RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: Army

CASE NUMBER: PD1001256 SEPARATION DATE: 20060913

BOARD DATE: 20120405

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was a Reserve Major/O-4 (38A/Civil Affairs Officer), medically separated for bilateral shoulder and right wrist/hand injuries sustained from an improvised explosive device (IED) while deployed to Iraq in March 2004. He suffered penetrating trauma (shrapnel) to the left shoulder and blunt trauma to the right (dominant) shoulder; and, underwent surgical interventions for both. He suffered shrapnel injuries and burns to the right hand and long finger, and was subsequently diagnosed with carpal tunnel syndrome. He required surgical intervention for the latter, and tendon repair of the long finger. Despite some improvement with the surgeries and rehabilitative interventions, the CI did not improve adequately to perform soldiering skills required of his Military Occupational Specialty (MOS) or meet physical fitness standards. He was issued a permanent U3 profile and underwent a Medical Evaluation Board (MEB). Left shoulder IED injury, chronic right shoulder pain, and right carpal tunnel syndrome were forwarded to the Physical Evaluation Board (PEB) as separate medically unacceptable conditions IAW AR 40-501. Three other conditions, as identified in the rating chart below, were forwarded by the MEB as medically acceptable. Other conditions included in the Disability Evaluation System (DES) file are addressed below. The PEB adjudicated the left and right shoulder conditions (under a combined bilateral rating) and the carpal tunnel condition as unfitting, rated 0% and 10% respectively; with application of the US Army Physical Disability Agency (USAPDA) pain policy to the shoulder rating, and the Veterans Administration Schedule for Rating Disabilities (VASRD) to the carpal tunnel rating. The remaining conditions were determined to be not unfitting. The CI requested and was granted an Active Reserve continuance to retirement (COAR); withdrew a preceding appeal for a Formal PEB; and entered COAR with a 10% combined disability rating.

CI CONTENTION: The CI elaborates no specific contentions regarding rating or coding. He refers to an attached VA rating decision (as elaborated in rating chart below); and specifically lists the following conditions: “Post Traumatic Stress Disorder (PTSD), Right Median Nerve Damage, Left Shoulder Shrapnel Wound, DJD [degenerative joint disease] of Right Knee, Right Clavicle Condition, Cervical Strain, Scar (Right Long Finger), Arthritis of Left Median Nerve.” A contention for service rating of these conditions is thus implied.

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service PEB – Dated 20060309** | **VA (5 Mo. After Separation) – All Effective Date 20060422** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| R Carpal Tunnel Syndrome | 8599-8515 | 10% | Right Median Nerve Damage | 8512 | 30% | 20060910 |
| Post Operative Scar, R Wrist | 7805 | 0% | 20060910 |
| Bilateral Shoulder Pain | 5099-5003 | 0% | Group III Injury, L Shoulder | 5303 | 20% | 20060910 |
| Distal R Clavicle Resection | 5203 | 10% | 20060910 |
| Hyperlipidemia | Not Unfitting | No Corresponding VA Entry |
| Allergic Rhinitis | Not Unfitting | No Corresponding VA Entry |
| L Hearing Loss / Perforation | Not Unfitting | L Tympanic Perforation | 6211 | 0% | 20060925 |
| ↓No Additional MEB/PEB Entries↓ | PTSD | 9411 | 50% | 20060829 |
| DJD Right Knee | 5260-5010 | 10% | 20060910 |
| Cervical Strain | 5237 | 10% | 20060910 |
| Painful Scar, R Long Finger | 7804 | 10% | 20060910 |
| Arthritis Left Median Nerve | 8615 | 10% | 20060910 |
| 0% x 4/Not Service Connected x 0 | 20060910 |
| **Combined: 10%** | **Combined: 90% (Incorporating BLF)** |

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, 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.

Combined Shoulder Rating. The PEB combined the bilateral shoulder conditions as a single unfitting condition, coded analogously to 5003 and rated 0%, relying on the USAPDA pain policy for not applying separately compensable VASRD codes. The Board must apply separate codes and ratings in its recommendations if compensable ratings for each condition are achieved IAW VASRD §4.71a. As elaborated below, separate compensable ratings for each shoulder were well supported by the evidence in this case. Having determined that separate ratings are warranted, the Board must also satisfy the requirement that each “unbundled” condition was unfitting in and of itself. Not uncommonly, this approach by the PEB reflects its judgment that the constellation of conditions was unfitting and that there was no need for separate fitness adjudications, not a judgment that each condition was independently unfitting. The Board therefore exercises the prerogative of separate fitness recommendations in this circumstance, with the caveat that its recommendations may not produce a lower combined rating than that of the PEB. In this case, the bilateral shoulder impairments were well supported as unfitting by evidence from the narrative summary (NARSUM) and service treatment record (STR). As to the judgment as to whether each shoulder condition was independently unfitting, neither the profile nor the commander’s statement specifically implicated the right or left shoulder as the primary unfitting condition. Separating the impairment related to the left shoulder from that related to the right requires undue speculation; and, there is clinical evidence of significant functional impairment referable to each joint. After deliberation, all members agreed that (more likely than not) each of the shoulder conditions, in isolation, would have rendered the CI incapable of continued service within his MOS; and, accordingly each merits a separate service disability rating.

Right Shoulder Condition. The CI’s right shoulder injury from the IED blast was initially undiagnosed, but was subsequently manifest as acromioclavicular (AC) joint pain; for which he underwent a right distal clavicle resection (Mumford procedure). The pain persisted and was reported in the NARSUM as constant and moderately severe (2/10); but, worse with repetitive movement or use (6/10). Imaging studies demonstrated post-operative changes with no evidence for fracture, dislocation, or calcific tendinitis; and an intact glenohumeral joint. The goniometric range-of-motion (ROM) evaluations in evidence which the Board weighed in arriving at its rating recommendation are summarized in the chart below.

|  |  |  |  |
| --- | --- | --- | --- |
| ROM – R Shoulder | MEB ~8 Mo. Pre-Sep | PT ~3 Mo. Pre-Sep | VA C&P ~5 Mo. Post-Sep |
| Flexion (0-180⁰) | 148⁰ | 150⁰ | 100⁰ / 80⁰\*\* |
| Abduction (0-180⁰) | 149⁰ | >100⁰ | 100⁰ |
| §4.71a Rating | 10%\* | 10%\* | 10% / 20%\*\* |

 \*IAW 4.59 (painful motion). \*\*DeLuca deduction of 20⁰ flexion.

The NARSUM examiner documented only a two inch surgical scar and referred to the MEB ROMs charted above; but, the physical therapy (PT) examiner specifically tested motor strength with right shoulder flexion and noted a 4/5 loss. The VA examiner documented point tenderness over the AC joint and diffuse tenderness over the entire shoulder joint; a well-healed scar that did not impair function; diminished strength with repetitive use, degradation of flexion with DeLuca testing as charted above; and, no instability. The NARSUM and the VA examiner both documented specific occupational impairments, i.e., inability to carry a backpack, lift more than 30 lbs with both hands, carry or fire a weapon, and interference with activities of daily living which required repetitive use of the right upper extremity or overhead work. Similar restrictions were documented in the permanent (bilateral shoulder) profile.

The Board directs its attention to its rating recommendations based on the evidence just described. There was a clear disparity between the MEB and VA ROM measurements. There was corroborating evidence from the PT exam prior to separation, to support the MEB ROM’s. There was also noted diminished motor strength in the PT exam which correlated with the diminished strength on repetition in the VA exam. Due to the completeness, proximately to separation and overlapping findings with both the MEB and VA exams, the Board agreed that the PT exam should be assigned the most probative value on which to base its recommendation. The PEB coded analogously to 5003 (degenerative arthritis); and, the VA coded the condition 5203 (for impairment of clavicle). A compensable rating under 5203 requires malunion or nonunion of the clavicle, neither of which was demonstrated by imaging. The Board considered that, although the probative ROM measurements were non-compensable; the residual occupational and daily activity impairments due to pain and the diminished strength in evidence adequately supported application of either VASRD §4.40 (functional loss) or §4.59 (painful motion) to achieve a minimum compensable rating (10%) under 5003 criteria. There was no clinical and/or radiologic evidence that suggested ankylosis, loss of the humeral head, deformity, or recurrent dislocations that would have justified any code with higher rating potential. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a separation rating of 10% for the right shoulder condition. The action officer prefers the code 5010 (traumatic arthritis, rated per 5003) for its clinical compatibility.

