RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: . BRANCH OF SERVICE: ARMY

CASE NUMBER: PD1001103 DATE OF PLACEMENT ON TDRL: 20050607

BOARD DATE: 20120127 Date of Permanent SEPARATION: 20070227

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SSG/E-6 (11B, Infantryman) medically separated for posttraumatic stress disorder (PTSD) and reflex sympathetic dystrophy (RSD) of the right (dominant) hand. The conditions were sequelae of trauma sustained while deployed to Iraq in 2004. The Diagnostic and Statistical Manual of Mental Disorders (DSM IV) criteria for an Axis I diagnosis of PTSD were met, and specialists in orthopedics and pain management concurred with the diagnosis of RSD. Neither condition responded adequately to treatment, and the CI unable to perform within his Military Occupational Specialty (MOS) or meet physical fitness standards. He was consequently issued permanent U3 and S3 profiles, and referred for a Medical Evaluation Board (MEB). PTSD and ankylosis (frozen joint)/RSD of the right long finger were forwarded to the Informal Physical Evaluation Board (IPEB) as medically unacceptable conditions IAW AR 40-501. No other conditions appeared on the MEB’s submission. Other conditions included in the NARSUM and disability Evaluation System (DES) file will be discussed below. The IPEB adjudicated the PTSD and right hand conditions as unfitting, rated 10% and 10% respectively, with application of Department of Defense Instruction (DoDI) 1332.39 and the Veterans Administration Schedule for Rating Disabilities (VASRD), respectively. The CI did not concur with the decision of the IPEB and requested a formal hearing. Prior to convening the Formal PEB (FPEB), additional examinations were requested; and, as a result, the MEB’s DA Form 3947 was modified to include depressive disorder as a third medically unacceptable condition. The modified MEB submission was readjudicated by the IPEB and there was no change in regard to the PTSD and right long finger conditions; however, a third unfitting condition was added: right index finger limitation of motion, rated 10% with application of the VASRD. The depressive disoder was determined to be not independently unfitting. The CI was placed on the Temporary Disability Retired List (TDRL) for a period of 21 months until it was determined that all conditions were sufficiently stable for final adjudication. The IPEB at permanent separation combined the RSD and finger conditions, rated 10% each, as one unfitting condition rated 20% with application of the VASRD. The PTSD condition was permanently rated 0%, with presumptive re-application of DoDI 1332.39; and, the depressive disorder was again determined to be not unfitting. An appeal for a Formal PEB was withdrawn, and the CI was medically separated with a 20% combined disability rating.

CI CONTENTION: The application states “I was assigned less than 50% disability rating by the military for my unfitting PTSD upon discharge from active duty. … assign the highest final disability rating applicable consistent with 38 CFR 4.I29 and DOD policy…” He additionally lists all of his VA conditions and ratings as per the rating chart below. A contention for their inclusion in the separation rating is therefore implied.

RATING COMPARISON:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Final Service IPEB – Dated 20070727** | | | | **VA – All Effective Date 20050607** | | | |
| **Condition** | **Code** | **Rating** | | **Condition** | **Code** | **Rating** | **Exam** |
| **On TDRL – 20050607** | **TDRL** | **Sep** |
| RSD Right Hand\* | 8599-8512 | 20% | 20% | Loss of Use of Right Hand | 5125 | 70% | 20050816 |
| PTSD | 9411 | 10% | 0% | PTSD with Depression | 9411 | 50% | STR\*\* |
| Depressive Disorder | | Not Unfitting | |
| ↓No Additional MEB/PEB Entries↓ | | | | Low Back Pain | 5237 | 10% | 20050816 |
| R Hip Residuals of Bone Graft | 5252 | 10% | 20050816 |
| Residuals/ Neck GSW | 5323 | 10% | 20050816 |
| Tinnitus | 6260 | 10% | 20050826 |
| 0% x 1/Not Service Connected x 8 | | | 20050816 |
| **Final Combined: 20%** | | | | **Combined: 90%** | | | |

\* At time of placement on TDRL, this condition was rated as two conditions – ankylosis with RSD of long finger coded 5226 at

10% and right index finger limitation of motion coded 5229 at 10%. \*\* Service Treatment Record.

ANALYSIS SUMMARY: The Board acknowledges the CI’s contention that suggests Service ratings should have been conferred for other conditions documented at the time of separation. The Board wishes to clarify that it is subject to the same laws for service disability entitlements as those under which the DES operates. While the DES considers all of the service member's medical conditions, compensation can only be offered for those medical conditions that cut short a Service member’s career, and then only to the degree of severity present at the time of final disposition. However the Department of Veterans’ Affairs (DVA), operating under a different set of laws (Title 38, United States Code), is empowered to compensate all service-connected conditions and to periodically reevaluate said conditions for the purpose of adjusting the Veteran’s disability rating should the degree of impairment vary over time.

Right Hand Condition. RSD (interchangeable with the currently preferred, and VA applied, nomenclature of complex regional pain syndrome, CRPS) is a fairly uncommon, but well recognized, peripheral nerve dysfunction following trauma. It is characterized by hypersensitivity of the involved nerves 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 for the diagnosis, and his reported severity of symptoms is concordant with the condition. The CI sustained gunshot wounds (GSW) and shrapnel injuries to his neck, face, and right hand during combat operations. He suffered loss of bone in the right hand which required fusion of the proximal interphalangeal (PIP) joint of the right long finger via a bone graft from the right hip. He subsequently developed CRPS. The diagnosis was established by orthopedic and physiatrist consultants; with symptoms of constant pain, allodynia (pain from light touch or slight pressure), temperature asymmetry, skin changes, weakness, and decreased range-of-motion (ROM). There was also significantly limited ROM and PIP ankylosis of the right long finger as a residual of trauma, rather than a consequence of CRPS. Various trials of treatment directed at CRPS were unsuccessful in relieving the CI’s symptoms. At the VA Compensation and Pension (C&P) examination (two months after temporary retirement), the CI complained of constant pain that required regular use of narcotics for pain control; loss of ROM; decreased grip and weakness; abnormal sensation with tingling and numbness; and loss of use of the right long finger. The neurologic exam was positive for decreased grip strength of the right hand and decreased pinprick sensation along the back of the right long finger. The muscle groups impacted by the injury included the intrinsic muscles of the right hand which impaired the CI’s coordination and grip strength. Despite these findings, the CI was able to perform activities of daily living and worked in assembly at a faucet factory; although, examples were cited for inability to perform common fine motor tasks with the right hand. The orthopedic addendum to the narrative summary (NARSUM) at the time of temporary retirement documented a painful, deformed right long finger. There was no active motion at the distal interphalangeal joint (DIP) joint and only 10⁰ of passive motion. The PIP joint was fixed at 40⁰ of flexion and angulated 25⁰ such that the finger significantly overlapped the right ring finger. The metacarpophalangeal (MCP) joint flexed to 85⁰ and extended to 0⁰. The orthopedist indicated that the ankylosed finger “gets in the way of anything requiring lifting, fine motor control, grasping, writing, and using a keyboard. He clearly cannot fire a weapon.” He further opined that the CI’s prognosis was “poor because the hand will always be a function problem.” A ROM evaluation from occupational medicine more proximate to TDRL placement is also in evidence (requested by the PEB because the above examination was now outdated). This more proximate examination documented similar marked ROM limitation at the MCP, PIP, and DIP joints of the right long finger; bony ankylosis of the PIP and functional ankylosis of the DIP; and, modest ROM limitations at the contiguious index and ring fingers.

At the time of the final TDRL evaluation, the findings were similar; but the intensity and location of the pain had changed. The pain was worse and was now radiating up the entire arm. Objectively, the hypersensitivity extended to the entire hand and the remaining neurologic findings were similar to those at the time of temporary retirement. The CI had taken a new job as a fork lift operator, but had to reduce his hours due to this pain. Major complaints included limited use of the right hand, although he was able to write and use a computer “somewhat.” Formal ROM measurements of the fingers were not repeated at this time, but informal observations were consistent with previous measurements. It is also noted that the similar results from the sequential measurements over time, as cited in the MEB evidence, suggest a stable and permanent functional impairment of right long finger mobility. Diagnoses at the time of permanent separation included CRPS affecting the right upper extremity, but predominantly the hand and ankylosis of the PIP joint, right long finger. The orthopedic surgeon opined that the condition was stable and that the CI had “limited use of his right hand primarily because of pain but also because of the loss of motion of the long finger.”

The Board directs its attention to its rating recommendations based on the evidence just described. It is clear from the clinical records that the CI’s functional impairment stemmed both from the neuropathic CRPS condition and the functional impairment of the right long finger; both sequelae of the combat injury. As previously note, the PEB applied different coding approaches at the time TDRL placement and at final separation. The IPEB commencing TDRL applied separate 10% ratings for the long and index fingers, confining RSD impairment to the long finger. The permanent rating (although the documented ratable evidence had not significantly changed) incorporated the entire disability as RSD coded analogously under the peripheral nerve code 8599-8512 (lower radicular group) and rated at 20% (mild). The VA (also without any significant evolution of ratable data) initially rated only the right long finger (20% with application of the amputation rule); but, then (incorporating all of the CRPS and finger impairment) conferred a 70% rating under the 5125 code for loss of use of the dominant hand. All members agreed that the latter VA strategy was far excessive for the significant and well documented residual functional capacity of the hand. All members did agree however, that both the RSD (CPRS) impairment and the right long finger impairment were well supported by the evidence as separately unfitting and separately ratable conditions for Service disability. Regarding the finger rating, the specific code 5226 (long finger, ankylosis of) allows a maximum rating 10% for either favorable or unfavorable ankylosis. There is no ready rationale for applying the amputation rule, since the pathology is clearly no worse than unfavorable ankylosis of the finger, and any attendant pain or other impairment would be pyramided if incorporated with a separate CRPS rating. Regarding a rating for the CRPS condition, all members agreed that the applicable code was 8599-8512 as applied by the PEB; but, deliberation ensued as to whether the 20% rating for “mild” or the 40% rating for “moderate” was most consistent with the evidence. It was concluded that the modest occupational constraints and basic functional integrity (minus the separately rated finger impairment) in evidence was consistent with the 20% rating. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends separate disability ratings attendant to the right hand injury: a 20% rating for RSD (CRPS) coded 8599-8512; and, a 10% rating for the right long finger ankylosis coded 5226. All members agreed that these ratings were fairly applied to the TDRL and permanent recommendations.

PTSD Condition. The PEB rating, as described above, was derived from DoDI 1332.39 and preceded the promulgation of the National Defense Authorization Act (NDAA) 2008 mandate for DoD adherence to the Veterans Administration Schedule for Rating Disabilities (VASRD) §4.129. IAW DoDI 6040.44 and DoD guidance (which applies current VASRD 4.129 to all Board cases), the Board is obligated to recommend a minimum 50% PTSD rating for a retroactive six-month period on the Temporary Disability Retired List (TDRL). Since the Service was in compliance with the §4.129 TDRL requirement, the Board need not apply a constructive TDRL rating interval in this case; although the 50% minimum TDRL rating remains applicable as held by Federal court in the *Sabo, et al v. United States* class action settlement. The Board must then determine the most appropriate fit with VASRD 4.130 criteria at the end of the TDRL interval for its permanent rating recommendation. The most proximate source of comprehensive evidence on which to base the permanent rating recommendation in this case is the TDRL psychiatric re-evaluation performed one month prior to permanent separation. There were no VA psychiatric evaluations or treatment during the TDRL period.

The severity of the CI’s PTSD condition at the time of temporary retirement could best be described as moderate. The psychiactric addendum submitted to the MEB documented flashbacks, intrusive memories, physiologic response to triggers, sleep disturbance/nightmares, avoidance, emotional withdrawal, and anhedonia. The mental status exam (MSE) documented mood and affect disturbance with a withdrawn but cooperative attitude, and moderate psychomotor retardation. The rest of the exam was normal, including the absence of suicidal/homicidal ideation or psychotic/delusional content, and cognitive performance was normal. The CI was engaged in group therapy and compliant with psychotherapeutic medications at the time he was released on TDRL. His sole occupational responsibility was to work a 24-hour staff duty rotation once every five days, but no psychiatric impairment was documented by the commander. The Global Assessment of Functioning (GAF) score assigned by the MEB psychiatrist was 53, which was indicative of moderate impairment.

At the time of permanent separation, the TDRL psychiatric examiner documented the presence of chronic dysphoria, sleep disturbance/nightmares, physiologic reactions to triggers, and episodic alcohol use on weekends. It was noted that the CI had not been compliant with medication (stating they made him feel “like a zombie”) or psychiatric follow-up (“claims they told him they couldn’t help him”). The MSE was positive for dysthymic mood, limited judgment (given non-compliance with treatment), and limited insight (in terms of minimizing alcohol intake). The MSE and cognitive exam was otherwise normal. Occupationally, the CI had made a geographic move and was employed in an industrial setting. His only work loss and occupational impairment was clearly ascribed to his physical disabilities. Socially, he had separated from his wife and relocated to this father’s home, establishing a stable relationship with a girlfriend. His outside social and recreational functioning was not elaborated. The GAF assignment was 62, indicative of mild impairment and the DoDI 1332.39-defined social-industrial impairment was assessed as “mild.” The TDRL psychiatrist opined, “high index of suspicion for alcohol abuse that could be contributing to mood/anxiety symptoms, particularly in combination with opiate analgesics. Despite his reported psychiatric symptoms, he has been able to work and entered into a new relationship. No acute safety issues. Recommend that the CI be considered for permanent retirement. The patient would not be able to tolerate the stress of combat if he were to return to active duty.”

The Board directs its attention to its rating recommendations based on the evidence just described. As regards the permanent rating recommendation, the evidence suggests that there was no psychiatric impairment to civilian occupational functioning at the time of medical separation. There was sparse evidence relative to social impairment; although, it may be assumed that there was some adverse impact on the CI’s domestic life from his psychiatric condition. Members readily agreed that the 50% TDRL rating could no longer be supported by VASRD §4.130 criteria. The Board deliberated therefore between a 10% (mandated as a minimum by the PEB adjudication) vs. a 30% permanent rating recommendation. An argument for a 10% permanent rating can be sustained by the §4.130 description for that rating, i.e., “occupational and social impairment due to mild or transient symptoms which decrease work efficiency… only during periods of significant stress or symptoms controlled by continuous medication.” As noted above, the evidence points to no decreased work efficiency and only speculative social impairment; with or without reference to stress. Although symptoms were not fully controlled, the CI had himself abandoned treatment; and, the symptom severity at that time does not serve as a valid measurement for permanent psychiatric disability, which should reflect the severity of the condition in a stable and treated state. The Board concedes that the assumed alcohol abuse during that period could have itself been a manifestation of PTSD; but, does not concede that the impairment from untreated alcohol abuse due to untreated psychiatric illness should reasonably reflect an expected permanent state of affairs, or coincide with the intent of §4.129. The 30% rating IAW VASRD §4.130 requires “occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks.” Some level of work inefficiency might be expected to result from the reported symptoms; although, there was no documented evidence of such, and the evidence clearly indicates that there were no “intermittent periods of inability” relative to occupational capacity based on psychiatric impairment. Conversely, the members agreed that the CI’s symptoms at the time of permanent separation could not be fairly characterized as “transient” or “mild,” although deliberated as to whether or not there was any presumptive social or occupational impairment to which to attach a higher rating. After due deliberation and in consideration of all the evidence and reasonable doubt, the Board recommends 10% as the fair permanent separation rating for PTSD in this case.

Other PEB Conditions. The only other condition forwarded by the MEB and adjudicated as not unfitting by the PEB was depressive disorder. However, any disability associated with the depressive disorder is subsumed in the §4.130 rating for the PTSD condition as recommended above; therefore, any discussion of rating based on the appropriateness of the PEB’s fitness adjudications for depressive disorder is moot. The Board therefore finds no practical basis for changing the PEB’s fitness adjudication regarding the depressive disorder.

