of likely in-service labile HTN, and that the VA HTN exam three months post separation could indicate worsening of the CI’s condition. After due deliberation, considering all of the evidence, the Board determined that the CI’s HTN would meet only the rating criteria for a 0% (non-compensable) determination were it to have been unfitting at the time of separation.

 Renal Condition (Nephropathy): The diagnosis of DM with nephropathy was made while on AD and determined to be unfitting. The rating criteria for Nephropathy IAW §4.115b code 7541 (Renal involvement in diabetes mellitus…) directs rating using the criteria for renal dysfunction.There was no evidence in the record that the CI required dialysis, had edema, definite decrease in kidney function, or, generalized poor health. The discussion for rating the CI’s renal condition focused on if the CI had sufficient evidence for rating under the 30% criteria “Albumin constant or recurring with hyaline and granular casts or red blood cells; or, transient or slight edema or hypertension at least 10 percent disabling under diagnostic code 7101.” The CI had recurring albumin in the urine, but never had any hyaline or granular casts. The U/A accomplished at the three month post-separation VA exam was abnormal for: 3+ glucose, trace ketones, 1+ occult blood, 5-10 red blood cells, and trace bacteria. It was normal for negative protein, negative casts and 0-5 epithelial cells. This urinalysis may indicate worsening of the CI’s condition, but is most likely due to contamination of the urine during collection (trace bacteria [abnormal] and epithelial cells even though in the “expected range”). No other comparison U/A is in the record until 20090513 which was negative for protein and RBCs, although epithelial cell and white blood cells were noted. As nephropathy is a progressive disease, the probative value of the earlier abnormal values is further reduced. The Board considered the low probative value of the single post-separation U/A documenting red blood cells and the CI’s post-separation HTN as potentially supporting a rating of 30% for renal dysfunction at separation. After due deliberation, considering all of the evidence and in the interest of clarity, the Board determined that the CI’s renal condition should be separated from the CI’s DM condition for rating; the Board recommends a separation rating of 7541 at 0%.

Other Conditions Considered by the PEB [Seasonal Allergic Rhinitis (SAR), Migraine Headaches (HAs) and Hypertriglyceridemia]: The PEB considered SAR and HA to be “not currently compensable or ratable.” There is no evidence in the medical record that these conditions caused any duty limitations. Neither was profiled nor cited by the Commander as duty limiting. It is noted that hypertriglyceridemia is a laboratory finding and not ratable. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the SAR or HA conditions; or Category III determination for the hypertriglyceridemia condition.

Other Conditions Mentioned in the Disability Evaluation System (DES) (DJD L hip). Left hip bursitis was mentioned in the DES package; however, there was no indication that it limited duty (other than a weight loss exercise program) or was profiled. The only documented physical limitations were those attributed to the adjudicated conditions as inability to deploy. No link to fitness can be drawn for the left hip condition. All evidence considered, there is not reasonable doubt in the CI’s favor supporting addition of the left hip as an unfitting condition for separation rating.

Other Conditions [DJD R Hip, PFS R and L Knee, R Tennis Elbow, R Shoulder Tendonitis, Lumbar Strain, Sinusitis, Bronchitis, R Breast Scar, Hemorrhoids, R Scar from Cholecystectomy, Pes Planus, Bilateral Foot Condition, Intra-menstrual Bleeding, Vaginal Candidiasis, Abnormal Uterine Bleeding, Sehorrheic Keratosis and Axillary Dermatitis, and Left Lymphandenitis]: The other diagnoses rated by the VA (DJD R hip; PFS R and L knee; R tennis elbow; R shoulder tendonitis; lumbar strain; sinusitis, bronchitis; R breast scar; hemorrhoids; R scar from cholecystectomy, pes planus; bilateral foot condition; intra-menstrual bleeding; vaginal candidiasis, abnormal uterine bleeding; sehorrheic keratosis and axillary dermatitis; and left lymphandenitis) were not mentioned in the Disability Evaluation System (DES) documentation. The Board does not have the authority under DoDI 6040.44 to render fitness or rating recommendations for any conditions not considered by the DES. The CI retains the right to request the Air Force Board for Correction of Military Records (AFBCMR) to consider adding these conditions as unfitting. 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. IAW DoDI 6040.44, the Board used the VASRD as the most favorable basis for rating. In the matter of the Type II DM with nephropathy condition, the Board unanimously recommends that it be rated for two separate unfitting conditions as follows: Type II DM coded 7913 and rated 20%; and, Nephropathy, secondary to DM coded 7541 and rated 0%; IAW VASRD §4.119, §4.115a, and §4.104. In the matter of the SAR, Migraine Headaches, and Hypertriglyceridemia, the Board unanimously recommends no re-characterization of the PEB determinations (Category II and III) as not unfitting. In the matter of the left hip condition or any other medical conditions eligible for Board consideration, 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 her prior medical separation.

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| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Diabetes Mellitus, Type II | 7913 | 20% |
| Nephropathy secondary to Type II DM | 7541 | 0% |
| **COMBINED** | **20%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20091013, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

 Deputy Director

 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-2009-00630.

 After careful consideration of your application and treatment records, the Physical Disability Board of Review determined that the physical condition found unfitting at the time of final disposition of your disability evaluation system processing was not appropriately coded under the guidelines of the Veterans Administration Schedule for Rating Disabilities (VASRD). Accordingly, the Board recommended modification of your assigned VASRD coding without re-characterization 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, accept their recommendation and direct that your records be corrected as set forth in the attached copy of a Memorandum for the Chief of Staff, United States Air Force. The office responsible for making the correction will inform you when your records have been changed.

 Sincerely

Director

Air Force Review Boards Agency

Attachments:

1. Directive

2. Record of Proceedings

cc:

SAF/MRBR

DFAS-IN

PDBR PD-2009-00630

MEMORANDUM FOR THE CHIEF OF STAFF

 Having received and considered the recommendation of the Physical Disability Board of Review and under the authority of Section 1554, Title 10, United States Code (122 Stat. 466) and Section 1552, Title 10, United States Code (70A Stat. 116) it is directed that:

 The pertinent military records of the Department of the Air Force relating xxxxxxxxxxxx, be corrected to show that the diagnosis in her finding of unfitness be amended to include Nephropathy secondary to Type II Diabetes Mellitus, VASRD Code 7541, rated at 0% with a combined disability rating of 20%.

 Director

 Air Force Review Boards Agency