RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXX BRANCH OF SERVICE: Air force

CASE NUMBER: PD1100326 SEPARATION DATE: 20060929

BOARD DATE: 20120330

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SrA/E-4 (2A651A, Aerospace Propulsion Journeyman) medically separated for reactive arthritis that began in 2002. He did not respond adequately to treatment and was unable to perform within his Air Force Specialty (AFS) or meet physical fitness standards. He was issued a U4 L4 profile and underwent a Medical Evaluation Board (MEB). Reactive arthritis was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AFI 48-123. No other conditions appeared on the MEB’s submission. Other conditions included in the Disability Evaluation System (DES) file will be discussed below. The PEB adjudicated the reactive arthritis condition as unfitting, rated 20% IAW the Veterans Administration Schedule for Rating Disabilities (VASRD). The CI made no appeals and was medically separated with a 20% disability rating.

CI CONTENTION: The CI states: “My condition for migratory arthritis, right knee, bilateral hips, thoracolumbar spine, bilateral elbows, bilateral wrists, and bilateral hands are far more severe than a 20% rating. My migratory arthritis condition creates a very uncomfortable condition needs to be controlled by medicine and rehabilitation appointments. A medical retirement would really help my progress with this condition.” He further indicates that the VA “dramatically increased my rating from the previous 10%.” He elaborates no specific contentions regarding rating or coding and mentions no additionally contended conditions.

RATING COMPARISON:

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| **Service PEB – Dated 20060817** | | | **VA (4 Mo. After Separation) – All Effective 20060930** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Reactive Arthritis | 5099-5002 | 20% | Migratory Arthritis | 5009-5002 | 10%\* | 20070209 |
| ↓No Additional MEB Entries↓ | | | 0% x 4 / Not Service Connected x 3 | | | 20070209 |
| **Combined: 20%** | | | **Combined: 10%\*** | | | |

\*Increased to 40% effective 16 May 2008

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application, that the gravity of his condition and predictable consequences merit consideration for a higher separation rating. It is a fact, however, that 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. This role and authority is granted by Congress to the Department of Veterans’ Affairs (DVA). 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.

Reactive Arthritis Condition. The CI first developed pain involving his hands and wrists in 2002 that waxed and waned over a few months. He subsequently developed intermittent problems in his knees, elbows, proximal upper extremities, ankles, and lower back. Per a rheumatology evaluation on 23 August 2005 (13 months prior to separation), episodes of pain typically lasted less than 24 hours, but after one joint improved another joint would often become bothersome. Morning stiffness until noon or longer occurred, but no visible joint swelling was present with pain flares. At that time, there was no joint swelling or tenderness on examination and the rheumatologist concluded there was no clearly defined diagnosis but thought the CI was manifesting initial non-specific symptoms of an arthritis condition (possible palindromic rheumatism, a syndrome of intermittent arthritis, or rheumatic disease not yet clearly defined). Magnetic resonance imaging (MRI) of the lumbosacral spine in January 2006 was normal, showing no intervertebral disc disease and normal sacroiliac joints without evidence of sacroiliitis. At follow-up on 14 March 2006 (6 months prior to separation) the rheumatologist recorded a CI report of increasing arthralgias in the hands but that the symptoms were less migratory than before. Treatment with pain medication was partially effective, but the CI was not taking the medication as recommended. Examination at that time revealed tenderness along the tips of both elbows, and a modest amount of swelling (indicating inflammation; synovitis) of the knuckle joints (specifically the proximal interphalangeal joints) of the second through fourth right fingers and second and third left fingers; however there was no tenderness of these joints. There was some tenderness of the knees and along the lumbosacral junctions. Lumbar flexion was 80 degrees (normal to 90 degrees) and extension was 20 degrees (normal to 30 degrees). The rheumatologist noted the normal lumbosacral spine MRI results. The assessment was considered to be most consistent with reactive arthritis (also called seronegative arthritis and seronegative spondyloarthropathy) and he was prescribed an anti-arthritis medication. In a note on 18 April 2006 the rheumatologist recommended activity restrictions to include no heavy lifting more than one-third of the day and no prolonged sitting due to lower back stiffness. Breaks every hour for 10-15 minutes were also suggested. To date, no evidence of joint damage was present. The long-term prognosis was considered to be highly variable, but 85% of patients were expected to experience remission within 5 years.

The last rheumatology note in evidence (27 April 2006) reported some side effects from his medication regimen which limited the amount of medication he had been taking. He continued to experience transient pain, especially in the knees, elbows and low back. His pain was considered improved, but it continued to limit his activity. Examination showed good mobility of shoulders, elbows, wrists and small joints of the hands, but there was some tenderness of the left elbow and right knee. There was no joint swelling (prominent synovitis) and no knee effusion. Lumbar spine flexion was 80 to 90 degrees, and extension was 15 degrees. There was some mid-lumbar tenderness, but no sacroiliac joint tenderness. Laboratory evaluation revealed no specific abnormalities; specifically, there was no evidence of anemia. Previous radiologic evaluations including X-rays of knees, right hip, cervical spine and lumbar spine, bone scan of lower extremities, magnetic resonance imaging of lumbar spine and CT scan of the pelvis were unremarkable except for a benign bone cyst of the left iliac area. An MEB narrative summary (NARSUM) dated 15 May 2006, based on examination performed 24 April 2006 (5 months prior to separation) reported that walking was sometimes prohibited due to pain severity. Examination revealed no appearance of discomfort in general, but some pain was noted specifically with lumbar flexion. There was no swelling or tenderness of the joints of the upper or lower extremities. A family practice clinic encounter recorded continued intermittent pain rated six on the ten-point scale. The examiner observed that the CI did not appear uncomfortable and the musculoskeletal examination was documented to show no abnormalities including absence of back muscle spasm. An updated MEB NARSUM (23 July 2006) based on examination performed 6 June 2006 (3 months prior to separation) noted no interval change in symptoms or physical examination compared to the earlier NARSUM exam. The examination of the joints was recorded as showing no abnormalities in strength or range of motion (ROM). The CI’s weight at this exam was 205 pounds. A review of outpatient notes for 2 years prior to separation shows a weight range from 175 pounds (22 September 2003) to 205 pounds near the time of separation.

The commander’s statement on 6 July 2006 reported that the CI continued to work in his career field but could not work on the flight line, and was able to work full shifts performing ancillary maintenance duties. His condition caused him to miss minimal time from work. An outpatient visit for headaches on 30 August 2006 indicated that the CI was “not tiring easily.” An examination 26 September 2006 recorded normal gait and stance and pain level report of three affecting the back. The VA Compensation and Pension (C&P) examiner on 9 February 2007 (4 months after separation) stated that the anti-arthritis medication was discontinued because it was ineffective. Daily activities including chores, shopping, exercise, sports and bathing were moderately affected due to his condition. Examination revealed a weight of 205 pounds, a normal gait, no muscle weakness or atrophy, and no swelling, effusion or tenderness of any joint. The lumbar spine showed 90 degrees of painless flexion (normal 90 degrees) and 240 degrees (normal to 240 degrees) of painless combined ROM. Laboratory evaluation was unremarkable except for an erythrocyte sedimentation rate of 25 (ESR – a measure of generalized inflammation; normal 0 – 15); however, another indicator of inflammation was normal (c-reactive protein) not indicative of the presence of any inflammation, and anemia was absent (an indication of absence of systemic chronic inflammation).

The PEB and the VA used the 5002 code, but approached the rating in different ways. Under the analogous 5002 code used by the PEB, the rating is based on the number of incapacitating disease exacerbations and overall impairment of health. The PEB’s 20% rating reflected an assessment that the CI’s condition was most accurately described by “one or two exacerbations a year.” The next higher 40% level required “symptom combinations productive of definite impairment of health objectively supported by examination findings or incapacitating exacerbations occurring 3 or more times a year.” Although the VA used a 5009-5002 code, a 10% rating was assigned based on non-compensable limitation of joint motion. The Board agreed that the PEB’s coding approach was appropriate, and considered the severity of the CI’s condition based on the evidence at hand. All members agreed that the 60% criteria were not approached (“…with weight loss and anemia productive of severe impairment of health or severely incapacitating exacerbations occurring 4 or more times a year or a lesser number over prolonged periods”), and that “incapacitating exacerbations occurring 3 or more times a year” (supportive of a 40% rating) were not in evidence. Except for the March 2006 rheumatology examination documenting swelling of the finger joints without tenderness, physical examinations consistently documented full range of motion without swelling. Although restricted from strenuous flight line mechanical work, the CI was working full shifts performing maintenance duties within his specialty and had missed “minimal time” from work. The Board therefore concluded the CI’s condition did not result in definite impairment that was objectively supported by examination findings or incapacitating exacerbations 3 or more times per year that would support a 40% rating. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s rating decision for the reactive arthritis condition.

Remaining Conditions. Other conditions identified in the DES file were hypertension, headaches and chest pains. Several additional non-acute conditions or medical complaints were also documented. Headaches, thought possibly to be migraines, began four months prior to separation and were helped by over the counter pain medicine. None of these conditions were clinically or occupationally significant 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 pseudofolliculitis and several other non-acute conditions 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.

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 reactive arthritis condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the hypertension, headaches and chest pain 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. The Board unanimously agrees that there were no other conditions eligible for Board consideration which could be recommended as additionally unfitting for rating at separation.

RECOMMENDATION: The Board therefore recommends that there be no recharacterization of the CI’s disability and separation determination.

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Reactive Arthritis | 5099-5002 | 20% |
| **COMBINED** | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110425, 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

SAF/MRB

1500 West Perimeter Road, Suite 3700

Joint Base Andrews MD 20762

Dear XXXXXXXXXXXX

Reference your application submitted under the provisions of DoDI 6040.44 (Title 10 U.S.C. §  1554a), PDBR Case Number PD-2011-00326

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 appropriate. Accordingly, the Board recommended no re-characterization or modification 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 and their conclusion that re-characterization of your separation is not warranted. Accordingly, I accept their recommendation that your application be denied.

Sincerely,

XXXXXXXXX

Director

Air Force Review Boards Agency