RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXX BRANCH OF SERVICE: NAVY

CASE NUMBER: PD2009-00685 SEPARATION DATE: 20030801

BOARD DATE: 20100412

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SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty Chief Petty Officer (ECW, Electronics Warfare Technician) medically separated from the Navy in 2003 after 13 years of service. The medical basis for the separation was pulmonary embolism. The CI’s was recommended to MEB due to his inability to either deploy nor maintain his physical readiness requirements consistent with being an Electronics Warfare Technician, without risking further injury to himself. The pulmonary embolism were addressed in the narrative summary (NARSUM) and forwarded to the Physical Evaluation Board (PEB). The PEB adjudicated the pulmonary embolism as unfitting, rated 0%; with application of the SECNAVINST 1850.4E and DoDI 1332.39 (E2.A1.5), respectively. The CI made no appeals, and was medically separated with a 0% combined disability rating.

CI CONTENTION: The CI requests review of his “separation findings and conclude a 60% disability rating due to my chronic pulmonary thromboembolism requiring anticoagulant therapy.” He additionally lists his VA service connected rating for scoliosis as per the rating chart below.

RATING COMPARISON:

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| --- | --- |
| **Service IPEB – Dated 20030410** | **VA (5 Mo. Post Separation) – All Effective 20030802** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Pulmonary Embolism | 6817 | 0% | Bilat Pulmonary Embolism | 6817 | 30% | 20031202 |
| Thrombophilia w/Heterozygous Factor V | Related diagnosis | Prothrombin II Deficiency | 7799-7700 | NSC | 20031202 |
| Factor V Leiden Deficiency | 7799-7700 |
| Familial Hyperlipdemia | Not Unfitting | Hyperlipdemia | 7099-7005 | NSC | 20031202 |
| ↓No Additional MEB Entries↓ | Grade 1 Spondylolisthesis L5-S1 and Scoliosis | 5239-5292 | 10% | 20031202 |
| 2 Add’l Non Service Connected Conditions | 20031202 |
| **Combined: 0%** |  **Combined: 40%** |

ANALYSIS SUMMARY: The military services, by law, can only rate and compensate for those conditions that were found unfitting for continued military service based on the severity of the condition at the time of separation and not based on possible future changes. The VA, however, can rate and compensate all service connected conditions without regard to their impact on performance of military duties, including conditions developing after separation that are direct complications of a service connected condition. The VA can also increase or decrease ratings based on the changing severity of each condition over time. The Board’s role is confined to the review of medical records and all evidence at hand to assess the fairness of PEB rating determinations compared to VA Schedule for Rating Disabilities (VASRD) standards in effect at the time, as well as the fairness of PEB fitness adjudications. The Board’s threshold for countering Disability Evaluation System (DES) fitness determinations is higher than the VASRD §4.3 reasonable doubt standard used for its rating recommendations but remains adherent to the DoDI 6040.44 “fair and equitable” standard.

Pulmonary Embolism with Thrombophilia. The CI sought emergency care for chest pain diagnosed as pulmonary emboli to both lungs in March 2001 following a long car trip. He was hospitalized and treated with blood thinning medication. Treatment records (civilian and military) from March 2001 to the time of the MEB two years later reflected recovery and absence of recurrent blood clots or pulmonary emboli (pulmonary thromboembolism). Evaluation by hematology diagnosed the presence of genetic abnormalities of the clotting system predisposing to the formation of blood clots (thrombophilia). Based on the results of these tests, and a possible prior history of a leg blood clot, long term (possibly lifelong) treatment with blood thinning medication (warfarin/Coumadin) was recommended by the hematologist. An episode of calf pain in December 1998, while on ship, was noted and retrospectively attributed to possible deep vein thrombosis. The treating medical officer at the time considered a diagnosis of deep vein thrombosis but concluded the symptoms were due to muscle strain and the pain resolved after several days of treatment with a non-steroidal anti-inflammatory drug. There were no symptoms suggestive of pulmonary embolism at that time. In January 2003, an episode of chest pain prompted reevaluation that found no evidence of recurrent pulmonary embolism (negative chest CT scan) or evidence of heart disease. A Mayo Clinic internal medicine clinic encounter in January 2003, six months before separation, records no symptoms of thromboembolic disease including shortness of breath or leg symptoms. The physician records the CI was obese and not exercising, but he had quit smoking when hospitalized in March 2001 (smoking, as well as obesity, increases risk for clot formation). The February 2003 NARSUM reflected no recurrent venous thrombosis or pulmonary embolism, and no residual signs, symptoms, examination findings or impairments. At the time, he was working as a recruiter but was scheduled to return to operational duties on a ship. Operational military duties were considered to be medically inadvisable while on chronic treatment with blood thinning medication. Therefore, the CI was referred for MEB and found unfit for continued military duty by the PEB due to the requirement for long term treatment with warfarin for thrombophilia. The genetic predisposition to blood clotting would be considered service connected by the PEB under the rules of the military DES because the CI had over eight years of active military service (the VA does not have this requirement).

The VA compensation and pension (C&P) exam in December 2003, five months after separation, records that there were no symptoms of recurrent venous thrombosis or pulmonary embolism, no symptoms attributable to residuals of prior pulmonary embolism, and no problems with warfarin treatment. The CI stated there was no shortness of breath at rest and that walking was unlimited; however, he did report shortness of breath with jogging. Physical examination noted obesity but was negative for stigmata of chronic or recurrent pulmonary embolism, or venous thrombosis in the extremities. Lung function testing (spirometry and diffusion testing) was normal, consistent with no evidence of residual lung function impairment. The VA rated the CI’s condition at 30% under the code for pulmonary vascular disease (6817) for symptomatic, after resolution of acute pulmonary thromboembolism, apparently due to the complaint of shortness of breath when jogging. The VA noted that the CI’s symptoms and lung function testing did not meet criteria for the higher rating.

The CI’s pulmonary embolism had occurred two years prior to the PEB, and objective evidence of record including the CT scan in January 2003 and the lung function testing in December 2003 documented no recurrent pulmonary emboli and no residual impairment of lung function. The Board considered whether the CI’s report of shortness of breath with jogging during the C&P exam was linked to the history of pulmonary embolism. Since the condition was stable, the Board concluded that shortness of breath was just as likely as not present prior to the time of separation. Based on the preponderance of evidence, the Board concluded (with one dissenting member) that the CI’s complaint of shortness of breath when jogging was not due to chronic/recurrent pulmonary emboli or residuals of pulmonary emboli but rather due to de-conditioning. The records show the CI was obese and was not exercising, and shortness of breath with jogging is a normal result when sedentary individuals attempt vigorous exercise they do not engage in on a regular long term basis.

The Board considered the CI’s contention that his condition meets VASRD criteria for a 60% rating. The CI submitted a letter from his VA clinic provider along with a copy of an Army Board for Correction of Military Records (ABCMR) case in support of his contention. The letter, dated August 11, 2008, addressed to the Board for Correction of Navy Records from the CI’s VA medical provider states that at the time of the PEB, the pulmonary embolism was completely resolved and the CI was asymptomatic. The provider opines that chronic preventive treatment with warfarin after a single resolved pulmonary embolism equates to criteria for a 60% rating. The ABCMR case, in which the ABCMR granted a 50% rating, is similar in that the applicant in that case also had a genetic predisposition for blood clot formation. However, the individual actually experienced multiple episodes of pulmonary embolism over one-and-a-half years; therefore, the Board concluded the ABCMR case was not comparable to the CI’s case.

The evidence clearly establishes that, after his initial event, the CI did not have recurrent or chronic pulmonary thromboembolism as specified in the criteria for the 60% rating. He had a genetic predisposition for the formation of blood clots and was taking warfarin to prevent possible recurrent pulmonary thromboemboli. However, the presence of the genetic predisposition does not equate to a diagnosis of actual chronic recurrent pulmonary thromboembolism. The fact that treatment for the predisposition has been recommended and followed does not equate with the serious level of occupation impairment that the 60% level describes and does not meet the criteria for a 60% evaluation.

IAW with § 4.1 (essentials of evaluative rating), the VASRD is designed to compensate for average impairments of earning capacity resulting from service-connected disability in civil occupations (not military). Although the lifelong need for maintenance on blood thinners is shown, medical evidence demonstrated no residual disability from the pulmonary embolism that can support a compensable evaluation at the time of separation from military service. Further, there were no significantly disabling side effects of the medication, and no unusual or exceptional disability factors were demonstrated with respect to the service-connected thrombophilia or lung condition. Without evidence of a symptomatic condition following resolution of an acute pulmonary embolism, a compensable rating cannot be awarded. The Board concluded that the evidence of the record did not support a rating higher than 0%, asymptomatic, following resolution of pulmonary thromboembolism under the diagnostic code for pulmonary artery disease (6817). There were no other residuals or manifestations of the unfitting condition that could support consideration for rating under any other codes. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s rating decision for the pulmonary embolism condition.

Other PEB Conditions. The familial hyperlipdemia condition was judged to be within standards and was not identified as impairment in the commander’s statement. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the familial hyperlipdemia condition.

Remaining Conditions. Other conditions identified in the DES file were back pain (grade 1 spondylolisthesis L5- S1, and scoliosis) and hypothyroidism (listed on DD Form 2807). Available records show the CI sought care for intermittent low back pain beginning in 1989. The last available medical record entry is from 1999 when he sought care for back pain of a few days duration. At the time of the MEB history and physical examination, the CI noted the history of recurrent low back pain but there was no comments made regarding symptoms or limitation. None of these conditions were clinically active during the MEB period, were the basis of a limited duty period, and none were implicated in the commander’s non-medical assessment. These conditions were reviewed by the action officer and considered by the Board. It was determined that none could be argued as unfitting and subject to separation rating. The Board therefore has no reasonable basis for recommending any additional unfitting conditions for separation rating.

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. In the matter of the pulmonary embolism and thrombophilia condition and IAW VASRD §4.97, the Board by a vote of 2:1 recommends no change in the PEB adjudication. The single voter for dissent (who recommended 30%) did not elect to submit a minority opinion. In the matter of the back 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.

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

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Pulmonary Embolism | 6817 | 0% |
| **COMBINED** | **0%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20091114, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

 Deputy Director

 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

 XXXXX, FORMER USN, XXX-XX-XXXX

Ref: (a) DoDI 6040.44

 (b) PDBR ltr dtd 19 Apr 11

 I have reviewed the subject case pursuant to reference (a) and, for the reasons set forth in reference (b), approve the recommendation of the Physical Disability Board of Review Mr. Jacobson’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.

 Assistant General Counsel

 (Manpower & Reserve Affairs)