RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXX BRANCH OF SERVICE: air force

CASE NUMBER: PD1100955 SEPARATION DATE: 20070926

BOARD DATE: 20120424 DATE OF PLACEMENT ON TDRL: 20070926

 Date of Permanent SEPARATION: 20090709

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SRA/E-4 (2A051B, Avionics Test Station & Component Journeyman), medically separated for cataplexy with narcolepsy symptoms. He did not respond adequately to treatment and was unable to perform within his Air Force Specialty (AFS) or meet physical fitness standards. He was issued a T4 profile and underwent a Medical Evaluation Board (MEB). Cataplexy with carcoleptic symptoms and obstructive sleep apnea (OSA) were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AFI 48-123. 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 cataplexy with narcoleptic symptoms and OSA conditions as unfitting, rated 40%; with application of the Veterans Administration Schedule for Rating Disabilities (VASRD). The CI was placed on Temporary Disability Retired List (TDRL)with ratings as reflected in the chart below until February 2009 when he was reevaluated. The PEB then adjudicated the cataplexy with narcolepsy symptoms condition as unfitting, rated 20%; with application of the Veterans Administration Schedule for Rating Disabilities (VASRD). The CI made no appeals, and was medically separated with a 20% combined disability rating.

CI CONTENTION: “Mr. Robbins was placed on TDRL with a 20 percent rating June 26, 2009. Since that time, he has been discharged from the Air Force and the VA has given a 90 percent rating. The enclosed rating decisions show a progressive trend in his service connected disabilities. We feel that this warrants a review for a consideration to The Permanent Disabled Retired List.” He elaborates no specific contentions regarding rating or coding and mentions no additionally contended conditions.

RATING COMPARISON:

|  |  |
| --- | --- |
| **Final Service PEB – Dated 20090420** | **VA\* – All Effective Date 20091123** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| **On TDRL – 20070926** |  | **TDRL** | **Sep.** |
| Cataplexy w/ Narcolepsy | 8999-8911 | 40% | 20% | Cataplexy w/ Narcolepsy | 8199-8108 | 10%\* | 20080321 |
| ↓No Additional MEB/PEB Entries↓ | Obstructive Sleep Apnea | 6847 | 50% | 20080321 |
| 0% x 0/Not Service-Connected x 0 | 20080321 |
| Combined: 20% | Combined: 60% then 90% |

\*Increased to 80% based on C&P 20100326

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. The PEB at the time of placement on TDRL combined cataplexy/narcolepsy symptoms with OSA as a single unfitting condition, rated 40%, while the IPEB at the time of removal from TDRL did not list OSA with the unfitting cataplexy with narcolepsy symptoms condition. Not uncommonly this approach by the PEB reflects its judgment that the constellation of conditions was unfitting, and that there was no need for separate fitness adjudications, not a judgment that each condition was independently unfitting. The Board must apply separate codes and ratings in its recommendations for conditions that are separately unfitting conditions; however, it must satisfy the requirement that each “unbundled” condition was unfitting in and of itself. Thus the Board must exercise the prerogative of separate fitness recommendations in this circumstance, with the caveat that its recommendations may not produce a lower combined rating than that of the PEB.

Cataplexy with Narcolepsy Symptoms Condition. The CI was diagnosed with cataplexy with narcolepsy symptoms OSA in 2005. Symptoms of leg weakness and buckling with hard laughter, and excess daytime sleepiness began in July 2005. A sleep study in October 2005 was consistent with the diagnosis but also diagnosed moderate OSA. Treatment records, including neurology and otolaryngology, documented that medication completely resolved cataplexy symptoms. However, the CI did not tolerate use of the recommended CPAP device and as a result did not use it. Daytime sleepiness was treated with a second medication. The MEB NARSUM, prepared by his family physician, dated 29 May 2007 with an update dated 10 July 2007, recorded CI report of continued problems with excessive daytime sleepiness including falling asleep within minutes at work several times per shift despite medications and use of CPAP. The CI reported that if he sits quietly for even a few minutes he will fall asleep and that this happened during duty hours all the time. The PEB, on 3 August 2007 cited the information from the MEB narrative summary (NARSUM) in its adjudication and placement of the CI on TDRL with a 40% rating for “considerable industrial impairment,” with application of DoDI 1332.39 and use of the VASRD 8100 code for migraine headaches.

“The Informal Physical Evaluation Board notes that you fall asleep within minutes at work several times per shift despite medications and CPAP use. Since the condition has not yet stabilized, the Informal Physical Evaluation Board finds you unfit and recommends temporary retirement with a disability rating of 40% lAW Department of Defense and Veterans Administration Schedule for Rating Disabilities guidelines. Cataplexy is a medical condition which often affects people who have narcolepsy, a disorder whose principal signs are EDS (excessive daytime sleepiness), sleep attacks, and disturbed night-time sleep. Since the symptoms of your conditions are so similar, the Board opines that they must be rated as one entity.”

The Board however noted a neurology clinic record dated 21 May 2007 that indicated the CI was not using CPAP, that prescribed medication completely controlled the cataplexy, and that medication was also controlling his daytime sleepiness. He reported feeling great with lots of energy. The CI agreed to give CPAP another try. The Board also noted the commander’s letter dated 23 April 2007 stating the CI’s medical condition resulted in no apparent work impairments at any point, and that in fact, the CI had excelled as an avionics journeyman and the commander recommended retention. The Enlisted Performance Report for the period 7 June 2006 to 7 April 2007 gave the CI the highest ratings for performance in all categories in performance of duties as an avionics journeyman working on the B1 bomber and recommended promotion. At the time of a VA neurology Compensation and Pension (C&P) examination, 21 March 2008, 6 months after placement on TDRL, the CI was employed fulltime as a mechanic and was doing well on medication. He had no falling spells in the last 12 months although he did report there was transient weakness two to three times per week. He complained of falling asleep with sedentary activities such as watching television but as long as he was active and working he did not have difficulty. He denied falling asleep while driving and had no restriction on his driving privileges.

The CI underwent TDRL reevaluation 17 February 2009. At this evaluation the CI reported that cataplexy was controlled during the day with medication but that he experienced episodes in the evenings. Daytime sleepiness was also controlled by medication and the excessive daytime sleepiness was graded as mild by the specialist. The role of OSA was considered and the CI encouraged to try to use CPAP and advised on desensitization techniques. The 20 April 2009 PEB recommended removal from the TDRL with a permanent rating of 20% for cataplexy with narcolepsy symptoms rated IAW VASRD 8911. The CI was removed from the TDRL on9 July 2009. At a 1 May 2009 VA C&P examination for his OSA, the examiner recorded that he was employed fulltime as a mechanic and had missed 4 days of work in past year; 2 days due to flu, and 2 days due to kidney stones. The CI reported he had not used the CPAP machine in 2 years due to inability to tolerate it and was not using it at all.

The examiner recorded that he sleeps well (approximately 8 hours per night), and that his wife reported snoring on some nights but no respiratory related awakenings. Although “extreme” daytime sleepiness was reported, no significant problems with staying awake during the day was indicated, and medication resulted in improved daytime alertness and ability to stay awake in his job as a mechanic. A 29 May 2009 VA rating decision proposed reducing the CI’s rating for OSA to 30% based on the recent examination reported he had not used the CPAP machine for two years. At a 4 September 2009 VA neurology appointment the CI reported that at a sleep study in the military he “was started on CPAP at that time which did significantly improve his symptoms;” “he recently has had same changes in the function of his CPAP machine and no longer works on a continuous basis.” Some recent episodes of drowsiness at work were believed to be due to the faulty CPAP machine. Cataplexy was noted to be much improved with medication. The neurologist recorded the CI was doing well with medication and CPAP treatment. In October 2009, the CI’s medications were changed due to change in his physicians. VA treatment records in December 2009 reflected medication was working well, but not completely, for daytime drowsiness (7 December 2009), and the CI denied cataplexy episodes (neurology 21 December 2009). At the time of the 26 March 2010 C&P examination, the CI reported almost complete control of cataplexy symptoms but reported severe daytime sleepiness, that he could fall asleep at any time, even every one to two minutes including during eating and conversations. When he was working, he would fall asleep when writing reports and "talk gibberish" after awakening and be disoriented. Despite falling asleep easily during the day he reported getting only one hour of sleep at night due to insomnia.

As previously elaborated, the Board considered whether OSA remained separately unfitting at the time of separation and placement on TDRL, when de-coupled from a combined PEB adjudication. In analyzing the intrinsic impairment from the condition, the Board is left with a questionable basis for arguing that OSA was independently unfitting. Although the CI did not use the recommended CPAP, his duty performance was not impaired according to his commander. After due deliberation, the Board agreed that evidence does not support a conclusion that OSA, as an isolated condition, would have rendered the CI incapable of continued service within his AFS, and accordingly cannot recommend a separate service rating for it.

The Board next considered the disability rating for cataplexy with narcolepsy symptoms at the time of entry on the TDRL. The VASRD directs that narcolepsy (8108) is to be rated as epilepsy: petit mal, under the general rating formula for minor seizures (8911). A minor seizure consists of a brief interruption in consciousness or conscious control associated with staring or rhythmic blinking of the eyes or nodding of the head, or sudden jerking movements of the arms, trunk, or head (myoclonic type), or sudden loss of postural control. The CI did lose postural control during untreated cataplexy episodes but did not lose consciousness consistent with the VASRD definition of a minor seizure. He did not have a seizure disorder that would cause a major seizure (generalized tonic-clonic convulsion with unconsciousness). The Board noted the IPEB listed the 8100 code, migraine headaches, with likely application of DoDI 1332.39. However the Board considered the rating under 8911 independent of service regulation. Although the PEB based its rating on the MEB NARSUM, the Board opined that based on the contemporaneous neurology record, and documented occupational performance, the CI’s condition more nearly approximated the 10% rating. Therefore, the Board concluded there was no evidence to support a higher rating at the time of placement on TDRL. With regard to the rating at time of permanent disability determination and removal from the TDRL, the Board considered the evidence of the TDRL NARSUM and VA records proximate to that time in order to develop a consistent picture of the CI’s condition.

Cataplexy symptoms were well controlled, and described variously as absent or manifesting as mild transient weakness without falling. Daytime sleepiness remained a problem but medications controlled it such that he was able to safely drive and function in his occupation as a mechanic. The CI had not been using CPAP due to intolerance. He reported getting a full night sleep with occasional snoring but no respiratory related awakenings. Again, the Board concluded that the OSA condition, although associated with the cataplexy and narcolepsy, did not arise to the level to be considered separately unfitting. The Board considered the frequency of unwanted falling asleep spells and cataplexy episodes in rating under diagnostic code 8911. Board members agreed that the evidence proximate to the time of permanent disability disposition and removal from the TDRL did not more nearly approximate the 40% level (five to eight per week). Although some evidence indicated that continuous medication controlled the condition warranting a 10% rating, the Board noted the persistent symptoms that did not prevent working or driving. The Board noted the apparent worsening of symptoms by the time of the March 2010 C&P examination despite reported use of CPAP and medications that was inconsistent with prior medical documentation. All of the evidence, bolstering and reducing support for a rating higher than 20% was debated. As many conflicting opinions as possible were resolved in favor of the CI when it was reasonable to do so. The Board failed, on balance, to find adequate reasonable doubt favoring the CI in support of a recommendation for the higher rating. The Board therefore concludes that the permanent rating for cataplexy with narcolepsy symptoms condition in this case is best recommended as 20%.

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. No other conditions were service-connected with a compensable rating by the VA within 12 months of separation or contended by the CI. 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, IPEB reliance on the DoDI 1332.39 at the time of placement on the TDRL was operant in this case and the condition was adjudicated independently of that policy regulation by the Board. The Board did not surmise from the record or PEB ruling at the time of permanent disability disposition and removal from the TDRL in this case that any prerogatives outside the VASRD were exercised. In the matter of the cataplexy with narcolepsy symptoms and IAW VASRD §4.124a, the Board unanimously recommends no change in the PEB adjudication at separation or permanently. In the matter of the OSA condition, 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:

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| --- | --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **TDRL RATING** | **PERMANENT****RATING** |
| Cataplexy w/ Narcolepsy Symptoms | 8999-8911 | 40% | 20% |
| **COMBINED** | **40%** | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110921, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans Affairs Treatment Record

 X

 President

 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-2011-00955

 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 appropriate. Accordingly, the Board recommended no re-characterization or modification of your separation with severance pay.

 I have carefully reviewed the evidence of record and the recommendation of the Board. I concur with that finding and their conclusion that re-characterization of your separation is not warranted. Accordingly, I accept their recommendation that your application be denied.

 Sincerely,

X

Director

Air Force Review Boards Agency

Attachment:

Record of Proceedings