RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: Army

CASE NUMBER: PD1001220 SEPARATION DATE: 20060503

BOARD DATE: 20120203

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty PV2/E-2 (09B, Trainee Unassigned), medically separated for reflex sympathetic dystrophy (RSD) of the left knee. The CI developed an abscess in the area of the left knee that required surgical drainage in May 2005. Post surgery, he developed persistent, severe pain that was evaluated and treated by multiple specialists using various treatment modalities, but he did not respond adequately to treatment to fully perform within his Military Occupational Specialty (MOS) or meet physical fitness standards. He was issued a L3 profile and underwent a Medical Evaluation Board (MEB). Compartment regional pain syndrome (CRPS, aka RSD) of the left knee was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Two other conditions, mood disorder (secondary to medical condition with depression, anxiety, and adjustment disorder) and klinefelter’s syndrome, were forwarded on the MEB’s DA Form 3947 submission as medically acceptable conditions. Other conditions included in the Disability Evaluation System (DES) packet will be discussed below. The PEB adjudicated the RSD condition as unfitting, rated 10%, with likely application of AR 635-40 and the Veterans Administration Schedule for Rating Disabilities (VASRD). The mood disorder and Klinefelter’s syndrome conditions were determined to be not unfitting. The CI made no appeals and was medically separated with a 10% disability rating.

CI CONTENTION: The CI states: “The issue of reflex sympathetic dystrophy of the left knee secondary to surgery for an abscess and cellulitis in May 2005 the Army gave me a rating of 10% which was not in line with the changes in law under the National Defense Act of 2008, which started using the VA ratings to standardize a one rating system between DOD and VA under the new DES/VA pilot. Upon discharge I was awarded 40% and also given a rating for my mood disorder of 50% which under currently laws and changes in the disability system being used the mood disorder would have been found unacceptable in accordance with 40-501.” He elaborates no specific contentions regarding rating or coding and mentions no additionally contended conditions.

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service IPEB – Dated 20060314** | **VA (2 Mo. After Separation) – All Effective Date 20060504** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Reflex Sympathetic Dystrophy | 8799-8726 | 10% | CRPS, Left Leg | 8620 | 40% | 20060720 |
| Mood Disorder … | Not Unfitting | Mood Disorder and Depression | 9434-9435 | 50% | 20060720 |
| Klinefelter’s Syndrome | Not Unfitting | Klinefelter’s Syndrome | 7599-7523 | NSC | 20060720 |
| ↓No Additional MEB/PEB Entries↓ | Scars, Left Leg | 7804 | 10% | 20060720 |
| 0% x 0/Not Service Connected x 4 | 20060720 |
| **Combined: 10%** | **Combined: 70%\*** |

\* Individual Unemployability granted

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 service connected conditions and to periodically re-evaluate said conditions for the purpose of adjusting the Veteran’s disability rating should the degree of impairment vary over time.

Reflex Sympathetic Dystrophy. RSD is a fairly uncommon, but well recognized, peripheral nerve dysfunction following (often minor) soft tissue trauma. The principal symptoms are pain, hypersensitivity, and mechanical allodynia confined to the territory of the involved nerve which are usually 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 a multi-specialty evaluation which included specialized imaging (bone scan and magnetic resonance imaging), 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 RSD as the sole etiology; and, the Board finds no probative value concerns relative to the stated severity of the associated disabilities. The comprehensive narrative summary (NARSUM) done four months prior to separation documented the subjective presence of pain, increased sensitivity; and organic changes of absence of sweating with skin color and temperature changes in the area above, below, and adjacent to the medial right knee. The physical exam was pertinent for dysesthesia (an unpleasant sensation produced by normal stimuli) in the 12 cm x 30 cm area noted above that included the three incision scars from surgery; intact temperature, vibration, light touch, and pinprick sensations; decreased strength (MEB Addendum three months pre-separation noted “Left lower extremity hip flexion 4/5. Hip extension 4+/5. Knee flexion 4+/5. Knee extension 4/5. Dorsiflexon is 4+/5, and plantar flexion is 4+/5.” Strength testing on the right was normal at 5/5); normal muscle tone; normal coordination and gait; and normal ankle deep tendon reflex (the left patellar deep tendon reflex was unobtainable due to profound hyperesthesia at the site). Vascular exam was normal and no peripheral edema was noted. Range-of-motion (ROM) of the knee was flexion 118⁰ (normal 140⁰) and extension 0⁰ (normal 0⁰). The NARSUM examiner opined that the CI “was unable to perform any exercise due to pain. He is unable to wear any constrictive clothing over the left lower extremity due to the hyperesthesia of the left lower extremity medial knee area.” The MEB DD Form 2807 indicated a history of “my knee gives out while walking.” The commander’s statements noted that “he is unable to train. He will not be able to obtain an MOS, and lives in constant pain.” “The only daily duties he can presently perform are that of CQ (charge of quarters, an overnight desk duty). He sits at the company CQ desk to perform functions as a secretary. Moreover, he can only perform these duties when he is not on quarters for intense pain associated with his condition.” The physical profile essentially precludes the CI from doing military-related functional activities and standard or modified aerobic conditioning activities.

The VA Compensation and Pension (C&P) examination done two months post-separation documented subjective burning pain from midthigh to midcalf on the left that worsened with even light pressure; alternating warm and cool in the left leg; and swelling. The exam was pertinent for use of a cane; poor propulsion on gait; skin around the left knee (left mid thigh to mid calf) that was extraordinarily tender to light touch (hyperesthesia) and slightly warm as compared to the right; mild edema; normal pulses; no muscle weakness; slight muscle atrophy of the left quadriceps; no spasm; tenderness of the left knee with very painful movement; and ROM of 90⁰ of flexion with pain starting at 45⁰ (DeLuca positive with ROM reduced to 45⁰ flexion after repetitive use from pain). Ankle reflex was decreased and knee reflex could not be ellicited due to the pain. All of the operative scars were noted to be tender to palpation. The VA examiner noted that the CI was not employed and that he was highly disabled. “He has persistent pain which is increased by light pressure such as a blanket or clothing. Weight bearing is very painful. At times it is even difficult to rise from a chair.” Activities of daily living were documented as being either severely or moderately impacted by this condition to include his being prevented from doing exercise or driving.

The Board directs its attention to its rating recommendations based on the evidence just described. Both exams, performed proximate to the date of separation, documented clinical findings on exam that reflected the severity of the CI’s clinical condition, with the VA exam, more proximate to the date of separation, documenting slightly greater ROM limitation, abnormal gait/cane, and muscle atrophy. The NARSUM documented weakness that was not mirrored in the VA exam. Therefore, the Board relied on the findings in both exams in determining its coding and rating recommendations, with the NARSUM addendum and service exams having the predominate weighting. The Board concurred with both the PEB and VA in choosing a peripheral nerve code for rating this condition since RSD is functionally and pathologically a neurological condition. However, choice of code for neuritis or neuralgia and the level of the specific nerve in this circumstance is important because of the potential for a higher rating depending on the peripheral nerve code used. The PEB applied the analogous peripheral nerve code 8799-8726 (neuralgia, anterior crural nerve (femoral)) to achieve a 10% rating (“mild” severity) and the VA applied peripheral nerve code 8620 (Sciatic Nerve, neuritis) to achieve a 40% rating (“moderately severe” severity). The action officer opined that although some functions of the sciatic nerve were implicated, anatomic localization of the CI’s symptomatology was more closely indicative of the level of the anterior crural nerve (femoral) as noted by the PEB, although sciatic coding was possible. Therefore, the Board determined that femoral nerve coding was predominant to rate this condition. The determination for coding under neuritis (§4.123) versus neuralgia (§4.124) is discussed below.

The PEB return of disability case indicated that “RSD/CRPS is rated analogous to a peripheral nerve injury based on muscle strength.” Although this interpretation appeared countenanced in the AR-635 rules in effect at the time, it is not IAW VASRD §4.120 (Evaluations by comparison) guidance. VASRD Code 8626, 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, incomplete paralysis. This applies in this case in that quadriceps weakness or atrophy, sensory disturbances, organic skin symptoms, and constant pain were documented in the exams discussed above; patellar reflex was unobtainable due to CI’s pain. Given the organic changes documented in the record, the §4.123 lower maximum rating provision of moderate for non-sciatic involvement without organic changes, was clearly overcome. The Board deliberated as to the CI’s level of impairment from mild, moderate, to severe incomplete under the 8626 criteria. Providers for both the VA and the MEB detailed marked occupational impairment related directly to this the RSD condition. Commanders’ statements and physical profile documented inability to do military-related activities; and the VA documented severe to moderate limitations in activities of daily living. Additionally, the VA examination and the NARSUM examination and its addendums documented a mood disorder condition as a sequelae of the CI’s chronic pain condition (see below: MEB mood disorder secondary to general medical condition; VA depression secondary to chronic pain) which indirectly contributed to the CI’s impairment and supported the high level of functional loss. Alternate coding under the sciatic nerve was not considered predominant. The Board adjudged that the CI had evidence for neuritis of the anterior crural nerve (femoral) with organic changes, severe sensory abnormality and pain; with consideration of functional loss (IAW §4.40), a severe incomplete rating of 30% (severe, incomplete) is justified for this condition. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board majority recommends a separation rating of 30% for the RSD condition coded 8699-8626.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were mood disorder secondary to general medical condition (with depression, anxiety, and adjustment disorder) and Klinefelter’s syndrome. Klinefelter’s Syndrome is a genetically acquired disorder that was diagnosed while the CI was on active duty, but was not permanently aggravated by active duty; and therefore, is not considered a ratable condition. In addition, VASRD §4.9 states that mere congenital defects are not diseases or injuries in the meaning of applicable legislation for disability compensation purposes. As relates to the mood disorder, it’s onset was insidious beginning as the result of the inability of medicine to control the CI’s leg pain. The NARSUM psychiatric addendum, done four months prior to separation, documented that the CI suffered from insomnia, increased irritability, frustration; psychomotor agitation; decreased concentration; and fatigue. His mental status exam (MSE) indicated moderately depressed mood, irritability, constricted affect, and was otherwise normal. The Global Assessment of Functioning (GAF) was 60, indicative of moderate difficulty in occupational or social functioning. The psychiatrist opined that his “symptoms have the following impact on social and daily functioning: Until he experiences symptom relief [leg pain], he is unable to complete anything but the simplest rote tasks and completely unable to function effectively in a work setting with people as he is easily irritated and in chronic pain. He can accomplish self-care activities of daily living.” The psychiatrist linked the prognosis for this condition directly to the pain of the RSD: “Prognosis is good once his chronic pain can be controlled and he is able to become effectively challenged both academically and vocationally.” In this case, the stressor was the pain related to the RSD condition and the implication was that the mood disorder would resolve if the leg pain could be resolved. As regards future potential for civilian employment, the psychiatrist opined that “this soldier is currently fully capable to work full-time in civilian employment in a position with salary commensurate with his current military pay grade. His current mood dysregulation would not interfere with further employment or vocational training.” The psychiatrist, in his list of diagnoses, stated that the condition was unacceptable IAW AR 40-501, but in his conclusions specifically indicated that the service member met retention standards IAW 40-501. Despite this confusion, the MEB chose to forward this condition to the PEB as a medically acceptable condition. That said, however, the final determination of fitness is not the role of the MEB, but the role of the PEB; and the PEB adjudicated this condition as not unfitting. The Board deliberated the fitness determination of the PEB and determined that any occupational impairment related to the CI’s RSD condition is subsumed within the rating for the unfitting peripheral nerve condition above. RSD and its associated pain was the primary cause for the occupational impairment documented in this case. The Board concurred that the psychiatric condition also contributed to any occupational and social impairment experienced by the CI, but determined that separating the impairment due to the RSD from that due to the mood disorder would require undue speculation with potential violation of VASRD §4.14 (avoidance of pyramiding) that prohibits evaluation of the same disability under various diagnoses. Both Klinefelter’s syndrome and the mood disorder were reviewed by the action officer and considered by the Board. Adjustment disorder is a condition not constituting a physical disability, and is not ratable. All evidence considered, there is not a preponderance of evidence in the CI’s favor supporting recharacterization of the PEB fitness adjudication for either of these conditions.

Remaining Conditions. Other conditions identified in the DES file were sinusitis and left knee instability. The left knee instability was considered by the Board in its deliberations regarding the primary unfitting RSD condition above. The sinusitis condition was not of clinical or occupational significance during the MEB period and was not profiled or implicated in the commander’s statement. The sinusitis condition was reviewed by the action officer and considered by the Board. It was determined that it was not unfitting or subject to separation rating. Additionally left leg scars and several other non-acute conditions were noted in the VA rating decision proximal to separation, but were not documented in the DES file. Any knee impairment secondary to the scars was considered in the CI’s primary unfitting RSD condition. 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. As discussed above, presumptive reliance by the PEB on AR 635-40 for rating the RSD condition was operant in this case and the condition was adjudicated independently of that instruction by the Board. In the matter of the reflex sympathetic dystrophy (RSD) condition, the Board by a 2:1 vote recommends a rating of 30% coded 8699-8626 IAW VASRD §4.124a. The single voter for dissent who recommended application of the same code, rated 20% for moderate symptoms did not submit a minority opinion. In the matter of the Klinefelter’s syndrome and the mood disorder conditions, the Board unanimously recommends no change from the PEB adjudications as not unfitting. In the matter of the sinusitis, 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.

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** |
| Reflex Sympathetic Dystrophy of the Left Knee | 8699-8626 | 30% |
| **COMBINED** | **30%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20101029, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans Affairs Treatment Record

 President

 Physical Disability Board of Review

SFMR-RB

MEMORANDUM FOR Commander, US Army Physical Disability Agency

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation

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 recharacterize the individual’s separation as a permanent disability retirement with the combined disability rating of 30% effective the date of the individual’s original medical separation for disability with severance pay.

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 permanent disability retirement 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 date of the original medical separation for disability with severance pay.

 c. Adjusting pay and allowances accordingly. Pay and allowance adjustment will account for recoupment of severance pay, and payment of permanent retired pay at 30% effective the date of the original medical separation for disability with severance pay.

 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)