RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1100866 SEPARATION DATE: 20051209

BOARD DATE: 20120417

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SPC/E-4 (91R10/Food Inspector), medically separated for major depressive disorder and bilateral plantar fasciitis*.* She did not respond adequately to treatment and was unable to perform within her Military Occupational Specialty (MOS) or meet physical fitness standards. She was issued permanent L3 and S3 profiles and underwent a Medical Evaluation Board (MEB). Major depressive disorder (MDD) and chronic plantar fasciitis were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Migraine headaches, as identified in the rating chart below, was forwarded on the MEB submission as a medically acceptable condition. No other conditions appeared on the MEB’s submission. Other conditions included in the Disability Evaluation System (DES) packet will be discussed below. The PEB adjudicated the MDD and the bilateral plantar fasciitis conditions as unfitting, rated 10% and 0% respectively; with application of the Veterans Administration Schedule for Rating Disabilities (VASRD), and the US Army Physical Disability Agency (USAPDA) pain policy, respectively. The CI made no appeals, and was medically separated with a 10% combined disability rating.

CI CONTENTION: The CI requests consideration for a higher rating for her depression; “I feel my active duty psychiatrist and first sgt. knew that I was unable to maintain a regular work lifestyle. While I was on active duty I was moved to the medical hold platoon and given a shorter duty day. My psychiatrist gave me a permanent profile that I could not report to work until 9 am. I usually reported to my first sgt at 9 am and ran the cash register in the chow hall for 2 hours. I was released every day at 1 pm. I was given a part time duty schedule before I left active duty because my doctors and unit knew that I was having some complications and did not feel good every day. Please consider my application for medical retirement as things are not well for me right now.” She elaborates no specific contentions regarding rating or coding and mentions no additionally contended conditions.

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service PEB – Dated 20051108** | | | **VA (~10 Mos. After Separation) – All Effective Date 20051210** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Major Depressive Disorder | 9434 | 10% | Major Depressive | 9434 | NSC | 20060902 |
| Bilateral Plantar Fasciitis | 5399-5310 | 0% | Bilateral Plantar Fasciitis | 5299-5276 | 0% | 20060902 |
| Migraines | Not Unfitting | | Migraines | 8100 | 10% | 20061014 |
| ↓No Additional MEB/PEB Entries↓ | | | Chondromalacia Patella, Rt Knee | 5010 | 10% | 20061014 |
| Chondromalacia Patella, Lt Knee | 5010 | 10% | 20061014 |
| 0% x 3/Not Service-Connected x 1 | | | |
| **Combined: 10%** | | | **Combined: 30%** | | | |

ANALYSIS SUMMARY: The 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. 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 nor for conditions determined to be service-connected by the Department of Veterans’ Affairs (DVA), but not determined to be unfitting by the PEB. 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 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.

Major Depressive Disorder. The CI developed symptoms of depression at the end of November 2004 and was treated with medication. At the time of the MEB psychiatry narrative summary (NARSUM), 20 June 2005, she continued to endorse symptoms of depression including depressed mood, crying spells, irritability, decreased energy, and decreased concentration. The psychiatrist noted associated stressors of divorce, separation from family, and inability to cope with the military. On mental status examination, thought processes were normal (linear, logical, goal directed) without hallucinations, delusions, or suicidal ideation. Impairment for social and industrial adaptability was estimated as definite. Prior to the MEB psychiatry NARSUM at primary care clinic appointments on 7 March 2005 and 8 April 2005, the CI answered “no” to depression screening questions (feeling down, depressed or hopeless, loss of interest or pleasure in doing things). Following the psychiatry MEB NARSUM, at an 11 July 2005 internal medicine appointment, the CI checked “no” to depression screening questions (feeling down, depressed or hopeless, loss of interest or pleasure in doing things). The physical profile, S3, recommended a later start to the duty day at 0900 and no overnight duty due to medication side effects. The commander’s statement (on 27 October 2005) stated the CI was performing administrative duties satisfactorily during duty hours from 0900 to 1600 hours. A performance feedback form for September 2005 noted that comments from her section supervisor were excellent. The PEB rated the depression 10% citing satisfactory performance of in-garrison duties. At the time of the VA mental health Compensation and Pension (C&P) examination, 2 September 2006, 7 months after separation, the CI was asymptomatic off of medications, pursuing a master’s degree and working part-time. The examiner recorded: “she reports that she was treated for depression while in the service approximately 2 years ago. After a couple of weeks on medications (Trazodone and Wellbutrin), she decided that treatment was too much of a hassle considering that she was feeling better and she stopped treatment soon after it was initiated.” “The veteran doesn’t report that she is depressed, nor has any symptoms of MDD at the present time, nor for about 2 years.” The examiner documented that the CI had completed her bachelor of arts degree prior to separation. The examiner estimated that her capacity for adjustment during periods of remissions was excellent. The VA rating decision dated 20 November 2006 denied service-connection for depression since no disability was shown at the time of the C&P examination. A 28 February 2007 VA clinic encounter records recurrent depressed mood and sleep difficulties associated with marital discord and she was referred for mental health evaluation and treatment. All Board members agreed that at the time of separation, criteria for a 30% rating were not present (“occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks”). The Board concluded that the preponderance of evidence indicates that the impairment from the depressive disorder at the time of separation was mild which would decrease work efficiency and ability to perform occupational tasks only during periods of significant stress. After due deliberation, considering the preponderance of the evidence the Board failed, on balance, to find adequate reasonable doubt favoring the CI in support of a recommendation for the higher rating than the 10% adjudicated by the PEB at the time of separation.

Bilateral Plantar Fasciitis. The STR documented care for right foot pain beginning in January 2005. The CI reported right foot pain for approximately 5 months. A March 2005 primary care encounter records complaint of pain in both feet. Medical examination on 21 April 2005 noted some improvement with use of orthotics. Podiatry treatment records in June, July, and September 2005, record right foot pain with tenderness at the bottom of the heel, for which the CI received local injection therapy on two occasions with incomplete relief. The left foot was not a focus of clinical attention by the podiatrist. The CI was overweight (BMI 31) and was encouraged to lose weight to help the condition. At the time of the podiatry MEB NARSUM addendum, 14 September 2005, the examiner recorded that there was persistent bilateral painful heels with prolonged standing, walking, and prevented running. The bottoms of the heels were tender on examination. The examiner noted mild pes planus with weight bearing. The remainder of the foot and ankle examination was normal. The examiner stated that the pain was slight but frequent with weight bearing. The PEB rated the bilateral plantar fasciitis condition 0%, coded 5399-5310 (group X muscle function), with application of the USAPDA pain policy. At the time of the VA C&P examination on 2 September 2006, 7 months after separation, the CI reported Intermittent sharp pain of heels while walking but not standing without flare ups. She was not taking any medications and was not using any inserts or corrective shoes. There was no interference with occupation or daily activities (walking, shopping, recreational activities). On examination, the gait was normal. The examiner did not find evidence of pes planus (flat feet, or fallen arches). There was normal alignment of foot structures, and there was no evidence of abnormal weight bearing such as callouses or abnormal shoe wear. There was no swelling, ankle problems, hammer toes, or hallux valgus. There was tenderness with palpation and the examiner concluded with diagnosis of bilateral plantar fasciitis.

During the general medical C&P examination on 5 September 2006, the gait was normal and the CI was able to walk on her heels without difficulty. The VA rated the bilateral plantar fasciitis condition 0%, coded 5299-5276, analogously to acquired flat foot. The PEB and VA chose different coding options for the condition, but this did not bear on rating. There is not a specific code for plantar fasciitis and the Board considered rating under alternate codes. The PEB rated under an analogous 5310 code for muscle function, however, the DA Form 199 reflected application of the USAPDA pain policy assigning a rating of 0% based on slight pain. The Board noted that there was not any muscle condition or muscle disability and considered the approach used by the VA. The VA adjudicated a 0% rating with application of the diagnostic code 5276 for acquired flatfoot based on an assessment of the plantar fasciitis, as “mild” concluding there was no objective findings to support the next higher rating. The rating criteria for acquired pes planus (5276) more nearly describes the CI’s condition of plantar fasciitis associated with mild pes planus than the code selected by the PEB (although the pes planus was developmental not acquired). Board members agreed that the CI’s condition did not approach the 30% rating for severe as described in the criteria under VASRD 5276 and more nearly approximated the mild (0%) than the moderate level (10%). The mild to moderate rating is for the condition whether it is bilateral or unilateral. Similarly, consideration under the code for other foot injuries, diagnostic code 5284 did not attain the minimum 10% for moderate symptoms. Rating under other codes would result in a rating higher than that adjudicated by the PEB. Therefore, all evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s rating decision for the plantar fasciitis.

Other PEB Conditions. Migraine headaches was referred by the MEB as meeting retention standards and adjudicated as not unfitting by the PEB. The CI was treated for migraine headaches that had been presence since approximately 1997 during a prior period of active military service when the headaches were treated with abortive medication. During the year prior to separation, she was evaluated and treated by neurology with abortive medication and prophylactic medication. The STR reflected satisfactory response to treatment. The neurology NARSUM addendum 7 July 2005, concluded that the migraine headaches were medically acceptable for continued military service. The STR and the commander’s statement do not reflect problems with prostrating headaches. The migraine headache condition was not profiled, implicated in the commander’s statement or noted as failing retention standards. It was reviewed by the action officer and considered by the Board. There was no indication from the record that migraine headaches 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 migraine headaches.

Remaining Conditions. Other conditions identified in the DES file were chest pain and shortness of breath with negative evaluation, high blood pressure, seasonal hay fever, sinusitis, keratoconus suspected but excluded by specialty examination, near sightedness status post laser eye surgery, dry eyes status post laser eye surgery, low back pain with prolonged standing or carrying a ruck sack, intermittent numbness and tingling left arm (no findings on evaluation, and neurology evaluation recorded no complaint of tingling or numbness), knee pain only with running, hemorrhoids status post surgery, and heart burn. 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, a benign solitary thyroid nodule was noted in the VA proximal to separation, but was 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. As discussed above, PEB reliance on the USAPDA pain policy for rating plantar fasciitis was operant in this case and the condition was adjudicated independently of that policy regulation by the Board. In the matter of the major depressive disorder and IAW VASRD §4.130, the Board unanimously recommends no change in the PEB adjudication. In the matter of the bilateral plantar fasciitis condition and IAW VASRD §4.71.a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the migraine headache condition, the Board unanimously recommends no change from the PEB adjudication as not unfitting. In the matter of the chest pain, shortness of breath, high blood pressure, seasonal hay fever, sinusitis, eye condition, low back pain, knee pain, 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. 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, therefore, recommends that there be no recharacterization of the CI’s disability and separation determination as follows:

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Major Depressive Disorder | 9434 | 10% |
| Bilateral Plantar Fasciitis | 5399-5310 | 0% |
| **COMBINED** | **10%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110930, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans Affairs Treatment Record

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President

Physical Disability Board of Review

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 XXXXXXXXXXXX, AR20120007683 (PD201100866)

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 and hereby deny the individual’s application.

This decision is final. The individual concerned, counsel (if any), and any Members of Congress who have shown interest in this application have been notified of this decision by mail.

BY ORDER OF THE SECRETARY OF THE ARMY:

Encl XXXXXXXXX

Deputy Assistant Secretary

(Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA