RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1001188 SEPARATION DATE: 20080727

BOARD DATE: 20120106

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SPC/E4 (68W, Health Care Specialist), medically separated for postphlebitic syndrome. The CI developed a deep vein thrombosis (DVT) of the left lower extremity (LLE) while deployed to Iraq in 2005. He was treated, but persisted with LLE pain that required daily narcotic pain relief. He was unable to perform within his Military Occupational Specialty (MOS) or meet physical fitness standards; was issued a permanent L3 profile and referred for a Medical Evaluation Board (MEB).The LLE postphlebitic syndrome was forwarded to the Physical Evaluation Board (PEB) as a medically unacceptable condition IAW AR 40-501. Hypertension and migraine headache were also evaluated by the MEB and forwarded as medically acceptable conditions.Other conditions included in the Disability Evaluation System (DES) file will be discussed below. The PEB adjudicated the LLE condition as unfitting, rated 10%, with application of the Veterans Administration Schedule for Rating Disabilities (VASRD). The remaining conditions were found to be not unfitting. The CI made no appeals and was medically separated with a 10% disability rating.

CI CONTENTION: The CI states: “I was found 20% disabled for post phlebitis syndrome of my lower left extremity by the VA but only 10% by the MEB. I feel the rating by the VA was more fitting to the extent of my disability with my leg.” He additionally lists all of his VA conditions and ratings as per the rating chart below and adds, “At the time of my MEB proceedings, I claimed migraine headaches. I was not given a percentage. Also, I was not allowed to claim post-concussion syndrome along with the headaches. I could only claim one or the other. I claimed the headaches because during my time in the army, I was not given a thorough workup for TBI [traumatic brain injury] as the VA has given me. So I didn’t have all of the medical evidence to back up my claim. Now I have been rated 30% for migraine and 40% TBI and concussion as a result of a thorough study. In the army, I was given migraine headache medications and so I claimed the condition that I actually got treatment for. When I was trying to make the medical providers understand the scope of the problems, I was having with memory, sleep, and cognition, I only got treated for pain. When in the army, I wasn’t thinking about getting out medical evidence and medical retirement. I just wanted to get better and do my job to the best of my abilities. I am unable to obtain gainful employment because of my conditions. Even with PTSD [post-traumatic stress disorder] which I am rated at 30%, I was basically told that unless you were a danger to the unit or about to kill yourself, you were fine. I was not a medical expert just a soldier following direction. Hopefully, some of these things can be rectified with this board review.

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service PEB – Dated 20080325** | | | **VA (1Mo. Pre-Separation) – All Effective 20080728** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Postphlebitic Syndrome, LLE | 7121 | 10% | Postphlebitic Syndrome, LLE | 7114-7121 | 20% | 20080627 |
| Hypertension | Not Unfitting | | Hypertension | 7101 | 10% | 20080627 |
| Migraine Headaches | Not Unfitting | | Postconcussion … Headaches | 9304\* | 10%\* | 20080627 |
| ↓No Additional MEB/PEB Entries↓ | | | Lumbar Strain | 5237 | 10% | 20080627 |
| Bilateral Tinnitus | 6260 | 10% | 20080909 |
| Pseudofolliculitis Barbae | 7813-7806 | 10% | 20080627 |
| PTSD | 9411 | 70%\*\* | 20090824 |
| 0% x 7/Not Service Connected x 8 | | | |
| **Combined: 10%** | | | **Combined: 50% → 90%\*\*** | | | |

\* Citing 20089023 (post-separation) VASRD schedule change for TBI and applying that effective date; this was subsequently

split into migraine 8100, rated 30%, and 8045, rated 40% (VARD dtd 20100915).

\*\*PTSD not incorporated into proximate rating decision; added on VARD dtd 20100413 citing exam 14 months post-separation,

but applied retroeffectively.

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impairment with which his service-incurred condition continues to burden him. The Board wishes to clarify that it is subject to the same laws for Service disability entitlements as those under which the military Disability Evaluation System (DES) operates. The DES has neither the role nor the authority to compensate service members for anticipated future severity or potential complications of conditions resulting in medical separation. That role and authority is granted by Congress to the Department of Veteran Affairs (DVA), operating under a different set of laws (Title 38, United States Code). The Board evaluates DVA evidence proximal to separation in arriving at its recommendations, but its authority resides in evaluating the fairness of DES fitness decisions and rating determinations for disability at the time of separation. The Board further acknowledges the CI’s contention for ratings for other conditions documented at the time of separation, and notes that its recommendations in that regard must comply with the same governance. While the DES considers all of the service member's medical conditions, compensation can only be offered for those medical conditions that cut short a service member’s career, and then only to the degree of severity present at the time of final disposition. The DVA, however, is empowered to compensate service-connected conditions and to periodically re-evaluate said conditions for the purpose of adjusting the Veteran’s disability rating should his degree of impairment vary over time.

The Board further acknowledges the CI’s accurate assertion regarding the discrepancy between the Service and VA ratings for his headache and TBI-associated conditions, but notes that DoDI 6040.44 (under which the Board operates) specifies that it must apply the VASRD criteria in effect on the day of separation (see first footnote in the above rating comparison chart). Finally, the Board acknowledges the CI’s assertions quoted above regarding suspected medical management and procedural improprieties in the processing of his case. It is noted for the record that the Board has neither the jurisdiction nor authority to scrutinize or render opinions in reference to such assertions. 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 VASRD standards) and fitness adjudications (based on the fitness consequences of conditions as they existed at the time of separation) as elaborated above.

Postphlebitic Syndrome. The CI was diagnosed with DVT in Iraq after he developed LLE pain that was worsening over a trial of conservative treatment in theater; which was followed by medical evacuation and a nine month course of treatment with anticoagulant after redeployment. The CI was thoroughly assessed by specialty consultations and multiple ancillary studies following this treatment course; which verified the absence of any sequela (specifically pulmonary embolus) or persistent clot propagation. Doppler studies demonstrated some residual diminished flow indices on the left which had normalized by April 2007. The MEB narrative summary (NARSUM) noted that the CI was experiencing daily pain and paresthesias of the left lower extremity; this requiring narcotic pain medication, rest, elevation and use of a support hose. The pain was specifically exacerbated by exertional activities and by various mechanical activities, such as knee bending. This imposed significant functional limitations relative to the MOS. His profile prohibited running, but allowed self-paced walking. The NARSUM physical exam documented full active range-of-motion, posterior LLE tenderness (popliteal and calf), mild edema, no physical signs of active DVT, a slight decrease in LLE strength, and no additional signs of neurologic or vascular compromise. Also in evidence is a vascular specialty exam, performed a few weeks after the NARSUM exam, which documented the absence of edema. The VA compensation and pension (C&P) examiner (a month prior to separation) confirmed the subjective complaints documented in the NARSUM. The only documented physical finding was tenderness similar to that noted by the MEB examiner; although, the VA examiner recorded normal motor findings and absent edema (confirmed by measured calf circumferences). Also in evidence were VA clinic examinations, quite proximate to separation, which documented edema.

The Board directs its attention to its rating recommendation based on the evidence just described. The logical code for rating is 7121 (post-phlebitic syndrome of any etiology), which was applied by the PEB; although, the VA employed the hyphenated code 7114 (arteriosclerosis obliterans) rated under 7121. The VA rated the condition at 20% based on persistent edema incompletely relieved by elevation of the extremity; deep vein venous insufficiency; and, for intermittent claudication (exertional leg pain caused by poor blood supply). This approach actually applies criteria derived from both hyphenated codes, not just the rated code (7121). The VA rating decision referenced the initial residual diminished flow indices in the follow-up Doppler testing (noted above) and cited post-separation VA treatment records. The PEB rated the condition at 10% based on persistent leg aching, intermittent edema, and fatigue. It was agreed by the Board that at the time of separation, while there was pain with activity, the normalized flow indices and the lack of evidence for true claudication undermined any support for application of rating criteria derived from the 7114 code (minimally rated 20%); and that all residuals of the postphlebitic syndrome were appropriately rated solely under 7121. IAW with VASRD 4.104 criteria for rating under 7121, the 40%, 60%, and 100% ratings were not supported; since, there was no evidence for “board-like edema”, constant pain at rest, skin changes, ulceration or any of the other cited criteria. The Board therefore deliberated between the 10% and 20% ratings. The pivotal distinction between these ratings is the presence of “persistent edema, incompletely relieved by elevation” (20%) or “intermittent edema … with symptoms relieved by elevation” (10%) of the LLE. The MEB examiner and the VA examinations proximate to separation confirmed the presence of edema, whereas the specialty exam and the VA C&P exam (verified by measurement) confirmed the absence of edema. The Board is therefore satisfied that intermittent edema, consistent with the 10% criteria, is convincingly documented. There is not, therefore, reasonable doubt in the CI’s favor supporting a change from the PEB’s adjudication of the LLE postphlebitic condition.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were migraine headaches and hypertension. The Board’s main charge in respect to these conditions is an assessment of the appropriateness of the PEB’s fitness adjudication. The Board’s threshold for countering 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. The migraine headache is intertwined with the contended TBI condition, which will be discussed in more detail in the following section. The MEB neurologist documented episodic migrainous headaches which occurred 1-2 times per month, and resolved with medications (in most cases with over-the-counter medications). It was specifically noted that the headaches were not severe enough to interfere with work. The pre-separation VA C&P examiner also indicated that the CI, even with a headache, was able to function at work. There were few entries in the service treatment record (STR) related to rescue treatment for these headaches and there were none after the treatment period for DVT. Finally, the CI’s headaches were not severe enough to prevent him from reenlisting in 2006. The migraines were not profiled; the commander’s statement made no mention of them; and the MEB judged the condition to meet retention standards. Hypertension was diagnosed in September 2003. It was well controlled on medication at the time of the MEB, as evidenced by numerous normal measurements in the record. It was likewise not profiled, implicated by the commander, or judged to be medically unacceptable. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change in the PEB fitness adjudications for these two conditions.

Contended TBI and PTSD Conditions. The clinical evidence related to TBI is as follows. There are conflicting accounts as to the nature of the head trauma (fall during training or struck by a tent pole) and whether or not there was associated loss of consciousness (LOC). The neurologist who conducted an exam within two months of the incident stated that there was no LOC and that the CI just felt “stunned.” The headaches, as just discussed, developed subsequent to the head injury; and, the CI additionally described “blackouts” (characterized as "a clouded head" and altered awareness) occurring 1-2 times daily. He was diagnosed by the neurologist with post-concussive migraine headaches, and possible complex partial seizures versus post-concussive syncope/presyncope. The condition was extensively worked up throughout the 2003 and 2004 time period by multiple providers including neurology, cardiology, and neuropsychology. Diagnostic tests included a normal holter monitor (ruling out dysrhythmias), normal electroencephalograms (awake and asleep), and multiple normal imaging studies. These effectively ruled out seizures, transient ischemic attacks, or other neurogenic or cardiovascular etiologies as the cause for the reported periods of altered sensorium. These normal studies prompted the neurologist to opine that these attacks were possibly “nonphysiologic given their atypical features”. Neuropsychological testing revealed some unevenness of performance and mild cognitive inefficiencies; and there were test indicators of symptom exaggeration. The consultant’s impression, derived from this evaluation, was that psychological factors were predominant in the CI’s clinical presentation (e.g., not wanting to deploy); but, that the CI was fit for deployment from a neuropsychological point of view. Ultimately, the neurologist indicated that none of the blackout spells had been witnessed by the command; that the spells had not interfered with work (other than the need for a temporary profile); and, that they were not epileptic in nature. The consultant deemed the CI fit for full duty from a neurology standpoint. There was thus no evidence for concluding that either baseline cognitive impairment, the blackout episodes, or the headaches (previously addressed) - which comprised the entire TBI symptom complex - interfered with duty performance to a degree that could be argued as unfitting. After due deliberation in consideration of the totality of the evidence, and mindful of VASRD §4.3 (reasonable doubt), the Board concluded that there was insufficient cause to recommend the addition of TBI as an unfitting condition for separation rating.

With respect to the contended PTSD condition, there is potential overlap of symptoms related to TBI and PTSD. However, the symptoms discussed above in the context of TBI were not linked to any psychiatric diagnosis during the CI’s time in service. There are entries by the CI on the MEB physical regarding prior treatment for depression and anxiety, but there was no mention of such in the NARSUM; there were no psychiatric medications prescribed at separation; and, there was no active psychiatric treatment during the MEB period. There is no mention of PTSD throughout the STR or anywhere in the core DES file. PTSD was not, in fact, diagnosed by the VA until 13 months after separation. 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 Board, therefore, has no reasonable basis for recommending PTSD as an additional unfitting condition for separation rating.

Remaining Conditions. Other conditions identified in the DES file were hemorrhoids, chronic sinusitis/nasal polyps, pseudofolliculitis barbae, gastroesophageal reflux disease, and liver hemangioma (small vascular growth). Several additional non-acute conditions or medical complaints were also documented. None of these conditions were significantly clinically or occupationally active 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. Additionally, tinnitus and lumbar strain were noted in the VA rating decision proximal to separation, but were not documented in the DES file. 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 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 postphlebitic syndrome condition and IAW VASRD §4.104, the Board unanimously recommends no change in the PEB adjudication. In the matter of the contended migraine headache and hypertension conditions, the Board unanimously recommends no change from the PEB adjudications as not unfitting. In the matter of the contended TBI and PTSD conditions, the Board unanimously agrees that it cannot recommend a finding of unfit for additional rating at separation. In the matter of the hemorrhoids, depression/anxiety, chronic sinusitis/nasal polyps, pseudofolliculitis barbae, gastroesophageal reflux disease, liver hemangioma, 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** | **RATING** |
| Postphlebitic Syndrome, Left Leg | 7121 | 10% |
| **COMBINED** | **10%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20101026, w/atchs.

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans' Affairs Treatment Record

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President

Physical Disability Board of Review

SFMR-RB

MEMORANDUM FOR Commander, US Army Physical Disability Agency

(TAPD-ZB / ), 2900 Crystal Drive, Suite 300, Arlington, VA 22202

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation for XXXXXXXXXXXX, AR20120009662 (PD201001188)

I have reviewed the enclosed Department of Defense Physical Disability Board of Review (DoD PDBR) recommendation and record of proceedings pertaining to the subject individual. Under the authority of Title 10, United States Code, section 1554a, I accept the Board’s recommendation and hereby deny the individual’s application.

This decision is final. The individual concerned, counsel (if any), and any Members of Congress who have shown interest in this application have been notified of this decision by mail.

BY ORDER OF THE SECRETARY OF THE ARMY:

Encl XXXXXXXXXXXX

Deputy Assistant Secretary

(Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA