RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXXXXXXXX BRANCH OF SERVICE: AIR FORCE

CASE NUMBER: PD1100509 SEPARATION DATE: 20080701

BOARD DATE: 20120208

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an Air National Guard member, Airman First Class / E-3 (Student / Trainee Status) medically separated for bilateral plantar fasciitis. History of right exertional anterior compartment syndrome status-post fasciotomy, resolved contributed to her unfitness, but was not separately unfitting or subject to disability rating. Despite surgical and conservative treatments the CI did not respond adequately to perform within her training status or meet physical fitness standards. The CI was issued a temporary profile U2L4 and underwent a Medical Evaluation Board (MEB). On 18 December 2007 an MEB was held and initially return to duty was recommended but the case was forwarded to the Informal Physical Evaluation Board (IPEB). The MEB forwarded “lower leg compartment syndrome (CS) status post (S/P) surgical release right leg with residual pain as medically unacceptable IAW AFI 48-123. Other conditions included in the Disability Evaluation System (DES) packet will be discussed below. The CI sent a Letter of Exception to Recommendations the the MEB. The first IPEB dated 1 February 2008, adjudicated “bilateral lower leg pain associated with CS and aggravation of congenital (existed prior to service, EPTS) pes planus” as unfitting with a combined disability rating of 20% and “mechanical low back pain with degenerative changes at T9-10 conditions” as unfitting, rated 0%, with application of the Department of Defense Instruction (DoDI) 1332.39 and Veterans’ Administration Schedule for Rating Disabilities (VASRD). The IPEB also adjudicated obstructive sleep apnea (OSA) well-controlled with CPAP, currently with minor equipment difficulties in use of the machine and left wrist pain with extensor carpi ulnaris tenosynovitis as category II (“conditions that can be unfitting but are not currently compensable or ratable”) and obesity as category III (“Conditions that are not separately unfitting and compensable or ratable”). An IPEB dated 7 April 2008 adjudicated “bilateral lower leg pain with CS as unfitting rated 21% (including bilateral factor) with application of the DoDI 1332.39 and VASRD. The Formal PEB (FPEB) also adjudicated “bilateral pes planus, EPTS; low back pain; left wrist pain with extensor carpi ulnaris tenosynovitis; and OSA, well-controlled with CPAP as category II. The CI appealed the FPEB’s decision and the case was reviewed by the Secretary of the Air Force Personnel Council (SAFPC). On 8 June 2008 SAFPC adjudicated bilateral plantar fasciitis as unfitting and rated each foot at 10% for a combined rating of 21%. SAFPC also adjudicated history of right exertional anterior CS; status post fasciotomy, resolved condition as contributing to her unfitness but not separately unfitting and a 0% rating was applied. Both of these decisions were based on the application of the DoDI 1332.39 and VASRD. SAFPC also adjudicated bilateral leg pain and numbness of undetermined etiology without objective findings or evidence of impairment; OSA well-controlled with CPAP; lumbago without causative anatomic abnormalities or objective evidence of impairment; radiological evidence of mild degenerative changes at T9-10 EPTS; and history of left wrist tenosynovitis also category II and obesity and adjustment disorder as category III. The CI was then medically separated with a 20% combined disability rating.

CI CONTENTION: The CI states: “In accordance with the Department of Defense Directive Type-Memoranda (DTM), dated 14 Oct 08, the applicant requests that the Board review the VA Automated Medical Information Exchange (AMIE) worksheets to ensure that all impairments were submitted by the MEB and evaluated by the PEB. If it is discovered, that all of the applicants' conditions were not submitted, and thus not properly evaluated, the applicant requests that the Board ensures that this happens during their review. The applicant requests that if the Board disagrees with any part or subpart, of the items in which the applicant seeks relief, a clearly described rationale shall be given as to why the Board disagrees. The applicant requests a review of her disability case and that this review culminate in a recommendation, by the Board, that the she should be permanently retired at a compensable rate of thirty-percent (30%) or higher. For the foregoing reasons, the relief sought by the Applicant must be granted in all respects.”

