RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: ARMY

CASE NUMBER: PD0900009 BOARD DATE: 20100217

SEPARATION DATE: 20070629

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SUMMARY OF CASE: This covered individual (CI) was a Guard MSG/E-8 (Signal) medically separated from the Army in 2007 after 27 years of combined service. The medical basis for the separation was a neck condition. This first became symptomatic during a 2004 OIF deployment. He also developed an exacerbation of right shoulder and left knee pain during the deployment. All of the complaints were treated conservatively in theater, but he was placed on medical hold after demobilization. A cervical MRI diagnosed Klippel-Feil deformity (congenital spine disorder) and multilevel degenerative disc changes. This was not surgical and did not respond adequately to conservative management for continued MOS performance. In 2006 he underwent arthroscopic meniscal debridement (cartilage repair) of the left knee as well as arthroscopic surgery for the right shoulder. He was placed on a permanent U3/L3 profile for all three conditions and underwent a Medical Evaluation Board (MEB). During the MEB period he was diagnosed with new-onset diabetes mellitus (DM), obstructive sleep apnea (OSA) and irritable bowel syndrome (IBS). In addition he was evaluated for psychiatric symptoms related to the deployment and received Axis I diagnoses of anxiety, depression and post-traumatic stress disorder (PTSD). The cervical, knee, shoulder, DM, OSA and IBS conditions were all forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR-40-501 on the DA Form 3947. The three psychiatric conditions were forwarded individually as medically acceptable conditions. The PEB adjudicated only the cervical condition as unfitting and the CI was medically separated with a 10% disability rating. An initial Army Board for Correction of Military Records (ABCMR) appeal was re-directed to the PDBR.

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CI CONTENTION: The CI requests that ‘I be medically retired and placed on the Permanent Disability Retirement List (PDRL) with a disability rating consistent with my Department of Veterans Affairs rating which is based upon my diagnosed chronic neck and shoulder pain, sleep apnea, post-traumatic stress disorder, and type II diabetes mellitus.’

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RATING COMPARISON:

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| --- | --- |
| **Service PEB** | **VA (6 Mo. after Separation) – All Effective 20070630** |
| **Condition** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Neck and Shoulder Pain… | 5299-5237 | 10% | 20070525 | Klippel Feil Syndrome… | 5237 | 10% | 20071212 |
| Right Shoulder Impingement… | Not Unfitting | 20070525 | Right SLAP Labral Tear… | 5201 |  0%  | 20071212 |
| Left Knee Pain… | Not Unfitting | 20070525 | L Knee Osteoarthritis… | 5003-5257 | 10% | 20071212 |
| IBS | Not Unfitting | 20070525 | IBS | 7319 | 0% | 20071212 |
| Type II DM | Not Unfitting | 20070525 | DM, Type 2 | 7913 | 20% | 20071212 |
| OSA | Not Unfitting | 20070525 | OSA | 6847 | 50% | 20071212 |
| Generalized Anxiety Disorder | Not Unfitting | 20070525 | PTSD | 9411 | 70% | 20071217 |
| Depressive Disorder, NOS | Not Unfitting | 20070525 |
| PTSD | Not Unfitting | 20070525 |
| No Additional DA 3947 Entries. | Non-PEB X 3 / NSC X 3 |  |
| **TOTAL Combined: 10%** | **TOTAL Combined (*Includes Non-PEB Conditions*): 90%**   |

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ANALYSIS SUMMARY:

Cervical Condition. The wording of the DA Form 199 implied application of the US Army Physical Disability Agency (USAPDA) pain policy to the cervical rating, but the 10% rating determination would have been unaffected by rating strictly IAW Veterans Administration Schedule for Rating Disabilities (VASRD) §4.71a. The PEB acknowledged that the condition existed prior to service (EPTS) (the congenital Klippel-Feil anomaly) but appropriately attributed service aggravation. The MEB and VA goniometric range-of-motion (ROM) exams are summarized in the chart below.

|  |  |  |
| --- | --- | --- |
| Cervical ROM | MEB – 04/30/07 | VA C&P – 12/12/07 |
| Flexion | 35⁰ | 35⁰ |
| Combined | 200⁰  | 180⁰ |
| §4.71a Rating | 10% | 10% |

The MEB exam did not specify pain end-points but reflects the average of three measurements for active ROM and is adequate for rating purposes. The VA examiner specified pain thresholds. Both exams identified tenderness and/or spasm; neither noted abnormal contour. Both examinations are consistent with 10% ratings IAW the VASRD and there are no entries in the medical record suggesting they were not reflective of the severity of the cervical condition. There was no evidence of ratable peripheral nerve impairment in this case. There is no reasonable doubt in the CI’s favor, therefore, to justify a Board recommendation for other than the 10% rating assigned by the PEB for the neck condition. PEB coding was appropriate, although the 5299 prefix is unnecessary.

