RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD11-00254 DATE OF PLACEMENT ON TDRL: 20020901

BOARD DATE: 20120530 Date of Permanent SEPARATION: 20041117

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was a National Guard Soldier, SGT/E-5(88M, Heavy Vehicle Driver), medically separated for coronary artery disease and three vessel bypass surgery. The CI initially did well after an initial myocardial infarction with cardiac catheterization and stent placement. However, his angina later increased and he required coronary artery bypass surgery on three vessels. His activity was severely limited and he was not able to meet the physical requirements of his Military Occupational Specialty (MOS) or satisfy physical fitness standards. He was issued a permanent P4 profile and referred for a Medical Evaluation Board (MEB). Coronary artery disease; morbid obesity with metabolic syndrome; severe hyperlipidemia, not responsive to medical management; type II diabetes mellitus, controlled; and severe obstructive sleep apnea (OSA) were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. No other conditions appeared on the MEB’s submission. The PEB adjudicated the coronary artery disease associated with hyperlipidemia and obesity as unfitting, with application of the Veterans’ Administration Schedule for Rating Disabilities (VASRD). The PEB adjudicated the type II diabetes mellitus, controlled, and the severe obstructive sleep apnea as not unfitting. CI was placed on Temporary Disability Retired List (TDRL) with ratings as reflected in the chart below. A second PEB determined the CI should be removed from the TDRL with a 0% disability rating. The CI submitted a non-concurrence statement but did not submit any additional medical information and he was permanently medically separated with a 0% disability rating.

CI CONTENTION: The CI states: “I feel the rating that was giving to me by the PEB for my removal from the Temporary Disabled List did not actually refect [*sic*] the extent of my true disabilities. Their determination was based on a remark from the Cardiologist the White River Jct., VT VA. In my appeal I submitted a corection [*sic*] leter [*sic*] from the Cardiologistat [*sic*], but the Board refused to accept the updated information. The Board would only consider the Cardiac issues, they would not consider the other issues that was [*sic*] listed on the (TDRL) discharge.” A contention for conditions determined to be not unfitting by the initial PEB is implied.

SCOPE OF REVIEW: The Board wishes to clarify that the scope of its review as defined in DoDI 6040.44, Enclosure 3, paragraph 5.e.(2) is limited to those conditions which were determined by the PEB to be specifically unfitting for continued military service; or, when requested by the CI, those condition(s) “identified but not determined to be unfitting by the PEB.” The service ratings for unfitting conditions will be reviewed in all cases. The conditions type II diabetes mellitus, controlled and severe OSA as requested for consideration meet the criteria prescribed in DoDI 6040.44 for Board purview; and, are addressed below, in addition to a review of the service ratings for the unfitting condition of coronary artery disease, status post three vessel bypass surgery and now rated as a New York class III with associated hyperlipidemia and obesity. Any conditions or contention not requested in this application, or otherwise outside the Board’s defined scope of review, remain eligible for future consideration by the Army Board for the Correction of Military Records (BCMR).

RATING COMPARISON:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Service PEB – Dated 20040901** | | | | **VA\* – All Effective Date 20020901** | | | |
| **Condition** | **Code** | **Rating** | | **Condition** | **Code** | **Rating** | **Exam** |
| **PEB TDRL Entry – 20020610** | **TDRL Entry**  **20020901** | **TDRL**  **Exit**  **20041117** |
| Coronary Artery Disease , status post Three Vessel Bypass Surgery, NYHA Class III with associated Hyperlipidemia and Obesity | 7005 | 60% |  | Coronary Artery Disease, status post Coronary Artery Bypass Graft | 7017 | 60% | 20030501 |
| History of Coronary Artery Disease and Three Vessel Bypass Surgery | 7005 |  | 0% |
| Type II Diabetes Mellitus, Controlled | Not Unfitting | | | Type II Diabetes Mellitus | 7913 | 20% | 20030501 |
| Severe Obstructive Sleep Apnea | Not Unfitting | | | Obesity with Obstructive Sleep Apnea | 7899-6847 | 50% | 20030501 |
| ↓No Additional MEB/PEB Entries↓ | | | | Right Knee Arthritis with Chondromalacia | 5003 | 10% | 20030501 |
| Left Knee Arthritis with Chondromalacia | 5003 | 10% | 20030501 |
| Degenerative Arthritis, Lumbar Spine | 5003-5292 | 10% | 20030501 |
| 0% x 1/Not Service-Connected x 1 | | | 20030501 |
| Combined: 0% | | | | Combined: 90%\*\* | | | |

\* VA rating based on exam most proximate to date of permanent separation.

\*\* Includes bilateral factor of 1.9%.

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 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. However the Department of Veterans’ Affairs (DVA), 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 the degree of impairment vary over time. The Board utilizes DVA evidence proximal to separation in arriving at its recommendations; and, DoDI 6040.44 defines a 12-month interval for special consideration to post-separation evidence. The Board’s authority as defined in DoDI 6040.44, however, resides in evaluating the fairness of DES fitness determinations and rating decisions for disability at the time of separation. Post-separation evidence therefore is probative only to the extent that it reasonably reflects the disability and fitness implications at the time of separation.

In addition to any condition determined to be unfitting by the PEB, the Board’s recommendations are confined to those conditions determined to be unfitting at the time of the CI’s placement on TDRL. Unlike the VA which provides compensation for all service-connected conditions, the DES (and by extension the Board) provides compensation only for those conditions determined to render the member incapable of further military duty. The Board may review the appropriateness of the PEB’s fitness adjudications for all conditions at the onset of TDRL, but does not have the prerogative of recommending a rating for conditions which did not become unfitting until after that point. It should be noted, however, that conditions determined to be unfitting at the time of temporary retirement are subject to a change in that determination (i.e., no longer unfitting) at the time of permanent separation. In cases encompassing a period of TDRL, although the Board’s review of fitness adjudications is relevant to the time of temporary retirement, the Board’s final rating recommendations are based on severity evidenced at the time of permanent separation.

Coronary Artery Disease status post Three Vessel Bypass Surgery with Associated Hyperlipidemia and Obesity. The CI had a myocardial infarction in December 1997 with a subsequent cardiac catheterization with placement of one stent. A January 1998, PEB determined he was fit for duty. He returned to duty with a P3 profile for coronary artery disease. He developed recurrent angina with exertion despite maximal medical management and underwent a second cardiac catheterization in September 2000 which noted significant blockage in three vessels, calculated ejection fraction of 68%, and left ventricular end diastolic pressure of 15mm. He underwent coronary artery bypass grafting of the three vessels on 28 September 2000 and did well post-operatively.

TDRL Entry. The CI underwent an MEB narrative summary (NARSUM) in March 2002 which described the clinical history above. Although he did well after his surgery, he was unable to do more than light activity and was considered to be New York Heart Association class (NYHAC) III. His EKG showed normal sinus rhythm with evidence of an inferior infarct and abnormalities consistent with lateral ischemia. His diagnoses included coronary artery disease, status post three vessel coronary bypass; morbid obesity with metabolic syndrome; severe hyperlipidemia, not responsive to medical management; type II diabetes mellitus, controlled; and severe OSA. His profile dated 9 November 2001 was a P4 with significantly limited activities. An initial VA Compensation and Pension (C&P) examination was completed 31 October 2002, approximately 2 months after TDRL entrance, and it noted that in the last few months the CI had experienced four to five episodes of chest pain, graded 2/10 and associated with shortness of breath. These occurred upon awakening in the morning and when getting his newspaper and were relieved with rest. The examiner noted a stress thallium test was scheduled. This procedure was completed in April 2003, 7 months after TDRL entrance. The test was stopped secondary to angina with ECG changes indicative of ischemia after three minutes on a Bruce protocol, stage I, which is 4 METs.

The PEB determined the coronary artery disease, status post three vessel bypass surgery, rated as New York class III condition prevented satisfactory performance of duty in his grade and specialty. This condition had not stabilized to the point that a permanent degree of severity can be determined and the CI was placed on the TDRL. The PEB rated the condition at 60% under the VASRD code 7005, arteriosclerotic (atherosclerotic) heart disease (coronary artery disease, CAD). The VA initially applied a rating of 10% under code 7017 coronary bypass surgery based on the service treatment and other medical records. However, after the thallium stress test was done, the VA increased the rating to 60% based on a workload of greater than 3 METs but not greater than 5 METs resulting in angina. Another VA C&P examination was completed in May 2003 after the thallium stress test was done. In addition to the results of the thallium stress test, this examination also noted the CI would develop angina after fifteen minutes of light raking and angina with dyspnea after walking more than ¼ mile. The CI denied chest pain at rest. Although the PEB and the VA used different codes, both codes have the same rating criteria and neither offers any advantage to the CI. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s rating decision for the coronary artery disease, status post three vessel bypass surgery condition at the time of TDRL entry.

TDRL Exit. No Army periodic TDRL examinations are present in the record for review and it appears than none were completed. There is a TDRL report of examination form stating the findings and recommendations of the TDRL report of examination from the VA Medical Center, Manchester, NH, had been reviewed and are approved. The approval authority signed this form on 18 April 2004 and the CI concurred on 4 May 2004. It appears this VA examination, which was completed on 25 March 2004 (8 months prior to final separation from the TDRL), was used by the PEB as the TDRL examination. This examination noted the CI had undergone gastric bypass surgery in June 2003 and had lost fifty pounds. He had also been admitted for 6 days in October 2003 for a bleeding ulcer that required two blood transfusions. The CI had experienced another myocardial infarction during this admission as evidenced by angina, ECG changes, and elevated troponin levels. Although the CI’s hemoglobin was not lower than 12 and his baseline was 15, his heart had not been able to compensate for the acute decrease in hemoglobin and the transfusions were required to treat his cardiac ischemia. The VA exam did not include either laboratory determination of METs by exercise testing or estimation by the medical examiner of the level of activity (expressed in METs and supported by specific examples, such as slow stair climbing or shoveling snow) that results in dyspnea, fatigue, angina, dizziness, or syncope. The examiner noted the CI’s current state of health to be “improving with weight loss and diet control brought about by gastric bypass surgery. His prognosis, however, remains guarded because of the previous severity of the coronary artery disease and metabolic precursors.” He also noted, “improvements to date would not qualify as recovery, and therefore it does not appear that he has yet recovered from any of the impairments that have been previously noted.” He opined that while the CI’s medical condition had improved, his basic impairment of coronary artery disease remained and he had “some compromise of his previous coronary artery bypass grafts” and his prognosis remained guarded. The examiner also opined the condition had not become stable but that the CI needed continued management with diet, medication, and follow-up cardiac testing to establish the stability of his condition.

An outpatient visit to a VA cardiologist on 26 May 2004 noted the CI was able to mow his lawn, shovel dirt, landscape, and cut and split wood without experiencing angina and hadn’t needed to take any sublingual nitroglycerin lately. The CI saw the same cardiologist on 20 September 2004 and reported recurrent chest pain which lasted about 10 minutes and were relieved with sublingual nitroglycerin. He also remained on aspirin and metoprolol. The cardiologist noted the CI most likely would not be able to perform a treadmill stress test secondary to intermittent claudication in his left lower leg. Recent vascular studies had shown moderate occlusive disease in the left lower extremity.

The PEB convened on 1 September 2004 and determined the CI’s coronary artery disease, status post three vessel bypass had stabilized for permanent rating and recommended separation at 0% disability rating. It noted, “current cardiology consult notes Soldier has "no angina, despite vigorous activity like mowing lawns, shoveling dirt, landscaping, cutting and splitting wood (“didn't have to slow down one bit”). Physical exam is non-contributory to the rating. Rated as Soldier's description of current work load exceeds the table 3A (DoDI 1332.39) greater than 10 METS criteria. (TDRL Exam and Cardiology note on 26 May 2004).” The CI submitted a statement of issues of disagreement dated 9 September 2004 stating he continued to have angina and his bypassed arteries were again compromised and he had been told he would need another bypass surgery in the future. He also requested the PEB consider his other conditions of sleep apnea, arthritis, and skin condition. The PEB responded 14 September 2004 stating the conditions he requested to add had not been unfitting at the time of TDRL entry or were not listed on the original MEB. It mentioned scheduling a formal board. The record contains orders dated 16 September 2004 authorizing temporary duty and travel for the CI to attend a formal hearing on or about 27 October 2004. However, there is no evidence of a formal hearing in the record and there is a document dated 20 October 2004 stating the CI did not agree with the PEB decision but was not going to submit any additional information.

The CI’s VA cardiologist wrote a letter to the PEB dated 15 October 2004 explaining that the CI’s activities noted on 26 May 2004 were not as vigorous as they may have appeared and that the CI had been using a riding mower to mow his lawn. He stated the CI was now experiencing angina with exercise and also with emotional stress. He recommended the CI not perform any activity exceeding 7 METs to avoid angina. The cardiology also submitted a letter in October 2004 stating the CI was on the border between NYHAC II and III and restated his recommendation the CI should not exceed 7 METs. It does not appear that the PEB considered this information.

The PEB cites table 3A (DoDI 1332.39) greater than 10 METS criteria in its determination of a 0% rating for his coronary artery disease. However, even if the CI could perform more than 10 METS without angina he still required continuous medication and this supports a 10% rating. While this DoDI has since been rescinded, this table contains workload estimations from the American Heart Association and the estimates are consistent with estimates from other sources. The activities described by the cardiologist in May 2004 do not exceed the 7 METs criteria and are consistent with the cardiologist’s estimation of the level of activity that would produce symptoms of angina as described in his October 2004 letter to the PEB. Mowing using a riding lawn mower is 2-3 METs, raking leaves and hoeing are 4-5 METs, digging in a garden and shoveling light earth are 5-6 METs, splitting wood and shoveling up to 10 pounds of earth ten times a minute is 6-7 METs. None of the activities described exceed 7 METs. Additionally, at the visit in September 2004, the CI was much less active than he had been in May 2004 and having angina with stress at rest and with light exercise.

While the CI does appear to have improved overall from the time of TDRL entry to his permanent separation, he remained on medication the entire time and at no time did he ever engage in activity that exceeded 7 METs. The cardiologist stated he was unable to perform a stress test and estimated 7 METS as the workload the CI could perform without angina. At the time of TDRL entry the CI was NYHAC III and by the time of his exit from the TDRL he had improved to the border between class II and III. These functional limitations warrant a 30% rating under either code 7005 or 7017. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a permanent disability rating of 30% for the coronary artery disease, status post three vessel bypass surgery condition.

Contended Original PEB Conditions. The contended conditions adjudicated as not unfitting by the initial PEB were type II diabetes mellitus, controlled and severe OSA. The Board’s first charge with respect to these conditions is an assessment of the appropriateness of the PEB’s fitness adjudications at the time of TDRL entry. The Board’s threshold for countering 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.

While the CI’s permanent profile dated 9 November 2001 does include the diagnosis of diabetes mellitus but the diagnosis includes the term medically controlled and most, if not all, of the restrictions are attributable to his coronary artery disease. The MEB NARSUM on 7 March 2002 also stated this condition was under control with oral medications and his HgbA1c was 6.2. A VA C&P examination in May 2003, 8 months after TDRL entry, noted a HgbA1c of 8.4. The initial VA rating decision on 9 October 2002 also noted this condition was controlled with diet and oral medication and applied a 20% rating. The commander’s statement in March 2003 does not specifically mention diabetes. After due deliberation in consideration of the preponderance of the evidence, the Board concluded that there was insufficient cause to recommend a change in the PEB fitness determination for the type II diabetes mellitus condition.

In January 2002, the CI underwent a preoperative evaluation for gastric bypass surgery which included a sleep study. The study noted frequent obstructive apnea and hypopnea in both REM and non-REM sleep. The MEB NARSUM on 7 March 2002 noted that he was diagnosed with severe sleep apnea and treatment with nasal CPAP at 10cm of water provided some relief of his symptoms and improvement of his sleep. At the time of the VA C&P examination in May 2003, he was reportedly continuing to use the CPAP and was being followed by the pulmonary service. No daytime somnolence was reported. This condition was not profiled and was not specifically mentioned in the commander’s statement. After due deliberation in consideration of the preponderance of the evidence, the Board concluded that there was insufficient cause to recommend a change in the PEB fitness determination for OSA.

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 coronary artery disease, status post three vessel bypass surgery condition, the Board unanimously recommends no change in the initial TDRL rating of 60% and unanimously recommends a 30% permanent rating, coded 7017 IAW VASRD §4.104. In the matter of the contended type II diabetes mellitus, controlled and severe OSA conditions, the Board unanimously recommends no change from the PEB determination as not unfitting.

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:

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| **PERMANENT** |
| Coronary Artery Disease, status post Three Vessel Bypass Surgery | 7017 | 30% |
| **COMBINED** | **30%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110401, 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 XXXXXXXXXXX, AR20120010169 (PD201100254)

1. Under the authority of Title 10, United States Code, section 1554(a), I approve the enclosed recommendation of the Department of Defense Physical Disability Board of Review (DoD PDBR) pertaining to the individual named in the subject line above to recharacterize the individual’s separation as a permanent disability retirement with the combined disability rating of 30% effective the date of the individual’s original medical separation for disability with severance pay.

2. I direct that all the Department of the Army records of the individual concerned be corrected accordingly no later than 120 days from the date of this memorandum:

a. Providing a correction to the individual’s separation document showing that the individual was separated by reason of permanent disability retirement effective the date of the original medical separation for disability with severance pay.

b. Providing orders showing that the individual was retired with permanent disability effective the date of the original medical separation for disability with severance pay.

c. Adjusting pay and allowances accordingly. Pay and allowance adjustment will account for recoupment of severance pay, and payment of permanent retired pay at 30% effective the date of the original medical separation for disability with severance pay.

d. Affording the individual the opportunity to elect Survivor Benefit Plan (SBP) and medical TRICARE retiree options.

3. I request that a copy of the corrections and any related correspondence be provided to the individual concerned, counsel (if any), any Members of Congress who have shown interest, and to the Army Review Boards Agency with a copy of this memorandum without enclosures.

BY ORDER OF THE SECRETARY OF THE ARMY:

Encl XXXXXXXXXXXXXXXXX

Deputy Assistant Secretary

(Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA