RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: xxxxxxxxxxxxxx BRANCH OF SERVICE: Army

CASE NUMBER: PD1200100 SEPARATION DATE: 20070817

BOARD DATE: 20120809

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty Soldier, SSG/E-6(19K, Tank Crewman), medically separated for chronic cough condition. The CI did not improve adequately with treatment to meet the physical requirements of his Military Occupational Specialty (MOS) or satisfy physical fitness standards. He was issued a permanent P3 profile and referred for a Medical Evaluation Board (MEB). The first MEB in April 2004 forwarded asthma to the Physical Evaluation Board (PEB) who found him fit for duty (FFD). A second MEB was completed in February 2007 for progressive worsening cough. Violent coughing of unknown etiology was forwarded to the PEB as medically unacceptable IAW AR 40-501. No other conditions appeared on the MEB’s submission. The PEB adjudicated the chronic cough condition as unfitting, rating it 10% with application of the Veteran’s Affairs Schedule for Rating Disabilities (VASRD). The CI made no appeals, and was medically separated with a 10% disability rating.

CI CONTENTION: The CI states: “after separation from us army with 10% rating for asthma and 100% ptsd [*sic]* both conditions were connected to service effective date a [*sic*] in the interest of justice I request that a waiver for time expiration be considered since my case is older than 4 yrs and I did not came about this information until it was published in news papers and from my dav rep around 24 jan 2011.”

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 other requested condition of posttraumatic stress disorder (PTSD) is 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 Army Board for the Correction of Military Records (BCMR).

RATING COMPARISON:

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| --- | --- |
| **Service PEB – Dated 20070615** | **VA (1 Mos. Post-Separation) – All Effective: 20070818** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Cough of Unknown Etiology | 6699-6602 | 10% | Bronchial Asthma also claimed as Chronic Cough of Unknown Etiology \* | 6699-6602\* | 30%\* | 20080619 |
| ↓No Additional MEB/PEB Entries↓ | PTSD\*\* | 9411 | 100% | 20081203 |
| Hypertension\*\*\* | 7101 | 10% | 20100421 |
| 0% X 0 / Not Service-Connected x 8 | 20070925 |
| **Combined: 10%** | **Combined: 100%** |

\*DRO VARD of 20080912 changed the following: diagnosis from Chronic Bronchitis to Bronchial Asthma also claimed as Chronic Cough of Unknown Etiology, code from 6600 to 6699-6602, rating from NSC to 30% effective 20070818.

\*\*VARD of 20081209 added PTSD, effective 20070818, combined 100%.

\*\*\*VARD of 20100721 added Hypertension, effective 20070818.

ANALYSIS SUMMARY: The Board acknowledges the CI's contention suggesting that ratings should have been conferred for conditions not diagnosed while in the service but later determined to be service-connected by the Department of Veterans’ Affairs (DVA). 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 DVA, however, 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.

Chronic Cough Condition. The CI was in good health until October 2001 when he arrived for duty in Germany. He was treated over the course of the next 2 years for wheezing and shortness of breath associated with a cough that responded to oral Prednisone (anti-inflammatory medication) and Fluticasone/Salmeterol, (Advair, an anti-inflammatory and long acting bronchodilator medication). These symptoms were worse from January to March and in the cold weather. He was seen in pulmonary in April 2003, had normal pulmonary function tests (PFTs) at baseline but improved by 16% post bronchodilator, and was diagnosed with asthma and seasonal rhinitis. The CI deployed to Iraq in April 2003. While in Iraq he developed worsening symptoms necessitating increasing doses of Advair and in January 2004, after 9 months of deployment, was medevac'd back to Germany due to lack of Advair in theater and his cough was unresponsive to Triamcinolone, (Azmacort anti-inflammatory medication). Upon restarting his Advair his symptoms resolved in 2 days. There were multiple temporary profiles starting in 2003 which led to a permanent profile in April 2004 and they all labeled the medical condition, asthma. The limitations included; run at own pace and distance, may take run for army physical fitness testing (AFPT) aerobic event, deployment to dusty environment only to areas where medical clearing company or combat support hospital (CSH) were within 30 minutes of dust-off. He underwent a MEB and was found FFD. Over the next 3 years he had progressive worsening of his cough, sought care acutely over 12 times and was extensively reevaluated by pulmonary. The pulmonologist questioned the diagnosis of asthma as the CI had multiple normal PFTs showing no improvement on bronchodilators, the latest June 2006, and a negative methacholine challenge test. The CI was thus referred to allergy and gastroenterology.

In January 2007, the allergy service documented an immunodeficiency disorder and treated him for low titers of pneumococcus and H. flu bacteria with vaccination which resulted in an excellent response with documented protective titers. The allergist, therefore, opined there was no evidence of asthma and that his cough had been due to non-specific sensitivity to irritants because of airway sensitivity and that the progression of disease had been interrupted by immunization and by giving symptom-relieving medications, Ipratropium Bromide, (Atrovent, an anti-cholinergic inhaler). He further opined the CI would need future annual monitoring of his immune status and that his current medical condition, chronic cough due to immunodeficiency which led to airway inflammation with normal PFTs and was not disqualifying IAW 40-501; however, certain duty positions may have requirements with increased fitness standards and cross-training might be considered. The allergist diagnosed cough, bronchitis, and placed him on 3 months of antibiotics and Atrovent and recommended follow-up in 3 months. The CI continued to have recurrent episodes of violent coughing with any activity that required full lung expansion, with exposure to cold weather, and with exposure to hot and dusty weather. A bronchoscopy, completed in April 2007, revealed normal lung airway anatomy. A gastroenterology evaluation was completed and included an esophagogastroduodenoscopy(EGD), gastric biopsies, trial of proton pump inhibitors and pH monitoring. The EGD revealed antral gastritis, normal biopsies and a pH monitoring day one revealed a DeMeester score of 23, (a DeMeester score of > 14.72 indicates reflux). However, his trial on medication for reflux did not improve his cough. A new permanent profile was written in March 2007 which labeled the medical condition as chronic cough with the following more restrictive limitations than his prior permanent profile; physical training at own pace and distance, indoor duty only, no AFPT, unable to move with a fighting load at least 2 miles, unable to wear protective mask, unable to construct an individual fighting position, unable to do 3-5 second rushes and unable to deploy. A review of the service treatment pharmacy record documented multiple different allergy and asthma prescriptions to include; Albuterol, both inhaler and solution for nebulizer, Atrovent, Spirivia, Advair, Allegra, Singulair, and Flovent. The pharmacy record reflected refills of Advair; however, refills were inconsistent with the prescription directions.

There were four pulmonary exams in evidence, two of which specifically met the VASRD §4.46 compliance which are referenced in the table below, with documentation of additional ratable criteria, which the Board weighed in arriving at its rating recommendation; as summarized in the chart below.

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| Pulmonary Exam | MEB ~6 Mo. Pre-SepPost-Bronch | VA ~ 6 Mo. Post-SepPost-Bronch |
| FEV1 % Predicted | 99.83% Pre Bronch 80% | 100% Pre Bronch 84% |
| FVC % Predicted | 98.37%Pre Bronch 86.18% | 96%Pre Bronch 85% |
| FEV1/FVC % Predicted | 101.60% | 103% |
| Meds | Coughing during exam, had taken Flovent within last 7days | Daily inhaled corticosteroid (Asmanex), intermittent inhaled bronchodilator |
| §4.97 Rating | 30% | 30% |

At the MEB exam completed on 4 June 2007, the CI reported taking Atrovent, Flovent and Spiriva. The MEB physical exam demonstrated the CI had a frequent non-productive cough and a normal lung exam. The examiner referenced a pulmonary function test in March 2004 which showed a normal baseline spirometry with no significant change after Methacholine challenge, and the above February 2007 PFT. The examiner also documented normal pneumococcus and H. flu titers, high lipids and abnormal IgE levels. The computer tomography (CT) of the chest from February 2007 revealed two small right lung nodules and an increase in the right middle lobe scarring when compared to the August 2006 chest CT. At the post –separation VA Compensation and Pension (C&P) exam, the CI reported severe coughing, sensation of chest tightness and shortness of breath which had improved since he had moved to Puerto Rico but, intermittently, he coughed severe enough that he would need a few minutes to recover his normal respiratory pattern. The symptoms worsened with stressful situations, on exercising, on walking fast, and it did not follow a specific pattern of appearance during the day and also occurred at night. He was not taking medications for management of this condition. The C&P physical exam demonstrated a cough, moderate to severe, during the interview otherwise a normal lung exam. The VA examiner cited the February 2007 CT scan report. The CI was not working and the evidence reflects he remained unemployed at the time of his application likely due to PTSD.

