RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: coast guard

CASE NUMBER: PD1100560 SEPARATION DATE: 20011219

BOARD DATE: 20120224

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty FS2/E-5 (Food Service Specialist) medically separated for post-phlebitic syndrome. The condition began in 1994 when he developed a deep venous thrombosis (DVT) of his right leg. The condition resolved with a course of anticoagulation therapy (“blood thinner”), but then in 2000 he suffered a pulmonary embolus (PE; “clot to the lung”) as a consequence of a recurrent right leg DVT. With anticoagulation treatment his condition was stabilized, but due to ongoing right leg pain and the need for permanent anticoagulation, he was rendered unable to perform within his rating. He was placed on limited duty and underwent a Medical Evaluation Board (MEB). Nonspecific hypercoagulable state was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable. Ventral hernia with persistent hypermobility post repair was also identified and forwarded on the MEB submission as a second diagnosis. Additional conditions supported in the Disability Evaluation System (DES) file are discussed below, but were not forwarded for PEB adjudication. The PEB adjudicated the post-phlebitic syndrome condition as unfitting, rated 0% IAW the Veterans Administration Schedule for Rating Disabilities (VASRD). The ventral hernia condition was not listed as unfitting on the PEB document. The CI made no appeals and was medically separated with a 0% disability rating.

CI CONTENTION: The CI states: “I was medically separated from the US Coast Guard on December 19, 2001 with a 0% disability and severance pay. On November 12, 2002 the VARO granted service-connection compensation for the same disability and a combined rating of 60% effective December 20, 2001. I believe that I should be medically retired from the US Coast Guard under Chapter 61 and PDRL.” He elaborates no specific contentions regarding rating or coding and mentions no additionally contended conditions.”

RATING COMPARISON:

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| --- | --- |
| **Service IPEB – Dated 20011002** | **VA (5 Mo. After Separation) – All Effective 20011220** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Post-Phlebitic Syndrome | 7121 | 0% | Hypercoagulable State | 6899-6817 | 60% | 20020531 |
| Ventral Hernia\* | Not listed as unfitting  | Ventral Umbilical Hernia | 7339 | 0%\*\* | 20020531 |
| ↓No Additional MEB Entries↓ | Hypertension | 7101 | 10% | 20020531 |
| 0% x 1 / Not Service Connected x 5 | 20020531 |
| **Combined: 0%** | **Combined: 60%** |

\*MEB form lists as a second diagnosis; not listed by the PEB as an unfitting condition

\*\*Increased to 20% effective 20040818

ANALYSIS SUMMARY: The Disability Evaluation System (DES) is responsible for maintaining a fit and vital fighting force. 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 without regard to impact on performance of military duties and to periodically re-evaluate said conditions for the purpose of adjusting the Veteran’s disability rating should the degree of impairment vary over time. 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. 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. Furthermore, a “crystal ball” requirement is not imposed on the service PEB’s by the Board; and, the 12 month window specified in DoDI 6040.44 is appropriate for rating comparisons but not for new developments after separation.

Post-Phlebitic Syndrome Condition. Due to the significant differences between the ratings adjudicated by the PEB and VA, the Board carefully considered the whole record in order to develop a consistent picture of the CI’s condition. The CI developed a deep vein thrombosis (DVT) of the right calf in September 1994. He required a limited course of Coumadin anticoagulation at that time. He did well until May 2000 (19 months prior to separation) when, following surgery, shortness of breath symptoms led to the diagnosis of pulmonary embolism (PE) from recurrent DVT. Although a complete hematology evaluation identified no specific genetic clotting disorder, the presence of such a condition was presumed due to a family history of hypercoagulable state and his personal history. Life-long Coumadin therapy was therefore recommended in order to prevent recurrent DVT. This therapy imposed duty and assignment restrictions due to risks of bleeding from trauma. A commander’s statement noted that the requirement to avoid ship ladders and use of sharp instruments were significant limitations that prevented performance of his primary duties. The narrative summary (NARSUM) examiner (19 July 2001, five months prior to separation) reported that the CI continued to have intermittent right leg pain, but also bilateral symptomatic (painful) varicose veins. Leg pain rendered him unable to fully perform his duties, including office work. The NARSUM was silent regarding pulmonary symptoms, and the CI documented on the MEB History and Physical (H&P) that shortness of breath was “in May, 2000,” at the time of the embolic event. There was no indication that this symptom persisted or recurred, and multiple clinic entries following recovery from the PE document the absence of shortness of breath or respiratory symptoms. A 6 August 2001 clinic encounter for knee pain noted extensive use of stairs and ladders without mention or complaint of shortness of breath. The NARSUM examination revealed bilateral symptomatic leg varicosities. An exercise tolerance test (ETT) performed December 2000, one year prior to separation, was normal and was stopped due to leg cramps. Although “fair exercise capacity limited by leg cramps” was noted, shortness of breath was not reported. The Compensation and Pension (C&P) examiner also did not mention pulmonary complaints, but reported that the lower extremity varicose vein issue was now asymptomatic. Physical exam revealed no varicosities and no edema. A chest X-ray was normal and pulmonary function testing revealed normal spirometry results. Post-separation records similarly do not show evidence of recurrent DVT or PE. An echocardiogram 12 August 2004, after separation, was normal including normal pulmonary artery pressure, indicating absence of chronic pulmonary embolism.

The PEB’s use of the 7121 code reflected the relevant limiting symptom reported by the CI, which was intermittent leg pain. The exercise stress test examiner noted mild performance-limiting leg pain and the NARSUM documented complaint of right leg aching. No clinical notes documented the presence of edema, secondary stasis or eczematous changes, or the need for lower extremity compression devices. The C&P examiner specifically stated that edema was not present. Board members concluded that the right leg pain associated with the history of DVT more nearly approximated with 10% than the 0% rating.

The VA elected to use an analogous 6817 code for pulmonary vascular disease in its rating for hypercoagulable state. The CI’s last episode of DVT, and the only episode of pulmonary embolism, occurred 17 months prior to the PEB. While the VA quoted the language for the 60% rating under the 6817 code in its decision, the CI only had the single PE, and clearly did not have recurrent episodes indicative of “chronic pulmonary thromboembolism” upon which that rating should be based. Furthermore, an echocardiogram following separation showed no evidence for presence of chronic pulmonary thromboembolism such as pulmonary hypertension, right ventricular hypertension. The CI had no pulmonary symptoms reflective of lung impairment, thus even the 30% criteria were not met. The description of the 0% rating, “asymptomatic, following resolution of pulmonary thromboembolism” most accurately depicted the CI’s clinical picture under the 6817 code. The evidence clearly establishes that, after his initial event, the CI did not have recurrent or chronic pulmonary thromboembolism as specified in the criteria for the 60% rating. He had a possible genetic predisposition for the formation of blood clots and was taking warfarin to prevent possible recurrent deep vein thrombosis and pulmonary thromboemboli. However, the presence of the genetic predisposition does not equate to a diagnosis of actual chronic recurrent pulmonary thromboembolism. The fact that treatment for the predisposition has been recommended and followed does not equate with the serious level of occupational impairment that the 60% level describes and does not meet the criteria for a 60% evaluation under diagnostic code 6817. IAW with §4.1 (Essentials of evaluative rating), the VASRD is designed to compensate for average impairments of earning capacity resulting from service-connected disability in civil occupations (not military). Although the need for long term maintenance on blood thinners was recommended, medical evidence demonstrated no residual disability from the pulmonary embolism that can support a compensable evaluation at the time of separation from military service. Further, there were no significantly disabling side-effects of the medication, and no unusual or exceptional disability factors were demonstrated with respect to the service-connected thrombophilia or lung condition. Without evidence of a symptomatic condition following resolution of an acute pulmonary embolism, a compensable rating cannot be awarded. The Board concluded that the evidence of the record did not support rating using the code for pulmonary vascular disease as there were no duty limiting respiratory symptoms and no evidence of chronic or recurrent pulmonary embolism. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a separation rating of 10% for the post-phlebitic syndrome condition.

Other PEB Conditions. The other condition forwarded by the MEB but not listed as unfitting by the PEB was ventral hernia with persistent hypermobility post repair. In May 2000 the CI underwent operative repair of an abdominal wall hernia that developed approximately three months prior. Follow-up six months after surgery noted some continuing pain in the upper abdomen that was assessed as likely due to scar tissue. The NARSUM examiner (14 months after surgery) stated the CI complained of “anterior abdominal wall laxity and discomfort primarily with positional changes and lifting,” while the MEB H&P reported complaints of a persistent ache. Examination showed hypermobility of the anterior abdominal wall and a 15 cm midline scar, but no hernia. The C&P examiner recorded a complaint of discomfort when lifting greater than 20 pounds and documented no tenderness to palpation. The VA assigned a 0% rating. This condition did not carry duty limitations and was not identified as an impairment in the commander’s statement. It was reviewed by the action officer and considered by the Board. There was no indication from the record that it significantly interfered with satisfactory performance of duty requirements. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a recommendation as unfitting and subject to separation rating.

Remaining Conditions. Other conditions identified in the DES file were high blood pressure, right knee pain, ventral herniorraphy scar and lipoma excision. Several additional non-acute conditions or medical complaints were also documented. None of these conditions were clinically or occupationally significant during the MEB period, none were associated with duty limitations, 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 hypercholesterolemia 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 post-phlebitic syndrome condition, the Board unanimously recommends a rating of 10% coded 7121 IAW VASRD §4.104. In the matter of the ventral hernia with persistent hypermobility post repair condition, the Board unanimously agrees that it cannot recommend a finding 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 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** |
| Post-phlebitic Syndrome | 7121 | 10% |
| **COMBINED** | **10%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110719, w/atchs.

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans' Affairs Treatment Record

 President

 Physical Disability Board of Review

