RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: Army

CASE NUMBER: PD1100660 SEPARATION DATE: 20070622

BOARD DATE: 20120308

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SPC/E-4 (92F, Fuel Handler) medically separated for a hypercoaguable state due to factor V leiden deficiency (abnormally excessive clotting due to a genetic absence of an enzyme). The CI first experienced leg pain in 2003 while deployed to Iraq, which was treated as muscle strain. During his third deployment in August 2006, his condition worsened; and, he was medically evacuated to Germany where he was diagnosed with deep vein thrombosis (DVT) in his left lower extremity (LLE). The genetic disease was then diagnosed, and he was placed on anticoagulant. After a recurrence of DVT, he was again hospitalized; and, it was determined that he would require life-long anticoagulation. Despite therapy, he continued to experience leg pain and LLE swelling. He was unable to meet the physical requirements of his Military Occupational Specialty (MOS) or satisfy physical fitness standards. He was issued a permanent P3 profile and referred for a Medical Evaluation Board (MEB). Thrombophlebitis was forwarded to the Physical Evaluation Board (PEB) as a medically unacceptable condition IAW AR 40-501. Three other conditions, as identified in the rating chart below, were addressed by the MEB and forwarded as medically acceptable. The PEB adjudicated the hypercoaguable condition as unfitting, but unratable because it existed prior to service (EPTS) without service-aggravation. The CI appealed to the Formal PEB (FPEB), which conceded the condition as service-aggravated; rated 10% citing criteria of the Veterans Administration Schedule for Rating Disabilities (VASRD). The CI made no further appeals and was medically separated with that service disability rating.

CI CONTENTION: “Lower back pain with blood clots that resulted into permanent damage. Awarded 20% and 10% is paying off disability severance pay.” He elaborates no specific contentions regarding rating or coding and mentions no additionally contended conditions.

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service FPEB – Dated 20070502** | | | **VA (9 Mo. Post-Separation) – All Effective 20070623** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Hypercoaguable State… | 7199-7120 | 10% | Residuals Deep Vein Thrombosis | 7199-7121 | 10% | 20080316 |
| Lumbago (low back pain) | Not Unfitting | | Low Back Strain | 5237 | 10% | 20080316 |
| Myopia | Not Unfitting | | Not VA Rated | | | 20080316 |
| Regular Astigmatism | Not Unfitting | | Not VA Rated | | | 20080316 |
| No Additional MEB/PEB Entries | | | No Additional VA Entries | | | 20080316 |
| **Combined: 10%** | | | **Combined: 20%** | | | |

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impairment with which his service-incurred condition continues to burden him. 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. 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. That role and authority is granted by Congress to the Department of Veterans’ Affairs (DVA), operating under a different set of laws (Title 38, United States Code). The Board evaluates DVA evidence proximal to separation in arriving at its recommendations, but its authority resides in evaluating the fairness of DES fitness decisions and rating determinations for disability at the time of separation. The Board further acknowledges the CI’s contention for service ratings for other conditions documented at the time of separation, and notes that its recommendations in that regard must comply with the same governance. 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. The DVA, however, is empowered to compensate service-connected conditions 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.

Hypercoaguable Condition. VASRD §4.104 (cardiovascular system) does not provide an overall code for rating the underlying disease in coagulapathies, but rather rates under specific sequelae such as DVT or pulmonary embolus. The Board’s rating recommendation will therefore be derived from one of the commonly applied analogous codes: 7120 (varicose veins) as per the PEB, or 7121 (post-phlebitic syndrome, specifying DVT). The 7120 code is a better clinical fit in this case, although the distinction is fairly moot since the rating language for the spectrum of disease in evidence is identical in both codes. In addition to assessing the fairness of the rating assignment itself; however, the Board is also faced with the §4.104 stipulation under these codes that, “these evaluations are for involvement of a single extremity. If more than one extremity is involved, evaluate each extremity separately and combine (under §4.25), using the bilateral factor (§4.26), if applicable.” Although the more severe pathology in this case was referable to the LLE, there was some involvement of the right lower extremity (RLE) as will be elaborated below. The Board’s initial deliberation was whether the §4.104 stipulation (just quoted) obligates the Board to recommend a service rating for any ratable disability attributable to the right lower extremity (RLE) involvement (via a tie to the DoDI 6040.44 mandate to adhere to the VASRD); or, whether the RLE impairment must meet the DES requirement for being itself unfitting to qualify for a service rating. After considerable deliberation, members agreed that the DES principle of fitness determination must be satisfied to qualify a rating element as service disability; despite a VASRD link to the only analogous code available for rating the unfitting coagulopathy. This principle was judged to be equivalent to the well established Board precedent for fitness consideration in separate rating for peripheral neuropathy linked to unfitting spine disease, as well as ratable residuals of diabetes and other unfitting primary conditions. In light of the conclusion just elaborated, the evidence before the Board relevant to the rating and fitness considerations for each affected extremity are separately presented below.

Left Lower Extremity. The CI first reported pain in his left calf in 2003. This was initially considered to be related to a strain injury and improved over time; but, was a recurrent complaint. He was treated for bilateral calf strain in 2005, but the complaints progressed despite therapy. A later treatment note from August 2006 documents a preceding two year history of bilateral symptoms, and states, “no prior U/S [ultrasound] showed a DVT.” It is clear that the definitive diagnosis of DVT, and subsequent diagnosis of Factor V Leiden deficiency, occurred in the aftermath of the 2006 medical evacuation from theater. It is also clear that the DVT was confined to the LLE at that time. It was complicated by cellulitis; and, was ultimately complicated by recurrent DVT (confined to the LLE) which mandated permanent anticoagulation. One outpatient note six months prior to separation documents that the LLE pain and edema had resolved. It is flanked by entries around the period of hospitalization which note pain, edema, and other positive findings; and, by the positive findings of the MEB exam which follow. At the MEB exam (three months prior to separation), the CI reported pain and swelling whenever his recurrent DVT was active. The MEB examiner noted active LLE symptoms at the time of the exam; and, referenced a contemporary ultrasound which documented extensive LLE thrombosis. On examination, the physician noted dark pigmentation and edema in the lower posterior left calf. It was noted that the CI could not run, walk any distances, climb stairs, or easily get in and out of vehicles. At the VA Compensation and Pension (C&P) exam (nine months after separation), the physician noted intermittent symptoms of pain and edema in the LLE; although, DVT symptoms were not active at that time. He also noted dark pigmentation and ulceration of the skin; but, the exam provided no specific documentation of the presence or degree of real-time LLE edema.

Right Lower Extremity. The CI first reported pain, redness and swelling in his right calf in 2005. He was initially treated for calf strain, but an ultrasound that same year suggested cellulitis; but, excluded DVT. After the LLE condition was diagnosed and anticoagulation begun, the predominant clinical attention was focused on the LLE. There is no ultrasonic confirmation of DVT of the RLE in evidence at any point before or after separation. There are passing notes, both the one noted above before the DVT and coagulopathy diagnoses and subsequently, which note bilateral symptoms. It may be assumed that there was an intermittent (or possibly constant) bilateral pain complaint; although, it would be speculative to assume that there was edema (intermittent or persistent) of the RLE. There is no focused RLE exam documented in the outpatient records proximate to separation, in the MEB physical, or in the narrative summary (NARSUM). The VA C&P examiner documented a normal neurologic exam of the RLE, but did not comment on other physical findings. The post-separation VA rating decision (VARD) stated that the RLE was “within normal limits;” but, that would have been a simply an assumption based on the C&P exam. A vascular flow study was performed by the VA (9 months post-separation) which noted “minimal decrease” in RLE vascular flow parameters. Regarding evidence directed at fitness considerations, the commander’s statement referred to “extreme debilitating pain in both legs.” As just detailed, however, there is no corroboration for the commander’s conclusion. The MEB’s correlation with AR 4-501 retention standards, the profile limitations, and the PEB’s DA Form 199 went to the coagulopathy rather than extremity impairment; and, therefore are not relevant to a fitness distinction between the two lower extremities.

