RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: ARMY

CASE NUMBER: PD0900054 BOARD DATE: 20100105

SEPARATION DATE: 20030612

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SUMMARY OF CASE: This covered individual (CI) was an ARNG-AGR SSG Information Systems Operator-Analyst medically separated from the Army in 2003 after 6 years of active and 9 years of total service. The medical basis for the separation was chronic low back pain (LBP) and multiple painful joints (Bilateral degenerative joint disease [DJD] of hips and knees as well as the left ankle) without any history of trauma. The LBP and joint pain was present for 2 years with worsening, poor response to multiple treatments, and a poor prognosis. The CI was on a permanent limited profile, and underwent an MOS/Medical Retention Board (MMRB) 20020516 that directed an MEB/PEB. LBP and bilateral DJD of shoulders, hips, knees and left ankle were determined to be medically unacceptable IAW AR 40-501. The Depression and Adjustment Disorder with mixed anxiety were determined to be medically acceptable. The CI was referred to the PEB, found unfit only for the LBP and bilateral degenerative joint disease of the hips, knees and left ankle. The CI was determined unfit for continued military service and separated at 10% combined disability (10% LBP, 0% DJD of multiple joints) using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Armyand Department of Defense regulations including the Physical Disability Agency pain policy.

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CI CONTENTION: "Please review DA form 3947 and compare with supporting documents. I feel the following listed issues should have been rated during my PEB. 6847-sleep apnea, 8521 paralysis of external popliteal nerve, 5203 right and left clavicle or scapula, 5275 flat foot condition, 5003 arthritis degenerative, 5257 knee condition, right and left, 5271 limited motion of ankle, anxiety adjustment disorder with depressed mood."

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RATING COMPARISON:

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| --- | --- |
| **Service PEB** | **VA (Service Treatment Records)** |
| **Unfitting Conditions** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| Chronic Low Back Pain  | 5293-5299-5295 | 10% | 20030219 |  Chronic Low Back Pain | 5293-8521 | 10% | STR | 20030613 |
| Bilateral degenerative joint disease of the hips, knees and left ankle. … Rated at 0% for pain IAW the PDA pain policy.  | 5099-5003 | 0% | 20030219 | Bilateral Hip Condition | 5099-5003 | 10% | STR | 20030613 |
| Left Knee | 5299-5257 | 0%10% | STR20071031 | 2003061320071031 |
| Right Knee | 5299-5257 | 0%10% | STR20071031 | 2003061320071031 |
| Left Ankle Condition | 5299-5271 | 0% | STR | 20030613 |
| Arthralgia (claimed as osteoarthritis) of Multiple Joints to Include Spine, Elbows, and Wrists | 5099-5003 | 0% | STR | 20030613 |
| - | MEB & NARSUMBilateral degenerative joint disease of **acromioclavicular joints of the shoulders** | Left Shoulder Condition | 5299-5203 | 10% | STR | 20030613 |
| - | Right Shoulder Condition | 5299-5203 | 10% | STR | 20030613 |
| Depression | Not Unfit |  |  | Depression | NSC |  | STRLater VA exams |  |
| Adjustment disorder with depressed mood  | Not Unfit |  |  |  |  |  |  |  |
| - | MEB H&P  | Bilateral Foot Condition; Right Arm Condition | NSC | - | STR | 20030613 |
| - | Not in PEB file | Pes Planus | 5276 | 0%10% | STR20051115 | 2003061320051018 |
| - | Not in PEB file | OSA | 6847 | 50% | 20060516 | 20060403 |
| **TOTAL Combined: 10%** | **TOTAL Combined (*Includes Non-PEB Conditions*):** **40% from 20030613** **50% from 20051018****70% from 20060403** **80% from 20071031** |

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ANALYSIS SUMMARY: The primary issues in this case are the CI's multiple painful joints considered under a single code by the PEB and rated IAW the Army pain policy. Additionally, the MEB listed bilateral shoulders (Bilateral degenerative joint disease of acromioclavicular joints of the shoulders) under their medically unacceptable diagnosis #1, while the PEB did not address the bilateral shoulders as either fitting or unfitting, but noted MEB Dx #1 as unfitting with a different disability description. The CI's contention for mental health rating was clearly addressed. The CI's radiculopathy was minor and provided insufficient disability to be considered unfitting. The CI's OSA and Pes Planus were not mentioned in the PEB file.

**MEB Diagnoses**:

1. Bilateral degenerative joint disease of **acromioclavicular joints of the shoulders**, hips and knees as well as the left ankle (Medically Unacceptable, IAW AR 40-501, para 3-39 c)

2. Spondylitic changes in LS-SI region (Medically Unacceptable, IAW AR 40-501, para a3-39 a 3)

3. Chronic low back pain (Medically Unacceptable, IAW AR 40-501, para 3-30 j)

4. Depression (Medically Acceptable)

5. Osteoarthritis of multiple joints (Medically Unacceptable, IAW AR 40-501, para 3-39 c)

6. Axis I Adjustment disorder with mixed anxiety and depressed mood (Medically Acceptable)

**PEB Diagnoses**:

- "Chronic low back pain without any specific history of trauma or injury. Soldier reports pain with motion. Physical exam notes normal gait and muscle power. Remainder of exam within normal except for mildly decreased pinprick over left ankle. MRI notes L4/5 mild broad disk bulge and spondylitic changes L5/S1 (MEB Dx 2-3)."

- "Bilateral degenerative joint disease of the hips, knees and left ankle. Soldier has been evaluated by Rheumatology without a related diagnosis. Bone scan notes degenerative versus stress changes in these areas. Physical exam notes full ranges of motion with 5/5 muscle strength. Pain is reported with these tests. Rated at 0% for pain in accordance with the Physical Disability Agency pain policy. (MEB Dx **1**, 5)"

- MEB Dx 4, 6 (Axis I) Medically acceptable

**Condition 1: Chronic Low Back Pain (MEB #2, 3)**

**MEB (20020917)** Spondylitic changes in L5-S1 region (Medically Unacceptable, IAW AR 40-501, para a3-39 a 3). Chronic low back pain (Medically Unacceptable, IAW AR 40-501, para 3-30 j)

**IPEB (date 20030219):** "Chronic low back pain without any specific history of trauma or injury. Soldier reports pain with motion. Physical exam notes normal gait and muscle power. Remainder of exam within normal except for mildly decreased pinprick over left ankle. MRI notes L4/5 mild broad disk bulge and spondylitic changes L5/S1 (MEB Dx 2-3)." MEB Exam 20030117

**NARSUM (date 20020917):** Noted a two-year history of back pain that progressively worsened. The CI had a permanent profile. "He has been followed by multiple different care providers and has had attempted multiple different medications with limited improvement in his symptoms. He has also participated in physical therapy and he fails to progress and show signs of improvement." "His low back pain is worsened by activity as well. It is also aggravated by sitting for prolonged periods." Exam showed "In his low back, he has pain and tenderness to palpation over the left SI joint. He has low back pain with forward flexion. He has aggravation of his low back pain with straight leg raise. There are no radicular symptoms associated with his back pain." "He is neurovascularly intact distally." "…has a bone scan from the 5 February 2002 that shows degenerative versus stress changes within the … sacrum. He has an MRI dated 9 August of 2002 that shows spondylitic disease of L5, S1 with transitional anatomy with lumbarization of S1." "The patient is currently on Peroxin and amitriptyline." "He also does not meet the medical retention standards of AR40-501 Chapter 3, 39-A3 with the MRI consistent with the spondylitic disease of L5, S1 with low back pain and this has limited his ability to participate in physical activities, as well as having persistent pain. The patient also defers surgical intervention at this time, even if any options were available."

**Neuro Addendum noted:** "Back pain and leg pain started when patient was at BNCOC in JUN2001 when he developed low back pain with radiation to left leg. Pain was primary complaint at that time and it limited his ability to complete basic PT test. In addition to the back pain he was also found to have stress fractures of lower extremities. The leg also has been noted to give out when walking up stairs that seems to be related to pain. He also notes intermittent tingling of left ankle which seems to occur more frequently with prolonged standing. The pain will awaken the patient from sleep and so he was placed on Elavil qhs to help with sleep. This medication provided some benefit in sleep but his dose has to be reduced due to side effects in the AM. MEB initiated due to problems with completing PT test without pain. No urinary or bowel incontinence. No diplopia, vision, dysarthria, dysphagia. He does describe loss of grip strength in the hands that was previously evaluated by NNMC Neurology. This hand weakness is typically associated with wrist pain. Has fallen once when leg gave out but otherwise no other falls." PMH**:** Multiple joint pain, Depression. Medications:Elavil & Piroxicam. Detailed neuro/motor exam was normal except for **pinprick mildly decreased over left ankle**; temperature, vibration, joint position sense intact, negative Romberg. "Diagnoses: 1) Chromic Low Back Pain, 2) Depression, 3) Osteoarthritis of multiple joints". Impression: "… he continues to have significant pain complaints limiting his ability to perform PT and certain activities at work. Examination reveals only mild evidence of prior left L5 radiculopathy in decreased sensation at the lateral malleolus but has preserved EHL, TA strength and preserved reflexes throughout the lower extremities. **Prior EMG showed positive waves suggestive of denervation in left TA and lumbar paraspinals which could correlate with radiculopathy but MRI showed foraminal stenosis on the contralateral side**. Currently, there is minimal clinical evidence for radiculopathy and patient's main problems are pain related. Because of his intractable pain refractory to multiple treatment modalities, he is medically unacceptable IAW AR 40-501, Ch. 3-30j."

**VA:** The Veterans Administration (VA) rated this disability as 5293-8521 at 10% using the CI's Service Treatment Records and PEB file.

Rating Decision (date 20030428): The service medical records show you have been treated for chronic low back pain throughout your period of military service. X-rays taken in July 2001 showed mild degenerative disc disease at L5-S1. An examination and study performed in September 2002 showed minimal clinical evidence of radiculopathy and suggestion of a mild, chronic left L5 root lesion. The examiner concluded your main problems were pain related. Service connection for chronic low back condition with radiculopathy has been established as directly related to military service.

There was no disparity between the Service and VA 10% rating for Low Back Pain and both appeared to rely on painful motion. The noted left lower extremity non-pain radiculopathy (paralysis of external popliteal nerve) of "pinprick mildly decreased over left ankle" with a prior abnormal EMG was not to the level of being unfitting and it should not be added as a new unfitting diagnosis. There is no basis for changing the rating for this condition.

**Condition 2: Bilateral degenerative joint disease of the hips, knees and left ankle (MEB #1 [*partial*] and #5)**

PEB: "Bilateral degenerative joint disease of the hips, knees and left ankle. Soldier has been evaluated by Rheumatology without a related diagnosis. Bone scan notes degenerative versus stress changes in these areas. Physical exam notes full ranges of motion with 5/5 muscle strength. Pain is reported with these tests. **Rated at 0% for pain in accordance with the Physical Disability Agency pain policy**."

MEB: "Bilateral degenerative joint disease of **acromioclavicular joints of the shoulders**, hips and knees as well as the left ankle (Medically 2000 Unacceptable, IAW AR 40-501, para 3-39 c)"

**NARSUM (date 20020917):** CHIEF COMPLAINT: This is a 26-year-old male with two-year history of bilateral shoulder pain, back pain, bilateral hip pain, bilateral knee pain left greater than right, and left ankle pain. HPI: "…approximately two years ago, started to develop the above complaints that have progressively worsened over the past two years. He has been on several different profiles and now is on a permanent profile. He has been followed by multiple different care providers and has had attempted multiple different medications with limited improvement in his symptoms. He has also participated in physical therapy and he fails to progress and show signs of improvement. (*deleted shoulders and LBP from this section*) His bilateral hips are also worsened with activity, relieved by rest. His bilateral knees, left greater than right, are aggravated by activity and relieved by rest. All of the above symptoms are never pain-free, but are controllable with rest when he is not active. He also complains of left ankle pain over the same time period again aggravated by activity and relieved by rest. …" Exam: "… His bilateral hips have full flexion to 130 degrees. He has internal rotation to 45 degrees. He has external rotation to 60 degrees. He has 5/5 strength about his hip. He is neurovascularly intact distally. He does also report of pain in the hip joint area with range of motion as well as muscle testing. His bilateral knees have full range of motion from 0 to 130 degrees. There is no varus or valgus instability. There is no tenderness to palpation. There is no joint line tenderness. He has a negative Lachman, negative anterior drawer, negative posterior drawer, and negative McMurray. He again does complain of pain across those joints with motion of those joints. His left ankle has full range of motion from +10 neutral to 40 degrees of plantar flexion. He has a negative anterior ankle drawer. He has no tenderness to palpation. Again, he complains of pain with motion about that ankle. His right upper extremity has 5/5 strength in shoulder abduction, forward flexion, and extension, as well as internal and external rotation. He has 5/5 strength of his elbow flexors and extensors, 5/5 strength in his wrist, extensors and flexors, as well as his finger grasp and finger extension." "Imaging studies in April of 2001: he underwent a bone scan that showed stress changes versus grade I stress fracture to the posterior proximal tibia. Currently the patient has no symptoms associated with this type of injury. It is only mentioned as addition to his Medical Board Summary. The images are not available for review at this time. He also has a bone scan from the 5 February 2002 that shows degenerative versus stress changes within the acromioclavicular joint of the shoulder the bilateral hips, and the sacrum. He has an MRI dated 9 August of 2002 that shows spondylitic disease of L5, S1 with transitional anatomy with lumbarization of S1." DIAGNOSIS: 1. Bilateral degenerative joint disease of his acromioclavicular joints of his shoulders, hips, and knees, as well as his left ankle. 2. He also has spondylitic changes in L5, S1 region. DISPOSITION/RECOMMENDATIONS: The prognosis for this gentleman is poor in a military setting. He will most likely never attain the ability to participate in physical activities, as well as job activities that require effort of any sort. His symptoms will progressively worsen, as well as be detrimental to his psychiatric well-being. This will not be improved by a new geographic assignment or change in MOS. The patient is not qualified for full duty and, in my opinion the patient is currently on a permanent profile. In regards to disposition and recommendations, it is my opinion based on the evaluation of the records and this patient's physical examination, this soldier does not meet medical retention standards of AR40-501 Chapter 3, paragraph C of osteoarthritis of multiple joints, both shoulders, low back, A.C. joints, which that have not failed to respond to conservative measures, as well as failing to respond to physical therapy. These will continue to limit his duty to the point that his pain is debilitating. He also does not meet the medical retention standards of AR40-501 Chapter 3, 39-A3 with the MRI consistent with the spondylitic disease of L5, S1 with low back pain and this has limited his ability to participate in physical activities, as well as having persistent pain. The patient also defers surgical intervention at this time, even if any options were available."

**Neuro Addendum:** "HPI**:** 26 yo RHD AAM referred to neurology for MEB addendum for low back pain, hip pain and radiculopathy." (see condition 1)

**VA:** The Veterans Administration (VA) rated this disability using the CI's Service Treatment Records and PEB file. Their coding was: Bilateral hip condition 10% as 5099-5003, and initially 0% for each knee, left ankle, wrists, and arthralgia. They increased the knees' rating to 10% four years post-separation following a new exam. **Rating Decision (date 20030428):**

**Bilateral hip condition (5099-5003) at 10%:** The service medical records show you complained of bilateral hip pain while on active duty. A body scan conducted in November 2001 showed degenerative changes of the hips. An examination conducted in September 2002 shows you have full flexion to 130 degrees, internal rotation to 45 degrees, and external rotation to 60 degrees. You have full strength of the hips; however, you report pain with range of motion and muscle testing. Service connection for bilateral hip condition has been established as directly related to military service.

An evaluation of 10 percent is assigned from June 13, 2003. A 10 percent evaluation is assigned for painful or limited motion of a major joint or group of minor joints, and may also be applied once to multiple joints if there is no limited or painful motion.

**Left knee condition 5299-5257 at 0%:** The service medical records show you complained of left knee pain while on active duty. X-rays taken in July 2001 showed no evidence of a fracture, loose body, or effusion. There was a 5mm sclerotic density in the central distal femur just inferior to the patella. The impression was no significant degenerative changes and no evidence of fracture or effusion. The examination of September 17, 2002, shows bilateral knees have full range of motion from 0 to 130 degrees; no varus or valgus instability; no tenderness to palpation; and no joint line tenderness. However, you do complain of pain during movement of the knee.

**Right knee condition 5299-5257 at 0%:** The service medical records show you complained of knee pain while on active duty. Xrays taken in July 2001 showed no evidence of a fracture, loose body or effusion. There were no significant degenerative changes shown. The examination in September 2002 shows bilateral knees have full range of motion from 0 to 130 degrees; no varus or valgus instability; no tenderness to palpation; and no joint line tenderness. However, you do complain of pain on movement of the knee.

**Left ankle condition 5299-5003 at 0%:** The service medical records show you sprained your left ankle in 1998. X-rays taken in October 2000 showed the ankle joint was unremarkable; no fracture was noted and the joint spaces were preserved. X-rays taken in July 2001 showed no evidence of fracture and mild degenerative changes. An examination conducted in September 2002 shows the left ankle has full range of motion from +10 neutral to 40 degrees of plantar flexion. There is no tenderness to palpation; however you do complain of pain on motion.

**Arthralgia (claimed as osteoarthritis) of multiple joints to include spine, elbows and wrists 5099-5003 at 0%:** The service medical records show you had complaints of pain in multiple joints; a diagnosis of osteoarthritis of multiple joints was given; however, there is no x-ray evidence showing a diagnosis of arthritis. The examination of September 2002 does not specify which joints are currently affected. Your service medical records reflect treatment for arthralgia of the lumbar spine and lower extremities. Service connection for arthralgia (claimed as osteoarthritis) of multiple joints to include spine, elbows and wrists has been established as directly related to military service. A noncompensable evaluation is assigned from June 13, 2003. A noncompensable evaluation is assigned unless there is objective evidence of painful or limited motion of a major joint or group of minor joints, or multiple joint involvement.

The NARSUM clearly indicated painful motion of the CI's **bilateral** hips, knees and left ankle with full range of motions. Unfortunately, there is no specific degree listed for the onset of, or limitation due to, pain. From analysis of the NARSUM and STR, it is more likely than not that the pain on motion was prior to the full range of motion, especially as muscle testing is accomplished short of the limits of motion for joints. The CI had a 20020205 bone scan that showed degenerative versus stress changes within the acromioclavicular joint of the shoulders and the bilateral hips. The 20010411 bone scan of the lower extremities showed bilateral minor pathology. The left ankle imaging of 20010122 showed osteophytes at the navicular cuneiform joint and an impression of mild degenerative changes. The CI did have some psychological overlay to his painful joints and profile limitation, with his "not unfitting" mental health diagnoses. The VA did not accomplish an exam for their original rating, but used the STR. It is unclear if the VA did not note the abnormal imaging of each joint. The VA RD described painful motion for each joint mentioned in the MEB. They rated the hips together under 5099-5003 at 10%, and initially rated the bilateral knees and left ankle at 0%. The VA raised the knees to 10% each following VA examination in 2007.

The PEB and STR evidence indicated that the bilateral hips, knees and left ankle each had painful motion and DJD. Under historical Army Guidance, only mechanical limitation of motion was typically rated outside of the pain rule. For rating multiple painful joints with degenerative joint disease, absent the Army Pain rule and IAW the VASRD alone, each joint should be considered and rated separately IAW §4.59 Painful motion. VASRD Code 5003, specifies that "Degenerative arthritis established by X-ray findings will be rated on the basis of limitation of motion under the appropriate diagnostic codes for the specific joint or joints involved (DC 5200 etc.). When however, the limitation of motion of the specific joint or joints involved is noncompensable under the appropriate diagnostic codes, a rating of 10 pct is for application for each such major joint or group of minor joints affected by limitation of motion,…" The combining of multiple joints for a single rating under 5003 criteria for 10% is used "In the absence of limitation of motion".

Each joint coded separately (left hip, right hip, left knee, right knee, left ankle) meets the criteria for a 10% rating for DJD and painful motion coded as 5009-5003, or analogously to the specific joint ROM code, IAW §4.59 painful motion.

**Condition 3: Depression; Adjustment disorder with depressed mood (MEB #4 and #6)**

The MEB found these conditions Medically Acceptable, and the PEB found them not unfitting. The 20021010 Psychiatry memo to the PEB clearly lays out the CI's mental health diagnoses and his condition at the time of MEB as Medically Acceptable.

**VA:** The service medical records show that in a Memorandum dated October 10, 2002, from a military psychiatrist it was reported you had a three month history of irritability and anxiety secondary to perceived mistreatment at work because of your physical condition. Your mental state did not significantly hinder your ability to function at work. It was also noted you were receiving psychotherapy from another physician. You were diagnosed with adjustment disorder with mixed anxiety and depressed mood. The examination of September 2002 does not show you have current complaints of depression.

All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the Depression or Anxiety with depressed mood conditions. No mental health diagnosis should be added as unfitting.

**Condition 4: Bilateral degenerative joint disease of acromioclavicular joints of the shoulders (MEB #1 [*partial*])** (*5203* right and left clavicle or scapula)

MEB Diagnoses: 1. Bilateral degenerative joint disease of **acromioclavicular joints of the shoulders**, hips and knees as well as the left ankle (Medically Unacceptable, IAW AR 40-501, para 3-39 c)

PEB: "Bilateral degenerative joint disease of the hips, knees and left ankle. Soldier has been evaluated by Rheumatology without a related diagnosis. Bone scan notes degenerative versus stress changes in these areas. Physical exam notes full ranges of motion with 5/5 muscle strength. Pain is reported with these tests. Rated at 0% for pain in accordance with the Physical Disability Agency pain policy. (MEB Dx **1**, 5)"

NARSUM (20020917) HPI: "Currently he complains of bilateral shoulder pain that is worsened with activity and it has progressively worsened." And, "He also has now developed, over the past one year, right arm weakness, a transient arm weakness that, when participating in activities, he feels his arm occasional gives out or does not have the same strength as his left. This is a transient episode and only usually lasts a second or two and then has returned to full function." Exam: "He has full range of motion with forward flexion to 180 degrees, internal rotation to 60 degrees, external rotation to 45 degrees. He has 5/5 strength about his shoulder joint. All activities as well as muscle testing aggravate his bilateral pain in his shoulders. There is no tenderness to palpation. There is no crepitus. There is no bony abnormality." "His right upper extremity has 5/5 strength in shoulder abduction, forward flexion, and extension, as well as internal and external rotation. He has 5/5 strength of his elbow flexors and extensors, 5/5 strength in his wrist, extensors and flexors, as well as his finger grasp and finger extension." Imaging: "He also has a bone scan from the 5 February 2002 that shows degenerative versus stress changes within the acromioclavicular joint of the shoulders…"

**Addendum (Neuro--undated):** He does describe loss of grip strength in the hands that was previously evaluated by NNMC Neurology. This hand weakness is typically associated with wrist pain. Upper extremity neuro/motor/sensory exams were normal.

**VA:**  Right shoulder and left shoulder conditions have the same Rating Determination language for 10% for each shoulder coded as 5299-5203. The service medical records show you complained on several occasions of bilateral shoulder pain. The examination conducted in September 2002 shows you have full range of motion of both shoulders with forward flexion to 180 degrees, internal rotation to 60 degrees, and external rotation to 45 degrees. You have full strength about the shoulder joints. However, all activities are shown to aggravate the pain in your shoulders. There is no tenderness to palpation; no crepitus; and no bony abnormalities. A whole body scan conducted in November 2001 showed degenerative and/or stress changes within the shoulders. The provisions of DeLuca v Brown in regard to pain, lack of coordination, or fatigability on extended use have been considered. Service connection for right (similar for left) shoulder condition has been established as directly related to military service. An evaluation of 10 percent is assigned from June 13, 2003. An evaluation of 10 percent is assigned if there is a malunion or nonunion of the clavicle or scapula. A higher evaluation of 20 percent is not warranted unless the record shows dislocation of the clavicle or scapula, or nonunion of the clavicle or scapula with loose movement. This disability is not specifically listed in the rating schedule; therefore, it is rated analogous to a disability in which not only the functions affected, but anatomical localization and symptoms, are closely related.

The MEB diagnosis #1 (Medically Unacceptable) described "bilateral degenerative joint disease of acromioclavicular joints of the shoulders," as the first of multiple joints with DJD. The NARSUM and MEB history & physical detail painful motion of both shoulders, with the physical (DD Form 2808 dtd 20030117) specifying #33 upper extremities as abnormal, crepitus left shoulder, and osteoarthritis both shoulders under provider's comments. The CI had an abnormal scan of his bilateral AC joints in 2002. The Neurology MEB Addendum did not assess the bilateral shoulders. The PEB did not address bilateral shoulder condition as either fitting or unfitting; although listing MEB Dx 1 as unfitting, the bilateral DJD of acromioclavicular joints of the shoulders was not part of the PEB disability description. The CI's profile was U2. The CI had documented abnormal imaging of both shoulders with painful motion. The PEB did not address the fitness/unfitness of this condition which was included as part of MEB Dx #1. The PEB may have missed the condition from administrative oversight of listing multiple painful joints with DJD, especially as the Neurology Addendum did not list the shoulder conditions as the original NARSUM did; or, the PEB may have considered the shoulders as "not unfitting" even though not listing them separately as such. It appears from the record that the bilateral DJD of the shoulders could be considered as part of the CI's unfitting multiple painful joints exacerbated by motion or activity, but this is conjecture. The right arm radicular-like symptoms clearly did not rise to the level of being unfitting. The Board must consider if the bilateral shoulders were either 1) intended to be unfitting, but not listed by the PEB as an oversight, or 2) were considered by the PEB to be "not unfitting" (DJD multiple joints) although not explicitly noted. If initially noted as "not unfitting" they should be de novo addressed as possible new unfitting and ratable conditions. If each shoulder were coded separately IAW the VASRD alone, they would be coded at 10% each using 5299-5203 IAW §4.59 painful motion.

Other Conditions: Bilateral Foot Condition; Right Arm Condition

Both of these conditions were addressed in the MEB history and physical and upon review of all available evidence, there is not sufficient evidence to add them as unfitting ratable diagnoses.

Other Conditions. The OSA (Obstructive Sleep Apnea) and flat foot (Pes Planus) conditions were not addressed in the PEB file and are beyond the scope of the Board.

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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 and specified by the PEB, the PEB reliance on the USAPDA pain policy for rating bilateral degenerative joint disease of the hips, knees and left ankle was operant in this case and the condition was adjudicated independently of that policy by the Board.

In the matter of the bilateral degenerative joint disease of the hips, knees and left ankle the Board had to consider the PEB finding of unfit for these joints as administratively final. The Board unanimously recommended that each joint (Left Hip, Right Hip, Left Knee, Right Knee and Left Ankle) be rated separately at 10% each IAW §4.59 painful motion.

In the matter of the bilateral degenerative joint disease of acromioclavicular joints of the shoulders, the Board considered the shoulder conditions de novo for an unfitness determination. The Board opined by a simple majority that given the CI's U2 profile and specific profile duty limitations, lack of Commander's statement mention of duty limitations attributable to the shoulders, and all evidence considered: that the bilateral shoulder condition did not rise to the level of being unfitting and is therefore not ratable.

In the matter of the chronic Low Back Pain condition and IAW VASRD §4.71a, the Board unanimously recommends no recharacterization of the PEB coding or 10% rating.

All evidence considered there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the Depression or Anxiety with depressed mood conditions. The Board unanimously recommends no recharacterization of the PEB adjudication for mental health conditions as not unfitting.

The other diagnoses, OSA and flat foot (Pes Planus) conditions rated by the VA were not mentioned in the Disability Evaluation System (DES) package and are therefore outside the scope of the Board. The CI retains the right to request his service Board of Correction for Military Records (BCMR) to consider adding these conditions as unfitting.

The Board voted 2:1 that the CI be rated as chronic LBP at 10%; and 10% each for Left Hip, Right Hip, Left Knee, Right Knee and Left Ankle IAW VASRD §4.59 and §4.71a, for a combined rating (including bilateral factor) of 50%. The single voter for dissent (combined rating of 60% with adding each shoulder as unfitting and coded as 5299-5203 at 10% each) did not elect to submit a minority opinion.

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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** |
| Chronic Low Back Pain  | 5293-5299-5295 | 10% |
| Left hip Condition | 5009-5252 | 10% |
| Right Hip Condition | 5009-5252 | 10% |
| Left Knee Condition  | 5299-5260 | 10% |
| Right Knee Condition | 5299-5260 | 10% |
| Left Ankle Condition  | 5299-5271 | 10% |
| **COMBINED (Incorporating BLF)** | **50%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090122, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

