RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXX BRANCH OF SERVICE: marine corps

CASE NUMBER: PD1001290 SEPARATION DATE: 20040331

BOARD DATE: 20110818

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SSgt/E-6 (6256, Fixed Wing Aircraft Airframe Mechanic) medically separated for asthma. His symptoms of shortness of breath and episodic coughing and wheezing began after an episode of pneumonia in December 2002. Methacholine challenge was positive in January 2003. His treatment included daily inhaled and oral medications, and occasional systemic corticosteroids, with only transient improvement. His exercise tolerance was limited to approximately nine minutes of running, and he had a thirty pound weight gain. He did not respond adequately to treatment and was unable to perform within his military occupational specialty (MOS) or meet physical fitness standards. He was placed on limited duty and underwent a Medical Evaluation Board (MEB). “Asthma, severe persistent, poorly controlled with likely [confounding] gastroesophageal reflux disease (GERD), chronic sinusitis with allergic components, and depression” were forwarded to the Physical Evaluation Board (PEB) IAW SECNAVINST 1850.4E. Other conditions included in the Disability Evaluation System (DES) file are discussed below. The PEB adjudicated the asthma condition as unfitting, rated 10%, with likely application of DoDI 1332.39 and SECNAVINST 1850.4E, and adjudicated the GERD and sinus conditions as category III (not unfitting), with adjustment disorder with mixed anxiety and depressed mood as category IV (not a disability). The CI did not appeal, and was medically separated with a 10% disability rating.

CI CONTENTION: “Because it does not accurately reflect the severity of the disabilities/disability. It should be higher.” The CI also enclosed VA rating decisions from 2008 and 2009. A contention for inclusion of those VA rated conditions in the separation rating is therefore implied.

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service IPEB – Dated 20040129** | **VA (4 Mo. After Separation) – All Effective Date 20040401** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Asthma | 6602 | 10% | Asthma | 6602 | 30% | 20040729 |
| Chronic Sinusitis with Allergic Components | Cat III | Recurrent Sinus Infections, HAs  | 6512 | 10% | 20040729 |
| GERD | Cat III | No VA Entry | 20040729 |
| Adjustment Do. w/ Mixed Anxiety & Depressed Mood | Cat IV | Major Depressive Disorder, Recurrent, Moderate | 9434 | 10%\* | 20040617 |
| ↓No Additional MEB/PEB Entries↓ | Cervical Pain … | 5237 | 20% | 20050721 |
| Right Shoulder Pain … | 5299-5203 | 10%\* | 20050721 |
| R. Hand Carpal Tunnel Syn.  | 8515 | 10% | 20040729 |
| L. Hand Carpal Tunnel Syn. | 8515 | 10% | 20040729 |
| 0% x 1/Not Service Connected x 5 | 20040729 |
| **Combined: 10%** | **Combined: 70%\*** |

\*R shoulder code change with increase to 20% and MDD (9434) increase to 30% effective 20080611 (combined 80%)

ANALYSIS SUMMARY:

Asthma Condition. The narrative summary (NARSUM) six months pre-separation noted the CI’s treatment regimen included a twice-daily inhaled corticosteroid/bronchodilator combination, a daily leukotriene inhibitor, pre-exercise and rescue inhaled bronchodilator, and, temporarily, a theophylline preparation and a systemic corticosteroid. The examiner noted that the CI’s asthma symptoms caused him to use his bronchodilator rescue inhaler up to 15 times per week, caused nocturnal awakening four times per week, and caused a 30-pound weight gain in the past ten months. Spirometry in 2004 two months pre-separation showed an FEV1 of 78%, FEV1/FVC 79%, with slight improvement after bronchodilator administration. The technician performing the spirometry noted the CI’s current medications included an inhaled corticosteroid, a bronchodilator and a leukotriene inhibitor. The service treatment record showed one emergency room visit for asthma, and five courses of systemic corticosteroids in 2003. In addition, the record demonstrated at least monthly visits to a physician during the first six months of 2003 (less thereafter). The MEB physical exam notes only one emergency room visit for asthma among five emergency room visits from July 2000 to April 2003. The VA compensation and pension (C&P) exam four months post-separation stated the CI was no longer able to run or bicycle due to his asthma, and he endorsed three emergency room visits in the past year for asthma exacerbations. At the time of the C&P exam, the CI was no longer prescribed oral corticosteroids; his medication regimen included a daily oral leukotriene inhibitor and two (as needed, daily) inhaled medications.

The PEB and VA each coded the condition as asthma (6602). For the reader’s convenience, the VA Schedule for Rating Disabilities (VASRD) §4.97 criteria for the 10%, 30%, and 60% ratings for 6602 are excerpted below:

FEV-1 of 40- to 55-percent predicted, or; FEV-1/FVC of 40 to 55

percent, or; at least monthly visits to a physician for required

care of exacerbations, or; intermittent (at least three per year)

courses of systemic (oral or parenteral) corticosteroids………………………..60

FEV-1 of 56- to 70-percent predicted, or; FEV-1/FVC of 56 to 70

percent, or; daily inhalational or oral bronchodilator therapy,

or; inhalational anti-inflammatory medication ...................................................30

FEV-1 of 71- to 80-percent predicted, or; FEV-1/FVC of 71 to 80

percent, or; intermittent inhalational or oral bronchodilator therapy ..................10

The history of five courses of systemic steroids over eight months and monthly visits to a physician during the first six months after symptoms onset was early in the course of the illness, prior to stabilization; the condition appeared to stabilize proximate to separation. At separation and beyond, the preponderance of evidence suggests the CI’s condition was not severe enough to meet the 60% threshold, requiring “at least monthly visits to a physician for required care of exacerbations, or; intermittent (at least three per year) courses of systemic (oral or parenteral) corticosteroids” despite the systemic corticosteroid history prior to medication stabilization within the year prior to separation.

The ratable pulmonary function parameters (FEV-1 and FEV-1/FVC) pre-separation were greater than 70%, corresponding with the 10% rating criteria IAW VASRD §4.97. The treatment regimens documented in the NARSUM and VA C&P exam both included either daily inhalational or oral bronchodilator therapy, or; inhalational anti-inflammatory medication in addition to intermittent and rescue medications. The daily medication use meets the criteria for the 30% rating, and the PEB worksheet indicated daily use of Advair (inhaled corticosteroid/bronchodilator combination).

It is acknowledged that the VASRD is somewhat outdated for asthma since modern treatment has expanded to include many treatment agents not available at the time the standards were written. Contemporary treatment regimens commonly employ daily maintenance use of a variety of inhaled steroids (anti-inflammatory) and long-acting inhaled bronchodilators. The VA routinely concedes the 30% rating, if there is a prescription for any of these agents. The Board’s precedent has been to follow suit, although it is clear that this encompasses many cases of relatively mild disease associated with minimal limitations and disability. The Board does take the reasonable position that the evidence in such cases should foster the 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. There is no evidence in this case that the CI did not require daily maintenance with medication in order to maintain control of his asthma. The Board therefore recommends 30% as the fair and equitable rating for asthma in this case, coded 6602.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were chronic sinusitis with allergic components (VA 10% for recurrent sinus infections, headaches), GERD, and adjustment disorder with mixed anxiety and depressed mood (VA 10% for major depressive disorder, later 30%). Adjustment disorder, IAW DoDI 1332.38, does not constitute a physical disability and is not ratable in the absence of an underlying ratable causative disorder. A psychiatric addendum to the NARSUM indicated an Axis I diagnosis of “adjustment disorder with mixed anxiety and depressed mood chronic.” The VA diagnosed Axis I of “major depressive disorder, recurrent, moderate” which, if unfitting, may have been compensable. However, the NARSUM addendum specifically noted the CI’s symptoms of depression and anxiety resulted from situational stressors, and those symptoms were “fairly mild and understandable.” Other symptoms included difficulty concentrating, little motivation, and a decrease in energy. Impairment of social and occupational functioning was not described. A subsequent VA exam noted the CI had not missed any work due to his depressive symptoms. He was treated with one psychotropic medication. Mental status exam revealed mild psychological distress, with mood described as “up and down – depressed and stressed at times,” and affect described as “a bit dysthymic and flat.” The remainder of the exam was normal, without suicidal ideation, psychotic symptoms, speech disturbance, cognitive impairment, or other abnormalities. Global assessment of functioning (GAF) was 61-70, indicating some mild symptoms or some difficulty in social or occupational functioning. The VA C&P psychiatric examination three months after separation described continued depressive symptoms, cyclical in nature, “mild-moderate most of the time,” and diagnosed major depressive disorder, recurrent, moderate. The CI had discontinued his medications due to side effects. The examiner made no mention of employment, but proximate VA outpatient notes indicate the CI was employed at five months post-separation. The mental status exam was unremarkable, and GAF was 58, suggesting moderate symptoms or moderate difficulty in social or occupational functioning. The VA rated this exam at 10% IAW VASRD §4.130.

The Board noted that depression was listed on the MEB submission, but that there was no non-medical assessment contention or limitation of duty attributable to any mental health condition. The detailed NARSUM addendum did not indicate any symptoms that would have led to a finding of unfit if the diagnosis were major depressive disorder rather than adjustment disorder.

Chronic sinusitis with allergic components and GERD can often exacerbate asthma, and any contribution to the CI’s primary unfitting asthma condition was considered above. Neither condition was cause for duty limitations, implicated in the non-medical assessment, or noted as failing retention standards. Anxiety disorder, sinusitis and GERD conditions were reviewed by the action officer and considered by the Board. There was no indication from the record that any of these conditions significantly interfered with satisfactory performance of MOS duty requirements. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB’s adjudication as not unfitting for any of the stated conditions.

Other Contended Conditions. The CI’s application asserts that compensable ratings should be considered for chronic cervical pain (VA 20%), chronic right shoulder pain (VA 10%), and bilateral carpal tunnel syndrome (VA 10% for each hand). The neck and shoulder conditions 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 bilateral hand/wrist conditions were reviewed by the action officer and considered by the Board. There was no evidence for concluding that the conditions interfered with duty performance to a degree that could be argued as unfitting. The Board determined therefore that none of the stated conditions were subject to service disability rating.

Remaining Conditions. Other conditions identified in the DES file were hypercholesterolemia, high blood pressure, cramps in hands, acne, actinic keratoses (two) on face, weight gain, dizziness associated with sinusitis, and poor vision in right eye (20/50 near and distant). Several additional non-acute conditions or medical complaints were also documented. None of these conditions were clinically or occupationally significant during the MEB period, none were the bases for limited duty and none were implicated in the 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. As discussed above, PEB reliance on DoDI 1332.39 for rating asthma was likely operant in this case and the condition was adjudicated independently of that instruction by the Board. In the matter of the asthma condition, the Board unanimously recommends a rating of 30% coded 6602 IAW VASRD §4.97. In the matter of the chronic sinusitis with allergic components and GERD conditions, the Board unanimously recommends no change from the PEB adjudications as not unfitting. In the matter of the adjustment disorder with mixed anxiety and depressed mood condition, the Board unanimously recommends no change from the PEB adjudication as category IV, not a physical disability. In the matter of the chronic cervical pain, chronic right shoulder pain, and bilateral carpal tunnel syndrome conditions 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 recommends that the CI’s prior determination be modified as follows and that the discharge with severance pay be recharacterized to reflect permanent disability retirement, effective as of the date of his prior medical separation:

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

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20101108, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

 President

 Physical Disability Board of Review

MEMORANDUM FOR DEPUTY COMMANDANT, MANPOWER & RESERVE AFFAIRS

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATION

 ICO XXXXX, FORMER USMC, XXX XX XXXX

Ref: (a) DoDI 6040.44

 (b) PDBR ltr dtd 6 Sep 11

1. I have reviewed the subject case pursuant to reference (a) and approve the recommendation of the Physical Disability Board of Review reference (b).

2. Subject member’s official records are to be corrected to reflect the following disposition: Separation from the Naval service due to physical disability rated at 30 percent (increased from 10 percent) with transfer to the Permanent Disability Retired List effective 31 March 2004.

3. Please ensure all necessary actions are taken to implement this decision, including the recoupment of previously paid disability separation pay if warranted, and that subject member is notified once those actions are completed.

 Assistant General Counsel

 (Manpower & Reserve Affairs)