Other Contended Conditions. The CI’s application asserts that compensable ratings should be considered for low back pain, right hip residuals related to his bone graft, residuals related to his neck gun shot wound, and tinnitus. Intermittent low back pain started in 1993 and was not associated with any radicular symptoms. Entries relative to the back condition are sparse in the Service medical records, and the MEB physical documented a normal spine exam. The VA C&P examination proximate to temporary retirement indicated that the condition did not cause any incapacitation or lost time from work. Neither this condition or any of the other three conditions were of clinical or occupational significance during the MEB period; none carried attached profiles; and, none were 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 pes planus; varicocele; hypercholesterolemia; chronic elbow, knee, and wrist pain; heartburn; dizzy spells; and syncope. Several additional non-acute conditions or medical complaints were also documented. None of these conditions were of clinical or occupational significance 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. No other conditions were service connected with a compensable rating by the VA within twelve months of separation or contended by the CI. 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. In the matter of the right hand condition, the Board unanimously recommends that it be rated for two separate unfitting conditions, both for the period of TDRL and at the time of permanent separation, as follows: reflex sympathetic dystrophy of the right hand, coded 8599-8512 and rated 20% IAW 4.124a; and, ankylosis of the right long finger, coded 5226 and rated 10% IAW VASRD §4.71a. In the matter of the posttraumatic stress disorder, the Board unanimously recommends a 10% permanent rating at the time of permanent separation IAW VASRD §4.130. In the matter of the depressive disorder condition, the Board unanimously recommends no change from the PEB adjudication as not unfitting. In the matter of the contended back pain, tinnitus, right hip and neck conditions; the Board unanimously agrees that it cannot recommend a finding of unfit for additional rating at separation. The Board unanimously agrees that there were no other conditions eligible for Board consideration which could be recommended as additionally unfitting for rating at separation.

RECOMMENDATION:

The Board recommends that the CI’s prior determination be modified to reflect a rating of 60% for the 21-month TDRL period following the CI’s prior medical separation and then a permanent 40% disability retirement as indicatedbelow.

|  |  |  |  |
| --- | --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **TDRL RATING** | **PERMANENT**  **RATING** |
| Post-Traumatic Stress Disorder | 9411 | 50% | 10% |
| Reflex Sympathetic Dystrophy, Right Hand | 8599-8512 | 20% | 20% |
| Ankylosis, Right Long Finger | 5226 | 10% | 10% |
| **COMBINED** | **60%** | **40%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20100805, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans Affairs Treatment Record

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President

Physical Disability Board of Review

SFMR-RB

MEMORANDUM FOR Commander, US Army Physical Disability Agency

.2900 Crystal Drive, Suite 300, Arlington, VA 22202

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation

for .

1. Under the authority of Title 10, United States Code, section 1554(a), I approve the enclosed recommendation of the Department of Defense Physical Disability Board of Review (DoD PDBR) pertaining to the individual named in the subject line above to constructively place the individual on the Temporary Disability Retired List (TDRL) at 60% disability for six months effective the date of the individual’s original medical separation for disability with severance pay and then following this six month period recharacterize the individual’s separation as a permanent disability retirement with the combined disability rating of 40%.

2. I direct that all the Department of the Army records of the individual concerned be corrected accordingly no later than 120 days from the date of this memorandum:

a. Providing a correction to the individual’s separation document showing that the individual was separated by reason of temporary disability effective the date of the original medical separation for disability with severance pay.

b. Providing orders showing that the individual was retired with permanent disability effective the day following the six month TDRL period.

c. Adjusting pay and allowances accordingly. Pay and allowance adjustment will account for recoupment of severance pay, provide 60% retired pay for the constructive temporary disability retired six month period effective the date of the individual’s original medical separation and then payment of permanent disability retired pay at 40% effective the day following the constructive six month TDRL period.

d. Affording the individual the opportunity to elect Survivor Benefit Plan (SBP) and medical TRICARE retiree options.

3. I request that a copy of the corrections and any related correspondence be provided to the individual concerned, counsel (if any), any Members of Congress who have shown interest, and to the Army Review Boards Agency with a copy of this memorandum without enclosures.

BY ORDER OF THE SECRETARY OF THE ARMY:

Encl

Deputy Assistant Secretary

(Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA