RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXX BRANCH OF SERVICE: air force

CASE NUMBER: PD201100093 SEPARATION DATE: 20020723

BOARD DATE: 20111007

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty member, A1C/E-3 (3P051 / Security Forces Journeyman), medically separated for neurocardiogenic syncope associated with depressive disorder. The CI’s symptoms began in September 2000 when he experienced syncope or pre-syncope (lightheadedness, nausea) after running. His evaluation included a normal treadmill stress test (followed by a pre-syncopal hypotensive episode), normal echocardiogram, and abnormal tilt table testing demonstrating neurocardiogenic syncope with a vasodepressor and cardioinhibitory response. He was treated with medication, but did not respond adequately to perform within his Air Force Specialty (AFS) or meet physical fitness standards. He was issued a P4 profile and underwent a Medical Evaluation Board (MEB). “Neurocardiogenic syncope; pes planovalgus (EPTS); depressive disorder not otherwise specified; and mixed headache syndrome, responding,” were forwarded to the Physical Evaluation Board (PEB) IAW AFI 48-123. No other conditions appeared on the MEB’s submission. Other conditions included in the Disability Evaluation System (DES) file are discussed below. The Informal PEB (IPEB) combined the neurocardiogenic syncope and associated depressive disorder, and adjudicated the combined condition as unfitting, rated 10%, with application of the Veterans Administration Schedule for Rating Disabilities (VASRD). The CI did not appeal for a Formal PEB, and was medically separated with a 10% disability rating.

CI CONTENTION: “My rating from the Air Force combined two disabilities into one, where the VA found it to be two separate conditions. My overall rating was 20% from the Air Force and my initial Rating from the VA was 60%. I appealed and it went to 90% and also granted IU and the decision was then made permanent and total.” He additionally lists all of his VA conditions and ratings as per the rating chart below. A contention for their inclusion in the separation rating is therefore implied. All service conditions are reviewed by the Board for their potential contribution to its rating recommendations.

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service IPEB – Dated 2000506** | | | **VA (5 Mos. After Separation) – All Effective 20020724** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Neurocardiogenic Syncope Associated w/Depressive Disorder | 8210-8299 | 10% | Neurocardiogenic Syncope | 8199-6204 | 30%\* | 20021212 |
| Major Depressive Disorder | 9434 | 30%\* | 20021202 |
| Pes Planovalgus (EPTS) | 5276 | Cat II | Bilateral Pes Planus… | 5276 | 30% | 20021212 |
| Headaches, controlled | 8100 | Cat II | Migraine Headaches | 8199-8100 | 50%\* | 20021212 |
| ↓No Additional MEB/PEB Entries↓ | | | Gastritis | 7307 | 30% | 20021212 |
| Lumbar Strain | 5295 | 20%\* | 20021212 |
| Tinnitus | 6260 | 10% | 20021212 |
| 0% x 1 / Not Service Connected x 5 | | | 20021212 |
| **Combined: 10%** | | | **Combined: 90%** | | | |

\* Syncope changed from 8199-8108 at 10% to 8199-6204 at 30% with same effective date via DRO decision (de novo review) 20040302; other changes in DRO decision include MDD 9434 from 10% to 30%, Headaches 8199-8100 from 10% to 30% (later 50% in second DRO decision), and Lumbar Strain 5295 from 10% to 20%

ANALYSIS SUMMARY:

Neurocardiogenic Syncope Associated with Depressive Disorder. The PEB combined neurocardiogenic syncope and depressive disorder as a single unfitting condition, coded analogously to 8210 (tenth [vagus] cranial nerve paralysis) and rated 10%. The Board’s initial charge in this case was therefore directed at determining if the PEB’s approach of combining conditions under a single rating was justified in lieu of separate ratings. The Board must apply separate codes and ratings in its recommendations if compensable ratings for each condition are achieved IAW the VASRD. If the Board judges that two or more separate ratings are warranted in such cases, however, it must satisfy the requirement that each ‘unbundled’ condition was unfitting in and of itself. Not uncommonly this approach by the PEB reflected its judgment that the constellation of conditions was unfitting, and there was no need for separate fitness adjudications or implied adjudication that each condition was separately unfitting. Thus the Board must maintain the prerogative of separate fitness recommendations in this circumstance, with the caveat that its recommendations may not produce a lower combined rating than that of the PEB. The evidence in the record is summarized below.

The narrative summary (NARSUM), three months pre-separation, reported the CI experienced “a couple episodes” of syncope and “multiple episodes” of pre-syncope shortly after exercise (running). He also experienced one episode of orthostatic syncope seven months pre-separation. His pre-syncope was characterized by lightheadedness and nausea, and it required him to lie down for approximately 20 minutes until the feeling resolved. After a treadmill stress test which was otherwise normal, the CI became pre-syncopal, hypotensive (100/50), and tachycardic (180). Tilt table testing reproduced syncope with vasodepressor and cardioinhibitory response.

The Department of Veterans’ Affairs (VA) exam, five months post-separation, reported a similar history, although less detailed than the NARSUM. The CI reported that temperature changes were another trigger for his hypotensive episodes. The physical exam was devoid of significant neurological or cardiovascular findings, and no additional tilt table or stress testing was performed.

The Board first considered if the syncope condition, having been de-coupled from the combined PEB adjudication, remained independently unfitting as established above. All members agreed that the CI’s recurrent neurocardiogenic syncope, as an isolated condition, would have rendered the CI incapable of continued service within his AFS; and, accordingly merits a separate service rating. The Board considered multiple coding options, including: the PEB’s analogous coding to 8210, tenth (vagus) nerve paralysis; the VA’s analogous coding to 6204, peripheral vestibular disorders; analogous coding to 7020, cardiomyopathy, and analogous coding to 8911, petit mal epilepsy. The PEB’s 8210 coding was more physiologically accurate, and was indicated in the alphabetical listing of analogous code. Given the frequency of syncope episodes and severity of pre-syncope events described in the record, the Board majority considered that the “moderate” 10% rating rather than the “severe” 30% rating more accurately reflected the severity of the CI’s condition. After due deliberation, considering all of the evidence, the Board majority recommends a separation rating of 10% for the neurocardiogenic syncope condition, coded 8299-8210.

Depressive Disorder. The NARSUM Addendum, three months pre-separation, described significant depressive symptoms. These included depressed mood, irritability, poor sleep, conflicts with supervisors and coworkers, decreased energy, decreased motivation, anhedonia, and decreased concentration/forgetfulness. Social withdrawal was also noted, without additional details. The NARSUM reported the CI was prescribed two psychotropic medications, and the addendum noted two sessions of psychotherapy. The commander’s statement noted the CI’s syncopal episodes “may have physical and emotional causes,” but did not identify any other mental health-related impairment; the commander further noted the CI’s condition interfered with his functional reliability such that he could not perform his Security Forces duties, “although it did not preclude him from serving in the military in some other capacity.” Mental Status Exam (MSE) revealed depressed mood and blunted affect. The remainder of the exam was normal, with no suicidal or homicidal ideation, psychotic symptoms, cognitive impairment, or speech abnormalities. Global Assessment of Functioning (GAF) was not found in the record. The CI was on two psychotropic medications for mental health symptoms. The MEB noted the CI’s social and industrial impairment was “mild,” and the NARSUM stated that the CI’s psychiatric examiner “believes that psychological factors may play a role affecting his other medical conditions, but that his depression is otherwise well controlled.”

The VA exam, five months post-separation, diagnosed major depressive disorder, recurrent, mild. In addition to his pre-separation symptoms, the CI noted insomnia with three to four hours of sleep per night, and occasional anxiety in social situations. The CI reported no improvement from his three drug psychotropic regimen. The CI was unemployed and “had to file for bankruptcy and collect unemployment due to being unable to find a job since his discharge from the military.” The examiner noted mild difficulties in establishing and maintaining social relationships due to his depression. MSE was significant for mildly depressed mood with congruent affect. There was no suicidal ideation, psychotic symptoms, speech disturbance, cognitive impairment or other abnormalities. GAF was 55, indicating moderate symptoms or moderate difficulty in social or occupational functioning. The VA rated the exam at 30% IAW VASRD §4.130.

Although remote from separation, a VA outpatient note at 13 months post-separation, reported the CI stated he was hospitalized for homicidal ideation toward a coworker for one week at some point prior to separation (not confirmed in record). The CI also reported a history of occasional auditory hallucinations. The examiner assigned a GAF of 65, indicating some mild symptoms or some difficulty in social or occupational functioning, but generally functioning pretty well, having some meaningful interpersonal relationships. Also, at a VA exam for headaches and syncope, 19 months post-separation, the examiner reported the CI was “unable to get any employment because of his medical background of migraine headaches and syncope,” without mention of occupational impact from any mental condition.

The Board considered if the depressive disorder, having been de-coupled from the combined PEB adjudication with syncope, remained independently unfitting as established above. There was no indication that the CI’s unfitting syncope was due to a psychiatric component, and there was sufficient diagnostic testing to support the diagnosis of neurocardiogenic syncope. The depressive disorder was attributed to occupational difficulties tied to his syncope and work restrictions. In addition to this workplace stress, the CI likely experienced stress attributable to the DES process and impending separation. Also, the neurology addendum “impression” conflicted with the psychiatric addendum list of diagnoses. The neurology addendum noted “adjustment disorder with depressed mood, chronic vs. major depressive disorder, recurrent,” (in addition to “psychological factors affecting physical condition”), while the psychiatric addendum listed “depressive disorder, not otherwise specified” as an Axis I diagnosis.

As previously elaborated, the Board must first consider whether depressive disorder remains separately unfitting, having de-coupled it from a combined PEB adjudication. In analyzing the intrinsic impairment for appropriately coding and rating the depressive disorder, the Board is left with a questionable basis for arguing that it was indeed independently unfitting. The CI had an S1 profile and the commander’s statement only mentioned that the syncope may have had emotional causes. After due deliberation, the Board agreed that evidence does not support a conclusion that depressive disorder, as an isolated condition, would have rendered the CI incapable of continued service within his AFS; and, accordingly cannot recommend a separate Service rating for it.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as Category II “conditions that can be unfitting but are not currently compensable or ratable” by the PEB were pes planovalgus (EPTS) and headaches, controlled. Of these, only pes planovalgus was profiled, and that was a temporary L3 profile for bilateral foot pain at 34 months pre-separation. The NARSUM reported the CI would typically stop running after about a mile due to his bilateral foot pain. The MEB stated pes planovalgus existed prior to service (EPTS) and was not permanently aggravated by service. The CI’s rebuttal to the MEB stated that his foot pain first began after a ruck march during tech school, and that, although mild flat feet was noted in his MEPS exam (confirmed in record), he did not re-experience foot pain until after his first year of active duty, when his job changed and required prolonged standing. Regarding the headache condition, the neurology addendum noted the CI experienced full relief with medications, and the NARSUM stated that, per neurololgy, the CI’s headaches “may moderately affect [CI’s] ability to perform his duties, but his symptoms have improved on treatment, and [the neurologist] believes they will continue to improve.” Neither of these conditions were implicated in the commander’s statement. Both were reviewed by the action officer and considered by the Board. There was no indication from the record that the pes planovalgus condition did not exist prior to service, or that the headache condition significantly interfered with satisfactory performance of AFS duty requirements. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for either of the stated conditions.

Other Contended Conditions. The CI’s application asserts that compensable ratings should be considered for gastritis (VA 30%), and lumbar strain (VA 20%), and tinnitus (VA 10%). Gastritis and tinnitus 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 lumbar strain condition was reviewed by the action officer and considered by the Board. There was no evidence for concluding that it 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. No other conditions were noted in the NARSUM or found elsewhere 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 neurocardiogenic syncope associated with depressive disorder condition, the Board unanimously recommends that it be rated for two separate conditions as follows: neurocardiogenic syncope as unfitting, rated 10% by a vote of 2:1 and coded 8299-8210 IAW VASRD §4.124a; and depressive disorder unanimously as not unfitting. The single voter for dissent (who recommended neurocardiogenic syncope be rated at 30%) submitted the addended minority opinion. In the matter of the pes planovalgus (EPTS) and headache conditions, the Board unanimously recommends no change from the PEB adjudications as Category II. In the matter of the gastritis, lumbar strain, and tinnitus 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, effective as of the date of his prior medical separation:

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Neurocardiogenic Syncope | 8299-8210 | 10% |
| Depressive Disorder | Not Unfitting | |
| **COMBINED** | **10%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110128, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans' Affairs Treatment Record

President

Physical Disability Board of Review

Minority Opinion:

The action officer (AO) recommended a 30% rating in this case, based on appropriate application of the VASRD and reasonable doubt regarding the severity of the CI’s condition as elaborated in the Record of Proceedings. The AO argues that the “moderate” 10% rating does not reflect the full scope of the CI’s disability, which included multiple episodes of total loss of consciousness (syncope) in addition to recurrent prostrating pre-syncope requiring the CI to lie down for 20 minutes to recover. Both the NARSUM and final PEB description clearly outline full syncopal episodes, rather than only pre-syncopal episodes.

The “moderate” 10% rating might have been justified were there no true syncopal episodes, and if the pre-syncopal episodes were not as debilitating as documented. However, the CI’s condition was much closer to a “severe” 30% rating under the analogous 8210 code (Tenth cranial nerve paralysis), supported by the fact that the CI experienced more than one episode of unconsciousness (total incapacitation) and multiple episodes of pre-syncopal lightheadedness requiring laying down to recover.

The VA Decision Review Officer (DRO) was acting reasonably when they corrected the CI’s VA coding and rating from 8199-8108 (analogous to narcolepsy) at 10% to 8199-6204 (analogous to vestibular disorder) at 30%. The DRO used only the service treatment record and initial VA C&P exam without any evidence further removed from separation. The rating change was supported by the same facts, including multiple episodes adjudged equivalent to “dizziness and occasional staggering” under 6204. The DRO decision adds credence to the AO opinion that the 30% (severe) rating much more accurately depicts the CI’s disability picture.

Although the record provided an imprecise number or frequency of full syncope (loss of consciousness) versus pre-syncope episodes, it is apparent that there were at least two episodes of syncope, and multiple episodes of significant pre-syncope after only moderate exercise. The CI’s P4 profile was extremely restrictive, including restrictions against all exercise including cycle ergometry, standing over 30 minutes, lifting over 10 pounds, push-ups, sit-ups, and handling of weapons. Clearly, the “severe” 30% rating is more appropriate in this case and especially so when the tenants of VASRD §4.3 (reasonable doubt).

The AO’s recommendations, summarized below, advocate that the CI’s prior determination be modified 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** |
| Neurocardiogenic Syncope | 8299-8210 | 30% |
| Depressive Disorder | Not Unfitting | |
| **COMBINED** | **30%** |

SAF/MRB

1500 West Perimeter Road, Suite 3700

Joint Base Andrews MD 20762

Dear XXXXXXXXXX:

Reference your application submitted under the provisions of DoDI 6040.44 (Section 1554, 10 USC), PDBR Case Number PD-2011-00093.

After careful consideration of your application and treatment records, the Physical Disability Board of Review determined that the rating assigned at the time of final disposition of your disability evaluation system processing was not appropriate under the guidelines of the Veterans Administration Schedule for Rating Disabilities. Accordingly, the Board recommended modification of your assigned disability rating 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

PDBR PD-2011-00093

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 XXXXXXXXX, be corrected to show that the diagnosis in his finding of unfitness was Neurocardiogenic Syncope, VASRD Code 8299-8210, rated at 10%; and Depressive Disorder, not unfitting with a combined disability rating of 10%; rather than Neurocardiogenic Syncope Associated w/Depressive Disorder, VASRD Code 8210-8299, rated at 10%.

Director

Air Force Review Boards Agency