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Service AFSC – Dated 20080608 | | | VA (1 Mo. After Separation) – All Effective Date 20080615 | | | |
| Condition | Code | Rating | Condition | Code | Rating | Exam |
| Right Plantar Fasciitis | 5399-5310 | 10% | Plantar Fasciitis | 5279 | 10% | 2080827 |
| Left Plantar Fasciitis | 5399-5310 | 10% |
| History of Right Exertional Anterior Compartment Syndrome, status-post Fasciotomy, resolved | 5399-5312 | 0% | Compartment Syndrome Right Leg | 5299-5251 | 10% | 20080904 |
| No entry | | | Compartment Syndrome Left Leg | 5299-5251 | Not Service Connected | |
| Bilateral Leg Pain and Numbness of Undetermined Etiology without Objective Findings or Evidence of Impairment | Category ll | | Not VA Rated | | | |
| Obstructive Sleep Apnea, Well Controlled with CPAP | Category ll | | Sleep Apnea | 6847 | 50% | 20080828 |
| Lumbago without Causative Anatomic Abnormalities or Objective Evidence of Impairment | Category II | | Lumbar Strain (Lumbago) | 5237 | 10% | 20080904 |
| Radiologic evidence of Mild Degenerative Changes at T9-10 (EPTS) | Category II | | Degenerative Changes at T9-T10 | 5242 | Not Service Connected | |
| History of Left Wrist Tenosynovitis, Resolved | Category II | | Left Wrist Tenosynovitis | 5024 | Not Service Connected | |
| Obesity | Category III | | Not VA Rated | | | |
| Adjustment Disorder | Category III | | Adjustment Disorder | 9440 | 0% | 20080904 |
| ↓No Additional MEB/PEB Entries↓ | | | Patellofemoral Syndrome Right Knee | 5257 | 10% | 20080904 |
| 0% x 4 other / Not Service Connected x 11 other | | | 20080904 |
| Combined: 20% (Bilateral Factor 1.9%) | | | Combined: 70% (Bilateral Factor 2.7%) | | | |

ANALYSIS SUMMARY: The Board acknowledges the CI’s assertions that the Board review the Department of Veterans’ Affairs (DVA) automated medical information exchange (AMIE) worksheets to ensure that all impairments were submitted by the MEB and evaluated by the PEB. It is noted for the record that the Board has neither the jurisdiction nor authority to scrutinize or render opinions in reference to asserted service improprieties in the disposition of a case. The Board’s role is confined to the review of medical records and all evidence at hand to assess the fairness of PEB rating determinations, compared to VASRD standards, based on severity at the time of separation. It must also judge the fairness of PEB fitness adjudications based on the fitness consequences of conditions as they existed at the time of separation. Additionally, 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 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 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.

Right and Left Plantar Fasciitis and History of Right Exertional Anterior Compartment Syndrome, status-post Fasciotomy, Resolved:

The IPEB in February 2008 determined the CI was unfit as a result of bilateral lower leg pain, congenital bilateral pes planus that was permanently aggravated by service and mechanical low back pain with degenerative changes on x-ray. The combined effect of these conditions resulted in an inability to perform her Air Force Specialty (AFS) which included walking, carrying litters or other strenuous activities for any significant duration. The FPEB in April 2007 determined the bilateral lower leg pain alone resulted in the CI’s unfitness for military service. While SAFPC stated the condition of bilateral plantar fasciitis in combination with the history of right anterior compartment syndrome was the cause of the CI’s unfitness, the symptoms and functional limitations cited by both the IPEB and the FPEB were used to support the SAFPC’s determinations of unfitness and disability ratings. It is noted by the Board that all three approaches determined a combined disability rating of 20%. The Board views this as a variance in rating procedures, not a change in diagnosis or level of disability.

In October 2006 the CI presented to the student healthcare clinic with complaints of bilateral anterior tibial tenderness, was treated with a nonsteroidal anti-inflammatory drug (NSAID), and a consult to physical therapy was requested for the diagnosis of shin splints. The physical therapist, four days later, noted that both legs had moderate tenderness to palpation (TTP) in the distal third anterior tibial area, worse on the right than the left. In December 2006 the CI was given a two week temporary duty restriction to avoid high impact activities, stating the CI would not perform the following activities: jumping jacks, dancing, sporting activities, and walk/run at own pace, march, or wear athletic shoes in and out of uniform. Throughout the course of her active duty the CI was given several temporary duty restrictions. A bone scan done in February 2007 showed left shin splints; stress changes of the knees, ankles and feet; and mild asymmetric activity at the right sacroiliac joint. Although the CI was undergoing physical therapy, the shin splints persisted. A Neurology consult in April 2007 documented a completely normal and symmetric neurologic examination including motor, sensory, and reflexes. Her right calf was 36.5cm and her left was 37.5cm. MRI of the right calf from late March was normal without evidence of stress fracture. An EMG/NCV test from early April was also normal. The CI was diagnosed with right lower extremity (RLE) compartment syndrome (CS) and underwent a RLE anterior compartment release and fasciotomy in April 2007. The MEB narrative summary (NARSUM) examination eight months prior to separation noted a history of leg cramps in her calves twice weekly significant elevation of the right anterior compartment with a pressure of 32 mmHg after a period of exercise and initiation of symptoms. The medical record indicated resolution of most symptoms. However, the CI requested a correction of her medical record as she disagreed that she had improved. The examiner further indicated continuing pain in both legs that prevented extended walking or running. She also complained of sharp pains in the incision area of the right leg and both feet and lower legs falling asleep at times approximately ten times a day. The paresthesias would resolve with getting up and moving around as well as with loosening her boots and blousing straps. The CI had not been running and felt that this had lead to somewhat of an improvement of her symptoms. She felt that if she would participate in any vigorous activity her symptoms would worsen. The physical examination revealed a well healed surgical scar on the right leg and normal and symmetric motor, sensory, and reflex examinations of bilateral lower extremities. X-rays of feet and ankles as well as the right tibia and fibula were normal. The examiner’s impression was demonstrable chronic CS of the right anterior compare condition of the leg, status-post surgical release with some decrease in symptoms but no resolution. The examiner further opined that this condition did not constitute a boardable condition. The CI sent a Letter of Exception to the MEB Recommendations objecting to the examiner’s comments in the NARSUM. A December 2007 MEB determined that the CI was fit for duty. However, an IPEB in February 2008 determined she was unfit for military service. The PEBs and SAFPC also determined the CI was unfit as described above. The commanders statement issued in December noted the CI was performing satisfactorily in her AFS in a clinic setting. However, he believed the CI would not do well carrying litters or other strenuous activities for any significant duration. He stated he would not accept her into a deployed environment.

The VA Compensation & Pension (C&P) foot examination noted bilateral foot pain, left greater than right, which had not responded to Motrin or orthotics. The patient had bilateral tenderness to palpation of the plantar fascia with a normal gait and no evidence of abnormal shoe wear or callosities. He noted “the patient’s walking ability; standing ability and distance tolerance appear normal and unimpaired without requirement for extra breaks, restriction of tasks or limitation of work hours.” She neither had, nor required assistive devices and there were no range of motion limitations or vascular changes. There were no additional limitations following repetitive use. She also had a mild right bunion deformity. The examiner opined plantar fasciitis was a continuity of her service complaint that was mild and would not lead to any significant limitation for ambulatory activities of daily living. Another VA C&P examination performed sixteen months after separation to evaluate muscles documented constant chronic aching, stabbing pain rated 6/10 in both legs causing difficulty standing for extended periods of time and affecting the muscles of the leg, both anterior and lateral. The CI had marked functional limitations with both occupational and daily activities that required standing of more than 10 to 15 minutes. The examination noted the surgical scar on the right anterior leg was tender to palpation. However, there were no loss or atrophy of muscle, no adhesions, no tendon damage, no bone, joint or nerve damage, no muscle herniation, and no loss of muscle function. A normal motor examination was noted. The left leg examination was normal and without pain. Service and VA examinations note similar symptoms and objective findings.

While the PEBs and SAFPC applied different rating configurations all determined a combined disability rating of 20% related to the CI’s bilateral lower extremity pain and inability to perform any sustained weight-bearing activity. The CI’s subjective complaints and objective physical findings do not fit completely into one specific diagnosis. However, her inability to perform the required activities of her AFS is clear. When considering all service and VA conditions rated as part of this lower extremity condition, the Board notes the service and the VA both applied a total rating of 20%. The service rated each lower extremity at 10% each for plantar fasciitis using VASRD code 5310 (group x muscles of the foot and leg) analogously. The VA rated bilateral plantar fasciitis at 10% analogous to 5279 (metatarsalgia, unilateral or bilateral) and right leg compartment syndrome at 10% analogous to 5251 (thigh, limitation of extension of). Both of these rata schemas cover the same symptoms and functional limitations and result in the same combined disability rating. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board concluded that there was insufficient cause to recommend a change in the PEB adjudication for the condition.

Obstructive Sleep Apnea:

Both PEBs and SAFPC adjudicated the OSA condition as category II, not currently unfitting. In August 2007 the CI underwent a diagnostic polysomnography to evaluate symptoms of excessive daytime somnolence, sleep apnea, and snoring. The CI also underwent an evaluation in October 2007 for CPAP machine titration which documented mild OSA with successful CPAP titration. The CI was not on any profile and had no duty restrictions related to this condition. The commander’s statement written in December 2007 briefly noted “the sleep apnea issue is still problematic” and he also documented that for the year 2007, the CI had nine appointments for the OSA. The CI was seen by pulmonary in December 2007 for OSA follow-up and it was noted that her excessive daytime somnolence was much improved with the CPAP machine at that time. However, she was having some trouble with condensation in the machine. No further follow-up visits with service pulmonologist are available in the record for review. The VA C&P examination approximately two months after separation indicated that the CI reported daytime hyper somnolence and was using her CPAP at 7cm of water. The examiner ordered repeat sleep studies. A VA treatment note from September 2008 noted the results of a sleep study and the plan for another study to determine optimal CPAP pressure. This note does not document the presence or absence of current symptoms. The VA rated this condition at 50% as the CI required a CPAP machine.

Both the service treatment note from December 2007 and SAFPC rationale from June 2008 document that the CI’s symptoms were controlled with the CPAP. The VA C&P examination approximately two months after separation documents return of symptoms while using the CPAP at 7cm of water. The CI had undergone a repeat sleep study at the VA to confirm the diagnosis and was scheduled for a study to titrate her CPAP. However, no further follow-up visit notes are available for the Board to review and it is unknown whether increased CPAP pressure led to resolution of symptoms. It appears that CI’s symptoms required a greater CPAP pressure after separation and this does not seem unreasonable as she was on a relatively low pressure of 7cm. The pressure required by most patients with sleep apnea ranges between 6 and 14 cmH2O. A typical CPAP machine can deliver pressures between 4 and 20cm of water. More specialized units can deliver pressures up to 25 or 30 cm. After due deliberation in consideration of the totality of the evidence, the Board concluded that there was insufficient cause to recommend a change in the PEB fitness adjudication for the OSA condition.

Other PEB Conditions: Other conditions forwarded by the MEB and adjudicated as category II were bilateral leg pain and numbness of undetermined etiology without objective findings or evidence of impairment; lumbago without causative anatomic abnormalities or objective evidence of impairment; radiologic evidence of mild degenerative changes at T9-10 (EPTS); history of left wrist tenosynovitis, resolved; and adjustment disorder. Patellofemoral syndrome (right knee) was included in the MEB NARSUM but was not adjudicated. None of these conditions were profiled, implicated in the commander’s statement, or noted as failing retention standards separately from the unfitting conditions of bilateral plantar fasciitis and history of right leg anterior compartment syndrome. All functional limitations were utilized to support the combined rating of 20% as described above. To use these same limitations to support the application of a disability rating to any of these conditions would be pyramiding and this is prohibited by the VASRD. All conditions were reviewed by the action officer and considered by the Board. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for any of the stated conditions.

Other Contended Conditions: The CI’s application asserts that compensable ratings should be considered for varicose vein (left leg), varicose vein (right leg), and scar to right lower extremities. All of these conditions were reviewed by the action officer and considered by the Board. There was no evidence for concluding that any of 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: Obesity was adjudicated as a category III condition. This condition does not constitute a disability and no rating is warranted IAW the VASRD. Herpes simplex type 1 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. 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. In the matter of the right and left plantar fasciitis and history of right exertional anterior compartment syndrome, status-post fasciotomy, resolved conditions; the Board unanimously recommends no change in SAFPC’s adjudication at separation. In the matter of the OSA; bilateral leg pain and numbness of undetermined etiology without objective findings or evidence of impairment; lumbago without causative anatomic abnormalities or objective evidence of impairment; radiologic evidence of mild degenerative changes at T9-10 (EPTS); history of left wrist tenosynovitis, resolved; adjustment disorder; and obesity conditions, the Board unanimously recommends no change from SAFPC adjudications as not unfitting. In the matter of the varicose vein (left leg), varicose vein (right leg), scar to right lower extremities, and herpes simplex type 1 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, therefore, recommends that there be no recharacterization of the CI’s disability and separation determination, as follows:

|  |  |  |  |
| --- | --- | --- | --- |
| **UNFITTING CONDITION** | | **VASRD CODE** | **RATING** |
| Right Plantar Fasciitis | | 5399-5310 | 10% |
| Left Plantar Fasciitis | | 5399-5310 | 10% |
| History of Right Exertional Anterior Compartment Syndrome, status-post Fasciotomy, resolved | | 5399-5312 | 0% |
| **COMBINED (Incorporating BLF)** | | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110705, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans Affairs Treatment Record

XXXXXXXXXXXXXXX

President

Physical Disability Board of Review

SAF/MRB

1500 West Perimeter Road, Suite 3700

Joint Base Andrews MD 20762

Dear xxxxxxxxx:

Reference your application submitted under the provisions of DoDI 6040.44 (Title 10 U.S.C. §  1554a), PDBR Case Number PD-2011-00509

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,

Xxxxxxxxxxxxxx

Director

Air Force Review Boards Agency

Attachment:

Record of Proceedings