Right Shoulder Condition. The CI stated to the VA examiner that his shoulder pain dated to 2000 and was initially associated with weight lifting. It was significantly exacerbated during deployment with lifting and the requirement for protective equipment. The initial diagnosis was a labral (joint lip) tear and impingement syndrome from AC (acromioclavicular) arthrosis. The surgery in 2006 entailed a partial resection of the clavicular head. Significant improvement after surgery was evidenced in the MEB and VA exams.

The initial Board consideration is directed to the PEB fitness adjudication. In explanation of the not unfitting determinations for the shoulder and other conditions, the DA Form 199 stated, ‘Although the Soldier has these conditions and presently requires treatment, the Soldier also had these conditions in the past, and the evidence provided does not indicate that he could not perform his assigned duties at that time because of these conditions.’ This may have reflected an opinion in the Commander’s statement that ‘None of these complaints affected his ability to perform exceptionally well in Iraq.’ The PEB rationale and the Commander’s statement would also have been equally applicable to the cervical condition which was conversely deemed unfitting. Regarding the shoulder condition, the PEB’s rationale is further undermined by the fact that the shoulder was significantly worse after deployment. This is evidenced by the fact that surgery was not required until after deployment. It is true that the post-operative course was favorable and that the condition may have improved to the prior baseline (or better), but that entails a degree of speculation. Albeit there were several non-orthopedic conditions, the narrative summary (NARSUM) focused on the cervical, right shoulder and left knee conditions. The MEB was initiated for the orthopedic conditions and the orthopedist clearly opined that all three conditions were medically unacceptable. Specifically the NARSUM stated that the cervical and shoulder pain prohibited use of Kevlar and body armor. Although the MEB’s judgment that a condition does not meet AR 40-501 retention standards is but a factor in the PEB’s fitness determination, it raises the bar for an adjudication of not unfitting. The permanent U3 physical profile included the right shoulder condition and the cervical condition. The Commander’s performance statement included the shoulder limitations in her assessment that the CI was no longer able to perform in his MOS. All evidence considered, the Board cannot find enough strength in the PEB position to overcome a good deal of reasonable doubt in the CI’s favor regarding the fitness adjudication for the right shoulder condition. The Board, therefore, recommends that it be rated as an additionally unfitting condition.

The Board now directs its attention to the coding and rating recommendation for the right shoulder condition. The MEB goniometric measurement for active abduction was 130⁰. The VA rating examination documented pain beginning at 150⁰ abduction. Both exams reflected impairment relative to the VASRD normal of 165⁰ (180⁰ is usual). The ROM was nevertheless in excess of the compensable threshold of 90⁰ stipulated in the only shoulder code based on ROM, i.e., 5201 (minimum rating is 20%). The VA applied the 5201 code and, disregarding painful motion, assigned a non-compensable rating for the reported ROM. Both the MEB exam and the VA exam documented painful motion, however. VASRD §4.59 (painful motion) states that joints so affected are ‘entitled to at least the minimum compensable rating for the joint’. Strict application of §4.59 to the 5201 code would result in a 20% rating, but 5201 is not the best clinical fit for the condition. Analogous coding to 5203 (clavicle or scapula, impairment of) is more accurate since impingement and arthrosis at the AC joint was the specific pathology identified in the NARSUM and DA Form 3947. It should also be recalled that the surgery entailed partial resection of the distal clavicle. Although nonunion or malunion as specified in 5203 was not present in this case, it is a good match as an analogous code. The Board therefore recommends the minimum rating under 5299-5203, i.e. 10%, for the right shoulder condition.

Left Knee Condition. The left knee condition shares much in common with the above discussion addressing the shoulder condition. The VA examiner dated the onset of the knee condition to 2002, noting significant exacerbation in Iraq. As with the shoulder, the evidence does not support the PEB rationale that it was not unfitting because of chronicity and prior duty performance. Surgery was required after deployment and, unlike the shoulder, there was no indication that it was improving afterwards. As with the shoulder and neck conditions, it was a focus of the MEB and was judged to be below AR 40-501 standards. A permanent L3 profile was in place based on the knee condition. The Commander’s performance statement specifically states, ‘he is still unable to run any distance without pain and swelling in his knee’. There is a surplus of evidence suggesting that the knee condition interfered significantly with MOS performance. The Board, therefore, recommends that it be rated as an additionally unfitting condition.

The Board now directs its attention to the coding and rating recommendation for the left knee condition. Although there was no compensable ROM impairment for the knee, there was documented painful motion in the MEB and VA exams. The VA coded the knee as osteoarthritis rated as 5257 for subluxation or instability (of which there was none). More clinically specific coding is reflected under 5259 for surgical residuals of cartilage removal. This is the pathology and surgery described in the NARSUM and the DA Form 3947. 5259 specifies a singular rating of 10%, which is the Board’s recommendation.

Psychiatric Conditions. The Board’s primary consideration regarding the psychiatric conditions is the PEB’s determination that they did not ‘independently, or combined, render the Soldier unfit for his assigned duties.’ The CI had a history of outpatient psychiatric treatment in 1999 and some of his documented PTSD stressors were derived from experiences before deployment. He developed sleep disturbance and mood lability during deployment and much of his stress was associated with military administrative events rather than combat experiences. On his post-deployment health assessment, he responded affirmatively to several PTSD-related questions but denied direct combat or witnessing dead or wounded casualties. As noted in the summary, he had mixed Axis I diagnoses rather than primary PTSD. He participated in outpatient Behavioral Health groups and psychotherapy, and was prescribed three psychoactive medications at the time of separation. There were no psychiatric admissions or episodes of psychosis. There was a history of suicidal ideation, but no active plans or attempts (notwithstanding a reported event of holding an unloaded gun to his head after a personal stressor). The MEB psychiatrist documented a normal mental status examination except for the statement, ‘His mood has been typically irritated or calm, and he has tended to display a broad range of affect and has been tearful and angry at times.’ The VA psychiatric rating examination documented a normal mental status without the mood caveat.

As rationale for the fitness adjudication of the psychiatric conditions, the DA Form 199 states, ‘all meet medical retention standards, are not listed on the Physical Profile as limiting any of the Soldier's functional activities, are not commented upon by the commander as hindering the Soldier's performance, and the case file contains no evidence that these Dx(es) independently; or combined, render the Soldier unfit for his assigned duties.’ Each of these points is supported by the evidence. The psychiatric addendum to the NARSUM unequivocally opined that there was no significant psychiatric impairment to military duty. The following comments are included, ‘... is able to perform the duties of his MOS and to generally function as a soldier to full capacity ... currently meets psychiatric retention standards ... does have full psychiatric capacity for worldwide deployment’. The physical profile was S1. Although the MEB physical form DD 2808 noted an S3, no such profile was issued (including one subsequent to the MEB exam). Although the Commander’s statement included a comment that the CI’s ‘physical and mental health challenges prevent him from being able to contribute to mission accomplishment on a constant basis’, all of the specific limitations she mentioned were physical ones. The statement also included the observation that he stood watch as Staff Duty NCO and all of his evaluations noted strong leadership and administrative skills. The VA rating examination stated that he was employed as a boiler operator since 2002. The CI remained well-motivated and performed to the level of his physical ability throughout the MEB period. There are numerous outpatient Behavioral Health notes in evidence, and none that document any significant psychiatric acuity or impairment.

It is noted that the CI was rated 70% for PTSD by the VA referencing a rating examination performed six months after separation. The VA rating was cited by the CI’s counsel (correspondence to ABCMR of 20081103) as evidence that the condition ‘could not have been medically acceptable at the date of separation’. There is no documentation by the VA rating psychiatrist, however, that supports a §4.130 rating of 70%. As stated above, the exam noted a normal mental status examination and the CI remained fully employed. The VA psychiatrist opined ‘moderate severity’ for PTSD. This notwithstanding, the Board cannot find any convincing argument supporting an opinion that any of the psychiatric conditions had risen to the level of an unfitting impairment at the time of separation. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the psychiatric condition.

Other DA Form 3947 Conditions (DM, IBS, OSA). The DA Form 199 rationale that DM and IBS were not unfitting because they were chronic without prior interference with military duties is not supported by the history of the conditions. DM was newly diagnosed in 2007 and IBS in 2006. The DM required an initial admission for stabilization, but was stable on oral medications at the time of separation. There were no complications, ketoacidosis, hypoglycemia or organ involvement. The Hgb A1c (reflects average blood sugar over time) was 7.4, indicating reasonably good control. There was a very brief addendum to the NARSUM which addressed diabetes. Although devoid of any supporting details or rationale, it opined that the ‘condition interfered with the reasonable performance of his assigned duties’. DM (along with IBS and OSA) was listed on the physical profile, which was P3 at the time of separation. The profile restrictions, however, did not specifically implicate DM or any general medical condition. Although it limited running to his own pace and distance, it allowed unlimited walking and biking. This would not suggest that routine activities were limited by DM or the other conditions. The Commander’s statement did not mention DM, IBS or OSA; and, it did not document any limitations that could be ascribed to them. The VA examiner documented that the DM was not associated with weakness, fatigue, weight change or requirement for regulation of activities. CI’s counsel (in the same correspondence cited above) stated that ‘Type 2 diabetes is an unfitting condition in all but the rarest of cases.’ The fact is, across all of the service PEB’s, stable DM 2 (even insulin requiring) is generally not considered to be independently unfitting. There is nothing in evidence suggesting that DM imposed such a restriction on activities that the CI would not have been able to perform his military duties in a signal battalion, including deployment. The Board cannot support a recommendation contrary to the PEB opinion that DM was not unfitting in this case.

The IBS condition was heralded by diarrhea associated with periods of stress, beginning during the deployment. During the MEB process, it was manifested as alternating periods of constipation and diarrhea with intermittent abdominal cramping. A colonoscopy in 2006 was normal except for a small polyp in the sigmoid colon. There was a cursory addendum to the NARSUM addressing the gastrointestinal condition. Like the DM addendum, there were no articulated details in support of an opinion that the condition interfered with performance of duties. The VA examiner stated that bowel movements were normal at that time. The VA rating was 0%. Like the DM, there was nothing in the physical profile or Commander’s statement specifically implicating IBS. There is no evidence of persistent frequent diarrhea, persistent vomiting, protracted abdominal pain, adverse medication requirement or any other features that would typically render a gastrointestinal condition incompatible with military service. The Board cannot support a recommendation contrary to the PEB’s determination that IBS was not unfitting in this case.

OSA was diagnosed by a sleep study in November 2006. It responded to CPAP. It was covered by the similar cursory addendum and opinion that it ‘interfered with the recent performance of his assigned duties’. Like the DM and IBS, there were no supporting details in the addendum, no specific limitations included in the physical profile or any comments in the Commander’s statement implicating OSA as unfitting. The DA 199 rationale for the OSA fitness adjudication read, ‘The use of a breathing device at night to improve the Soldier's sleep does not automatically make him unable to perform his duties, and potential difficulties in some deployment areas cannot be used as a sole basis to find this soldier unfit.’ Given the CI’s MOS and the fact that OSA is not generally judged to be unfitting by PEB’s across the services, the PEB’s fitness adjudication was expected and reasonable. The Board cannot support a recommendation contrary to the PEB’s determination that OSA was not unfitting in this case.

Other Conditions. The only relevant additional conditions documented in the DES packet were hypercholesterolemia, hypertension, intermittent headaches, left foot and left small finger orthopedic complaints and a history of kidney cysts. The hypercholesterolemia, hypertension and kidney cyst conditions were chronic and stable. Only hypertension was rated by the VA (10%) and no link to fitness is in evidence for any of these conditions. The additional orthopedic conditions were not noted in the physical profile or Commander’s statement and are not relevant for Board consideration as additionally unfitting and ratable. The headaches were related to the cervical condition and were not diagnosed as a specific condition by the military or VA. There is nothing to suggest they were incapacitating or linked to fitness. No other conditions were service connected with a compensable rating by the VA within twelve months of separation. 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. Any other contended conditions, except for those just elaborated or already discussed, remain eligible for ABCMR consideration.

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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 the cervical condition was operant in this case and the condition was adjudicated independently of that policy by the Board. In the matter of the cervical condition and IAW VASRD §4.71a, the Board unanimously recommends no recharacterization of the PEB rating. A more specific and applicable description for the cervical condition and modification of the code is offered in our summary chart. In the matter of the right shoulder condition, the Board unanimously recommends that it be added as an additionally unfitting condition for separation rating; coded 5299-5203 and rated 10% IAW VASRD §4.71a. In the matter of the left knee condition, the Board unanimously recommends that it be added as an additionally unfitting condition for separation rating; coded 5259 and rated 10% IAW VASRD §4.71a. In the matter of the anxiety disorder, depressive disorder, PTSD, diabetes, irritable bowel syndrome and sleep apnea conditions, the Board unanimously recommends no recharacterization of the PEB adjudication as not unfitting. In the matter of the hypercholesterolemia, hypertension, headaches, left foot condition, left small finger condition, history of kidney cysts 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.

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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** |
| Cervical Spine Klippel-Feil Abnormality with Multiple Levels of Degenerative Disc Disease | 5237 | 10% |
| Right Shoulder Impingement with Acromio-clavicular Joint Arthrosis | 5299-5203 | 10% |
| Left Knee Meniscal Injury Status-Post Arthroscopic Debridement and Chondroplasty | 5259 | 10% |
| **COMBINED** | **30%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090203, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