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 compliant with VASRD §4.46 (accurate measurement) and assigns the MEB and VA exams equal probative value. IAW VASRD §4.96 special provisions regarding evaluation of respiratory conditions PFT’s are required to evaluate respiratory conditions unless the condition meets exception to this requirement which in this case it did not. VASRD §4.96 also specifies when evaluating based on PFTs, use post-bronchodilator results in applying the evaluation criteria in the rating schedule unless the post-bronchodilator results were poorer than the pre-bronchodilator results. When carefully considering the whole record IAW VASRD §4.2 (Interpretation of examination reports) in order to develop a consistent picture of the CI’s chronic cough condition health condition the Board agreed the evidence reflects a consistent improvement in the post bronchodilator. While there were other PFT’s in the evidence which were VASRD compliant, they were pre bronchodilator exams, and did not offer the more complete information seen in the post-bronchodilator exam and therefore the Board agreed the post bronchodilator exams were more probative when considering its permanent rating recommendation. The PEB and VA chose different coding options for the condition originally but a year later the VA decision review officer (DRO) changed the VA code to that which was chosen by the PEB, and both were IAW §4.97—schedule of ratings–respiratory system. The original VA evaluator chose the 6600 code (chronic bronchitis) and assigned not service-connected (NSC) based on normal pre bronchodilator PFTs and lack of use of medications. The PEB coded analogous to the 6602 code (asthma, bronchial) and assigned a 10% rating based on normal PFT’s, normal Methacholine challenge test and intermittent use of bronchodilator medications with a review of the CI’s pharmacy record. The DRO changed the code to 6602 and assigned a rating of 30% based on this decision on review of the 6 month VA PFT exam as well as prior STR and the opinion of a “pneumonology” board. The DRO cited chronic cough manifested while in service was as least as likely as not the first manifestation of afterwards diagnosed and treated asthma with intermittent inhaled bronchodilator and daily anti-inflammatory medications.

The evidence reflects an original diagnosis of asthma however, due to worsening symptoms, normal baseline PFTs, and a normal Methacholine challenge test, the pulmonologist was skeptical of the diagnosis and referred the CI to other consultants for further evaluation. This resulted in a difference of opinion of the etiology of the chronic cough. The pharmacy record reflects some level of noncompliance while seeking care with these consultants and the AO opines this likely contributed to the non-specific, more general, diagnosis assigned by the PEB and the Board adjudged that the PEB diagnosis of chronic cough of unknown etiology and coding using 6699-6602 was considered administratively final. For the 6602 code, the 30% criteria specify daily inhalational or oral bronchodilator therapy, or; inhalational anti-inflammatory medication and the 10% criteria specify intermittent inhalational or oral bronchodilator therapy. The Board agreed the evidence reflects prescriptions and refills for use of daily Advair while in the service. While the refills suggests less than daily use of Advair, reflecting some level of non-compliance, there is no defensible basis for applying, or means of measuring, any deduction which might be considered. The Board must therefore disregard the influence non-compliance on ratable symptoms for its permanent rating recommendation and therefore recommends no deduction for non-compliance. Further the final permanent profile reflects a more functionally restrictive profile limiting activity to indoor only.

The Board looked for evidence reflecting post-separation employment due to his pulmonary impairment; however, the CI was diagnosed with PTSD and did not gain employment. The Board considered the 6600 code originally assigned by the VA but agreed IAW VASRD §4.7 (higher of two evaluations) the symptoms are more closely related to the 6602 code and agreed with the analogous code as the disability is not specifically listed in the rating schedule. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a disability rating of 30% for the chronic cough 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 chronic cough condition, the Board unanimously recommends a disability rating of 30%, coded 6699-6602 IAW VASRD §4.97. 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** |
| Chronic Cough of Unknown Etiology | 6699-6602 | 30% |
| **COMBINED** | **30%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20120130, 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 XXXXXXXXXXXXXXXXXXXXXXXXXXXX, AR20120015466 (PD201200100)

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 30% 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 30% 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.

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 XXXXXXXXXXXXXXXXXXXXXXXXXXXXX

 Deputy Assistant Secretary

 (Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA