RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: Army

CASE NUMBER: PD1200011 SEPARATION DATE: 20040818

BOARD DATE: 20120726

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty Soldier, PFC/E-3 (91W, Health Care Specialist), medically separated for idiopathic seizure disorder manifested as recurrent syncopal episodes. He did not respond adequately to treatment and was unable to perform within his Military Occupational Specialty (MOS) or meet physical fitness standards. He was issued a permanent P3 profile and referred for a Medical Evaluation Board (MEB). Idiopathic seizure disorder was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable in accordance with AR 40-501. Episodic migraine headaches, as identified in the rating chart below, was forwarded on the MEB submission as a medically acceptable condition. The PEB adjudicated the idiopathic seizure disorder as unfitting, rated it 20%, with application of Department of Defense Instruction (DoDI) 1332.39, paragraph E2.A1.4.3.5. The PEB did not address the episodic migraine headaches. The CI made no appeals, and was medically separated with a 20% disability rating.

CI CONTENTION: The CI states: “Was initially rated at proposed 20%, but condition has remained detrimental to work and increased in frequency.” He continues with: “Though rating has had its percentage increased over the years, doctors have informed me that condition will remain with me for remainder of my life. My wife has to constantly monitor my health (including driving me everywhere and majority of taking care of my children). Medical condition has caused me to lose job (lack of driving) and makes finding suitable employment rare.” [*sic*] He elaborates no additional contentions.

SCOPE OF REVIEW: The Board wishes to clarify that the scope of its review as defined in DoDI 6040.44 (4.a) is limited to those conditions which were determined by the PEB to be specifically unfitting for continued military service; and, when requested by the CI, those condition(s) “identified but not determined to be unfitting by the PEB.” 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 Army Board for the Correction of Military Records (BCMR).

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service PEB – Dated 20040609** | | | **VA (2 Mos. Post-Separation) – All Effective Date 20040819** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Idiopathic Seizure Disorder | 8910 | 20% | Idiopathic Seizure Disorder | 8911 | 40% | 20041005 |
| Episodic Migraine Headaches | Not Addressed by PEB | | No VA Entry |  |  |  |
| ↓No Additional MEB/PEB Entries↓ | | | 0% X 1 / Not Service-Connected x 1 | | | 20041005 |
| **Combined: 20%** | | | **Combined: 40%** | | | |

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impairment with which his service-incurred condition continues to burden him. 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. 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. That role and authority is granted by Congress to the Department of Veterans’ Affairs (DVA), operating under a different set of laws (Title 38, United States Code). The Board evaluates DVA evidence proximal to separation, within 12 months upon separation, in arriving at its recommendations, but its authority resides in evaluating the fairness of DES fitness decisions and rating determinations for disability at the time of separation.

Idiopathic Seizure Disorder. The CI had a history of recurrent syncopal episodes of uncertain etiology from July 2002. He reported the first and second episodes occurred during exercise/formation while he was in basic training. There was no warning or apparent trigger. He thought he blacked out for approximately 10-15 seconds and regained consciousness with no disorientation, confusion or grogginess. These first episodes were not in evidence for review. In March 2003 the CI was taken to the emergency room after being found by his wife on the floor not responding to her and awoke 3 minutes later with residual nausea after the episode. The episode was preceded by 45 minutes with a headache. He was released with a diagnosis of syncope. The service treatment record (STR) reflected an entry in July 2003 whereby he was found “convulsing and unconscious in a treatment room, pupils fixed and dilated for approximately 30 seconds,” treated with oxygen, and released to quarters. He had a follow-up the next day with residual complaints of fatigue and headaches and was diagnosed with s/p vasovagal syncope. He later reported this episode was preceded by nausea and the convulsing was characterized as “shaking his arms.” The CI underwent an extensive cardiac and neurologic work-up to include EKGs, echocardiogram, Holter monitor, tilt table testing, brain MRI, sleep-deprived EEG, waking EEG, which were all reported as negative. During this evaluation the CI reported he had a history of these episodes as a teenager (age 14-15), head trauma at 18 months of age striking his cranium (the top of his head) on a radiator that required stitches, headaches, diplopia and blurred vision. The cardiologist diagnosed no apparent cardiac etiology and the initial events in basic training were likely vasovagal syncope.

In October 2003 the neurologist diagnosed recurrent syncopal episodes, unknown etiology, for which one episode was accompanied with suspected convulsive activity; “however, this does not necessarily imply the event was epileptic, since syncope can often be associated with brief convulsive activity.” The CI elected to take an empiric trial with the anticonvulsant therapy Depakote which would also prevent the migraine headaches. The neurologist further recommended a temporary profile for a year with standard seizure restrictions and if he remained asymptomatic for that period, then the profile could be reduced to a permanent two with no restrictions. His limitations included; unable to carry and fire a weapon, no driving vehicles or operating heavy equipment, and no climbing to heights unrestrained. In follow-up 4 months later the CI had experienced one brief clonic episode during sleep with urinary incontinence in the context of sleep deprivation witnessed by his wife. The medication had decreased the intensity and frequency of the migraine headaches, now averaging one per week. The neurologist opined probable seizure disorder, migraine headache and recommended continued monitoring and a trial of the abortive headache medication Zomig.

At the MEB exam performed in April 2004, 4 months prior to separation, the CI reported one episode whereby the spouse found him lying on the floor unresponsive for 30-40 seconds with transient post-ictal grogginess and disorientation which was not witnessed. His treating neurologist tallied the recurrent syncopal episodes (probable epilepsy) for a total of four, two in November 2003, one in January 2004 and one in March 2004 (four in 7 months) since starting, titrating and being therapeutic on medications. He diagnosed idiopathic seizure disorder and episodic migraine headaches and opined the CI has continued to have breakthrough seizures despite adequate anticonvulsant drug levels and likely he had an increased probability of having recurrent seizures despite treatment. He recommended adjunctive therapy with another anticonvulsant, Keppra and dictated his MEB for referral to the PEB. At the VA Compensation and Pension (C&P) exam, 2 months after separation, the CI reported his seizure condition had existed for 26 months and over the last 2 years he had 13 attacks in total averaging 6 each year. The symptoms of the condition were loss of consciousness, uncontrolled shaking of the body, and loss of bowel and bladder function with residual fatigue resulting in the inability to perform any activities with a loss of work six times per year and he cannot drive. The C&P physical exam was normal. The examiner diagnosed idiopathic seizure disorder and opined it is a minor seizure disorder. The examiner further clarified the CI had subjective factors consistent with both major and minor seizures with the minor seizure predominating and no objective factors.

The Board directs attention to its rating recommendation based on the above evidence. The Board notes that both the MEB and VA exams were complete, well documented, and similar in terms of ratable data; and, therefore assigns them equal probative value. The PEB and VA chose different coding options for the condition which had significant implications on the rating for the Board to consider and both rated IAW §4.124a—schedule of ratings–neurological conditions and convulsive disorders. The PEB chose code 8910 (Epilepsy, grand mal) and rated 20% defined as at least one major seizure in the last 2 years; or at least 2 minor seizures in the last 6 months and based their decision on one breakthrough seizure since achieving adequate anticonvulsant therapy not counting the seizure that occurred during sleep as it was not shown to significantly impair industrial adaptability. While the PEB did not specify which episode upon which they based their decision, they likely labeled the March 2004 episode as a major seizure as the two in November were not in evidence. The VA chose code 8911 (epilepsy, petit mal) and rated 40% defined as at least 1 major seizure in the last 6 months or 2 in the last year; or averaging at least five to eight minor seizures weekly based on the CI report that the seizures occur without warning and occur approximately once every 6 months.

The Board considered likely this was an error as the evidence did not reflect five to eight weekly minor seizures; in fact the CI reported 13 attacks in total for 2 years averaging 6 each year, which is more consistent with the 20% rating. The challenge before the Board was to evaluate the hard subjective evidence and consider the tally of the CI’s major and minor seizure activity in order to apply the appropriate VASRD code to reflect the CI’s disability from his seizure disorder. While the future C&P exams completed 2 years and 6 years after discharge were outside of DoDI 6040.44, which specifies a 12-month interval for special consideration to VA findings, this does not mean that the later VA evidence was disregarded. The Board’s recommendations are directed to the severity and fitness implications of conditions at the time of separation. The VASRD §4.124a defines a major seizure as characterized by the generalized tonic-clonic convulsion with unconsciousness, and 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 (―pure‖ petit mal), or sudden jerking movements of the arms, trunk, or head (myoclonic type) or sudden loss of postural control (akinetic type). The initial manifesting seizure is sometimes referred to as the “index seizure.” The index seizure precedes the actual diagnosis of the CI’s seizure disorder and does count in the total tally. The evidence reflects the two initial episodes at basic training were characterized by the cardiologist as vasovagal syncope episodes and per the VASRD §4.124a these analogize to the code 8108 and are rated as epilepsy, petit mal. For the March 2003 episode, the neurologist did not discern concretely if this event was epileptic or still syncope. It is not until January 2004, that the evidence reflects clonic activity with loss of urinary continence and, albeit a sleep deprived seizure. It was the first documented subjective seizure that met the VASRD definition of a major seizure. The PEB did not count this seizure in its decision as the PEB was following the service policy for its fitness and rating decision. However the VASRD §4.124a specifies in note (3): There will be no distinction between diurnal and nocturnal major seizures.

The Board agreed that counting this major seizure and likely the March 2004 seizure as meeting the 40% criteria for the 8910 code. In addition, even not counting the sleep deprived seizure, the likely March 2004 major seizure was within 6 months of separation and therefore still meets the 40% criteria of “at least one major seizure in the last 6 months.” Finally, VASRD §4.124a specifies in note (2): In the presence of major and minor seizures, rate the predominating type. While the VA rated petit mal, the Board agreed to rate the condition as a major seizure as two of the four seizures in the MEB were major seizures. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a disability rating of 40% for the idiopathic seizure 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. As discussed above, PEB reliance on Department of Defense Instruction (DoDI) 1332.39 for rating idiopathic seizure was operant in this case and the condition was adjudicated independently of that policy by the Board. In the matter of the idiopathic seizure condition, the Board unanimously recommends a disability rating of 40%, coded 8910 IAW VASRD §4.124a. There were no other conditions within the Board’s scope of review for consideration.

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:

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| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Idiopathic Seizure Disorder | 8910 | 40% |
| **COMBINED** | **40%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, not dated, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans’ Affairs Treatment Record

President

Physical Disability Board of Review

**DEPARTMENT OF THE ARMY**

ARMY REVIEW BOARDS AGENCY *1901* SOUTH BELL STREET 2ND FLOOR   
ARLINGTON, VA *222024508*

SFMR-RB

**13** AUG 2012

MEMORANDUM FOR Commander, US Army Physical Disability Agency (TAPD-ZB *I* ), 2900 Crystal Drive, Suite 300, Arlington, VA 22202

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation for AR20120013944 (PD201200011)

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 recharacterize the individual's separation as a permanent disability retirement with the combined disability rating of 40% effective the date of the individual's original medical separation for disability with severance pay.
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 permanent disability retirement 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 date of the original medical separation for disability with severance pay.

c. Adjusting pay and allowances accordingly. Pay and allowance adjustment will account for recoupment of severance pay, and payment of permanent retired pay at 40% effective the date of the original medical separation for disability with severance pay.

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

SFMR-RB SUBJECT: Department of Defense Physical Disability Board of Review Recommendation for , AR20120013944 (PD201200011)

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

CF: ( ) 000 PDBR ( ) OVA