RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1100722 DATE OF PLACEMENT ON TDRL: 20020920

BOARD DATE: 20120606 Date of Permanent SEPARATION: 20050720

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SSG/E-6 (92Y3L/Supply Specialist), medically separated for fibromyalgia with muscle pain and fatigue; greater than 11 of 18 tender points*,* degenerative joint disease (DJD) status post rotator cuff repair, and obstructive sleep apnea (OSA) rated as mild industrial impairment. The CI’s fibromyalgia, DJD, and OSA did not improve adequately with treatment and the CI was unable to perform the duties required of his grade, meet the physical requirements of his Military Occupational Specialty (MOS) or satisfy physical fitness standards. He was issued a permanent P3 and U3 and referred for a Medical Evaluation Board (MEB). Diabetes mellitus type 2 conditions identified in the rating chart below, was also identified and forwarded by the MEB. The Physical Evaluation Board (PEB) initially adjudicated the fibromyalgia, DJD, and OSA conditions as unfitting, but determined they were not sufficiently stable for final adjudication. The CI was placed on the Temporary Disabled Retired List (TDRL) and the conditions were rated 20%, 10% and 0%, respectively, with application of the Veteran’s Affairs Schedule for Rating Disabilities (VASRD) and the Department of Defense Instruction (DoDI) 1332.39. Once the conditions had stabilized, the PEB again determined that each of the three conditions was unfitting and the CI was separated from the TDRL. The conditions were then rated at 10%, 10% and 0%, respectively, with application of the Veteran’s Affairs Schedule for Rating Disabilities (VASRD) and the Department of Defense Instruction (DoDI) 1332.39.

The CI appealed the ratings at the time of TDRL entry and at the time of final separation but no changes were made by the PEB. The CI appealed to the Army Board for the Correction of Military Records (ABCMR) in December 2006 requesting higher ratings IAW the VASRD. However, his application was denied and he was separated with severance pay.

CI CONTENTION: “The PEB initially awarded a 20% rating for Fibromyalgia (Code 5025) and a 10% for Degenerative Joint Disease (Code 5003). With a combined rating of 30% I was placed on TDRL. In 2005, during my second TDRL evaluation, the PEB lowered the Fibromyalgia rating to 10%. Thus, lowering my combined rating to 20%. VA awarded a rating of 40% and 30% respectively (See attachment).” A letter addressed to the PDBR with the subject of “Request to expedite case due to hardship conditions” detailed the CI’s financial difficulties.

SCOPE OF REVIEW: The Board wishes to clarify that the scope of its review as defined in DoDI 6040.44, Enclosure 3, paragraph 5.e.(2) is limited to those conditions which were determined by the PEB to be specifically unfitting for continued military service; or, when requested by the CI, those condition(s) “identified but not determined to be unfitting by the PEB.” The ratings for unfitting conditions will be reviewed in all cases; this includes fibromyalgia, DJD, and OSA. Any conditions or contention not requested in this application, or otherwise outside the Board’s defined scope of review, remain eligible for future consideration by the ABCMR.

RATING COMPARISON:

|  |  |
| --- | --- |
| **Final Service PEB – Dated 20050624** | **VA – All Effective Date 20020920** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| **On TDRL – 20020919** |  | **TDRL** | **Sep.** |
| Fibromyalgia Requiring Continuous Medication For Control | 5025 | 20% | 10% | Fibromyalgia | 5025 | 10%\* | 20021206 |
| Degenerative Joint Disease Status Post Rotator Cuff Repair | 5003 | 10% | 10% | Acromioclavicular Osteoarthritis with Impingement Syndrome; Status Post Rotator Cuff Repair, Right Shoulder | 5203 | 10%\*\* | 20021206 |
| Obstructive Sleep Apnea Rated As Mild Industrial Impairment | 6847 | 0% | 0% | Obstructive Sleep Apnea | 6847 | 50% | 20021206 |
| Diabetes Mellitus Type 2 | Not Unfitting | Type II Diabetes Mellitus | 7913 | 20% | 20021206 |
| ↓No Additional MEB/PEB Entries↓ | Migraine Headaches | 8100 | 10% | 20021219 |
| Tinnitus, Right Ear | 6260 | 10% | 20021223 |
| Temporomandibular Joint Syndrome  | 9905 | 10% | 20021227 |
| Hypothyroidism | 7904 | 10% | 20021206 |
| Not Service-Connected x 7 |
| Combined: 20% | Combined: 80%\*\*\* |

\*Increased to 40% effective 20070910.

\*\*Increased to 30% and code changed to 5200 effective 20070910.

\*\*\*90% effective 20070910. Additional ratings for complications of diabetes (one at 10% and three at 0%) were added effective 2008114 but this did not change the combined rating.

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application, i.e., that the gravity of his conditions merit consideration for a higher separation rating. The Board wishes to clarify that it is subject to the same laws for 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 utilizes DVA evidence proximal to separation in arriving at its recommendations; and, DoDI 6040.44 defines a 12-month interval for special consideration to post-separation evidence. The Board’s authority as defined in DoDI 6040.44, however, resides in evaluating the fairness of DES fitness determinations and rating decisions for disability at the time of separation. Post-separation evidence therefore is probative only to the extent that it reasonably reflects the disability and fitness implications at the time of separation.

Fibromyalgia with muscle pain and fatigue; greater than 11 of 18 tender points.

TDRL entry 20020920:

A MEB narrative summary (NARSUM) completed on 19 December 2001 noted the CI had symptoms of multiple joint pains with morning stiffness that started around 1995. He also later had muscular cramps in the legs and right upper extremity. He was referred to rheumatology and diagnosed with fibromyalgia on 6 December 2001. His pain was noted to be constant and moderate and exacerbated by strenuous physical activity. The NARSUM did not specify if this included the fibromyalgia, the DJD of the CI’s right shoulder or both. He was taking Mobic and Elavil daily as well as Tylenol #3 two to three times a day. At the time of the NARSUM he was doing his regular job with profile limitation and felt tired all the time with joint pains and muscular pains. An addendum to the NARSUM was completed by rheumatology on 12 December 2001. A similar clinical history was noted and included a history of muscle cramps involving his lower extremities and forearms, with greatest involvement in the left calf. The CI denied joint pain and swelling and primarily complained of muscular pain. At the time, his pain was severe and constant and involved his neck, shoulders, elbow, low back, knees, wrists, calf, hamstrings muscle group, and thighs. He also reported severe fatigue, morning stiffness lasting approximately an hour, poor non-restorative sleep with an hour to 2 hours of uninterrupted sleep per night, and discoloration of the fingers in cold temperatures secondary to a previous frostbite injury. The physical exam documented greater than 11/18 American College of Rheumatology tender points located above and below the diaphragm and occurring symmetrically on both sides of the body. Both shoulders had decreased flexion and abduction secondary to pain. Fibromyalgia was diagnosed and the rheumatologist noted the CI’s current condition and symptoms significantly impacted his ability to perform activities of daily living. Including dressing himself, getting in and out of the bed, washing and drying his entire body, bending down to pick up objects from the floor, turning regular faucets on and off, getting in and out of a car, bus, train, or airplane, walking 2 miles, participating in sports and games that he desires, and getting a good night's sleep. He considered his overall well-being as being very poor. Fatigue was a major component of his illness. His prognosis was dependent upon response to aggressive medical therapy and a graded aerobic exercise and stretching program.

An initial VA Compensation and Pension (C&P) examination for fibromyalgia was completed on 6 December 2002, 3 months after TDRL entry, and it also noted onset of symptoms in 1995 with diagnosis of fibromyalgia in December 2001. Heavy work and lifting precipitated symptoms and Elavil helped him sleep. His musculoskeletal pain was located in the neck, the back, the forearms, the posterior thighs, and the calves. He was also noted to have unexplained fatigue and sleep disturbance with nighttime cramping of the legs. He also reported symptoms of depression and anxiety but had not lost any work due to this condition. The examination noted tenderness of the neck, the spine, the hip areas, posterior thighs, the calves and trigger points in the aforementioned areas, the neck, the back, the anterior chest, the highs and the hip areas. Muscle strength was normal. The diagnosis was mild fibromyalgia.

The PEB determined this condition was unfitting but that the condition was not sufficiently stable for final adjudication. The CI was placed on the TDRL with a rating of 20%. The VA applied a 10% rating. The 10% rating is applied when continuous medications are required for control. The 20% rating requires that the symptoms of fibromyalgia are episodic with exacerbations often precipitated by environmental or emotional stress but are present more than one-third of the time. While neither the NARSUM nor the VA C&P specifically state the frequency of exacerbations, the CI’s continued to have significant symptoms despite medications. The fibromyalgia symptoms were improved but not controlled with medication. There is no evidence in the available record to support a rating greater than 20%. 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 fibromyalgia with muscle pain and fatigue; greater than 11 of 18 tender points condition at the time of TDRL entry.

Separation from TDRL:

Two VA clinical encounters from 2004 are available in the record for review. In March 2004, the CI was noted to have pain all over rated at 6/10 but this was acceptable with the medications he was receiving from Fort Polk. In July 2004 he reported morning stiffness lasting two hours that improved with movement, muscle weakness, pain in his legs, tiredness, and daily swelling of his fingers and phalanges. He had pain from head to toe every day. All fibromyalgia trigger points were positive except the left knee. He was currently taking Klonopin and he was referred to rheumatology, podiatry, and PACT (patient aligned care team). No follow-up appointments between this time and January 2005 are available in the record.

A second TDRL periodic evaluation for fibromyalgia was completed 28 January 2005. The CI reported continued poor sleep and pain in his right shoulder, right hip, right mid-foot, and left wrist. Greater than 11 of 18 tender points for fibromyalgia were noted on physical exam along with tender points in his mid-forearms and forehead. No tenderness was noted in either thigh. The CI also had diffuse paraspinal muscle spasm in the cervical, thoracic, and lumbar regions bilaterally. No muscle atrophy was noted and the sensory and reflex exams were normal. Pain rating for fibromyalgia alone was severe and constant and this was distinguished from the pain rating for the right shoulder DJD which was severe and chronic. The impression was fibromyalgia with chronic pain, severe and constant, manifested by classic tender points, poor sleep, and a pattern associated with irritability, fatigue, and depression. However, the examiner also noted the CI also had pain in control points suggestive of a psychogenic pain component as well and this pain was marked and constant. Additionally the examiner noted the diffuse paraspinal muscle spasm associated with fibromyalgia and chronic pain and this pain was marked and constant.

A PEB convened on 24 June 2005 and determined the CI’s condition had sufficiently stabilized for final adjudication and that he remained unfit for reasonable perform the duties of his previous grade and military specialty. The PEB determined a disability rating of 10% for fibromyalgia requiring continuous medication and noted the soldier was working. The CI did not concur and submitted a written appeal but waived a formal hearing. This appeal was related to the sleep apnea condition and is discussed below in the OSA section. He was permanently separated with a 10% rating for fibromyalgia on 20 July 2005.

The CI filed a VA claim for increased evaluation in September 2007 and the rating for fibromyalgia was subsequently increased to 40% based on ongoing treatment records and a subsequent VA C&P examination of 8 November 2007. The available record supports the increased rating with clinical encounters dating from August 2006 to October 2007. However all of this encounters are more than 12 months after the CI permanently separated and they show a worsening of the condition over time.

The rating criteria for fibromyalgia are based on the whether symptoms are controlled with medication, are present more than one third of the time with periodic exacerbations, or are constant or nearly so and are refractory to therapy. The PEBs of March 2002 and December 2003 determined the CI’s fibromyalgia symptoms were present more than one third of the time and were not controlled with medication. The final TDRL evaluation in January 2005 supports the same determination. There is no evidence that the CI’s fibromyalgia symptoms were controlled with medication. While the initial and final NARSUM examinations were completed by different providers, both examiners noted his pain was severe and constant. He was employed prior to TDRL entrance and during the entire time he was on the TDRL. The CI was able to work, within physical limitations, despite his symptoms both while on active duty and after entering the TDRL. There is nothing in the record that supports a determination that the CI’s fibromyalgia condition had improved prior to his final separation in July 2005. All three TDRL evaluations support a 20% disability rating for fibromyalgia. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends an initial TDRL rating of 20% and a 20% permanent rating, coded 5025 IAW VASRD §4.71a.

