RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: Army

CASE NUMBER: PD1000010 SEPARATION DATE: 20060810

BOARD DATE: 20110629

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SPC/E-4 (14J, Air Defense) medically separated for complex regional pain syndrome (CRPS) of the left foot. His pain started in August 2003 as a result of a fracture to one of the bones in his left foot (2nd metatarsal) and worsened while deployed in support of Operation Enduring Freedom from April 2004 until he had to be medically redeployed in July 2004. He was diagnosed with CRPS as a result of evaluations by various specialists including orthopedics, neurology, physical therapy, and pain management. He did not respond adequately to treatment and was unable to perform within his Military Occupational Specialty (MOS) or meet physical fitness standards. He was issued a permanent L3 profile and underwent a Medical Evaluation Board (MEB). The CRPS condition was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. No other conditions appeared on the MEB’s submission. Other conditions included in the Disability Evaluation System (DES) file will be discussed below. The Informal PEB (IPEB) adjudicated the CRPS as unfitting, rated 20%, with application of the Veterans’ Administration Schedule for Rating Disabilities (VASRD). The CI made no appeals, and was medically separated with a 20% disability rating.

CI CONTENTION: The CI states that ‘‘I was given a rating of 20% for my foot injury, which occurred during Basic Training and further aggravated during my deployment to Afghanistan in 2004. I feel that I should have been given a 40% rating for the loss of use of my left foot. I am unable to walk without assistance of crutches or a cane. I cannot stand for more than 2 minutes without assistance. … [enumerates other current impairments] … The VA gave me a rating of 51% [*sic*] for my left foot injury. The VA also rated me at 20% for mechanical low back pain, to give me a Global Assessment of Functioning score of 60. I feel that I should have also been rated for anxiety and depression. I have panic attacks under stressful situations. I also have had suicidal thoughts and was diagnosed with PTSD at the VA.”

RATING COMPARISON:

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| --- | --- |
| **Service IPEB – Dated 20060329** | **VA (3 Mo. After Separation) – All Effective 20060811** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Complex Regional Pain Syndrome, L. Foot | 8799-8720 | 20% | Fracture L 2nd Metatarsal w/CRPS  | 5284 | 30% | 20061102 |
| Pain Disorder a/w Fracture/CRPS | 9422 | 30% | 20061014 |
| ↓No Additional MEB/PEB Entries↓ | Mechanical Low Back Strain  | 5237 | 20% | 20061102  |
| GE Reflux Disease | 7346 | 0% | 20061102 |
| **Combined: 20%** | **Combined: 60%** |

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impairment with which his service-incurred condition continues to burden him. It is a fact, however, that the DES has neither the role nor the authority to compensate service members for anticipated future severity or potential complications of conditions resulting in medical separation. This role and authority is granted by Congress to the Veterans Administration. The Board utilizes VA evidence proximal to separation in arriving at its recommendations; and, DoDI 6040.44 defines a 12 month interval for special consideration to post-separation evidence. The Board’s authority as defined in DoDI 6040.44, however, resides in evaluating the fairness of DES fitness determinations and rating decisions for disability at the time of separation. Post-separation evidence therefore is probative only to the extent that it reasonably reflects the disability and fitness implications at the time of separation.

Complex Regional Pain Syndrome. CRPS is a fairly uncommon, but well recognized, peripheral nerve dysfunction following (often minor) trauma. It is characterized by hypersensitivity of the involved nerve and results in severe persistent pain out of proportion to that expected from the injury. There are no ancillary or exam findings which are expected to be abnormal or diagnostic. The CI’s case is typical, and the diagnosis was corroborated by multiple examiners. The CI underwent a multi-specialty evaluation which included multiple specialized imaging and ancillary studies, without evidence of any alternate etiology. The action officer concurs with the diagnosis and opines that the severity of symptoms evidenced in this case is consistent with CRPS as the sole etiology; and, the Board finds no probative value concerns relative to the stated severity of the associated disabilities. On the VA compensation and pension (C&P) examinations, the CI complained of “horrible, unretractable [*sic*] pain in the left foot.” The pain was constant and worse with any weight-bearing activities, such that he was unable to put any pressure on the foot, walk, or stand. He complained of weakness, fatigability, heat, redness, stiffness, and swelling. He was unable to put the left foot to the ground to support himself, and when not in his wheelchair he had to hop on the right foot to get around. The CRPS condition clearly had an occupational impact on the CI in that it prevented him from doing any occupation that would require him to stand and walk. While in the military, his activity was limited by “mild constant pain and severe pain when he applies any amount of pressure to his foot”, as validated by the commander’s statement. At home his activities of daily living were severely hampered because he was unable to walk. Objectively, he was noted to have atrophy of the left calf as compared to the right; coolness of the left foot; pain to palpation of the left foot such that he tended to draw away because of the pain; decreased light touch sensation; withdrawal type pain when tested for vibratory sensation; give-away weakness in the left lower extremity when he tried to walk or stand; painful motion of the left foot; edema; and decreased range of motion (ROM) of all left foot digits with exacerbation by repetitive motion. Pertinent negatives were a normal cerebellar exam; normal deep tendon reflexes; no atrophic changes; and normal range of motion of the ankle. The MEB examination was consistent with the findings of the C&P examiners as described above, although the CI was not in a wheelchair at that time. He was using crutches to ambulate with no ability to weight bear on the left lower extremity due to the severity of his pain. The foot demonstrated increased sensitivity to pinprick and intense pain with minor stimuli when the surface hairs were brushed; strength was mildly decreased at the ankle and there were modest limitations of ankle ROM.

The Board directs its attention to its rating recommendations based on the evidence just described. The NARSUM done seven months prior to separation had to be augmented with a neurology evaluation done 17 months prior to separation (March 2005) in order to give a clear depiction of the CI’s symptoms and findings. The VA C&P general examination done three months post separation and the focused VA C&P examination on the feet and spine done two and one half months post examination were both more proximate to the date of separation and more detailed in respect to the clinical symptoms and findings. Upon deliberation the Board agreed that the VA C&P examinations were more reflective of the severity consistent with the clinical pathology as it existed at separation. The Board therefore relied more heavily on the VA C&P examinations as regards to its coding and rating recommendations. The MEB evaluation and Service clinical records retained relevant probative value and did not contradict the VA evidence.

The PEB and VA chose different coding options for the condition. The VA applied a mental health disorder (Code 9422 - Pain Disorder) and a musculoskeletal disorder (Code 5284 - Foot Injury, Other), providing for separate 30% ratings under each code. The PEB applied an analogous peripheral nerve code (8799-8720 – Neuralgia, Sciatic) to achieve a 20% rating (‘moderate’ severity). The Board judged that the VA, by treating the symptoms associated with the CRPS as a residual of both the mental health disorder and the musculoskeletal disorder, i.e., evaluating the same disability under different diagnoses, was dubiously compliant with VASRD §4.14 (avoidance of pyramiding). The Board furthermore disagrees with Code 9422, Pain Disorder. Pain Disorder is a subset of the somatoform disorders and, by definition, represents a psychiatric condition because an individual’s physical symptoms cannot be fully explained by a medical disorder, substance use, or another mental disorder. That would not apply in this case since CRPS is a neurologic disorder affecting the central and peripheral nervous systems. The fact that CRPS is a medical disorder and can explain the physical symptoms presented by the CI would contradict the validity of assigning the 9422 code for separate rating. Even if this objection were conceded, the psychiatric diagnosis did not exist at separation and could not be linked to fitness or otherwise considered eligible for Service rating.

Having agreed that this case is more appropriately rated under a single code, the Board deliberated the choice of the best code under which to confer a fair rating recommendation. The VA’s choice, 5284, is open to question since the radiological evidence points to the fact that the foot injury per se, i.e. the metatarsal fracture, was resolved. Since CRPS could be considered a sequala of the foot injury, however, the 5284 code can be considered applicable especially if it supports a higher rating IAW VASRD §4.7 (higher of two evaluations). The only rating advantage conferred by 5284 over the PEB’s coding route for peripheral nerve impairment is that 5284 allows for a 40% rating if the disability is equivalent to the actual loss of the foot (as contended). VASRD §4.63 states that loss of use of a hand or foot “will be held to exist when no effective function remains other than that which would be equally well served by an amputation stump at the site of election below elbow or knee with use of a suitable prosthetic appliance”. An argument can be made that the severity of the pain and disability associated with the CRPS condition in this case was actually worse than that which would be expected to result from amputation and prosthesis. Conversely it was argued that the anatomically intact foot could not be compared to the disability incurred by amputation. Board consensus after deliberating this question was that §4.63 is not applicable to the circumstances of this case, and thus the 5284 code offers no rating advantage and is not recommended for the other reasons elaborated above. It is easily concluded that the pathology of CRPS is a better clinical fit with a peripheral nerve code. The Action Officer opined that anatomic localization of the CI’s neuropathy was not at the sciatic level, as coded by the PEB, but rather at the level of the common peroneal nerve (codes 8521-paralysis, 8621-neuritis, or 8721-neuralgia). VASRD Code 8621, neuritis, applies when the CI’s findings are characterized by a loss of reflexes, muscle atrophy, sensory disturbances, and constant pain (at times excruciating) IAW VASRD §4.123; and the condition is to be rated on the scale provided for injury of the nerve involved, with a maximum equal to severe. The Board agreed that these elements were closely approximated by the clinical evidence, justifying application of the 8621 code and rated for severe impairment. After due deliberation, and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a separation rating of 30% for the left foot condition.

Other Contended Conditions. The CI’s application asserts that compensable ratings should be considered for mechanical low back pain, anxiety, and depression. The CI’s mechanical low back pain was first noted in the service treatment record (STR) in July 2004 (25 months prior to separation). The CI indicated that the pain was related to the onset of his CRPS; and his examination consisted of localized low back pain and paraspinous muscle tenderness, stiffness, painful motion, and a normal neurological exam. The condition was not implicated in the commander’ statement submitted one year prior to separation; there was no mention of lumbar complaint on the narrative summary (NARSUM) done 7 months prior to separation; and the condition was not identified on the permanent physical profile signed five months prior to separation. For the depression or anxiety conditions, there is nothing in the DES file or the STR to adequately support the presence of unfitting psychiatric impairment. The CI carried no specific psychiatric diagnosis and his only psychoactive medications were prescribed for his foot neuropathy. Even though the CI indicated in his personal statement of 9 March 2006 that he had to “battle with depression and intense stress about the injury” [i.e., CRPS], there was nothing to indicate that he sought professional guidance specifically for depression or anxiety prior to separation. These conditions were not profiled and were not implicated in the commander’s statement. All of these conditions were reviewed by the action officer and considered by the Board. There was no evidence for concluding that any of the conditions interfered with duty performance to a degree that could be argued as unfitting. The Board determined therefore that none of the stated conditions were subject to Service disability rating.

Remaining Conditions. Other conditions identified in the DES file were right knee pain and headaches. Several additional non-acute conditions or medical complaints were also documented. None of these conditions were clinically active during the MEB period, none carried attached profiles and none were implicated in the commander’s statement. These conditions were reviewed by the action officer and considered by the Board. It was determined that none could be argued as unfitting and subject to separation rating. Gastroesophageal reflux disease was noted in the VA rating decision proximal to separation, but was not documented in the DES file. 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 Board, therefore, has no reasonable basis for recommending any additional unfitting conditions for separation rating.

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. The Board did not surmise from the record or PEB ruling in this case that any prerogatives outside the VASRD were exercised. In the matter of the CRPS condition, the Board unanimously recommends a rating of 30% coded 8699-8621 IAW VASRD §4.124a. In the matter of the mechanical low back pain, anxiety, and depression or any other medical conditions eligible for Board consideration; the Board unanimously agrees that it cannot recommend a finding of unfit for additional rating at separation.

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** |
| Complex Regional Pain Syndrome, Left Foot | 8699-8621 | 30% |
| **COMBINED** | **30%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20100104, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

