RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: army

CASE NUMBER: PD0900253 Separation date: 20061204

BOARD DATE: 20090901

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SUMMARY OF CASE: This covered individual (CI) served as an infantryman and was medically separated from the Army in 2006 after 2 years of service. The medical basis for the separation was chronic neck pain, chronic low back pain, and chronic bilateral knees and left shoulder pain. The left knee pain was due to trauma in Mar 2004, while the right knee, left (non-dominant) shoulder, neck and lower back pain were all insidious in onset (no specific recalled trauma). The CI had arthroscopic meniscal repairs and partial removals on both knees. His treatment was otherwise with medication only and his pain and limitations on carrying and running interfered with the performance of his MOS. The CI was referred to the PEB, found unfit and separated at 20% disability.

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CI CONTENTION: "My mental health records were not included in the Medical Board findings. VA has rated me 100% for PTSD (Post Traumatic Stress Disorder). My physical conditions have not improved and the medical board did not take into fact my future limitations. I have had another surgery on my left knee and awaiting for second on my right." There is an additional four page narrative that expounds on these contentions.

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RATING COMPARISON:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Previous Determinations** | | | | | | | | |
| **Service** | | | | **VA Exam 8 months post discharge** | | | | |
| **PEB Condition** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam Date** | **Effective date** |
| CHRONIC PAIN, BILATERAL KNEES AND LEFT SHOULDER. RATED AS SLIGHT/CONSTANT | 5099 - 5003 | 10% | 20061017 | RIGHT KNEE PAIN, STATUS POST LATERAL MENISCECTOMY | 5260 | 0% | 20070801 | 20061205 |
| LEFT KNEE PAIN, STATUS POST LATERAL MENISCECTOMY | 5260 | 0% | 20070801 | 20061205 |
| LEFT SHOULDER IMPINGEMENT | 5201 | 0% | 20070801 | 20061205 |
| CHRONIC NECK PAIN, WITHOUT NEUROLOGIC ABNORMALITY, CERVICAL ROM LIMITED BY PAIN WITH LOCALIZED TENDERNESS | 5299 -  5237 | 10% | 20061017 | NECK SPASM (CLAIMED AS CERVICAL SPINE CONDITION) | 5237 | 20% | 20070801 | 20061205 |
| CHRONIC LOWER BACK PAIN, WITHOUT NEUROLOGICAL ABNORMALITY, COMBINED THORACOLUMBAR ROM GREATER THAN 240˚ | 5299 -  5237 | 0% | 20061017 | LOW BACK CONDITION | 5237  5237 | Deferred  20% | 20070801  20070822 | 20061205 |
| NOT ADJUDICATED |  |  |  | **PTSD** | **9411** | **100%** | **20070801** | **20061205** |
| - |  |  |  | TINNITUS | 6260 | 10% | 20070801 | 20061205 |
| **TOTAL Combined: 20%** | | | | **TOTAL Combined (*incl non-PEB Dxs)*:  *100***% from 20061205 | | | | |

ANALYSIS SUMMARY:

**Post Traumatic Stress Disorder (PTSD).** PTSD and/or any other mental health diagnosis were not addressed by the MEB, PEB or NARSUM. PTSD was not diagnosed in service. No duty limitations were attributed to any mental health conditions by either profile restrictions or the commander's memo. The CI had a diagnosis of Adjustment insomnia and was on medicine to assist in sleep. Some treatment notes addressed adjustment disorder as a diagnosis and referral for counseling. The commander's memo addressed only bilateral knee pain as unfitting.

The VA conceded a stressor as the CI had been awarded a Combat Infantryman Badge. The VA exam (20070801) was 8 months post discharge (20061204). VA exam noted that the CI had been hospitalized in Jul 2007 and diagnosed with PTSD. Given sleep impairment, nightmares, flashbacks, anger and irritability, memory and concentration impairment, avoidance behavior, hypervigilance, startle response, difficulty with interpersonal relationships and suicidal ideation the VA rated the CI at 100%.

PTSD was not diagnosed in service and nothing in the medical records indicates mental health conditions that would have risen to the unfitting level at the time of service discharge. As there is no indication that any mental health diagnosis was considered within the disability evaluation system, adding or excluding PTSD as an unfitting diagnosis is beyond the scope of the Board.

**CHRONIC PAIN, BILATERAL KNEES AND LEFT SHOULDER.** As noted by the PEB, this was rated IAW U.S. Army Physical Disability Agency Policy/Guidance Memorandum #13, dated 28 February 2005, subject: Rating Pain (*Army pain rule*).

**Right Knee, Chronic Pain.** The CI had an arthroscopy in 2006 for partial removal of right lateral meniscus. Right knee MRI showed intrameniscal signal within the remaining posterior horn of the lateral meniscus and posterior horn and body of the medial meniscus with minimal chondromalacia evident. Plain X-rays were normal. "Physical exam of bilateral knees reveals range of motion bilaterally by goniometer testing of 0˚ **to 120˚** (normal 140). There is normal alignment of bilateral knees. He has a positive grind bilaterally with tenderness to palpation over medial greater than lateral joint lines bilaterally. There is no varus or valgus instability, negative Lachman, and negative drawer. The soldier has pain laterally with McMurray testing in bilateral knees. Pain rating: Bilateral knees - slight/constant.

**Left Knee, Chronic Pain.** The CI had had two arthoscopic surgeries of the left knee. Left knee MRI showed mild diffuse chondral cartilage thinning, particularly in the medial compartment. Plain X-rays (200601) showed mild patellofemoral joint space osteoarthritis and a very small joint effusion. "Physical exam of bilateral knees reveals range of motion bilaterally by goniometer testing of 0˚ **to 120**˚(*normal 140*). There is normal alignment of bilateral knees. He has a positive grind bilaterally with tenderness to palpation over medial greater than lateral joint lines bilaterally. There is no varus or valgus instability, negative Lachman, and negative drawer. The soldier has pain laterally with McMurray testing in bilateral knees. Pain rating: Bilateral knees-slight/constant.

The VA service connected both knees, but rated them at 0% for pain and tenderness. They noted in rating that "The examiner stated repeat arthroscopy would not be beneficial because you needed to lose weight first to see if the pain improved. At your VA exam, you reported you are limited in walking only two blocks due to your knee pain. You have daily flare-ups that are relieved with rest. You described the pain as deep within the knee joints. The examiner noted there was no effusion in the knees. You had tenderness along the medial and lateral joint lines of both knees. Range of motion included extension to 0˚ (normal) and flexion to **110˚** (140 normal), bilaterally. The knees were stable and ligaments were intact to anterior/posterior drawer testing, Lachman test and varus/valgus stress. X-rays showed no degenerative changes. The examiner diagnosed bilateral knee pain with bilateral meniscal tears." The actual exam (8 months post discharge) noted: "Exam shows no effusion. There is tenderness along the media and lateral joint lines of both knees. The range of motion is smooth without patellofemoral crepitus. Range of motion is 1-100˚ (0-140 normal) bilaterally."

RIGHT & LEFT KNEE (Mil exam: 20060810; VA exam: 20070801)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Movement | Normal ROM | ROM Mil | ROM VA | ROM VA PAIN  (# for VASRD) |
| Right Flex | 0 - 140 | **120** | 100 |  |
| Right Ext | 0 - 0 | 0 | 1 |  |
| Left Flex | 0 - 140 | **120** | 100 |  |
| Left Ext | 0 - 0 | 0 | 1 |  |

I cannot reconcile the VA rating given their VA exam findings, except that the examiner did not have MRI results and opined that all of the musculoskeletal pains may have been due to stressors linked to the CI's mental health diagnosis. The Right knee and Left knee demonstrated tenderness and pain, and each had surgery and a limited ROM. There is no indication from the examiners that 120˚of flexion should have been considered normal for this individual; despite the VA examiner's comment on weight loss required prior to any additional surgery. Each knee had abnormal imaging consistent with arthritic changes (Right Chondromalacia; Left joint space osteoarthritis) and IAW §4.59 Painful motion, each knee should be rated at 10%.

**Left Shoulder**. The NARSUM notes an examination of the left shoulder with tenderness to palpation over the deltoid. Forward flexion by goniometer testing is 170˚ (180˚ normal) on the left shoulder compared to 180˚ on the right shoulder with pain in the left shoulder from 150˚ to 170˚. Abduction in the left shoulder is also 170 versus 180 on the contralateral side, again with pain from 80 to 170 (180˚ normal). There is symmetric internal rotation to T-10. Abduction external rotation is noted to be 80˚ (90 normal) on the left shoulder and 90˚ on the right shoulder with abduction internal rotation noted to be 45˚ (90˚ normal) on the left shoulder and 60˚ on the right shoulder. He has a mild Hawkins and Neer test with negative cross-arm and a positive O'Brien. He is unable to lift greater than 20 pounds with the left shoulder without pain and unable to carry rucksack without pain in his back or his knees. Imaging showed evidence of rotator cuff tendinopathy with irregularity and degeneration. Small foci of partial thickness undersurface increased T2 signal intensity suggests small partial thickness tear of the distal supraspinatus tendon.

VA rating of 20070821 "assigned a 0% based on "reduced motion and positive impingement sign." MRI showed evidence of rotator cuff tendinopathy with irregularity and degeneration. There was a suggestion of a small partial thickness tear of the distal supraspinatus tendon. At your VA exam, you reported no specific trauma, but you related the pain to carrying heavy packs while in Iraq. You have a sharp pain that is localized in the trapezius region. Overhead movements are painful. The examiner noted both flexion and abduction were to 140˚ (180˚ normal), but you had pain at 90˚. There was no evidence of instability on load and shift testing. You had a positive impingement sign. X-rays were normal. The examiner diagnosed left shoulder impingement symptoms and later stated your exam was consistent with shoulder impingement." Exam shows pain beginning at 90˚ (180 normal) of abduction, although passively he can get 140˚ of abduction. Forward flexion pain begins at about 90˚ but passively gets up to about 140˚ (180 normal) of forward flexion. Three repetitions of flexion/extension of the left shoulder result in a decrease in range of motion due to DeLuca factors. External rotation is to 80˚ and internal rotation to 45˚ (90 normal). Again, there is pain at the end range of motion here. There is no evidence of left shoulder instability on load-and-shift testing. Tenderness is directly over the trapezius musculature. No tenderness at the AC joint, no tenderness out laterally to the acromion. Positive Hawkins sign, positive Hawthorn test, positive O'Brien's test and positive impingement sign.

LEFT SHOULDER: Mil exam: 20060810 VA exam: 20070801

|  |  |  |  |
| --- | --- | --- | --- |
| Movement | Normal | ROM Mil (NARSUM) | ROM VA |
| Forward Elevation (Flexion) | 0 - 180 | 170 **(pain from 80** – 170**)** | **90**  (Passive to 140) |
| Abduction | 0 - 180 | 170 **(pain from 80** – 170**)** | **90** (Passive to 140) |
| External Rotation | 0 - 90 | 80 | 80 |
| Internal Rotation | 0 - 90 | 45 | 45 |

I cannot reconcile the VA rating given their VA exam findings, except that the examiner did not have MRI results, there was no imaging demonstrating arthritis, and the examiner opined that all of the CI's joint related musculoskeletal pains may have been due to stressors linked to the CI's mental health diagnosis. The left shoulder demonstrated tenderness and pain, and had a limited ROM. The VA exam was significantly worse (pain limited at shoulder level) than the military exam and is adjudged as worsening of the CI's condition over the 8 months following separation. Since there was no evidence of arthritis in the left shoulder, it may be argued that §4.59 painful motion may not apply with code 5003. With clear evidence of impingement and pain-limited abduction at 80˚it might be reasoned that coding 5201 at 20% may be appropriate (limitation at shoulder level ((90˚)). I favor analogous coding under 5099-5003 at 10% given the preponderance of evidence showing at most minimal and episodic shoulder pain at or above the shoulder level.

**CHRONIC NECK PAIN, WITHOUT NEUROLOGIC ABNORMALITY.**  The PEB noted cervical range of motion limited by pain, with localized tenderness. Cervical spine MRI showed no evidence of severe degenerative changes. Examination of the cervical spine reveals the spine to be midline with no obvious abnormalities. Range of motion testing using a goniometer reveals forward flexion of 45˚ (45 normal) and extension of 45˚ (45 normal), which causes pain. Right and left lateral rotation of the cervical spine is symmetric and also limited by pain at 45˚ (80˚ normal). There is tenderness to palpation along the midline, and a positive Spurling on the left side. Pain rating: Lumbar and cervical spine: Intermittent, slight.

The VA assigned a 20% evaluation based on reduced neck motion. There was some radiating symptoms into your hands without focal signs or spasm in the neck. ROM included flexion of 30˚ (45 normal), extension 10˚ (45 normal), left and right rotation 30˚ (80 normal) each and left and right lateral bending 20˚ (45 normal) each. The combined range of motion was 140˚ (340 normal), but you had no additional loss following repetitive movements. X-rays were normal. The examiner diagnosed neck spasm and stated the neck pain is as likely as not related repetitive stress and workload while in service.

**SPINE CERVICAL**: Mil exam: 20060810; VA exam: 20070820

|  |  |  |  |
| --- | --- | --- | --- |
| Movement | Normal ROM | ROM Mil **Positive tender** | ROM VA |
| Flex | 0-45 | 45 (w/pain) | **30** |
| Ext | 0-45 | 45 (w/pain) | 10 |
| R Lat flex | 0-45 | **unk** | 20 |
| L lat flex | 0-45 | **unk** | 20 |
| R rotation | 0-80 | 45 (w/pain) | 30 |
| L rotation | 0-80 | 45 (w/pain) | 30 |
| TOTAL | 340=VA normal | (180 to 270 depending on lat flex) | **140** |

The cervical spine demonstrated tenderness and pain, and had a limited ROM. The VA exam was significantly worse (flexion limited to 30˚ and combined ROM of 140˚) than the military exam and is adjudged as worsening of the CI's condition over the 8 months following separation. The military exam was appropriately rated for tenderness and limited ROM at 10%.

**CHRONIC LOWER BACK PAIN, WITHOUT NEUROLOGIC ABNORMALITY.** The PEB noted combined thoracolumbar range of motion greater than 240˚. MRI of the lumbar spine performed 12 July 2006 showed mild disk bulging and posterior spondylosis at L3-4, L4-5, and L5-S1 with no disk protrusions or spinal canal stenosis. There is mild bilateral neural foraminal narrowing present at both L4-5 and L5-S 1. The lumbar spine is otherwise normal. X-rays showed normal spine. Per the NARSUM, the evaluation of the lumbar spine revealed the spine to be midline with no obvious abnormalities. There was minimal tenderness to palpation. ROM testing by goniometer reveals forward flexion of 45˚ (*90 normal*), extension of 15˚ (*30 normal*), left lateral bend of 20˚ and right lateral bend of 40˚ (*30 normal*). Right and left lateral rotation is symmetric at 30˚ (*30 normal*). Pain rating: Lumbar and cervical spine: Intermittent, slight. There were additional thoracolumbar ROM exams in the treatment records some indicating "normal ROM", some having only partial numerical results (missing some axis of motion). No evaluations noted ROM following repetitive motion, fatigue, or incoordination. No other ROM documented such limited flexion as the NARSUM. The MEB H&P documented tender T-8 paraspinous area, and L-spine areas with motion.

The VA noted a 3 month history of low back pain with an insidious onset, had complaints of intermittent muscle spasm and left lower extremity paresthesia. An MRI showed mild disk bulging and posterior spondylosis at L3-4, L4-5 and L5-Sl. There was mild bilateral neural foraminal narrowing at both L4-5 and L5-S 1. VA treatment records showed continuing complaints of back pain, and daily flare-ups that were moderate in nature and alleviated with rest. The examiner noted there was no spasm or focal tenderness in the low back. Range of motion included flexion of 90˚, extension 20˚, left and right lateral flexion 30˚ each and left and right rotation 45˚ each. Combined range of motion was 260˚ and there was no loss of motion following repetitive movements. Flexion was painful at the end range of the motion. There was no evidence of radiculopathy. X-rays showed no significant degenerative changes. The examiner diagnosed low back spasm.

Although there were no objective findings of disability at the VA exam, your MRI in service showed some disc narrowing, which is the basis for our grant of service connection. Flexion of the lower back is to 90˚ (*90˚ normal*), pain at the end of range of motion. The veteran walks with a non-antalgic gait and can toe-and-heel walk without difficulty. Extension is to 20˚ left and right lateral (*30 normal*), bending to 30˚ rotation to 45˚ bilaterally (*30 normal*). There is no focal tenderness or spasm present in the lower back.

SPINE: **Thoracolumbar** Mil exam: 20060810 VA exam: 20070801

|  |  |  |  |
| --- | --- | --- | --- |
| Movement | Normal ROM | ROM Mil | ROM VA |
| Flex | 0-90 | **45** | 90 (**pain at end of motion**) |
| Ext | 0-30 | 15 | 20 |
| R Lat flex | 0-30 | 40 (30) | 30 |
| L lat flex | 0-30 | 20 | 30 |
| R rotation | 0-30 | 30 | 45 (30) |
| L rotation | 0-30 | 30 | 45 (30) |
| TOTAL | 240=VA normal | **170** | **220**  (('Combined ROM was 260')) |

The PEB rated the thoracolumbar spine at 0% and stated a ROM greater than 240˚. The thoracolumbar spine exam from the NARSUM demonstrated a pain limited ROM with 45˚ of flexion and adding all the ROMs provided a combined ROM of 170˚. It is possible that the 45˚ flexion limitation is an administrative error as there is no mention of pain limited flexion to 45˚ or passive ROM, and this is the same flexion number from the immediately preceding NARSUM paragraph on cervical ROM. Other thoracolumbar exams in the record showed consistently greater thoracolumbar ROM, with many noting "ROM normal." There were few record entries for LBP treatment, no physical therapy entries, and no comment from the Commander regarding LBP. The MEB History and Physical (H&P) and some other AHLTA notes did document thoracolumbar **tenderness**. The VA exam was significantly better 8-9 months post discharge (combined ROM of 220˚) than the military NARSUM exam and could be supportive of the above reasoning or adjudged as improving of the CI's condition over the 8 months following separation. I would place the greatest probative value on the actual H&P exam (hand-written) with tenderness and slightly decreased (non-numeric) pain-limited ROM and rate LBP at 10% IAW either 5237 Lumbosacral strain and the General Rating Formulae for the Spine for tenderness or IAW **§4.59** for painful motion.

TINNITUS. Not unfitting for service.

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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 PDBR to the extent they were inconsistent with the VASRD in effect at the time of the adjudication. PTSD was not addressed in the disability file and is beyond the scope of the Board to address. The linkage of PTSD as a potentially unfitting condition is retained by the ABCMR. The VA's rating of both knees and the left shoulder at 0%, was likely due to lack of abnormal imaging and the examiner's conjecture that those three musculoskeletal pain complaints were potentially due to stressors of the CI's diagnosed PTSD. The Board unanimously agreed that absent the Army pain rule, each knee and the left shoulder should be rated at 10% IAW §4.59 Painful motion. The Board also unanimously agreed that the cervical spine and the lumbosacral spine should each be rated at 10% for tenderness or limited motion. The Board unanimously voted to maintain the 5009-5003 and 5299-5237 coding with each unfitting musculoskeletal diagnosis rated at 10% (x5) for a combined (including the bilateral factor of 1.9%) disability rating level of 40%.

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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 the CI’s prior medical separation.

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| --- | --- | --- |
| Unfitting Condition | VASRD Code | Rating |
| Right Knee, Chronic Pain | 5009-5003 | 10% |
| LEFT Knee, Chronic Pain | 5009-5003 | 10% |
| Left Shoulder Impingement | 5009-5003 | 10% |
| CHRONIC NECK PAIN, WITHOUT NEUROLOGIC ABNORMALITY | 5299-5237 | 10% |
| CHRONIC LOWER BACK PAIN, WITHOUT NEUROLOGIC ABNORMALITY | 5299-5237 | 10% |
| Combined | 40% |
| Note: Bilateral factor of 1.9% included | |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090329, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

