RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: Army

CASE NUMBER: PD1001221 SEPARATION DATE: 20050125

BOARD DATE: 20120207

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SPC/E-4 (91W, Health Care Specialist), medically separated for right foot pain, fibromyalgia, and left knee pain. The right foot pain began in May 2003 and persisted despite conservative and surgical treatment. The fibromyalgia started insidiously as diffuse muscle pains in June 2002 and was formally diagnosed as fibromyalgia in July 2004. In addition to worsening pain, the CI developed associated symptoms to include chronic fatigue and depression. The left knee pain began in 2002 as the result of an injury and persisted with physical activity. The CI did not respond adequately to treatment to fully perform within her Military Occupational Specialty (MOS) or meet physical fitness standards. She was issued a permanent P3, U3, and L3 profile and underwent a Medical Evaluation Board (MEB). Avascular necrosis of the right second metarsal head (right foot), asthma, and left knee patellar tendinitis were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Other conditions included in the Disability Evaluation System (DES) packet will be discussed below. The PEB adjudicated the right foot and left knee conditions as unfitting, rated 10% and 0% respectively with application of the Veterans Administration Schedule for Rating Disabilities (VASRD). The asthma was determined to be not unfitting. The CI appealed to a Formal PEB (FPEB). The MEB’s DA Form 3947 was amended prior to the FPEB and a fourth medically unacceptable condition, chronic pain syndrome (CPS), was added for consideration. The FPEB made no rating changes; however, the CI requested a reconsideration FPEB which validated the FPEB adjudications of the right foot (10%), left knee (0%), and asthma (not unfitting) conditions and adjudicated the CPS as unfitting fibromyalgia, rated 10% with application of the VASRD. The CI made no further appeals and was then medically separated with a 20% combined disability rating.

CI CONTENTION: CI states “Please review all addendums from PEB and MEB.” She lists 8 exhibits in her contention summarized as right foot, asthma, left knee, chronic pain syndrome and depression and a component of fibromyalgia syndrome with her VA ratings. She contends that fibromyalgia had been misdiagnosed and was actually systemic lupus erythematosus (SLE).

RATING COMPARISON:

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| **Service FPEB – Dated 20041217** | **VA (2 Mo. After Separation) – All Effective Date 20050126** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Right Foot Pain | 5279 | 10% | Right Foot and Toe Pain | 5284 | 0% | 20050406 |
| Fibromyalgia (MEB CPS) | 5025 | 10% | Fibromyalgia\* | 5025 | 40% | 20050406 |
| Left Knee Pain | 5099-5003 | 0% | L Patellar Tendonitis w/ Instability | 5257 | 10% | 20050406 |
| Asthma | Not Unfitting | Bronchial Asthma | 6602 | 10% | 20050406 |
| ↓No Additional MEB/PEB Entries↓ | 0% x 0/Not Service Connected x 0 | 20050406 |
| **Combined: 20%** | **Combined: 50%\*** |

\* Added Major Depressive Disorder, 9434 at 30%, and seizure disorder, 8911 at 10% effective 20071017 (combined 70%); VARD of 20090921 changed from fibromyalgia to SLE, coded 6350-5025, continued 40% rating

ANALYSIS SUMMARY: The Board acknowledges the CI’s contention that suggests service ratings should have been conferred for other conditions documented at or proximate to the time of separation and that a service medical error (incorrect diagnosis) was responsible for incorrect service disability rating. The Board’s role is confined to the review of medical records and all evidence at hand to assess the fairness of PEB disability ratings and fitness determinations as elaborated above. 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 Foot Pain. The CI’s primary foot complaint was persistent pain related to avascular necrosis of the second metatarsal head (damage from focal loss of blood supply to the bone in the metarsal joint) and to the surgical procedure that was done to try to relieve the pain. Physical findings on the MEB examination done five months prior to separation included a well-healed surgical incision; tenderness to palpation over the second metatarsal head; normal neurologic and vascular exams; and no ankylosis. X-ray of the toe showed callus and flattening in the joint. The VA Compensation and Pension (C&P) exam done two months post-separation validated the MEB findings and additionally documented no limitation of motion, mild weakness, normal gait, and no deformity. Functionally, the MEB examiner documented decreased functional capacity especially with impact activities and nonsedentary activities; and the VA, more proximate to separation, documented no functional impairment of the right foot.

The Board directs its attention to its rating recommendations based on the evidence just described. The PEB rated the condition as 10%, coded VASRD 5279 (metatarsalgia, anterior [Morton’s disease], unilateral or bilateral). The VA rated the condition as 0%, coded VASRD 5284 (foot injuries), based on less than moderate impairment of the right foot. As noted above, pain in the right second metarsal joint is the CI’s primary cause of functional impairment for this condition and is most closely related, both functionally and anatomically, to the metatarsalgia (pain and tenderness in the metatarsal region) indicated in the PEB’s coding choice of 5279. A rating of 10% is justified using this code as the logical choice to analogously rate this condition. There was no clinical and/or radiologic evidence that suggested deformity, swelling, limited range of motion (ROM), malunion or nonunion of metarsal bones, or moderately severe functional impairment that would have justified any alternate foot code with higher rating potential at the time of separation. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s rating decision for the right foot pain condition. The action officer favors analogous code 5299-5279 to rate the condition.

Fibromyalgia. Fibromyalgia is described in the VASRD as widespread musculoskeletal pain and tender points, with or without fatigue, sleep disturbance, stiffness, paresthesias, headache, irritable bowel symptoms, depression, anxiety, or Raynaud’s like symptoms. The rating is based upon the frequency of symptoms without regard to severity or impact on function. A 10% rating applies when the symptoms are controlled by continuous medication; a 20% rating applies when the symptoms are episodic, with exacerbations, present more than one third of the time; a 40% rating applies when symptoms are constant, or nearly so, and refractory to treatment.

At the time of the rheumatology addendum to the NARSUM, three months prior to separation, the CI’s symptoms had been present for over two years. The symptoms included muscle pain in the neck, shoulders, upper back, arms, and legs that was first associated with activity, but worsened to the point that she had chronic daily pain in all the involved areas. The muscle pain was aggravated by direct pressure such that she was unable to wear any of her military gear because the pressure caused intolerable pain. In addition to the pain, the CI reported severe, chronic fatigue on a daily basis (unrefreshed after awakening, fatigued throughout the day, and lacking energy to engage in any meaningful activities after work). Fatigue would become unbearable if she worked more than eight to ten hours in a day. Her exam was pertinent for no tenderness or swelling in the hands, wrists, elbows, knees, or ankles; no deformities or crepitus in the examined joints; positive wincing and pain withdrawal on palpation of 12 out of 18 American College of Rheumatology tender points; and a positive Patient Health Questionnaire-self report for moderately severe depression. The examiner opined that the CI was “not qualified for worldwide duty because she cannot wear load bearing equipment, body armor, and/or rucksack. She is unable to work more than 8-10 hours shifts due to fatigue. I wrote a permanent P3 profile for (CI).” She was started on daily antidepressant medication (Venlafaxine=Effexor) to treat her symptoms. In the “recommendations” section, the examiner stated that after being on medication for one month the CI’s depression and fibromyalgia symptoms were somewhat improved, but still limiting, and that the CI requested and was provided increased antidepressant medication to try to better control symptoms.

The VA C&P examination, two months after separation, validated the history and symptom distribution/exam on the rheumatology addendum and confirmed the diagnosis of fibromyalgia. The subjective complaints indicated increased daily pain symptoms and the addition of severe attacks at least twice per month where the CI “would have to stay home almost at bedrest.” The CI was not yet working at the time of the VA C&P examination.

The Board directs its attention to its rating recommendations based on the evidence just described. The most critical component of the Board’s deliberations to reach a fair and accurate adjudication recommendation in this case is to determine whether the CI’s fibromyalgia symptoms were “constant, or nearly so, and refractory to therapy” or “episodic, with exacerbations often precipitated by environmental or emotional stress or by overexertion, but that are present more than one-third of the time.” All Board members agreed that the 10% rating for symptoms “that require continuous medication for control” was clearly exceeded. The Board deliberated on the level of symptoms and the timing and severity of exacerbating episodes including associated symptoms of fatigue, sleep disturbance, headache, depression, or anxiety symptoms. The Board adjudged that the CI’s symptoms were not controlled by continuous medications, but did not adjudge that severe symptoms were nearly continuous and refractory to therapy. The CI’s fibromyalgia at separation presented a disability picture that was closest to that envisioned by the 20% rating criteria. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a separation rating of 20% for the fibromyalgia condition.

The Board acknowledges the CI’s contention that the VA changed the diagnosis of this condition from fibromyalgia to systemic lupus erythematosus (SLE) on the VA rating decision dated 21 September 2009 (56 months post separation) based on symptoms as they evolved after the time of separation. However, the rheumatologist, in an evaluation for SLE done five months prior to separation, documented that “these nonspecific findings are not diagnostic of systemic lupus erythematosus or any other connective tissue disorder … therefore, the diagnosis of systemic lupus erythematosus is not appropriate at this time.” The Board’s authority as defined in DoDI 6040.44 resides in evaluating the fairness of DES fitness determinations and rating decisions for disability at the time of separation. It is Board precedent that 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. Therefore, the rating in this case is based on the information proximal to the time of separation and not VA information that exceeds this 12-month window. The Board also noted that rating for any symptoms proximate to separation potentially attributable to SLE (VA DC 6350 or 7809) would not have been higher than rating under fibromyalgia (VA DC 5025). Fibromyalgia and not SLE was the working diagnosis at the time of separation.

Left Knee Pain. There were two examinations with goniometric ROM evaluations in evidence which the Board weighed in arriving at its rating recommendation.

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| Goniometric ROM –L Knee | MEB ~ 5 Mo. Pre-Sep(20040809) | VA C&P ~ 2 Mo. After-Sep(20050406) |
| Flexion (140⁰ normal) | 135⁰ | 125⁰ / 100 ⁰ on repetitive |
| Extension (0⁰ normal) | -3⁰ | -4⁰ / -2⁰ on repetitive |
| Comment | No laxity; Firm end-point ant drawer/Lachman; ant TTP; no jt line tender; “McMurray’s with pain only”; “normal 0-135⁰”, equal on right knee; | 1+ crepitus; mild quad muscle atrophy; 2+ laxity; some lateral instability; pain on motion; gait normal; sl weightbearing abnormality due to knee laxity |
| §4.71a Rating | 0%-10% (PEB 0%) | 10% (conceding painful motion) |

Subjective complaints on the MEB narrative summary (NARSUM) examination done five months prior to separation included pain associated with prolonged standing and walking and reported buckling of the knee. Physical findings documented in the NARSUM included ROM from -3⁰ extension (normal 0⁰) to 135⁰ flexion (VA normal 140⁰); tenderness on the patellar tendon with no joint line tenderness; no increased varus (medial) or valgus (lateral) laxity to the knee; and negative provocative testing for collateral ligament damage or for meniscal dysfunction. ROM testing indicated a “normal knee ROM of 0-135⁰” (versus the VA normal ROM of 0-140⁰) and specified the left knee’s ROM was equal to the unaffected right knee. The examiner indicated “McMurrays with pain only” – McMurray test is rotation with leg extension (motion). The corresponding orthopedic evaluation in the service treatment record (STR) from which these findings were extracted additionally documented no muscle weakness; no pain on motion of the knee; and no tenderness on ambulation of the knee. Magnetic resonance imaging of the knee showed a torn meniscus, but the NARSUM indicated that the CI’s orthopedic surgeons had made no recommendations for left knee surgery and there was no specific evidence for frequent episodes of locking, pain, and effusion in the knee. The rheumatology note, two months pre-separation, stated “no joint pathology.”

The VA C&P examination done two months post-separation documented subjective daily, constant pain in the left knee with no swelling, but intermittent buckling or laxity of the knee. The physical exam was pertinent for ROM -4⁰ to 125⁰ (normal 0-140⁰); painful motion; mild crepitus; mild varus deformity and mild atropy of the quadriceps muscle; 2+ laxity with some lateral instability of the left knee; normal gait; and no ankylosis. DeLuca testing was positive on repetitive motion. This evidence is probative only to the extent that it reasonably reflects the disability and fitness implications at the time of separation. VA records remote from separation indicated the CI underwent meniscal surgery. This was adjudged post-separation worsening and not indicative of the CI’s condition at separation.

The Board directs its attention to its rating recommendations based on the evidence just described. It is obvious that there is a clear disparity between these examinations. The Board carefully considered the probative values of the exams and determined the MEB examination accomplished by an orthopedic specialist to be of higher value, in particularly because there was no intervening trauma or event to account for the more severe VA findings documented on the General Medical Examination by a nonspecialist. The Board noted that both the MEB and the VA examiners diagnosed the knee condition as patellar tendinitis, but the conditions were rated utilizing different coding options. The reconsideration FPEB rated the condition as 0%, coded analogously as VASRD 5099-5003 (arthritis, degenerative), based on lateral meniscus tear, full ROM, good stability, normal McMurray sign (provocative test for meniscal impairment), and “knee pain with repetitive or strenuous use generates a profile limiting tasks associated with soldiering.” The VA rated the condition as 10%, coded VASRD 5257 (knee, other impairment of: recurrent subluxation or lateral instability), based on slight lateral instability but no gait abnormality. The Board determined that there was no limitation of motion (comparable to the non-affected side) and that the objective evidence preponderantly indicated no pain on motion which is integral to justifying a 10% rating IAW VASRD §4.59. Although the pain in the knee was adjudged as not being “painful motion,” this was considered as a pain symptom under the CI’s primary unfitting fibromyalgia condition. Additionally, there was no clinical and/or radiologic evidence that suggested subluxation or lateral instability; dislocated cartilage, semilunar, with frequent episodes of locking, pain, and effusion; ankylosis; or nonunion/malunion of the tibia or fibula that would have justified any alternate knee code with higher rating potential. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s rating decision for the left knee condition.

Other PEB Conditions. The other condition forwarded by the MEB and adjudicated as not unfitting by the PEB was asthma (mild intermittent). The Board’s main charge in respect to this condition is an assessment of the appropriateness of the PEB’s fitness adjudication. The Board’s threshold for countering DES fitness determinations is higher than the VASRD §4.3 (reasonable doubt) standard used for its rating recommendations, but remains adherent to the DoDI 6040.44 “fair and equitable” standard. The CI was seen initially for this condition in June 2003, 19 months prior to separation, when she was noted to wheeze after a diagnostic physical fitness test. She had spirometry and methacholine challenge performed which was felt to be consistent with mild reactive airway disease; laryngoscopy which was normal; and a cardiopulmonary exercise test that was normal for exercise tolerance. Medications at the time of the MEB included an as-needed inhaled bronchodilator medication (albuterol) and an oral anti-inflammatory medication (singulaire). Attacks were occurring about once per week (primarily with exercise) and would last a few hours. The CI felt at the time of her MEB exam that if not for her other medical problems, she would be able to pass the run portion of her Army physical fitness test. Her pulmonologist had recommended her for a P2 profile for her asthma and opined that the condition was ‘stable’ and was “more likely to remain a persistent condition which could be substantially controlled with medications.” In that the CI was able to wear a protective mask and all chemical defense equipment, there were no limitations on the final permanent profile that could be directly attributed to the asthma; and the condition was not implicated in the commander’s statement. Additionally, there was no indication from the record that this condition significantly interfered with satisfactory duty performance. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the stated asthma condition.

Other Contended Conditions. The CI’s application asserts that compensable ratings should be considered for depression (including anxiety and panic attacks), seizure disorder, migraines, and rhinitis. Symptoms of depression were identified by the rheumatologist in his evaluation of the CI’s fibromyalgia condition. The examiner opined that depression frequently coexists with fibromyalgia syndrome and can exacerbate the chronic pain syndrome or be a manifestation of someone who is in chronic pain. In review of the STR, it was noted that the mention of depression in any of the encounters was in context to the CI’s diagnoses of chronic pain. There was nothing in the STR to indicate that the CI was being seen specifically for her diagnosis of depression. It can be presumed that the PEB considered depression as a comorbid condition of the fibromyalgia and subsumed any rating for this condition under its rating for fibromyalgia. A note in the VA C&P examination dated 23 April 2008 mentioned a PEB addendum completed on 26 August 2004 that added the diagnosis of ‘atypical depressive disorder’ but the only reference seen was the mention of atypical depressive disorder in the past medical history cited by the rheumatologist in his addendum write-ups. The VA did not recognize depression as a specific condition until April 2008 (39 months post separation) and deemed the effective date of the depression as 17 October 2007 (32 months post separation). As relates to seizures, there was documentation in the STR that the CI was admitted to an Army medical facility for possible seizure disorder in November 2004. A computerized tomography imaging study of the brain was normal and an electroencephalography was done that was presumedly normal. She reportedly had a second seizure in 2005 that was not medically evaluated. The VA first identified this as a condition on its C&P examination dated 21 April 2008 (39 months post separation) and rated it as 10% effective 17 October 2007 (32 months post separation). References to migraine headaches in the STR were sparse. The pulmonologist who evaluated her for her asthma in August 2003 indicated that the CI should see her Primary Care Provider to help with her migraine headaches. There was nothing in the STR to indicate that this intervention occurred. There was no evidence of prostrating headache episodes that interfered with duty performance. The VA first evaluated the migraine headache condition 39 months post separation and rated it as 0% due to lack of supporting medical evidence. All of these conditions were reviewed by the action officer and considered by the Board. The rating for the CI’s unfitting fibromyalgia (5025) includes consideration of associated fatigue, sleep disturbance, headache, depression, or anxiety, symptoms. There was no evidence for concluding that any of the conditions interfered with duty performance to a degree that could be argued as separately 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 anxiety and panic attacks which were included in consideration of depression above. 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. 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 right foot pain and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB rating of 10%, but a change in VASRD code to 5299-5279. In the matter of the fibromyalgia condition, the Board unanimously recommends a rating of 20% coded 5025 IAW VASRD §4.71a. In the matter of the left knee pain condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the asthma condition, the Board unanimously recommends no change from the PEB adjudication as not unfitting. In the matter of the contended depression (including anxiety, panic attacks), seizure disorder, migraine headache, and rhinitis conditions, the Board unanimously agrees that it cannot recommend a finding of unfit for additional rating at separation. In the matter of 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 her prior medical separation:

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Fibromyalgia | 5025 | 20% |
| Right Foot Pain | 5299-5279 | 10% |
| Left Knee Pain | 5099-5003 | 0% |
| **COMBINED** | **30%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20101028, 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)