RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: ARMY

CASE NUMBER: PD0900094 BOARD DATE: 20100203

SEPARATION DATE: 20060712

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SUMMARY OF CASE: This covered individual (CI) was a Civil Affairs Major, 38A, medically separated from the Army in 2006 after 7 years active and 13 years of combined service. The medical basis for the separation was chronic right knee instability and pain. Member fell while on patrol in mountains in Afghanistan. Initially it felt like a minor injury, but the next morning the knee was very swollen. The CI received five steroid injections in the AOR and redeployed with his unit (not med-evaced). Right knee arthroscopic surgery in Aug 2005 did not result in significant improvement and the CI could not run, ruck march, hike in rough terrain or drive for greater than one hour.

The CI's right knee, post traumatic arthritis with grade IV chondral lesion was determined to be medically unacceptable IAW AR 40-501. The right knee was the only condition listed on the Medical Evaluation Board (MEB) Proceedings. The Narrative Summary (NARSUM) mentioned avulsion fracture of the left ankle in 2005 and fracture of the thoracolumbar spine on a jump which the CI stated was not found until later. Hypertension was mentioned as well as symptoms of depressions that had resolved following 10-12 sessions of counseling and with no chronic medication. The CI was referred to the Physical Evaluation Board (PEB), found unfit for the right knee instability and pain and separated at 20% disability using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Army and Department of Defense regulations.

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CI CONTENTION: The CI states: “The initial board rated my Knee condition as VA code 5257 Knee, other impairment (the VA as post surgery Traumatic Joint Disease assigned code (5010), while not considering the associated damage to my femur (indicated by my surgeon as a "huge crater (full thickness grade IV chondral defect) in his femoral sulcus measuring 2 cm in diameter") 5255 Femur, impairment, Malunion. With marked knee or hip disability appears appropriate for consideration as the chondral defect to my femur that was sustained by trauma in Afghanistan resulting in my knee condition required micro fracture of the femur in an attempt to surgically correct the bone/cartilage damage. This has resulted in functional loss due to absence of part, or all, of the necessary bones, joints and muscles or associated structures, or to deformity, adhesions, and pain. The daily use of braces has allowed continued function despite pain and weakness limiting my motion, alleviated most instability, and the use of hand rails has limited my injuries interference with sitting and standing."

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RATING COMPARISON:

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| **Service PEB** | **VA (6 Mo. after Separation)** |
| **Unfitting Conditions** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| Right Knee instability & pain | 5257 | 20% | 20060522 | R knee, post traumatic DJD | 5099-5010 | **10%** | 20070105 | 20060713 |
|  |  |  | **NARSUM, H&P** | Left Knee Sprain | 5099-5024 | 10% | 20070105 | 20060713 |
|  |  |  | **NARSUM** | Left Ankle | 5271 | 10% | 20070105 | 20060713 |
|  |  |  | **NARSUM** | Lumbar Spine | 5242 | 10% | 20070105 | 20060713 |
|  |  |  | NARSUM | Nummular Dermatitis | 7806 | 0%Then 10% | 20070105 | 2006071320070426 |
|  |  |  | NARSUM | Hypertension | 7101 | 10% | 20070105 | 20060713 |
| **Additional Conditions****(list all PEB conditions)** | **PEB** | **DES****(If Yes, List Where: NARSUM, H&P, Etc)** | **Condition****(list all VA compensable conditions)** | **Code** | **Rating** | **Exam** | **Effective** |
| Depression |  | Mentioned in NARSUM | Adjustment Disorder | 9440 | **30%** | 20080703 | 20071024 |
|  |  | H&P | TMJ | 9905 | DeferredThen**10%** | 20070105 and 20070507 | 20060713 |
|  |  | - | Hemorrhoids | 7336 | Deferred then denied | 20070105 and 20070507 |  |
|  |  | - | Headaches | 8199-8100 | 0% |  | 20071024 |
|  |  | - | Hearing Loss | 6100 | NSC | 20080703 |  |
|  |  | H&P | Tinnitus | 6260 | NSC | 20080814 |  |
|  |  | - | Decrease Vision | 6099-6000 | NSC | 20080703 |  |
| **TOTAL Combined: 20%** | **TOTAL Combined (*Includes Non-PEB Conditions*):**  **50% from 20060713****70% from 20071024**  |

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ANALYSIS SUMMARY: Commander's Statement (20060515) references only the CI's right knee condition. Profile L3S1. The CI's right knee had instability and painful decreased motion post operatively. The Army coded for instability only. The VA 6 months post separation coded for pain limited motion only. No other condition is contended for nor does review of all evidence indicate that any condition other than the right knee should be unfitting.

Condition 1: Right Knee Arthritis

IPEB (20060522): Chronic right knee instability and pain following a fall in 2004 while deployed to Afghanistan that resulted in surgery in August 2005. Soldier complains of pain described as constant of an intensity of 2-10/10 for which he takes non-opioid pain medications. Physical exam demonstrates tenderness to palpation, crepitus and a 2+ Lachmans with a range of motion that was measured as flexion 0-130 degrees. Rated 5257 at 20%.

NARSUM (20060426): The patient states that he had symptom onset while he was in Afghanistan in November 2004. He was on patrol with a Marine unit on a steep rocky hillside. He slipped and fell and states that he rolled about 100 meters. He twisted and landed on his knee. He was seen by a corpsman and took Motrin since he was still in the field. After two additional days in the field, he was seen by a physician at a Forward Operating Base. The doctor thought it was an ACL and meniscus tear, but the unit had no backfill. He got steroid shots in his knee from November through March, a total of five injections and would get relief for 1-2 days after the injection and then his symptoms continually worsened. A new physician arrived and the patient was not given any more shots; he took increased doses of Motrin. He stayed in Afghanistan until July '05 when his Civil Affairs Battalion redeployed. He was seen in a Primary Care Clinic and referred to Orthopedics. He had a scope of his right knee done in Aug '05 and was found to have a Grade IV chondral defect of the medical femoral condyle and ACL laxity. In conjunction with the MEB, he was evaluated by Orthopedics. They note that he had the arthroscopic right knee surgery on 29 Aug 05 and again was found a large Grade IV chondral defect of the trochlear groove in the medial femoral condyle with associated anterior cruciate ligament laxity. He still has pain in his right knee with crepitance with range of motion and recurrent effusion. He is unable to run, ruck, jump, march, or do deep knee bends because of these symptoms which did not improve with operative intervention. On their focused physical exam, his right knee had a moderate effusion and crepitance with range of motion. He had a 2+ Lachman, which was slightly lax with a firm endpoint. He had no tenderness to palpation at the patellar tendon, however deep palpation of the medial femoral condyle with patellar compression he had discomfort. After they reviewed his various imaging studies, their assessment was right knee posttraumatic arthritis With a Grade IV chondral lesion and ACL laxity with chronic pain. They found that he did not meet retention standards per AR 40-501, para 3-14 and 3-41e.

PAST MEDICAL HISTORY: The patient's surgical history includes the right knee scope in 2005, a urethral meatal dilation as an infant and wisdom teeth extraction at age 16. There have been no overnight hospitalizations. Fractures include an avulsion fracture of the left ankle in 'O5, fracture of the right second toe as a child, fracture of the vertebra of the T-spine on a jump which he states was not found until later. Major medical problems have included borderline hypertension for which he is not on any medications-and a weight gain of 50 pounds after surgery. He states that he has subsequently lost 30 of those pounds.

BEHAVIORAL HEALTH HISTORY: In Jan '06 the patient was suffering from symptoms depression. He was on no meds and went to counseling for 10 or 12 sessions and his symptoms resolved. He is not currently seeing anyone in Behavioral Health, has no symptoms, and is taking no medications. REVIEW OF SYSTEMS: Positive only for seasonal allergic rhinitis with which he has coryza, sore throat, and gets some relief with the Benadryl. The remainder of his review of systems was negative for anything not already covered.

PHYSICAL EXAM: Exam of the mouth and throat-notable for erythema of the posterior pharynx secondary to nasal sinus drainage from his allergies. Exam of the lower extremities-he was tender to palpation inferior to the patella and along the medial joint line of the right knee. There was a positive patellar apprehension test bilaterally, right greater than left and palpable crepitance. He was able to heel and toe walk but cannot squat or duck walk because of knee pain. There was no swelling or effusion noted. Exam of the skin- revealed a dark macular rash all over the body, compatible with tinea corporis. The remainder of his physical exam was normal.

IMAGING STUDIES: 21 July 'O5, MRI of right knee, read as-benign cystic lesion in the lateral proximal tibial condyle likely representing an enchondroma. Abnormal linear signal in the posterior horn of the medial meniscus, possibly representing a meniscal tear. 13 Oct 'O5, films of the right knee with tunnel view, read as-findings suggestive of a joint effusion. 12 Jan '06, right knee with tunnel and sunrise views, read as- unremarkable.

DIAGNOSIS: Right knee posttraumatic arthritis with Grade IV chondral lesion. This is disqualifying in accordance with AR 40-501, para 3-14 and 3-41e (1).

Service Treatment records:

Right knee imaging studies in 2005 showed Grade IV chondral defect of the medial Condyle and ACL laxity. Exam showed tenderness, patellar apprehension (R>L), palpable crepitance, and a 2+ Lachmans. CI could not squat or duck walk due to pain. ROM was limited 0-130 degrees (120˚ by PT). Military records demonstrated frequent evaluations of the right knee for pain and swelling. The 20050831 orthopedic statement addressed the chondral defect as being corrected by surgery "so he had a microfracture performed on the defect that will take several months to heal. The ACL was somewhat lax, and may need to be reconstructed in the future depending on symptoms. His torn cartilage had healed by itself in an acceptable position, so it was left alone" Right knee X-ray of 20060112 AP, lateral, sunrise and tunnel views of the right knee were unremarkable.

VA: Using an evaluation completed 20070105; 6 months post separation from the Army, the Veterans Administration (VA) rated this disability as 5099-5010 Status post arthroscopic surgery: post traumatic degenerative joint disease, right knee at 10%.

Rating Decision (200705010): Service connection for status post arthroscopic surgery; post traumatic degenerative joint disease; right knee has been established as directly related to military service. An evaluation of 10 percent is assigned from July 13, 2006. 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. Service medical records show that you sustained a right knee injury in November 2004. An MRI report in July 2005 confirmed post traumatic degenerative joint disease. You subsequently had arthroscopy of the right knee and chondral picking of chondral defect femoral sulcus in August 2005. Medical Evaluation Board dated April 26, 2006, shows that you failed to meet retention criteria. You reported on exam that you have persistent right knee pain with any weight bearing movements. Your right knee has progressively worsened. You reported that you have limitations with standing and walking. You are able to walk and stand for ten minutes solely due to bilateral knee pain. You reported having instability, pain, stiffness and weakness. You reported having flare-ups every two to three weeks with excessive use.

You reported having heat, redness, erythema and right knee tenderness. On exam right knee flexion was shown to be 0 to 110 degrees with pain starting at 90 degrees. Extension was from 110 to 0 degrees. There was no additional limitation of motion with repetitive use. There was no instability, effusion, dislocation or locking noted. You had tenderness, painful movement, guarding of movement. You also had crepitation along with grinding. You had grinding with posterior pressure on patella. Examiner diagnosed status post arthroscopic surgery; post traumatic degenerative joint disease; right knee.

VA Treatment Records: Orthopedic outpatient treatment notes of 20071015, & 31 (and PT note of 20071024) document continued use of knee brace for instability, ongoing multiple knee injections and physical therapy, with a determination to await surgery or total knee replacement due to young age. Knee X-rays of 20070730 showed mild three compartment osteoarthritis with mild medial compartment narrowing.

Discussion. The single MEB diagnosis was "Right knee posttraumatic arthritis with grade IV chondral lesion," so it is clear the PEB considered the femoral defect. They used the knee instability code 5257 and rated it as "moderate". The CI had a 2+ Lachmans and inter-operative assessment demonstrating ACL laxity, but there was no indication of locking or giving way of the knee on any exam. Code 5257 does not rely on either pain or limitation of motion; however, the PEB may have considered all disability due to CI’s right knee decreased flexion and painful motion under that single code. The CI’s contention, specifically mentioned VASRD code "5255, Femur, impairment, Malunion. With marked knee or hip disability" for consideration. Given that the CI had surgical correction of the femoral defect and imaging of the knee in 2006 showed an "unremarkable knee," this does not appear to be a predominate code. If used, it would most likely be at the "Moderate" knee disability 20% level considering the totality of CI's knee exam and post-separation VA exam which demonstrated no worsening of CI's knee condition. The VA rated the CI’s entire right knee as 10% under 5099-5010; Arthritis, due to trauma, substantiated by X-ray findings (tri-compartment arthritis), rating as arthritis, degenerative which precludes combination with ratings based on limitation of motion or codes 5013 to 5024. The VA did not rate the knee for instability, although there are VA treatment notes indicating continued instability and the required use of a knee brace. With the PEB code of 5257, instability, the VASRD permits adding limitation of motion coding. Adding code 5010-5260; traumatic arthritis with pain limited flexion of the knee, at 10% would best align with the CI's disability picture at separation, exam findings and the VA prior rulings for multiple ratings of the knee (VAOPGCPREC 23-97). Adding this code for pain-limited motion is IAW §4.59, painful motion and DeLuca, is consistent with VASRD guidance and was clearly part of the CI's unfit determination. It is possible that the Army PEB may have discounted painful motion (USAPDA Pain policy) or under Service specific guidelines combined painful motion into their instability coding. However, painful motion is not a specific criterion for rating under the instability code and should be separately rated IAW the VASRD alone. It would be difficult to justify decreasing the original PEB rating for right knee instability under code 5257 from 20% (Moderate) to 10% (Slight), given the comprehensive documentation in the STR for imaging defects of the CI's ACL and operative finding of ACL laxity, knee effusion(s) during exam and imaging, and a 2+ positive Lachmans as objective findings of instability. However, CI's statement of instability at his VA exam did not lead the VA to rate the CI for instability given a less dramatic knee exam 6 months post discharge. VA treatment notes did indicate continued use of knee brace for instability and ongoing knee treatments with consideration for surgery. All evidence considered and IAW VASRD §4.3, reasonable doubt is resolved in favor of the CI in recommending separation ratings of Chronic right knee instability, 5257 at 20% and Right knee pain limited motion, 5099-5260 at 10% IAW §4.71a and §4.59.

Other Conditions. The CI's Adjustment Disorder, Left Knee Sprain, Left Ankle, Lumbar Spine, Nummular Dermatitis, Hypertension, and TMJ conditions rated by the VA were mentioned in the NARSUM or MEB history and physical. There were no profile restrictions or Commander's comment on duty restrictions attributable to any of these conditions. All evidence considered the Board 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 right knee may have been operant in this case and the condition was adjudicated independently of that policy by the Board. In the matter of the Right Knee condition, the Board unanimously recommends separately coding the instability and painful motion of the CI's right knee with a rating of Chronic right knee instability s/p trauma, 5010-5257 at 20% and Right knee pain limited motion s/p trauma, 5010-5260 at 10% IAW §4.59. In the matter of the Adjustment Disorder, Left Knee Sprain, Left Ankle, Lumbar Spine, Nummular Dermatitis, Hypertension, and TMJ conditions 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. The Headache condition rated by the VA was not mentioned in the Disability Evaluation System (DES) package and is 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 this condition as unfitting.

The Board deliberated extensively on the appropriate coding for the CI's right knee condition. The PEB found the right knee condition as unfitting and coded the CI's right knee on demonstrated instability (5257 Moderate) that was well documented in the record, as was the CI's history of right knee traumatic injury requiring surgery. The PEB disability description also noted pain limited right knee motion, but did not separately code the right knee for painful motion. IAW VASRD guidance and VAOPGCPREC 23-97, the knee disability for instability and for pain limited motion should be coded separately. The Board determined that adding code 5010-5260; pain limited flexion of the right knee s/p trauma, at 10% would best align with the disability picture, exam findings and be IAW §4.59 in the absence of the Army pain policy. The Board considered, but rejected decreasing the 20% (Moderate) 5257 original coding from the PEB to 10% (Slight) due to the weight of evidence in the STR documenting ACL laxity and effusions and the post-separation continued use of a knee brace and active treatment for knee instability and pain as documented in VA treatment records. IAW §4.3, reasonable doubt was resolved in the CI's favor at keeping the right knee instability rated at the 20% level.

The Board voted unanimously to rate the CI as Chronic right knee instability s/p trauma, 5010-5257 at 20% and Right knee pain limited motion s/p trauma, 5010-5260 at 10%, and to not add any additional unfitting conditions outside of the right knee.

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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 Right Knee Instability s/p trauma | 5010-5257 | 20% |
| Right knee pain limited motion s/p trauma (DJD) | 5010-5260 | 10% |
| **COMBINED** | **30%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090129, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

