RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: xxxxxxxxxxxxxxxxxxxxxxxx BRANCH OF SERVICE: NAVY

CASE NUMBER: PD11-00878 SEPARATION DATE: 20080301

BOARD DATE: 20120530

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty E6/AC1, Air Traffic Controller, medically separated for neuropathic abdominal wall pain and mood disorder. The CI did not improve adequately with treatment to meet the physical requirements of her Rating or satisfy physical fitness standards. She was placed on limited duty [LIMDU] and referred for a Medical Evaluation Board (MEB). The MEB forwarded no other conditions for PEB adjudication. The PEB adjudicated the neuropathic abdominal wall pain and mood disorder as unfitting, rated 10% and 10%, with application of the SECNAVINST 1850.4E and Veteran’s Affairs Schedule for Rating Disabilities (VASRD). The CI requested reconsideration with inclusion of diabetes as an unfitting condition. Upon reconsideration, the PEB findings and recommendations were affirmed. The CI was then medically separated with a 20% disability rating.

CI CONTENTION: “Combined rating for conditions of member unfit for duty are greater than 20% when rated by VA. Conditions include mood disorder (Depression), scars (status post ceasarean section (abdominal wall pain) and diabetes mellitus. Member was found unfit for duty because she was unable to maintain flight status as an air traffic controller and was found undeployable.” She additionally lists tinnitus, recurrent urinary tract infections, and removal of right ovary in her application.

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. The diabetes mellitus condition as requested for consideration meets the criteria prescribed in DoDI 6040.44 for Board purview; and, is addressed below, in addition to a review of the ratings for the unfitting conditions, abdominal wall pain and mood disorder. The remaining conditions rated by the Department of Veterans’ Affairs (DVA) at separation and listed on the DA Form 294 application are not within the Board’s purview. 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 Board for Correction of Naval Records (BCNR).

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service PEB Recon – Dated 20071116** | | | **VA (11 Mo. Pre and 17 Mo After Separation) – All Effective Date 20080302** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Neuropathic abdominal wall pain, surgical incision | 7399-7301 | 10% | Scars s/p C-section/ovary removal | 7804 | 10% | 20070402 |
| Neuropathic scar s/p C-section | 8530 | 0% | 20070402  20090425 |
| Mood Disorder (Depression) | 9434-9422 | 10% | Mood Disorder | 9435 | 30% | 20090515 |
| Diabetes\* | Not unfitting |  | Diabetes | 7913 | 10% | 20070424 |
| ↓No Additional MEB/PEB Entries↓ | | | Tinnitus | 6260 | 10% | 20070420 |
| 0% x 3/Not Service-Connected x 1 | | | 20070424 |
| **Combined: 20%** | | | **Combined: 50%** | | | |

\*A NARSUM addendum was submitted for her diabetes after the MEB. PEB documentation reflects that the condition was reviewed and was determined to be not unfitting.

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. 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 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.

Neuropathic abdominal wall pain, surgical incision related. The CI developed lower abdominal wall pain following cesarean section in March 2005. The CI had a previous cesarean section in 1999 and surgery to remove an ovarian cyst in December 2004. The pain persisted and interfered with performing sit-ups, and heavy lifting. Extensive evaluation determined the cause to be a trapped or scarred abdominal cutaneous nerve. Local injection by a pain specialist in May 2007 alleviated most of her pain almost immediately and supported the diagnosis of neuropathic abdominal pain, surgical incision related. According the MEB narrative summary (NARSUM), dated 29 June 2007, the relief of pain lasted less than 2 weeks and the CI continued to experience pain exacerbated by moderate to heavy lifting and sitting up. On physical examination, there was point tenderness one to two inches below the umbilicus in the midline and the CI had difficulty arising from a supine position to sitting position. The examination was otherwise unremarkable. Gynecological examiners opined that post-surgical adhesions may be contributing to the CI’ symptoms. CT scanning in October 2006 specifically noted that there were no areas of abnormal attenuation to indicate sites of significant inflammatory changes or adhesions. Two subsequent CT scans made no mention of findings of adhesions, and none noted any findings to indicate abnormalities of other organs that would be indirect indicators of adhesions. Clinic appointments on 10 October 2007 and 24 October 2007, recorded pain as mild (2 and 3 on a 10 scale). The PEB rated the abdominal wall pain 10% analogously to adhesions of peritoneum (7399-7301). The VA assigned a 0% service-connected rating for neuropathic scar status post cesarean section analogously to incomplete paralysis of ilioinguinal nerve, mild or moderate (8530). The VA also assigned a 10% rating for tender scars (7804). The Board directs attention to its rating recommendation based on the above evidence. All members agreed that a higher rating than 10% was not supported under the diagnostic code 7301 used by the PEB, or the diagnostic codes utilized by the VA. 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 neuropathic abdominal wall pain condition.

Mood disorder (depression) associated with general medical condition. At the time of the MEB history and physical examination on 27 April 2007, the CI completed a DD Form 2807 report of medical history and checked “no” to question 17 regarding nervous trouble of any sort, anxiety, panic attacks, loss of memory, frequent trouble sleeping, depression, or excessive worry. However, in May 2007, a neurologist evaluating her abdominal pain condition noted symptoms of depression and recommended treatment. The MEB NARSUM, dated 29 June 2007, recorded a recent history of decreased mood over the preceding several months attributed to the chronic abdominal wall pain and impact on physical activities. She was treated with medication and at the time of the NARSUM, “she currently reports a mood that is improved and essentially euthymic with normal sleep. Her appetite remains decreased, and she notes some decreased concentration since having started the Paxil.” The CI denied anhedonia or suicidal ideation. A family practice clinic appointment 9 August 2007 made no mention of psychological symptoms.

The psychiatry MEB NARSUM, dated 29 September 2007, recorded complaint of depressive symptoms for 22 months. A reduction in medication dose due to side effects was accompanied by increased depressive symptoms. On examination there was depressed mood and tearfulness with full affect, and normal thought processes without suicidal ideation. There were complaints of decreased concentration and memory. A new medication was recommended. A 4 December 2007 mental health clinic follow up appointment documents treatment with the new medication recommended at the time of the psychiatry MEB NARSUM, a diagnosis of adjustment disorder, and notes “symptoms improved.” A 1 February 2008 family practice appointment was silent with regard to complaints. The VA psychiatry C&P examination was on 15 May 09, 14 months after separation at which time the CI had been off of medication since separation. She endorsed continued depressive symptoms including decreased concentration, memory, and sleep difficulties. Concentration and memory were noted as significant problems impacting functioning. On mental status examination her mood was depressed and tearful, yet she presented in a “friendly, relaxed and attentive” manner with normal affect. Tests of concentration were normal, speech was spontaneous clear and coherent, and thought processes were normal with normal content without delusions or suicidal ideation. Although the examiner did not record examination testing of memory, contemporaneous examinations (neurology and general medical) documented normal mental status examination and normal memory.

She was employed full time (recorded as an associate director of academic support and elsewhere recorded as a recruiter and advisor for a university with emphasis on education in the aeronautical field). The examiner commented: “due to medical condition including abdominal pain and weakness, patient is unable to work at goal career as an air traffic controller and has associated depressive symptoms.” No problems with work relationships or other occupational problems due to depressive symptoms were recorded in the C&P examination. The examination noted good relationships with her family. The Board directs attention to its rating recommendation based on the above evidence. Board members noted that at the time of the psychiatry NARSUM the dose of a previously effective medication was reduced with return of symptoms. A subsequent follow up mental health clinic encounter noted improved symptoms on a new medication. The VA C&P examination over a year after separation was conducted when the CI had been off of medication for approximately a year. Although she endorsed symptoms of depression, she was employed fulltime and reported no difficulty with family relationships. 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 depression condition.

Contended PEB Conditions. The contended condition adjudicated as not unfitting by the PEB was non-insulin dependent diabetes mellitus. In her PEB reconsideration request, the CI contended for the addition of diabetes as an additional unfitting condition. A NARSUM addendum was submitted for her diabetes after the MEB. PEB documentation reflects that the condition was reviewed and was determined to be not unfitting. The Board’s first charge with respect to this condition is an assessment of the appropriateness of the PEB’s fitness adjudication. The Board’s threshold for countering 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. The CI had a history of impaired fasting glucose for several years. She developed gestational diabetes during pregnancy in 2004 which resolved after delivery in March 2005. Laboratory testing in April and May 2007 showed mild impaired fasting glucose (102, 106), not diabetes. Diabetes was diagnosed in September 2007 and she was placed on medication. The MEB NARSUM addendum, dated 30 October 2007, concluded diabetes was controlled by diet and medication. The PEB determined the diabetes condition was not disqualifying for continued military duty. The diabetes condition was controlled on oral medication and did not fail retention standards as outlined in SECNAVINST 1850.4E. It was reviewed by the action officer and considered by the Board. There was no indication from the record that the diabetes condition interfered with satisfactory duty performance. After due deliberation in consideration of the preponderance of the evidence, the Board concluded that there was insufficient cause to recommend a change in the PEB fitness determination for the diabetes condition.

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 neuropathic abdominal wall pain, surgical incision related condition and IAW VASRD guidelines, the Board unanimously recommends no change in the PEB adjudication. In the matter of the mood disorder (depression) associated with general medical condition and IAW VASRD §4.130, the Board unanimously recommends no change in the PEB adjudication. In the matter of the contended diabetes condition, the Board unanimously recommends no change from the PEB determination as not unfitting. There were no other conditions within the Board’s scope of review for consideration.

RECOMMENDATION: The Board, therefore, recommends that there be no recharacterization of the CI’s disability and separation determination, as follows:

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| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Neuropathic Abdominal Wall Pain | 7399-7301 | 10% |
| Mood Disorder (depression) | 9434-9422 | 10% |
| **COMBINED** | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110914, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans’ Affairs Treatment Record

President

Physical Disability Board of Review

MEMORANDUM FOR DIRECTOR, SECRETARY OF THE NAVY COUNCIL OF REVIEW

BOARDS

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATIONS

Ref: (a) DoDI 6040.44

(b) CORB ltr dtd 2 Jul 12

In accordance with reference (a), I have reviewed the cases forwarded by reference (b), and, for the reasons provided in their forwarding memorandum, approve the recommendations of the PDBR that the following individual’s records not be corrected to reflect a change in either characterization of separation or in the disability rating previously assigned by the Department of the Navy’s Physical Evaluation Board:

XXXXXXX, former USN

XXXXXXX, former USMC

XXXXXXX, former USMC

XXXXXXX, former USN

XXXXXXX, former USN

XXXXXXX, former USMC

XXXXXXX, former USN

XXXXXXXXXX

Assistant General Counsel

(Manpower & Reserve Affairs)