Degenerative Joint Disease Status Post Rotator Cuff Repair Condition. There were four goniometric range-of-motion (ROM) evaluations in evidence, with documentation of additional ratable criteria, which the Board weighed in arriving at its rating recommendation; as summarized in the chart below. An additional evaluation showing a worsening of the condition over time is also included below.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Shoulder ROM | MEB NARSUM~11 Months Pre-TDRL Entry(20011101) | VA C&P ~3 Months Post-TDRL Entry(20021206) | TDRL RE-EVAL ~13 Months Post-TDRL Entry(20031023)  | TDRL RE-EVAL ~4 Months Prior to Final Separation(20050304) | VA C&P ~28 Months Post-Final Separation(20071108) |
| Left | Right | Left | Right | Right | Left | Right | Right |
| Flexion (0-180⁰) | 180⁰ | 125⁰ | 180⁰ | 160⁰ | 135⁰ |  | 160° | Ankylosis at 70° |
| Abduction (0-180⁰) | 180⁰ | 95⁰ | 0-180⁰ | 0-160⁰ | 130⁰ |  | 155° | Ankylosis at 60° |
| Comments | Right shoulder abduction limited due to pain; MRI 20000623 chronic degenerative changes of the AC joint with inferior osteophyte impinging on supraspinatus tendon | Right hand dominant; no joint swelling, effusion, tenderness, muscle spasm, joint laxity, or muscle atrophy; reflexes 2+ and equal bilateral | Tenderness over AC joint on the right with positive cross-body abduction side; positive Neer-Hawkins sign; significant weakness in external rotation; X-ray shows osteoarthritis | Positive cross-arm reduction test; positive Hawkin’s and Neer’s tests; Motor 4+/5 for subscapularis, others 5/5; neurovascularly intact to light touch; x-rays show large osteophyte, no AC elevation change with weight | Ankylosis at 70° of flexion is unfavorable; Ankylosis at 60° of abduction is favorable; ROM was not performed because the joint is ankylosed. On right, there is weakness, tenderness, and guarding of movement. No edema, effusion, redness, heat, or subluxation |
| §4.71a Rating |  | 10% |  | 10% | 10% |  | 10% | 30% |

TDRL entry 20020920:

The CI first noted right shoulder pain in March 2000. Plain X-rays in May 2000 documented degenerative changes of the right acromioclavicular (AC) joint. An MRI from 26 June 2000 showed chronic degenerative changes of the right AC joint with an inferior osteophyte causing impingement on, but no tear of, the supraspinatus tendon. His symptoms did not resolve with physical therapy and he underwent arthroscopic surgery in December 2000 for right shoulder acromioclavicular osteoarthrosis with impingement syndrome and partial thickness rotator cuff tear. However, he continued to have symptoms and had a second surgery of a mini open rotator repair in June 2001. He continued to have pain with impingement signs and was given a permanent profile for this failed rotator cuff repair condition in September 2001. The MEB NARSUM completed on 19 December 2001 noted his pain was constant and moderate and was exacerbated by strenuous physical activity. However, as discussed above, the NARSUM did not specify whether this description applied to his right shoulder pain or his fibromyalgia pain. The physical examination for this NARSM was completed on 1 November 2001 and is reported in the chart above. The diagnosis was degenerative joint disease, right shoulder, status post rotator cuff repair. The VA C&P examination of the right shoulder in December 2002, 3 months after TDRL entry, noted osteoarthritis of the right shoulder AC joint with impingement and a history of rotator cuff repair. The examination is also reported in the chart above. While the VA exam documents a greater ROM, neither examination includes a compensable limitation of motion. The MEB NARSUM examination was completed only 5 months after the CI’s second shoulder surgery and this might explain the more limited ROM. Both examinations document pain limited motion.

The PEB determined this condition was unfitting but that the condition was not sufficiently stable for final adjudication. The CI was placed on the TDRL with a rating of 10%. The VA also applied a 10% rating. There is no evidence in the available record to support a higher 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 DJD status post rotator cuff repair condition at the time of TDRL entry.

A periodic TDRL evaluation was completed on 23 October 2003, 13 months after TDRL entry and the physical examination is reported in the chart above. The examiner noted a poor functional outcome from the surgery and recommended another right shoulder arthroscopy with a Mumford procedure to potentially alleviate the CI’s symptoms. The examiner also recommended the CI remain on the TDRL for another year. On 5 December 2003 the PEB determined the CI’s impairment had not yet sufficiently stabilized for final adjudication and he remained on the TDRL. A third surgery was completed in March 2004 with debridement and repair of the rotator cuff; however no operative report was available for review. This surgery was arthroscopic, like the first surgery.

Separation from TDRL:

A second periodic TDRL evaluation was completed on 4 March 2005 and the physical examination is documented in the chart above. This was 4 months prior to final separation. The CI continued to have right shoulder pain that was exacerbated with any attempt to perform overhead activities, heavy lifting, and changes in the weather. He remained unable to perform the duties required of a supply specialist. Right shoulder x-rays continued to show a large osteophyte and evidence of the previous surgeries. Radiographs, with and without weight, did not show any change in the elevation of the AC joint. The pain was noted to be marked and constant. The examiner opined that while the CI’s symptoms might improve with time and activity modification, it was unlikely that he would ever be able to return to full duty. No other VA C&P examination was completed until more than 2 years after the CI separated from the TDRL. This examination from November 2007 did show a worsening of disease over time with an ankylosed shoulder joint. The VA increased the rating to 20% based on this examination. However, this degree of limitation of motion was not present at the time of separation and therefore does not affect the final separation disability rating.

The 24 June 2005 PEB determined the CI remained unfit for duty secondary to this right shoulder condition and applied a 10% rating. A 10% rating is warranted based on pain-limited motion of the joint. 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 DJD status post rotator cuff repair condition at the time of final separation.

Obstructive Sleep Apnea Rated As Mild Industrial Impairment Condition. The CI was diagnosed with OSA in 1993 and had uvulopalatopharyngoplasty (UPPP) surgery but continued to have symptoms. He was prescribed a CPAP machine and issued a permanent profile in August 2001.

TDRL entry:

The MEB NARSUM examination noted the CI was still having some symptoms of smothering spells at night. He was issued a permanent P3 profile which stated he must use the CPAP while sleeping. A VA Respiratory C&P examination was completed on 6 December 2002, about 3 months after the CI entered the TDRL. At that examination the CI reported excessive daytime somnolence while on CPAP at 14cm. The respiratory physical examination was within normal limits.

In March 2002, the PEB determined this condition was unfitting but was not sufficiently stable for final adjudication. The CI was placed on the TDRL with a 0% rating IAW DODI 1332.39, para E2.A1.2.21. However, the VA applied a 50% rating IAW VASRD §4.97 and based on the required use of breathing assistance device.

In January 2003 a repeat sleep study documented continued spontaneous and severe oxygen desaturations despite use of CPAP at high pressures. The physician recommended a combination BiPAP with oxygen along with outpatient dosimetry to ensure proper titration. This titration was successfully completed on 18 August 2003. This sleep study noted the CI had sleep disturbance associated with his fibromyalgia, and was not related to the sleep disturbance from his sleep apnea. Each condition independently affected his sleep. Alpha waves were noted and were, “significant with his underlying diagnosis of fibromyalgia.” The CI was successfully titrated with BiPAP of 17/13cm and oxygen with the apnea controlled. However the physician also noted he had “frequent arousals at times without respiratory events which may go along with his underlying diagnosis of fibromyalgia which in itself is associated with disrupted sleep.” At the time of the first periodic TDRL evaluation in October 2003 he was continuing to have frequently night time awakenings, approximately 10 to 15 times per night and increased snoring while on the BiPAP. The examiner recommended a pulmonary evaluation due to continued and worsening symptoms of OSA. On 5 December 2003, the PEB determined the CI’s impairment had not yet sufficiently stabilized for final adjudication and he remained on the TDRL.

Separation from TDRL 20050720:

A second periodic TDRL evaluation was completed for OSA on 8 July 2005. The history described above was also reported at this examination. The CI continued to have excessive daytime somnolence. He reported feeling drowsy while driving but had not fallen asleep while driving or had any accidents. He complained of decreased ability to concentrate during the day and while at work and stated this caused difficulties. He denied taking frequent naps during the day. He also continued to wake up frequently during the night and continued to snore while sleeping. The physician noted definite industrial impairment. The physical examination noted the oropharynx revealed mild macroglossia and a very small posterior oropharyngeal airway with a Mallampati Class III. The lungs were clear to auscultation and respiratory movements were normal. There is no wheezing or crackles. Pulmonary function tests were completed on the day of this examination and they showed a mild restrictive ventilator defect. The physician noted the CI continued to have significant symptoms related to his poorly controlled OSA including excessive daytime somnolence, decreased ability to concentrate, and nonrestorative sleep. He opined the condition was permanent and would not improve and recommended final adjudication.

On 24 June 2005, the PEB determined the CI’s conditions had sufficiently stabilized for final adjudication and that he remained unfit for continued service due to the OSA condition. Citing the now rescinded DoDI, the PEB determined the CI had a mild industrial impairment and applied a 0% rating at final separation. The VA rating of 50% from the time of TDRL entry remained in effect.

The PEB’s DA Form 199 assigned a 0% rating under DODI 1332.39 (E2.A1.2.21), and based the fitness adjudication solely on the basis of industrial impairment. Although the periodic TDRL evaluation supported a definite industrial impairment, the PEB determined only a mild industrial impairment was present. Contemporary PEBs across all of the services no longer consider OSA to be unfitting in general, but the Board, by legal opinion and firm precedent, does not make contrary recommendations to a PEB determination that a condition was unfitting. VASRD §4.97 mandates a minimum rating of 50% under 6847 for OSA requiring a breathing assistance device. In consideration of this evidence, and IAW DoDI 6040.44, the Board must recommend a final separation rating of 50% for the OSA condition. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends an initial TDRL rating of 50% and a 50% permanent rating, coded 6847 IAW VASRD §4.97.

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. As discussed above, PEB reliance on DoDI 1332.39 for rating OSA was operant in this case and the condition was adjudicated independently of that instruction by the Board. In the matter of the fibromyalgia condition, the Board unanimously recommends an initial TDRL rating of 20%, coded 5025 IAW VASRD §4.71a. The Board, by simple majority, recommends a 20% permanent rating, coded 5025 IAW VASRD §4.71a. The single voter for dissent (who recommended rating 5025 at 10%) submitted the addended minority opinion. In the matter of the DJD status post rotator cuff repair condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication at the initial TDRL rating or at permanent separation. In the matter of the OSA condition, the Board unanimously recommends an initial TDRL rating of 50% and a 50% permanent rating, coded 6847 IAW VASRD §4.97.

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** |
| **TDRL** | **PERMANENT** |
| Fibromyalgia | 5025 | 20% | 20% |
| Degenerative Joint Disease status post Rotator Cuff Repair | 5003 | 10% | 10% |
| Obstructive Sleep Apnea | 6847 | 50% | 50% |
| **COMBINED** | **60%** | **60%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110817, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans’ Affairs Treatment Record

 XXXXXXXXXX

 President

 Physical Disability Board of Review

MINORITY OPINION:

The CI was originally placed on the TDRL on 14 March 2002 for fibromyalgia at 20%. The CI initially non-concurred with the PEB’s findings on 19 March 2002, and appealed to the Physical Disability Agency (PDA). However, on 10 April 2002, the CI wrote a memorandum to the President of the PDA changing his non-concur election to accept the PEB’s finding. Upon re-evaluation on 23 October 2003, the PEB rated the CI for the unfitting Fibromyalgia condition with a permanent separation rating of 10%. Per the NARSUM 23 October 2003, a year after placement on the TDRL, the CI’s, “fibromyalgia has remained unchanged” and the CI, “has gained employment as a civilian contractor through Logistical Support doing predominantly clerical duties. He is able to lift up to about 50 pounds on occasion to carry things with his arms down.” The PEB’s finding of a final permanent 10% rating (dated 24 June 2005) for the fibromyalgia was upheld.

After a thorough review and examination of the whole recorded history, I believe the final rating of 10% for fibromyalgia accurately reflects the elements of the CI’s disability at the time of separation. According to the Commander’s Performance Statement dated 20011019, the CI, “…has managed the troop supply room for the past 27 months, and directly manages accountability for more than $9 million worth of government property. He was commended during the last regimental command inspection for his management of all facets of supply room operations.” The Commander also indicated, “There has been no decline in the quality of his duty performance since receiving the profile.” The CI “…is the finest supply sergeant I have seen in 16 years of service. He is a highly motivated, extremely knowledgeable NCO who other unit supply sergeants come for advice.” The CI “…was working in his primary MOS prior to and after treatment for this condition.” These statements by the CI’s Commanding Officer reflect the CI’s ability to perform the duties of his MOS without any declination in mission accomplishment due to his fibromyalgia.

Furthermore, per the VA C&P exam, performed on 6 December 2002, 3 months after placement on the TDRL, the CI, “…has gained employment working at Fort Polk as a forklift operator. Precipitating factors are heavy work and lifting. Alleviating treatments are Elavil, which he takes, that helps him with his sleep.” Furthermore, “His treatment for the fibromyalgia consists of Elavil 150 mg h.s. This has improved his sleeping. He has not lost any time of work because of his fibromyalgia. He does not have a loss of muscle strength.” “Diagnosis: fibromyalgia, mild.” The VA determined the CI’s condition did not warrant a 20% rating due to the CI’s fibromyalgia symptoms were diagnosed as “mild” and were not episodic or present more than one-third of the time. As the CI was working full time as a forklift operator and did not lose any time of work and his fibromyalgia was controlled using continuous medication (Elavil), a 10% rating is warranted.

The Board members unanimously agreed the TDRL rating for the CI’s Fibromyalgia was correctly rated at 20%. However, the Board members were not in agreement on a final rating of 10% at the time of the CI’s removal from the TDRL. This resulted in a split vote, 2:1, for rating the Fibromyalgia at 20% upon permanent separation. I do not believe the CI’s Fibromyalgia was significant enough at the time of removal from the TDRL to justify a continued rating of 20%.

Per the TDRL evaluation on 28 January 2005, the CI, “is exhausted at the end of each working day. He describes having a sedentary job. He does not see anyone for pain management and is not followed by a psychologist or a psychiatrist.”

I believe a final, permanent rating of 10% more accurately reflects the elements of the CI’s disability at the time of his separation. I believe the PEB accurately rated the CI’s impairment and I recommend no change from that adjudication.

SFMR-RB

MEMORANDUM FOR Commander, US Army Physical Disability Agency

(TAPD-ZB ), 2900 Crystal Drive, Suite 300, Arlington, VA 22202

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation

for XXXXXXXXXXXXXXXXXXXXXXXXXXXX, AR20120011905 (PD201100722)

1. Under the authority of Title 10, United States Code, section 1554(a), I approve the enclosed recommendation of the Department of Defense Physical Disability Board of Review (DoD PDBR) pertaining to the individual named in the subject line above to constructively place the individual on the Temporary Disability Retired List (TDRL) at

60% disability rather than 30% disability for the period of 20 September 2002 to

20 July 2005 and then following this period recharacterize the individual’s separation as a permanent disability retirement with the combined disability rating of 60%.

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.

 a. Providing a correction to the individual’s separation document showing that the individual was separated by reason of temporary disability effective the date of the original medical separation for disability with severance pay.

 b. Providing orders showing that the individual was retired with permanent disability effective the day following the TDRL period.

 c. Adjusting pay and allowances accordingly. Pay and allowance adjustment will account for recoupment of severance pay, provide 60% retired pay for the constructive temporary disability retired period effective the date of the individual’s original medical separation and then payment of permanent disability retired pay at 60% effective the day following the constructive TDRL period.

 d. Affording the individual the opportunity to elect Survivor Benefit Plan (SBP) and medical TRICARE retiree options.

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 XXXXXXXXXXXXXXXXXXXX

 Deputy Assistant Secretary

 (Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA