RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: Army

CASE NUMBER: PD1100462 SEPARATION DATE: 200300403

BOARD DATE: 20120123

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was a Reserve member, SGT (55B20/Ammunition Storage Specialist), medically separated for seronegative lyme disease. The CI initially presented in October 2000 with joint and muscle pain and fatigue and a vesicular skin rash after developing an inguinal rash from tick bite while on annual training in Germany. In February 2001, the CI had a negative Webster Blot for lyme disease and was treated with two courses of Doxycycline and one of intravenous Rocephin with only temporary improvement.The CI did not respond adequately to treatment and was unable to perform within his Military Occupational Specialty (MOS) or meet physical fitness standards. He was issued a permanent P3/U2/L2/E2 profile and underwent a Medical Evaluation Board (MEB). The MEB forwarded “chronic fatigue and arthralgias affecting shoulders, hands, knees, ankles and feet presumably due to seronegative lyme disease” on DA Form 3947 to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Vision defect as identified in the rating chart below, was forwarded on the MEB submission as a medically acceptable condition. The PEB adjudicated “seronegative lyme disease manifested by chronic fatigue and arthralgias of the shoulder, hands knees, ankles and feet” condition as unfitting, rated 20%, with application of the Veterans’ Administration Schedule for Rating Disabilities (VASRD). The CI made no appeals, and was medically separated with a 20% combined disability rating.

CI CONTENTION: “Initial rating by VA dated submitted April 14 2003 approved September 11, 2003 overall rating 30%, 20% residuals of lyme disease 10% recurrent rash with vesicles: 2005 20% Chronic Fatigue Syndrome added. Current rating 70% combined: 60% related to tick bite 20% Chronic Fatigue.”

RATING COMPARISON:

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| --- | --- |
| **Service IPEB – Dated 20030213** | **VA (6 Weeks after separation) – All Effective Date 20030414** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Seronegative Lyme Disease manifested by chronic fatigue and arthralgias | 5099-5002 | 20% | Residuals of Lyme Disease | 6319-6354 | 20% | 20030521 |
| Recurrent Rash with Vesicles | 6319-7806 | \*10% | 20030521 |
| Vision Defect | Not Unfitting | No Corresponding VA Entry |
| ↓No Additional MEB/PEB Entries↓ | 0% x 0/Not Service Connected x 0 | 20030521 |
| **Combined: 20%** | **Combined: 30%** |

\*Increased to 30% based on VA records 20051208-20060123 effective 20030414, then increased to 60% effective 20061127

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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 also makes note that some of the CI’s contended conditions are derived from VA evaluations performed well after separation and that his current VA ratings are higher than those reflected in the above rating chart. Although some of these conditions and ratings were assigned an effective date to the time of separation, the earliest VA rating examination underpinning them was performed two months after separation. The Board’s operative instruction, DoDI 6040.44, specifies a 12-month interval for special consideration to VA findings. Post-separation evidence therefore is probative only to the extent that it reasonably reflects the disability and fitness implications at the time of separation. This does not mean that the later VA evidence was disregarded, but the Board’s recommendations are directed to the severity and fitness implications of conditions at the time of separation. In this circumstance, therefore, the evidence from the Service record is assigned significantly more probative value as a basis for the Board’s recommendations.

Seronegative Lyme Disease: The CI has a long, well documented history in the service treatment record (STR) of joint pains, vesicular rash, and arthralgias starting in October 2000. The CI thought he may have removed a tick from his scrotum and developed a vesicular rash in the inguinal area and scrotum. Although the rash resolved without treatment, the CI was still treated with a non-steroidal anti-inflammatory drug (NSAID) Indomethacin. The CI was seen by his primary care (PC) provider in October for left leg, calf, thigh, and ankle and foot pain along with a vesicular rash in the left gluteal area and was diagnosed with shingles and treated with steroid and herbal medication. The CI returned to the PC clinic with new symptoms of persistent pain in the leg, prostrate and testicles and was treated with an antiviral (Valtrex) and steroid medication which according to the CI was repeated several times. The CI was seen for persistent fatigue and lymphadenopathy in February 2001, however testing for syphilis, herpes simplex, and western blot for lyme disease were negative. Although lyme testing was negative, Doxycycline was initiated for possible seronegative lyme disease and the CI was referred to an infectious disease specialist. Extensive testing was done to rule out collagen vascular disease. The CI was treated again with another course of oral antibiotics but the symptoms persisted. In the Spring 2001, the CI was given a profile for no Army physical fitness test. The CI was seen by a Rheumatologist in August 2001 who noted pain in the shoulders, wrists, hands, knees, ankles and feet with fatigue and night sweats for the prior five to six months. In a follow-up rheumatology visit in May 2002, there was no evidence of active arthritis. In June 2002, the CI complained of worsening arthralgias and flare-ups lasting for five to seven days but he was able to play basketball once a week. At this visit, the exam was unremarkable except for tenderness over a few metatarsophalangeal joints. Lab work done was negative for signs of chronic inflammation but the CI was treated with NSAIDS and an antidepressant. The examiner also noted an area of hyper-pigmentation in both inner thighs which was post-inflammatory. One month later, an Internist confirmed that Lyme testing was negative however four weeks of intravenous antibiotics were recommended for possible later stage seronegative disease and the macular rash on hands. The CI started feeling better after two weeks of treatment. In July 2002, the CI was continuing treatment for a recurrent joint pains and a macular rash on his hand with an oral antibiotic. In September 2002, at the time the CI reported for his medical board he was able to play basketball and walk two miles twice a week; however he still had morning arthralgias affecting his feet but not other joints. In October 2002, the Rheumatologist noted that there was significant improvement following a 28 day course of Rocephin but morning joint stiffness remained. The CI also reported a recurrence of muscle stiffness in the neck, shoulders, buttocks and legs which had initially resolved after the Rocephin. Overall, the CI estimated he was 60 to 70% improved after the treatment. However, he failed a diagnostic physical fitness test in early November. The commander’s statement noted this and the fact that the CI’s weakness in his hands and arms that prevented him from safely executing his MOS.

The MEB examination four months prior to separation noted an inability to play basketball; chronic knee and leg pain; fatigue; and poor endurance. Physical examination indicated tenderness to pressure over the proximal and distal interphalangeal joints of both hands in the second and third digits; tenderness over the proximal and interphalangeal joints of both hands in the fourth digit; tenderness or pressure over the patellar facets and popliteal area of the left knee; a positive McMurrays test with the right knee; and mild tenderness to pressure anterior to the lateral malleolus of the ankles. However, no decrease in any range-of-motion (ROM) was noted except for slightly decreased dorsiflexion of both ankles; both were 15 degrees and normal is 20 degrees.

The VA Compensation & Pension (C&P) examination six weeks after separation noted that the CI still had neck, shoulders, hands, knees ankles and feet pain daily and chronic fatigue with daily activities. On physical examination, there was tenderness on palpation in all of the joints with shoulder strength 4/5 along with a macular rash on the trunk and thighs to groin area. Additionally there were tender, erythemic vesicles on the face and approximately thirteen residual sites of prior fluid filled vesicles which remained as reddened areas which were flat and nontender.

The CI continued to pursue medical treatment along with evaluations by ID, rheumatology and dermatology undergoing numerous testing to determine an accurate diagnosis. The STR indicated difficulty in accurately diagnosing the cause of the joint aches, skin disease and fatigue. The CI was seen by rheumatology in December 2004 and based on aggressive workup and more medications, the working diagnoses were “likely osteoarthritis, reactive spondyloarthritis from prior Lyme arthritis. The CI underwent a second VA C&P examination twenty-eight months after separation and the diagnosis was still unresolved with current symptoms of shoulders, hands, knees, ankles and feet pain along with a chronic rash of fluid filled vesicles and pustular lesions on the trunk, face and extremities. The examiner further documented that the CI had undergone extensive oral and intravenous antibiotic therapy to resolve the joint pains and vesicular rash, however the entire symptomatology continued. As of the VA C&P examination, forty-four months after separation, the CI continued with the joint pains, fatigue and a pruritic rash on the trunk, albeit a decrease in symptomatology. The examiner noted that the CI was now working as a chemical dependence counselor, was able to ride a motorcycle and walk his dog every other day. The examiner further noted that the workup was ongoing to determine an exact cause for the symptoms and further specialty evaluations would be necessary.

In 2006, The CI filed a Formal Appeal to the VA regarding an entitlement to an initial rating in excess of 20% for residuals of lyme disease. The appeal noted that the CI had withdrawn his appeal for an initial rating in excess of 30% residuals of lyme disease in 28 March 2006 via a video-conferencing hearing. In November 2006, the VA board of appeals ruled that the CI “should be afforded a VA examination to determine whether he currently has active lyme disease and if not, the extent of the results of lyme disease…. Then after conducting any additional development, the regional office (RO) should readjudicate the issue on appeal.” No increase in disability rating for residuals of lyme disease was granted, however the disability rating for recurrent rash with vesicles was increased twice.

The PEB coded the seronegative lyme disease condition as 5099 analogous to 5002 (arthritis rheumatoid (atrophic) as an active process) rated 20% (One or two exacerbations a year in a well-established diagnosis) and the VA coded residuals of lyme disease 6319 (lyme disease) analogous to 6354 (chronic fatigue syndrome (CFS)) rated 20%. The CI had a well documented history of fatigue and joint pains which occurred from a possible tick bite although never proven. He underwent a variety of oral and intravenous antibiotics therapies to alleviate the symptoms, however they persisted. The specialists could not definitively diagnose the disease as either lyme disease or chronic fatigue syndrome or possibly a rare form of lyme disease, however the CI remained complaint with all therapies and vigilant in his pursuit of the correct diagnosis. The Board reviewed the criteria for 5002 arthritis rheumatoid (atrophic) as an active process, 6319 lyme disease, and 6354 chronic fatigue syndrome. All evidence considered there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s rating decision for the seronegative lyme disease condition. Since the choice of VASRD code conferred no rating advantage, and no code was clinically predominant, no change from the PEB designation is recommended.

Recurrent Rash with Vesicles: While the MEB NARSUM documents a history of a rash, no current rash is mentioned in the physical examination. The MEB history and physical examination from 18 September 2002 also does not mention any current rash. The STR does show the CI had post-inflammatory skin changes noted in both thighs in June 2002, indicative of a resolved rash. In July 2002, the CI developed a rash on both hands along with the joint pains and underwent a course of intravenous antibiotics. However, a rash was present the day of the CI’s VA C&P examination and this day was in close temporal proximity to the day of final separation from service. The recurrent rash with vesicles condition was coded as 6319 lyme disease analogous to 7806 dermatitis or eczema by the VA and it was initially rated at 10% (At least 5 percent, but less than 20 percent, of the entire body, or at least 5 percent, but less than 20 percent, of exposed areas affected, or; intermittent systemic therapy such as corticosteroids or other immunosuppressive drugs required for a total duration of less than six weeks during the past 12-month) period by the VA. In a January 2006 VA supplemental statement of the case, the VA noted this rating should have been 30% and this higher rating was applied retroactively. This decision was based on the rash involving more than 20% of the entire body surface area. This rating was also later increased to 60% based on worsening symptoms.

Although the PEB did not specifically adjudicate this condition, it was presented in the MEB evidence before the PEB. The Board must thus approach this issue as a de facto service determination that recurrent rash was not an unfitting condition. 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 established DES (and Board applicable) principle for fitness determinations is that they are performance-based. The Board could not find evidence in the commander’s statement or elsewhere in the service file that documented any interference of the recurrent rash condition with performance of duties. After due deliberation, the Board agreed that evidence does not support a conclusion that recurrent rash, as an isolated condition, would have rendered the CI incapable of continued service within his MOS, and accordingly cannot recommend a separate service disability rating for it.

Other PEB Conditions. The other condition forwarded by the MEB and adjudicated as not unfitting by the PEB was vision defect. This condition was not profiled, implicated in the commander’s statement, or noted as failing retention standards. This condition was reviewed by the action officer and considered by the Board. There was no indication from the record that this condition significantly interfered with satisfactory duty performance. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the stated condition.

Other Contended Conditions. The CI’s application asserts that compensable ratings should be considered for recurrent rash with vesicles and chronic fatigue syndrome. The recurrent rash with vesicles condition is discussed above. No rating for chronic fatigue syndrome was applied by the service or the VA. The CI’s residuals of lyme disease were rated analogous to arthritis by the PEB and analogous to chronic fatigue syndrome by the VA. Both rating schema resulted in the same percent disability rating as described above and neither offers any advantage to the CI. There is no basis for adding an additional condition of chronic fatigue syndrome as a separately unfitting condition.

Remaining Conditions. Other conditions identified in the DES file were gingivitis and dental concretions. Several additional non-acute conditions or medical complaints were also documented. The CI had periodontal disease (gingivitis) and dental concretions which were clinically active during the MEB period; however these conditions were not implicated in the commander’s statement and no profile was required. 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.

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 seronegative lyme disease condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication at separation. In the matter of the recurrent rash with vesicles condition and vision defect condition, the Board unanimously recommends no change from the PEB adjudications as not unfitting. In the matter of chronic fatigue syndrome and gingivitis and dental concretions, the Board unanimously agrees that it cannot recommend a finding 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:

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Seronegative Lyme Disease | 5099-5002 | 20% |
| **COMBINED** | **20%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110609, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans Affairs Treatment Record

SFMR-RB

MEMORANDUM FOR Commander, US Army Physical Disability Agency

 Crystal Drive, Suite 300, Arlington, VA 22202

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation for (PD201100462)

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

CF:

( ) DoD PDBR

( ) DVA