RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: Army

CASE NUMBER: PD1001171 Date of Placement on TDRL: 20050905

BOARD DATE: 20111218 DATE OF PERMANENT SEPARATION: 20070309

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SPC/E-4 (25U, Signal Support) medically separated for asthma*.* The CI stated that he had no history of respiratory problems until returning from a 2003-2004 deployment to Kuwait. He was diagnosed with asthma by pulmonary function testing (PFT), and did not respond adequately to treatment for continued performance within his military occupational specialty (MOS). He was issued a permanent P3 profile and underwent a Medical Evaluation Board (MEB). Asthma was forwarded to the Physical Evaluation Board (PEB) as a medically unacceptable condition IAW AR 40-501. Other conditions included in the Disability Evaluation System (DES) file will be discussed below. The Informal PEB (IPEB) adjudicated the asthma condition as unfitting, rated 30%, with application of the Veterans Administration Schedule for Rating Disabilities (VASRD). The CI was placed on the Temporary Disability Retired List (TDRL) in September 2005 and was reevaluated in October 2006. Based on this evaluation, the IPEB determined that the CI’s asthma condition was sufficiently stable for final adjudication and found the condition to be unfitting, rated 10% IAW the VASRD. The CI appealed to a Formal PEB (FPEB) which concurred with the 10% rating. The case was then forwarded to the US Army Physical Disability Agency (USAPDA) which reaffirmed the PEB’s findings and recommendations. The CI was then medically separated with a 10% disability rating.

CI CONTENTION: The CI states: “It was a split determination of the PEB Board, I ask about why only one condition was being rated when there was multiple. The answer was that DA would make that determination which it never did. My request to the board was retention. I had 9 years of service and I did not want to leave the service. The VA rated me on both conditions with a combined rating of 70%.” Although not specifically stated, it may be assumed that ‘both conditions’ refers to asthma and post-traumatic stress disorder (PTSD). He elaborates no specific contentions regarding rating or coding and mentions no additionally contended conditions.

RATING COMPARISON:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Final Service FPEB – Dated 20070309** | | | | **VA – All Effective 20050905** | | | |
| **Condition** | **Code** | **Rating** | | **Condition** | **Code** | **Rating** | **Exam** |
| **On TDRL – 20050905** | **TDRL** | **SEP** |
| Asthma | 6602 | 30% | 10% | Asthma | 6602 | 30%\* | STR |
| No Additional MEB/PEB Entries | | | | PTSD | 9411 | 50%\* | 20090416 |
| Not Service Connected x 5 | | | STR |
| **Combined: 10%** | | | | **Combined: 70%\*** | | | |

\* Asthma rating based on Service treatment record (STR) at the time of TDRL placement; PTSD and combined ratings based on most proximate exam following permanent separation (> 2 years) and rating decision of 20090430. The most proximate VA exam for asthma following permanent separation was > 3 years later.

ANALYSIS SUMMARY: The Board acknowledges the CI’s contention that suggests Service ratings should have been conferred for other conditions documented at the time of separation. The Board wishes to clarify that it is subject to the same laws for Service disability entitlements as those under which the Disability Evaluation System (DES) operates. While the DES considers all of the service member's medical conditions, compensation can only be offered for those conditions that cut short a service member’s career, and then only to the degree of severity present at the time of final disposition. However the Department of Veterans’ Affairs (VA), operating under a different set of laws (Title 38, United States Code), is empowered to compensate all service connected conditions and to periodically reevaluate said conditions for the purpose of adjusting the Veteran’s disability rating should his degree of impairment vary over time. The Board further clarifies that, in cases involving a period of TDRL, it must also adhere to the DES standard that only those conditions which were present and unfitting at the time of temporary retirement may be considered for Service rating; regardless of their status at the time of permanent separation.

Asthma. The CI’s asthma was a new development since returning from a one year tour in Kuwait. While in theater he was exposed to smoke from an oil refinery for three weeks and to other noxious fumes. Upon redeployment he noted dyspnea on exertion, some resting shortness of breath nocturnally, and declining aerobic tolerance on physical fitness tests. He was referred to the allergy clinic and underwent a thorough evaluation. Inducible bronchospasm was confirmed by a methacholine challenge test; and lung volumes were mildly decreased with a normal diffusing capacity for carbon monoxide (DLCO) suggesting a mixed obstructive (asthma) and restrictive pattern. Exercise induced bronchospasm, however, was a persistent feature documented in Service clinical entries. The CI was placed on the TDRL while undergoing aggressive therapy and failed to respond four months into this trial. He remained unable to pass fitness standards or tolerate the required chemical protective mask. There were two PFT evaluations in evidence, as referenced in the rating discussion. Both of these were Service examinations; no VA PFTs are in evidence. The ratable parameters from these two exams are charted below. Measurements of DLCO and other parameters did not affect rating and are omitted.

|  |  |  |
| --- | --- | --- |
| **Service PFTs\*** | **Entry TDRL (3 Mo. Prior)** | **Separation (5 Mo. Prior)** |
| FEV1 (% Predicted) | 77% | 76% |
| FEV1/FVC | 78% | 81% |
| §4.97 Rating\* | 10% | 10% |

\* Rating per PFT criteria alone; all 30% ratings stipulated treatment criteria.

It is clear that objective PFT parameters, in themselves, would support only 10% ratings for both the TDRL period and at separation. The PEB’s TDRL rating of 30% was derived from the treatment criteria elaborated in VASRD §4.97 for that rating under the 6602 (asthma) code; i.e., “daily inhalational or oral bronchodilator therapy, or; inhalational anti-inflammatory medication;” whereas the 10% rating designates “intermittent inhalational or oral bronchodilator therapy.” The PEB’s DA Form 199 conferring the 30% rating (required for placement on TDRL) stated “on daily inhalational therapy.” This treatment regimen was documented in the MEB’s narrative summary (NARSUM). The DA Form 199 entry by the IPEB (14 November 2006) which recommended permanent separation at 10%, however, referenced evidence from the medication profile which was inconsistent with daily treatment. The subsequent FPEB, after hearing formal testimony, and the USAPDA on review both arrived at the same conclusion; i.e., that the objective pharmacy evidence did not support the CI’s contention that he was maintaining a daily treatment regimen. It is noted that one member of the FPEB dissented in this conclusion and submitted a minority opinion (hereafter referred to as MO) which was reviewed by the Board. Since this is clearly a pivotal question for the Board to address in this case, the available evidence was carefully reviewed and the prescribed pharmacy procedural policies underlying the evidence reflected in the crucial medication log was independently investigated.

The evidence on record pertinent to this issue is as follows. The TDRL examiner cited asthma medications of Singulair™ (oral anti-inflammatory), Advair™ (inhaled bronchodilator/anti-inflammatory) and albuterol (inhaled bronchodilator). Dosing and compliance were not documented, other than a comment that the albuterol inhaler was employed “every other day average.” Although the clinical record is not in evidence, the MO documents testimony that the CI had recently seen a provider who prescribed a change in medications. The medication log documents new prescriptions for Pulmicort™ (inhaled steroid) and Foradil™ (inhaled long-acting bronchodilator) filled on 22 December 2006 (14 weeks pre-separation). The MO documents CI testimony that he had been consistently using daily medications, but could not document refills since he “had to turn in his containers to get his refills.” The CI provided prescription labels to the FPEB demonstrating that “he was actually taking the new medication.” The MO did not address the question as to how the CI was able to retain these labels in light of his testimony that the earlier refills were reclaimed and unavailable. There are clinical entries, preceding and following the 12 month rating period prior to separation (by significant intervals), which comment on daily compliance. There are no outpatient entries on record during the rating interval. The probative medication log itself documents: December fills of Albuterol and Advair™ (presumably replaced by the new medications one week later); fills for Advair™ 5 months earlier; and, for Albuterol nine months earlier. There are additional records from the afterhours pharmacy and inpatient pharmacy as well documenting a second and third source for obtaining prescriptions. The outpatient medication log document prescribed refills sufficient for monthly maintenance of all asthma medications, but indicates that no refills were dispensed. Per Board staff inquiry regarding the medication log methodology, if correct procedure was followed, it may be assumed that no refills were dispensed. On 12 October 2006 (preceding the contested IPEB), the CI acknowledged by signature that the medication log (including the afterhours and inpatient record) was his sole source of medication. On 25 January 2001, the USAPDA requested confirmation from the CI’s hospital command that the asthma medications were being dispensed. This cited a “note from the pharmacist that he has not picked up any medication.” Neither the referenced note nor a command response is in evidence.

The Board directs its attention to its rating recommendations based on the evidence just described. First it is noted that the Board entertained rating under the analogous 6845 code for restrictive lung disease (based on the mixed picture previously cited), but ascertained that this would yield only a 10% rating. Reverting to 6602, there was no evidence for any §4.97 criteria supporting a rating higher than 30% (respiratory failure, frequent exacerbations requiring physician intervention, daily use of high dose corticosteroids, immune-suppressive medications, or frequent use of systemic corticosteroids). The Board devoted ample attention to the issue of whether the requirement for daily bronchodilator and/or anti-inflammatory therapy was met in this case, as that is the pivotal criteria between a 10% or 30% rating IAW VASRD §4.97. It is acknowledged that the VASRD is somewhat outdated for asthma since modern treatment has expanded to include many treatment agents not employed when the existing rating criteria were promulgated. Contemporary regimens routinely employ daily maintenance with a variety of inhaled steroid (anti-inflammatory) and/or bronchodilator agents. The VA generally concedes the 30% rating if there is a prescription for any of these agents; and, the Board’s precedent has been to follow suit, even though it is clear that this encompasses many cases of relatively mild disease associated with minimal limitations and disability. The Board, however, does take the reasonable position that the evidence in such cases should satisfy an assumption that the treatment regimen supporting the higher rating is necessary to maintain good control of the condition. That question is only raised in cases where there is evidence that the condition is well controlled in spite of documented non-compliance or only sporadic use of the medications in question. It was debated as to whether it was satisfactorily established in this case that the CI, although clearly prescribed treatments meeting the 30% criteria, actually required (as specified in the VASRD rating language) the daily regimen to maintain the good control evidenced in his PFT results. It is clear that the medication logs document sporadic use of asthma medications and no refills prior to the IPEB. The preponderance of the evidence supports the accuracy of those logs, and the CI himself confirmed that they were his only source of his prescriptions. Even if the CI was unable to obtain personal copies of refills during this period, the automated log should have captured the refills to which he attested. All members concurred that the period after the IPEB could not be considered highly probative, since subsequent medication use was subject to secondary gain behavior; and, there is no evidence for exacerbation of the disease process itself imposing a requirement for more frequent treatment. Despite the CI seeking care for his asthma condition in 2004 and 2005, there were no Service treatment records reflecting chronic or acute asthma care while on TDRL and during the §4.97 rating interval of 12 months. Since the CI attested that he was not receiving medication outside his military facility, it may be presumed that the Service records captured all routine visits. Therefore the Board considered the period leading up to permanent separation after TDRL as a period requiring little medical care and only intermittent use of asthma medications. The TDRL PFT was performed prior to the IPEB, during the most probative period for pharmacy evidence, and reflected mild obstruction without daily medication use. The FPEB and the USAPDA, armed with all the evidence available to this Board plus the benefit of testimony not in evidence, thoroughly addressed the medication compliance issue; and, the Board finds no opposing evidence or adequate support in the FPEB minority opinion to conclude that the CI was using and requiring daily treatment during the rating period contrary to those findings. The Board therefore, after comprehensive deliberation and relying on the preponderance of the evidence, does not find adequate reasonable doubt in the CI’s favor supporting recharacterization of the FPEB’s permanent rating adjudication for the asthma condition.

Other Contended Conditions. The CI’s application asserts that a compensable rating should be considered for PTSD/depression. There was a paucity of clinical entries in the Service file related to PTSD, depression, or any other mental health diagnosis. A note in September 2003 indicated that the CI was seen emergently because he was “thinking about hurting himself.” He was diagnosed with an adjustment disorder and referred to mental health for evaluation, but this evaluation was not documented in the records. The MEB examination documented that the CI was on medications for chronic depression, but stated that his symptoms were well-controlled. The CI documented on his last post deployment health assessment that he considered his health very good, and did not indicate that he had any medical or mental health issues related to the deployment. He likewise did not acknowledge the exposures subsequently documented as Criterion A stressors for PTSD. The Board notes historical discrepancies among entries addressing his PTSD and subsequently claimed traumatic brain injury conditions. The PTSD/depression was not of clinical or occupational significance during the MEB period; nor carried attached profiles; nor was implicated in the commander’s statement. This condition was reviewed by the action officer and considered by the Board. There was no evidence for concluding that PTSD/depression interfered with duty performance to a degree that could be argued as unfitting. The Board determined therefore that PTSD/depression was not subject to Service disability rating.

Remaining Conditions. The other condition identified in the DES file was seborrheic dermatitis. Several other non-acute conditions or medical complaints were also documented. None of these conditions were noted to be of clinical or occupational significance during the MEB period; none carried attached profiles; and none were implicated in the commander’s statement. 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. No other conditions were service connected with a compensable rating by the VA within twelve months of separation or contended by the CI. 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. The Board did not surmise from the record or PEB ruling in this case that any prerogatives outside the VASRD were exercised. In the matter of the asthma condition, the Board unanimously recommends separation rating after TDRL of 10% coded 6602 IAW VASRD §4.97. In the matter of the PTSD, depression, seborrheic dermatitis, 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, as follows:

|  |  |  |  |
| --- | --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **TDRL RATING** | **PERMANENT**  **RATING** |
| Asthma | 6602 | 30% | 10% |
| **COMBINED** | **30%** | **10%** |

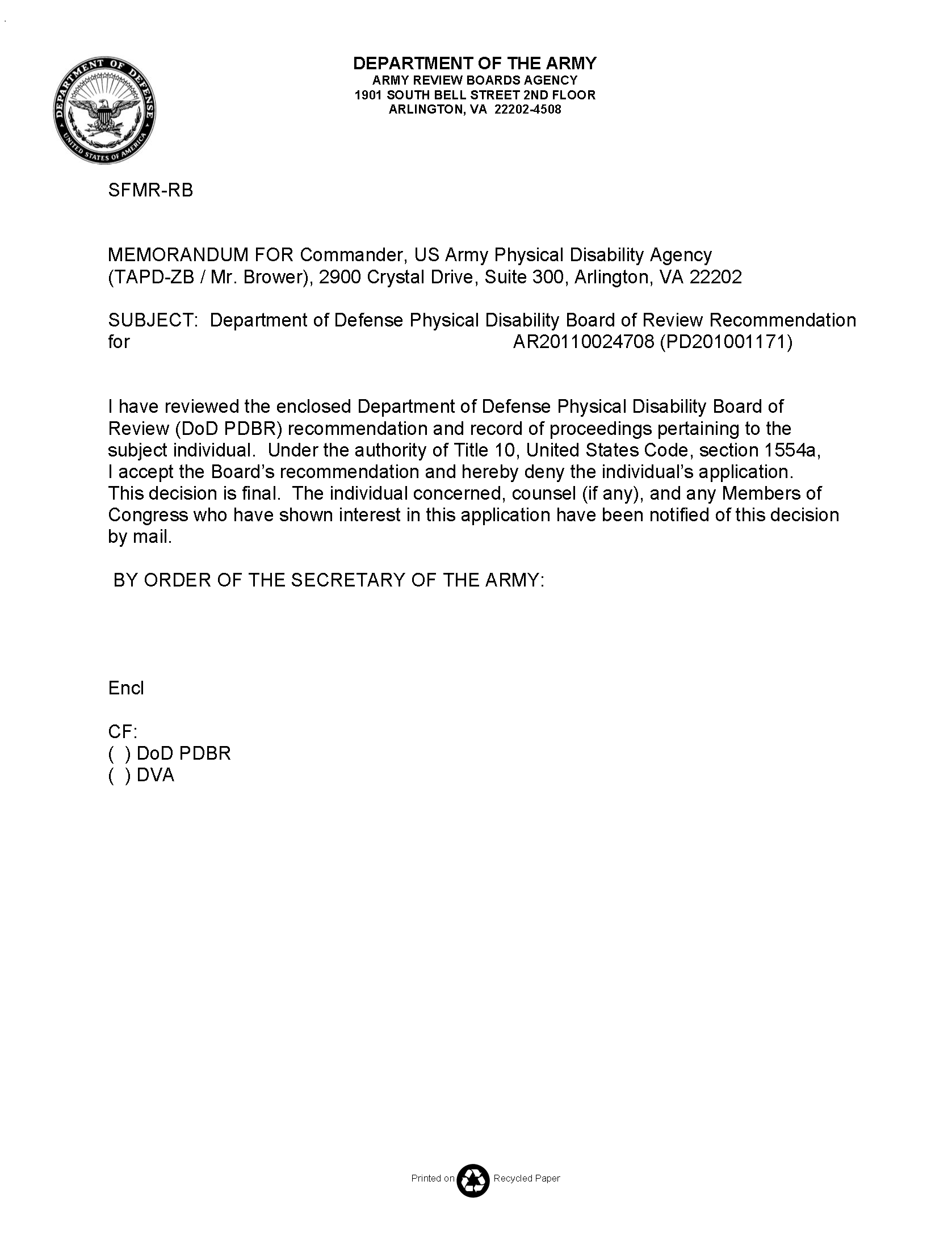
**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20100924, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans' Affairs Treatment Record

****