Left Shoulder Condition. The CI suffered shrapnel injuries to the left shoulder which were debrided in theater, and underwent delayed primary closure at Landstuhl Regional Medical Center (LRMC). The STR as submitted does not contain documentation from theater or LRMC, thus surgical details are not available. Imaging from the MEB and VA demonstrated retained fragments, but no bony abnormality or soft-tissue pathology related to joint integrity. The pain was reported in the NARSUM as constant and moderately severe (3/10); but, worse with repetitive use (8/10). The goniometric ROM evaluations in evidence which the Board weighed in arriving at its rating recommendation are summarized in the chart below.

|  |  |  |  |
| --- | --- | --- | --- |
| ROM – L Shoulder | MEB ~8 Mo. Pre-Sep | PT ~3 Mo. Pre-Sep | VA C&P ~5 Mo. Post-Sep |
| Flexion (0-180⁰) | 148⁰ | 150⁰ | 100⁰ / 90⁰\*\* |
| Abduction (0-180⁰) | 150⁰ | 130⁰ | 90⁰ / 80⁰\*\* |
| §4.71a Rating | 10%\* | 10%\* | 20% |

 \*IAW 4.59 (painful motion). \*\*DeLuca deduction of 10⁰ flexion and abduction.

The NARSUM examiner referred to the MEB ROMs charted above, and recorded a 1.5 inch scar on the anterior deltoid; but, did not comment on any other scar features. The VA C&P examiner; however, provided a detailed description of the scar characteristics and associated muscle injury. These were significantly probative to the Board’s recommendation, considering that the operative details and initial wound description are missing from the STR as noted above. The VA examiner documented “a deep wound apparently through and through the deltoid muscle.” His exam demonstrated a ragged, depressed, and disfiguring scar over the left deltoid which measured approximately 12 cm (4.7 inches) in length and 3 cm (1.2 inches) in greatest width. There was definite loss of underlying muscle tissue to a depth of approximately 1 cm (0.4 inches) in the center of the scar, and for a length of approximately 6 cm (2.4inches). The scar was adherent to the underlying structure, and attempts to abduct or internally/externally rotate the shoulder were limited by the adhesion. Actual movement of the shoulder demonstrated visible retraction of underlying tissues in the depth of the scar. Although without detailed physical findings, the functional implications of the scar and muscle injury were corroborated by the CI’s orthopedic surgeon; he opined that “this Army officer definitely needs evaluation by a plastic surgeon and probable revision of the scar and lysis of the adhesions in the left shoulder. This would improve the function of the shoulder.” Additional corroboration for muscle involvement was documented 5 days after separation by a neurology consultant who noted “atrophy of the left upper arm.” The VA examiner opined that the left shoulder condition “dramatically impairs the veteran’s ability to do any repetitive work with the left upper extremity due to aggravation of pain, as well as lack of endurance and diminished strength of the left shoulder. Impact on activities of daily living is the same as for the right shoulder.” Additionally, the examiner added that the CI “has not been found sufficiently fit for his civilian occupation to be allowed to return to unlimited activities in that occupation.”

The Board directs its attention to its rating recommendations based on the evidence just described. The Board agreed, as with the right shoulder, that the PT ROM measurements were more probative; but, relied heavily on the VA C&P examination after separation for the clinical detail necessary to consider a rating for muscle disability rather than ROM impairment. The PEB coding and rating approach (analogous to 5003) was, of course, identical to that for the right shoulder; and so did not accommodate the soft tissue injury unique to the left shoulder. The VA rated the left shoulder under the muscle code 5303 (muscle group III, the shoulder girdle and arm). The muscle disability was judged by the VA to be “moderately severe,” which rates 20% for the non-dominant arm under that code. The Board agreed that if alternate coding for muscle disability was not applied, a rating based solely on ROM impairment would be equivalent to that recommended for the right shoulder; i.e., 10% with application of §4.40 or §4.59 under a 5003 equivalent code. Given the compelling evidence for a functionally significant deltoid muscle injury with a residual adhesive scar impeding ROM; however, the Board considered whether a fair rating would be achieved solely under a joint code. It is noted that the findings in support of ratable muscle disability are documented almost exclusively in the VA C&P examination, but were of a nature that had to have been present at separation; further noted that the findings are not contradicted by the available STR evidence; and, finally noted that the findings were corroborated by the PT exam noting diminished strength, by the orthopedic exam prior to separation, and by the neurologist’s exam proximate to separation. After deliberations members agreed that a fairer rating would be reflected under muscle coding; and, the action officer concurred with the 5303 code applied by the VA. The Board then considered the appropriate rating under 5303, IAW the guidelines delineated in VASRD §4.56 (evaluation of muscle disabilities). Although some of the §4.56 criteria for a “severe” rating (30% for non-dominant) were documented, the “moderately severe” criteria were predominant and least speculative. After due deliberation in consideration of all of the evidence, and mindful of both VASRD §4.3 (reasonable doubt) and §4.7 (higher of the two evaluations), the Board recommends a service disability rating of 20%, moderate-severe for the left shoulder condition under the code 5303.

Right Hand Condition. The CI developed persistent pain and sensory symptoms in the right median nerve distribution, and underwent a carpal tunnel release in June 2005 with improvement of symptoms. This condition, which was attributed to the blast trauma from the IED, was added 4 months prior to separation as an addendum. The examiner (for the addendum) documented that the CI had “significant weakness in his right dominant hand and is unable to make a fist, shake hands or open door.” The exam demonstrated weak flexion of the second, third and fourth fingers; as well as decreased grip strength on the right (28 lb.) as compared to the left (97 lb.). There were non-compensable ROM limitations of wrist dorsiflexion, ulnar deviation and radial deviation (referencing PT measurements). An electromyelogram (EMG) in November 2005 demonstrated a “mild compression of the right median palmar nerve at the wrist but there was overall improvement in the median nerve.” Additionally the EMG revealed no evidence for denervation of any of the muscles of the right upper extremity (arm, forearm, and hand). The permanent profile referenced right hand weakness and specifically restricted lifting less than pounds with the right hand, pushups, and carrying or firing a weapon (there is presumptive overlap of some of these restrictions with the shoulder conditions). The VA examiner corroborated the above findings; noting aggravation of pain with grasping, subjective grasp weakness, and impediment of fine motor tasks with the right hand. These limitations had caused the CI to shift many activities of daily living to the left hand; and, significantly impaired writing. Of most importance, the right hand condition imposed stringent occupational limitations on the CI’s civilian career in law enforcement; since, it prevented safe use of his side arm. The VA physical exam documented a well-healed scar; no wrist tenderness; diminished sensation to light touch over the dorsal right forearm and hand; diminished strength (4/5) in the right hand and forearm as compared to the left; interosseus muscle wasting; and, diminished pinch and intrinsic muscle strength. ROM impairment was confined to non-compensable loss of radial deviation. A VA imaging study was negative for soft tissue, bony, or articular pathology; and, an EMG by the VA (a month after separation) demonstrated “mild evidence of denervation seen in the C6-C7 supplied muscles in the right upper extremity” and “residual carpal tunnel syndrome on the right.” The final impression of the VA C&P examiner was “paralysis, moderate right lower radicular group, moderately severe; this included loss of function in the median nerve, ulnar nerve and diminished strength in the forearm flexor and extensor muscle groups.”

The Board directs its attention to its rating recommendation for the right hand condition based on the above evidence. The challenge before the Board is to appropriately rate the total and significant disability of the right hand; as the available joint codes in VASRD §4.71a do not provide for a compensable rating based on the orthopedic features alone. Both the VA and the PEB rated the mix of hand, finger and nerve disabilities under a single peripheral nerve code; which the Board agreed was proper and the most straightforward approach, since it avoids conflict with VASRD §4.14 (avoidance of pyramiding). The VA used a more proximal peripheral nerve code, 8512 (lower radicular group), rated as 30% for “moderate” incomplete paralysis. The assigned rating, however, was erroneous; since this is the minor rating and the CI is right hand dominant. The major rating for the “moderate” characterization is 40%; and, 30% is not available as a major rating under 8512. The PEB assigned a more distal peripheral nerve code, 8515 (median nerve), rated as 10% for “mild” incomplete paralysis. The MEB addendum and the VA C&P exam evidence weakened flexion of the fingers encompassing median and ulnar nerve function, decreased grip strength, 3/4 loss of strength compared to the non-dominant hand, and sensory findings in the distribution of the median nerve. The functional impact, significant for both routine activities and occupational pursuits, was far from inconsequential as elaborated above. The Board deliberated between the 8512 (proximal) and 8515 (distal) codes; and, between the “mild” and “moderate” ratings. The clinical evidence for median nerve and ulnar nerve pathology, as well as the significant decrease in grip strength, was not totally reflected by the EMG findings cited above. The Board thus agreed on application of the 8512 code; since it subsumes disabilities of the ulnar, median, and any other lower radicular nerve which may have contributed to the physical findings and functional impairments. It was agreed; however, considering the overall distribution of that nerve group, that the fair characterization of impairment was “mild;” yielding a major rating of 20%. Considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a separation rating of 20% for the right hand condition coded 8599-8512.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were hyperlipidemia, allergic rhinitis, and left ear hearing loss with perforation of the tympanic membrane. The Board’s main charge in respect to these conditions 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 hyperlipidemia was controlled by medication, and furthermore does not constitute a ratable disability. Allergic rhinitis had been documented as early as 1990 and was well controlled on medication at the time of separation. The perforation of the tympanic membrane occurred at the time of the IED explosion and was associated with some (non-compensable) hearing loss; it carried an H2 profile at separation. A VA exam after separation documented that the perforation had healed. None of these conditions were profiled (except as noted for hearing), implicated in the commander’s statement, or noted as failing retention standards. All were reviewed by the action officer and considered by the Board. There was no indication from the record that any of these conditions 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 any of the stated conditions.

Other Contended and Remaining Conditions. The CI’s application implies that compensable ratings should be considered for PTSD, DJD of the right knee, cervical strain, scar of the right long finger, and “arthritis” of the left median nerve. PTSD was diagnosed by the VA after separation. Although the VA examiner documented mental health treatment in service, a diagnosis of PTSD was not established during that period; and, a mental health history was not documented in the NARSUM. The MEB physical documented some positive responses for sleep disturbance, anxiety, and depression; and there were a few psychotherapy notes in the STR. There was no evidence in the STR; however, for an acute and active psychiatric condition during the MEB period. Psychiatric impairments were not implicated in the commander’s statement, and a psychiatric profile was not in effect. The CI had remote arthroscopic surgeries for his right knee, but the condition was not clinically active at separation. Knee exams on the MEB physical and in the NARSUM are normal. Any disability related to the finger scar would have been subsumed in the hand rating as recommended. The cervical strain and left median nerve conditions, although identified by the VA after separation, were not documented in the DES file. The only other condition identified in the DES file, not already addressed, was onychomycosis (nail fungal infection). This was not associated with any ratable disability. No other conditions were service-connected with a compensable rating by the VA within 12 months of separation. 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.

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, PEB reliance on the USAPDA pain policy for rating the bilateral shoulder conditions was operant in this case and the conditions were adjudicated independently of that policy by the Board. In the matter of the bilateral shoulder condition, the Board unanimously recommends that each joint be separately adjudicated as follows: an unfitting right shoulder condition coded 5010 and rated 10% IAW VASRD §4.71a; and, an unfitting left shoulder condition coded 5303 and rated 20%, IAW VASRD §4.73. In the matter of the right hand condition, the Board unanimously recommends a rating of 20% coded 8599-8512 IAW VASRD §4.124a. In the matter of the hyperlipidemia, allergic rhinitis, and left ear conditions; the Board unanimously recommends no change from the PEB adjudications as not unfitting. In the matter of the contended PTSD, right knee condition, cervical strain, scar of the right long finger, and left median nerve condition; the Board unanimously agrees that it cannot recommend any 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 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:

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Peripheral Neuropathy and Trauma Residuals, Right Hand | 8599-8512 | 20% |
| Shrapnel Injuries, Left Shoulder and Deltoid  | 5303 | 20% |
| Traumatic Arthritis and Surgical Residuals, Right Shoulder | 5010 | 10% |
| **COMBINED (Incorporating BLF)** | **50%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20101116, 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 50% 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 50% 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)