The Board directs attention to its fitness and rating recommendations based on the above evidence. The Board first considered if the rating for the unfitting coagulopathy should be based on the residuals of both lower extremities, with the underlying assumption that each was separately unfitting (as clarified in the initial discussion). There is no doubt that the coagulopathy was unfitting, clearly implicating the LLE; and, it was readily concluded that the LLE was unfitting and ratable. There was considerable deliberation as to whether the RLE was itself unfitting and therefore should be rated and combined with the service rating for the coagulopathy. The action officer opined that some mild venous insufficiency of the RLE was likely present, and presumably a consequence of the underlying coagulopathy (possibly implying some clinically occult thrombotic disease). The action officer was confident that there was no active thrombotic disease or cellulitis of the RLE at the time of separation, nor was there a prognosis for likely recurrence of same. Members concluded, regarding RLE fitness consideration, that although the commander’s statement gives pause; there was no other citable evidence which would suggest that the RLE involvement was more than mild (even if actually present) at the time of separation. All members agreed, therefore, that the RLE impairment would not have independently rendered the CI incapable of fulfilling his MOS requirements or continuing his military service. It was thus concluded that a RLE rating should not be combined with the coagulopathy rating; and, furthermore, that achieving a compensable RLE rating would be poorly supported even if so conceded.

Regarding is rating recommendation based on the LLE findings, the Board notes the following spectrum of deliberated ratings as defined by §4.104 under the applicable codes:

Persistent edema and stasis pigmentation or eczema, with or without

intermittent ulceration ................................................................................................................40

Persistent edema, incompletely relieved by elevation of extremity,

with or without beginning stasis pigmentation or eczema ..........................................................20

Intermittent edema of extremity or aching and fatigue in leg after

prolonged standing or walking, with symptoms relieved by elevation of

extremity or compression hosiery ...............................................................................................10

Asymptomatic palpable or visible varicose veins .....................................................................0

Although there was single note, as cited above, documenting an edema free exam; the preponderance of the clinical evidence would support a conclusion that the edema was more or less persistent; i.e., consistent with the 20% rating. The stasis pigmentation cited for 20% was also present. The VA examiner noted ulceration, which is cited in the 40% criteria. Ulceration is not worded in obligatory terms, however, and ulceration during the probative rating period was not documented elsewhere in the record. The preponderance of the clinical evidence (as with the edema argument above) therefore was not consistent with the 40% criteria. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a separation rating of 20% for the condition of hypercoaguable state due to factor V leiden deficiency. The action officer prefers the 7199-7121 code for its clinical compatibility.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were lumbago, myopia, and regular astigmatism. None of these conditions were profiled, implicated in the commander’s statement or noted as failing retention standards. All were reviewed by the action officer and considered by the Board. There was no indication from the record that any of these conditions 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 any of the stated conditions.

Remaining Conditions. No other conditions were noted in the NARSUM, identified by the CI on the MEB physical or found elsewhere 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. 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 hypercoaguability condition, the Board unanimously recommends a service disability rating of 20%, coded 7199-7121 IAW VASRD §4. 4.104. In the matter of the lumbago, myopia, and regular astigmatism conditions, the Board unanimously recommends no change from the PEB adjudications as not unfitting. 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:

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Hypercoaguable state due to Factor V Leiden Deficiency | 7199-7121 | 20% |
| **COMBINED** | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294 dated 20110808, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans Affairs Treatment Record

President

Physical Disability Board of Review

SFMR-RB

MEMORANDUM FOR Commander, US Army Physical Disability Agency

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation

1. 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 to modify the individual’s disability rating to 20% without recharacterization of the individual’s separation. This decision is final.

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.

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

Deputy Assistant Secretary

(Army Review Boards)