RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXX BRANCH OF SERVICE: air force

CASE NUMBER: PD1100671 SEPARATION DATE: 20040820

BOARD DATE: 20120314

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was a TSgt/E-6 (2S071, Inventory Management Systems), medically separated for obstructive sleep apnea (OSA). The CI was initially diagnosed with OSA in March 2003. In July 2003, the CI was started on nasal continuous positive airway pressure (CPAP) with improvement in his condition, however over time he developed claustrophobia and could not tolerate the nasal or the face mask. The CI did not respond adequately to treatment and was unable to perform proficiently within his Air Force Specialty (AFS) or meet physical fitness standards. The CI was issued a temporary P4 profile and underwent a Medical Evaluation Board (MEB). The MEB forwarded “severe OSA” on AF Form 618 to the Physical Evaluation Board (PEB) as medically unacceptable IAW AFI 48-123. The PEB adjudicated “OSA, cannot tolerate CPAP and has elected not to undergo uvulopalatopharyngoplasty” as unfitting, rated 0% with application of DoDI 1332.39. No other conditions appeared on the MEB’s submission. Other conditions included in the Disability Evaluation System (DES) packet will be discussed below. The CI made no appeals, and was medically separated with a 0% disability rating.

CI CONTENTION: The CI states: “I self-identified my sleep apnea condition because I was concerned that it was affecting my duty performance. Incidentally, my commitment to the core values of integrity first, service before self and honor in all we do would be instrumental in ending my career with no retirement benefits. Ultimately, other mitigating circumstances led to my acceptance of the medical discharge. In January 2004, my mother, who had been my dependent for most of my career, passed away. With little to no concern of support shown from my unit, I felt abandoned and I secretly went into a deep depression. To make matters worse, my enlistment was coming to an end and after identifying my sleep apnea condition I was led to believe that my re-enlistment would be denied an extension was not an option. Having served 18 years and 10 months of honorable and decorated service, I felt railroaded!!! By the time I actually realized that I could fight the finding through a correctional board, the time constraints had already passed. Additionally, the MEB findings noted obesity a factor in my rating factor of 0% for my sleep apnea. However, I was not assigned to any weight management program based upon the Air Force standards calculated by height-weight-age-gender. Furthermore, many others who serve with sleep apnea, who may never expose their complication with performing at their best levels, will go on to retire. This leads me to ask 2 questions: 1. Was my nearly 19 years of faithful service any less valuable or commendable? 2. If my condition rendered my unfit for duty, how can I be considered 0% disabled? (My release condition was not obesity). He elaborates no specific contentions regarding rating or coding and mentions no additionally contended conditions.

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service PEB – Dated 20040701** | **VA (6 Mo. After Separation) – All Effective Date 20040821** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| OSA | 6847 | 0% | OSA | 6847 | 50% | 20080108 |
| Obesity | CAT III | No VA Entry |
| ↓No Additional MEB/PEB Entries↓ | Right Knee Osteoarthritis | 5010 | 10% | 20050108 |
| Degenerative Arthritis Left Knee  | 5010 | 10% | 20050108 |
| Left Knee Condition | 5260 | 10% | 20050108 |
| Hypertension | 7101 | 10% | 20050108 |
| Not Service Connected x 3 | 20050108 |
| **Combined: 0%** | **Combined: 70%** |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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, and not based on possible future worsening. 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 fitness for 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 acknowledges the CI’s assertions that he was led to believe his reapplication would be denied. It is noted for the record that the Board has neither the jurisdiction nor authority to scrutinize or render opinions in reference to the CI’s statements in the application regarding suspected service improprieties in the processing of his 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.

Obstructive Sleep Apnea Condition: The CI was seen in March 2003 for complaint of constant fatigue and unrestful sleep. The CI’s wife, who accompanied him to this medical clinic appointment, verified that he had periods of apnea at night. The examiner recorded a strong family history for OSA (mother, two brothers), noted that the CI had probable OSA along with obesity and recommended a pulmonary consult. In April 2003 the CI was evaluated by a pulmonologist who noted symptoms of apneic episodes, loud snoring, increased daytime somnolence with dry mouth on awakening, fatigue, restless non- restorative sleep and difficulty concentrating while working on computers at work. Pulmonary function studies were obtained ruling out a primary pulmonary etiology. In May 2003 the CI had a sleep apnea study (nocturnal polysomnogram) confirming the diagnosis of severe OSA/hypopnea syndrome which was significantly improved with application of 15 cm of CPAP. In July 2003, home-treatment with 15 cm of CPAP at night was initiated. The CI was given a temporary P4 profile for the OSA condition in July 2003. From September 2003 until April 2004 there are no entries in the DES relative to the OSA condition. An appointment for the Pulmonary Clinic was not kept by the CI in December 2003.In April 2004 the CI was seen again for OSA follow-up where he reported that he could not use the nasal CPAP secondary to headaches from the mask. At this time the CI was scheduled for assignment to Korea. As a result of the “poor compliance with nasal CPAP” the CI was referred to an ear, nose and throat (ENT) specialist for consideration for definitive corrective surgery. CI underwent ENT examination April 2004 where he reported “claustrophobia” as the cause of the CPAP difficulty. The ENT specialist documented that the CI had anatomic obstructions in both the nose and throat causing the OSA and recommended definitive corrective surgery in two stages - a nasal procedure (turbinoplasty and septoplasty) followed three to four weeks later by a throat procedure (uvulopalatopharyngoplasty). The CI elected not to undergo this surgery and discontinued regular use of CPAP in early June 2004. The MEB examination two months prior to separation indicated an initial good response to the nasal CPAP, however, discontinuance of CPAP caused a worsening of the OSA. The CI was not using the CPAP at the MEB exam and had symptoms of daytime somnolence, headache and fatigue; sleep apnea and snoring. In a letter to the MEB, the CI noted “it is virtually impossible to perform my required daily tasks without continually falling asleep.” The commander’s statement noted that the CI’s sleep apnea (untreated at the time) greatly affected his duty performance and made it difficult to concentrate and perform his day to day duties along with difficulty staying awake on his drive to work. The VA Compensation & Pension (C&P) examination five months after separation mentions diagnosis of OSA while in service treated with CPAP without further details. The PEB and VA chose the same coding option for the condition, but with different disability ratings. OSA is evaluated under diagnostic code 6847. Under the criteria for this code, a noncompensable rating is warranted for asymptomatic but documented sleep disorder breathing. A 30 percent disability rating is warranted for persistent day-time hypersomnolence. A 50 percent disability rating is warranted when the disability requires the use of a breathing assistance device such as a CPAP machine. Ratings higher than 50 percent require the presence of chronic respiratory failure with carbon dioxide retention or cor pulmonale, or, the requirement for tracheostomy which were not present in this case. The PEB assigned a zero percent rating citing DoD guidelines (presumed to be DODI 1332.39 (E2.A1.2.21), and made note that the CI’s obesity, a non-ratable/non-compensable condition, was a significant factor in the condition. The VA rated the condition at 50 percent under 6847, citing use of the CPAP machine. The Board noted that the CI was not using CPAP at the time of the separation. The Board also noted that the CI opted to not have definitive surgery, recommended as an alternative to CPAP use, but this was not considered in the discussions of the Board and had no impact on Board decision making. It was clear to the Board that, in the absence of CPAP use, the CI was experiencing “persistent day-time hypersomnolence;” findings consistent with requirements for disability rating of 30% under 6847. The Board considered that while the CI had difficulties tolerating the CPAP device, the presence of occupationally significant symptoms as noted in the commander’s statement, and the polysomnogram and clinical ENT examination clearly documenting severe OSA, indicated that use of the device was “required” meeting the standard for 50 per cent rating. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board unanimously recommends a separation rating of 50% for the OSA condition.

Other Contended Conditions. The CI’s application asserts that compensable ratings should be considered for secret deep depression. This was reviewed by the action officer and considered by the Board. This condition is 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.

Remaining Conditions. Other conditions identified in the DES file were hypertension, mixed hyperlipidemia, allergic rhinitis and left knee pain. 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 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 right knee osteoarthritis, degenerative arthritis left knee, left knee condition and several other non-acute conditions were noted in the VA proximal to separation, but were not documented in the DES file. Obesity, was included in the PEB as a category III but is not a ratable condition IAW both DoD and VA regulations and will be not be discussed. 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 OSA condition, the Board unanimously recommends a rating of 50% coded 6847 IAW VASRD §4.97. In the matters of the right knee arthritis, left knee arthritis, hypertension, hyperlipidemia and allergic rhinitis conditions, 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 and that the discharge with severance pay be recharacterized to reflect permanent disability retirement, effective as of the date of his prior medical separation:

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Obstructive Sleep Apnea (OSA) | 6847 |  50% |
| **COMBINED** |  **50%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110815 w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans Affairs Treatment Record

 X

 Physical Disability Board of Review

SAF/MRB

1500 West Perimeter Road, Suite 3700

Joint Base Andrews MD 20762

X

Dear X

 Reference your application submitted under the provisions of DoDI 6040.44 (Title 10 U.S.C. § 1554a), PDBR Case Number PD-2011-00671.

 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 not appropriate under the guidelines of the Veterans Administration Schedule for Rating Disabilities. Accordingly, the Board recommended your separation be re-characterized to reflect disability retirement, rather than separation with severance pay.

 I have carefully reviewed the evidence of record and the recommendation of the Board. I concur with that finding, accept their recommendation and determined that your records should be corrected accordingly. The office responsible for making the correction will inform you when your records have been changed.

 As a result of the aforementioned correction, you are entitled by law to elect coverage under the Survivor Benefit Plan (SBP). Upon receipt of this letter, you must contact the Air Force Personnel Center at (210) 565-2273 to make arrangements to obtain an SBP briefing prior to rendering an election. If a valid election is not received within 30 days from the date of this letter, you will not be enrolled in the SBP program unless at the time of your separation, you were married or had an eligible dependent child, in such a case, failure to render an election will result in automatic enrollment.

 Sincerely,

X

Director

Air Force Review Boards Agency

Attachment:

Record of Proceedings

cc:

SAF/MRBR

DFAS-IN

PDBR PD-2011-00671

MEMORANDUM FOR THE CHIEF OF STAFF

 Having received and considered the recommendation of the Physical Disability Board of Review and under the authority of Title 10, United States Code, Section 1554a (122 Stat. 466) and Title 10, United States Code, Section 1552 (70A Stat. 116) it is directed that:

 The pertinent military records of the Department of the Air Force relating to EXXXXXXXXXXXXX, be corrected to show that:

 a.  The diagnosis in his finding of unfitness for Obstructive Sleep Apnea, VASRD code 6847, was rated at 50% rather than 0%.

 b.  On 19 August 2004, he elected child and spouse coverage in the Survivor Benefit Plan.

 c.   He was not discharged on 20 August 2004; rather, on that date he was released from active duty and on 21 August 2004 his name was placed on the Permanent Disability Retired List.

 X

 Director

 Air Force Review Boards Agency