RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: ARMY

CASE NUMBER: PD0900033 BOARD DATE: 20100429

SEPARATION DATE: 20060705

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SUMMARY OF CASE: This covered individual (CI) was an active duty SGT/Petroleum Supply Specialist medically separated from the Army in 2006 after 6 years of service. The medical bases for the separation were a back condition and a bilateral knee condition. He had a history of low back pain associated with lifting and other requirements of his military occupational specialty (MOS) dating to 2002. He suffered exacerbations of the condition with various strain injuries as his career progressed. These were managed with periodic medications, routine conservative measures and temporary profiles. In 2005 a Magnetic Resonance Imaging (MRI) demonstrated two level disc disease (L4/5, L5/S1) and he underwent a trial of physical therapy and epidural injections. He did not respond adequately to meet the physical requirements of his MOS or participate in the Army Physical Fitness Test (APFT). Surgical options were discussed, but the CI opted out (reasonably so) since the benefits were not certain. He was placed on a permanent L3 profile and underwent a Medical Evaluation Board (MEB). There are conflicting histories in the narrative summary (NARSUM), orthopedic notes and VA examination regarding the onset and circumstances of his bilateral knee pain. Contusion type injuries are described in the NARSUM and strain mechanisms vs. spontaneous onset are reflected in the other evaluations. There are no records of unilateral knee pain or injury. The first temporary profile for his knees was Jun 2005. X-rays of both knees were normal. An MRI of the left knee Sep 2005 revealed some incidental edema-type findings, but no ligamental, cartilaginous or other significant pathologies. The knee condition failed to improve adequately with conservative measures. It was added to permanent profile prior to separation, although it was not noted in the Commander’s statement. The back and bilateral knee conditions were referred to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. No other conditions appeared on the MEB’s DA Form 3947 submission. Other conditions included in the NARSUM and Disability Evaluation System (DES) packet are discussed below. The PEB found the CI unfit for both conditions, rated 10% each, and he was medically separated with a combined disability rating of 20%.

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CI CONTENTION: The CI elaborates no specific contentions regarding rating or coding and mentions no additionally contended conditions.

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RATING COMPARISON:

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| --- | --- |
| **Service PEB – Dated 20060404** | **VA (Pre-Separation) – All Effective 20060706** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Lumbar Pain … | 5237 | 10% | DDD, Lumbar Spine  | 5242-5010 | 10% | 20060531 |
| Bilateral Knee Pain … | 5099-5003 | 10% | Right Knee Strain | 5099-5024 | 10% | 20060531 |
| Left Knee Strain | 5099-5024 | 10% | 20060531 |
| ↓No Additional DA Form 3947 Entries.↓ | Recurring Left Ankle Strain | 5099-5024 | 10% | 20060531 |
| Recurring Right Ankle Strain | 5099-5024 | 10% | 20060531 |
| Hypertension | 7101 | 10% | 20060531 |
| Non-PEB X 4 (0% Each) | 20060531 |
| **TOTAL Combined: 20%** | **TOTAL Combined (*Includes BLF*): 50%**   |

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ANALYSIS SUMMARY:

Back Condition. There are three range-of-motion (ROM) evaluations in evidence on which the Board may base its Veterans Administration Schedule for Rating Disabilities (VASRD) §4.71a rating recommendation. There was a physical therapy (PT) goniometric examination performed for MEB purposes and preceding measurements done by a P.A. (physician’s assistant) in the orthopedic clinic (use of a goniometer was not specified). The VA rating goniometric examination was performed closest to separation, at 2 months prior. The MEB PT exam was performed 11 months prior to separation. All three of these exams are summarized in the chart below.

|  |  |  |  |
| --- | --- | --- | --- |
| Thoracolumbar ROM | Ortho – 4/7/05 | MEB PT – 8/2/05 | VA C&P – 5/31/06 |
| Flexion | 90⁰ | 70⁰ | 90⁰ |
| Combined | 230⁰ | 230⁰  | 240⁰ |
| §4.71a Rating | 10% | 10% | 10% |

The NARSUM examination specified minimal tenderness; the VA examiner found no tenderness. There was no spasm, antalgic gait or abnormal contour noted on any exam. The PEB and VA chose different coding options for the condition, but this did not bear on rating. The PEB’s DA Form 199 reflected application of the US Army Physical Disability Agency (USAPDA) pain policy for rating, but its 10% determination was consistent with §4.71a standards. It is apparent that there is no foundation for a Board rating recommendation higher than the 10% applied by the PEB. The PEB code is acceptable. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB adjudication for the lumbar condition.

Knee Condition. The conspicuous issue with the PEB adjudication of the knee condition is the combined code for a single rating, contrasting with the VA approach which achieved separate 10% ratings. Although the DA Form 199 provided for application of the USAPDA pain policy to rating, it does not reflect application of AR 635-40 to justify combined coding. The analogous rating to 5003 as two major joints is IAW VASRD §4.71a. Since degenerative changes were not verified by imaging, the 5099 prefix was appropriate. Commonly with PEB combined ratings such as this, the VASRD §4.59 provision for separate ratings based on painful motion is not applied based on the pain policy. That does not appear to be the case in this instance, however, since there is no evidence of painful motion on the NARSUM examination. Other than some patellar crepitus (grinding under the knee cap) and patellar glide (increased mobility of the knee cap) on the left knee, both knee examinations were normal. Although the absence of painful motion was not specified, a comprehensive examination of the knees was documented with no indication that painful motion was implied or suspect. Knee flexion was measured at 130° bilaterally by the MEB and 140° bilaterally by the VA. Thus there is no compensable ROM impairment for either knee. The MEB and VA evaluations documented the absence of mechanical instability, locking or frequent effusions. Thus there is no route to a rating higher than 10% for either knee and no criterion for dual coding of either knee. The VA rating decision (VARD) implicated painful motion as the basis for its separate ratings, but the rationale is not grounded in the physical examination provided by the VA physician. The VA knee exam is excerpted in its entirety below.

The examination of the knee was normal, right and left. There is no edema, effusion, weakness, tenderness, redness, heat, abnormal movements, guarding, or subluxation. Range of motion of the knees joints is as follows: [ROM Chart not reproduced. Degree that pain occurs was left blank.] After repetitive use the joint function is not limited by pain, fatigue, weakness, lack of endurance or incoordination. The medial, lateral collateral ligaments were normal and cruciate ligament was normal. There were no clicks. Meniscus test was negative. Varus, valgus, drawer and McMurray signs were all negative.

The §4.71a exception to combined rating under 5003 specifies, ‘Limitation of motion must be objectively confirmed by findings such as swelling, muscle spasm, or satisfactory evidence of painful motion.’ These VASRD criteria are not met in this exam. The VARD in fact referenced the examiner’s medical history of the condition in support of a rating based on painful motion. This rationale from the VARD which is identical for each knee states, ‘We have assigned an evaluation of 10 percent based on your VA examination, which shows that you reported weakness, stiffness, and swelling with standing for long periods of time or running. You also reported intermittent pain, about four times per month that travels to the calf.’ In context the first sentence was derived from a description of symptoms at the onset of the condition after running an obstacle course in 2004. The real time symptoms were those in the second sentence reporting intermittent pain four times monthly. This history of pain does not support separate ratings under §4.59 (painful motion), or under the broader umbrella of §4.40 (functional loss). MEB outpatient notes were scrutinized for other knee examinations justifying Board application of §4.59 to obtain separate ratings. There were several cursory PT exams and two comprehensive orthopedic consultant exams. None described tenderness, spasm or any indications of painful joint motion. The closest suggestion of painful motion to be found was in the MEB PT goniometric exam of the knees. This specified pain as the end point of measurements. This single entry (11 months prior to separation) was far outweighed by all of the other evidence just described, and the Board could not ascribe enough probative value to it as the basis for a recommendation based on painful motion. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB adjudication for the bilateral knee condition.

Other Conditions. The NARSUM identified gastroesophageal reflux disease (GERD), hypertension and migraine headaches as co-existing medical conditions. GERD was not coded or rated by the VA and the headache condition received a non-compensable rating. All of these conditions were chronic and stable with no link to fitness. A right wrist condition was identified by the CI on the MEB physical and was not service connected by the VA. The profile was U1. Other less specific complaints were noted by the CI on the physical, but are not relevant for Board consideration as additionally unfitting. As noted in the summary, only the back condition was covered in the physical profile at separation or noted in the Commander’s statement. Bilateral ankle conditions were rated 10% each by the VA at separation, but were not noted by the CI on the MEB physical or otherwise within the DES packet. 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 ankle conditions and any contended conditions not covered above remain eligible for Army Board for Correction of Military Records (ABMCR) consideration. The Board, therefore, has no reasonable basis for recommending any additional unfitting conditions for separation rating.

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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 back and knee conditions was operant in this case and the conditions were adjudicated independently of that policy by the Board. In the matter of the chronic lumbar condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the chronic bilateral knee condition and IAW VASRD §4.71a, the Board by a 2:1 vote recommends no change in the PEB adjudication. The single voter for dissent (who recommended separate 10% ratings for each knee) submitted the addended minority opinion. In the matter of the gastroesophageal reflux disease, hypertension, migraine headache, right wrist 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.

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

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090114, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

MINORITY OPINION:

The CI has a long history of ‘Knee Pain’. The first doctor’s visit was to the TMC in June 2000. At that time the CI complained that the ‘pain mainly starts after marching and running PT’. Over the 6 year course of his military career, the CI made doctor’s visits on 10 occasions with the chief complaint of ‘Knee Pain’. On 19 Jul 01, knee pain; 2 Oct 01, knee pain; 8 Apr 02, knee pain; Jan 03, knee pain ‘fell on ice’; 27 Jun 03, knee pain Fell playing basketball; 4 Aug 04 knee pain; 17 Aug 04, knee pain; 29 Aug 05, knee pain; 26 Sep 05, knee pain.

On the 29 Aug 05 visit the doctor annotated ‘right knee joint pain accompanied by a popping sound, knee joint swelling on the right, on the left the knee joint feels unstable, knee suddenly buckled on right’.

On 26 Sep 05 the MRI report noted, ‘The condylar surfaces are unremarkable. A small patchy area of increased signal intensity of T2 weighted images is present with the intercondylar portion of the distal femur surrounding the ACL insertion. Again, the anterior cruciate ligament is intact. This may be the sequela of prior injury, direct contusion, or stress related changes. Mild amount of increased signal intensity is seen within the suprapatellar fat pad. Mild edema involving the suprapatellar fat pad. This may support suprapatellar fat pad impingement.’

There is adequate supporting evidence and substantial reasonable doubt favoring the applicant for recommending separate joint ratings in this case. Based on the collective medical reports, I maintain that the fair recommendation is a lumbar rating of 10% coded 5242 plus separate 10% ratings for each knee coded 5099-5024. This produces a combined disability rating of 30% and appropriately provides for medical retirement.

