RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXX BRANCH OF SERVICE: ARMY

CASE NUMBER: PD1100032 SEPARATION DATE: 20040923

BOARD DATE: 20111007

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SGT/E-5 (88M, Truck Driver) medically separated for chronic knee pain. He did not respond adequately to treatment and was unable to perform within his military occupational specialty or meet physical fitness standards. He was issued a permanent L3 profile and underwent a Medical Evaluation Board (MEB). Chronic knee pain was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Although the MEB and PEB listed the left knee as unfitting, the orthopedic surgery narrative summary (NARSUM), profile forms and treatment records are clear that the unfitting knee was the right knee, not the left. Other conditions included in the Disability Evaluation System (DES) file will be discussed below. The PEB adjudicated the knee condition as unfitting, rated 10%, with application of the US Army Physical Disability Agency (USAPDA) pain policy. The CI made no appeals and was medically separated with a 10% disability rating.

CI CONTENTION: The CI 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. He additionally lists diabetes, posttraumatic stress disorder (PTSD), high blood pressure and high cholesterol. He elaborates no specific contentions regarding rating or coding.

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service IPEB – Dated 20040901** | **VA (1 Mo. Pre Separation) – All Effective 20040924** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Left Knee Pain\* | 5099-5003 | 10% | Right Knee Arthritis | 5257 | 0% | 20040802 |
| ↓No Additional MEB / PEB Entries↓ | Left Knee Arthritis | 5010-5260 | 0% | 20040802 |
| Sleep Apnea | 6847 | 50% | 20040802 |
| Thoracolumbar Arthritis | 5242 | 10% | 20040802 |
| 0% x 2 / Not Service Connected x 1 | 20040802 |
| **Combined: 10%** | **Combined: 60%** |

\*Erroneous entry: record indicates a right knee condition

ANALYSIS SUMMARY: The DES is responsible for maintaining a fit and vital fighting force. 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 Veteran Affairs, operating under a different set of laws (Title 38, United States Code), is empowered to compensate all 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.

Unfitting Right Knee Condition. Although the MEB and PEB listed the left knee as unfitting, the orthopedic surgery NARSUM, physical profile, and treatment records are clear that the unfitting knee was the right knee, not the left knee. Service medical records infrequently mentioned the left knee and it was not a focus of significant clinical attention during the time leading up to the MEB. Prior to entering military service, the CI had a history of a right knee injury requiring a subtotal medial meniscectomy in March 1990. Service medical records document recurring problems with the right knee leading to MEB and disability discharge. While on active duty, he underwent reconstruction of the right knee anterior cruciate ligament (ACL) in 1991, with good result. He was medically cleared by an orthopedic surgeon for strenuous activity prior to reentering active duty in 1994. The right knee condition remained quiet for several years until insidious pain developed, and beginning in October 2001, the CI sought care for complaint of right knee pain leading to arthroscopy April 2002, with findings of degenerative changes including degenerative tear of the lateral meniscus. On a post-deployment health assessment, 18 June 2003, the CI complained of right knee recurring injury. Subsequently the right knee was the focus of clinical attention with occasional reference to the left knee. Continued right knee pain gradually worsened, interfering with performance of duties. Magnetic resonance imaging (MRI) imaging was solely of the right knee and the 29 June 2004 orthopedics record entry addressed only the right knee as interfering with activities, and referred the right knee for MEB. Duty limiting physical profiles completed by the orthopedic surgeon dated 10 June 2004 and 16 July 2004 are solely for the right knee. The Board concluded the MEB and PEB forms listing the left knee was an administrative error and it was the right knee intended to be unfitting by the MEB and PEB.

The Board first considered the appropriate rating for the unfitting right knee. There were two goniometric range of motion (ROM) evaluations in evidence which the Board weighed in arriving at its rating recommendation. Both of these exams are summarized in the chart below.

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| ROM – Right Knee | MEB ~ 2 Mo. Pre-Sep | VA C&P ~ 1 Mo. Pre-Sep |
| Flexion (140⁰ normal) | 120⁰ | 110⁰ |
| Extension (0⁰ normal) | 5⁰ | 0⁰ |
| §4.71a Rating | 10%\* | 0% |

 \*Painful motion / pain with use

The NARSUM examiner reported the CI could not climb in and out of vehicles without pain. All strenuous activities caused pain, and swelling occurred with prolonged walking. Examination noted a mildly antalgic gait, patellofemoral crepitus, a grade 1 Lachman consistent with mild laxity (<5mm movement; test for ACL laxity), and no side-to-side joint laxity. The right knee showed mild limitation of flexion, as noted above. An MRI showed medial and lateral meniscal tears and tricompartmental degenerative arthritis, however, the ACL was intact, as were the medial and lateral collateral ligaments. The VA compensation and pension (C&P) examiner noted a normal gait and posture. Examination of the knees demonstrated crepitus with “unremarkable” anterior drawer (test for ACL laxity) and McMurray (test for symptomatic meniscus) tests. The examiner concluded there were no findings of recurrent subluxation (instability), locking pain, or effusion. A VA clinic exam on 3 February 2005, four months after separation, recorded complaints of stiffness and pain with prolonged walking. On examination, the right knee was stable with a negative Lachman’s test. The PEB’s DA Form 199 reflected application of the USAPDA pain policy for rating, but its 10% determination was consistent with §4.71a standards. Although limitation of motion was noncompensable, there is sufficient evidence of pain with use (§4.40) to justify a minimal compensable rating under §4.71a. Due to physical examination findings of mild ACL laxity by the NARSUM examiner, and degenerative lateral meniscus tear, the Board considered 5257 (instability) and 5258 (locking due to dislocated meniscus) coding pathways to a higher rating. However, symptoms of instability were infrequently noted, and the examination most proximate to discharge (C&P) clearly showed a stable joint. Furthermore, MRI imaging demonstrated the ACL to be intact. There was no evidence of “frequent” episodes of locking required for the 20% rating under the 5258 code. After due deliberation in consideration of the totality of the evidence, the Board concluded that there was insufficient cause to recommend a change from the PEB fitness adjudication for the unfitting right knee condition. Because no increase in rating was recommended, the Board did not conclude a correction of the records showing the right was unfitting rather than the left was necessary, as no benefit to the member resulted.

Contended Left Knee Degenerative Joint Disease. Prior to entering military service, the CI had a history of left knee injury requiring surgical reconstruction of the anterior cruciate ligament in 1986. While in service, there was infrequent mention of left knee pain. An April 1994 orthopedic evaluation for reenlistment noted bilateral knee degenerative changes that caused no symptoms and imposed no limitations. A 22 January 2003 primary care record entry, shortly after deploying, notes pain in both knees, and prescribed usual conservative care. A primary care clinic record entry on 19 May 2004 noted bilateral knee degenerative arthritis. Although the condition was mentioned, along with the right knee by some providers prior to separation, occupationally significant symptoms were not detailed, and it was not profiled. The NARSUM refers to sensation of instability of the left knee and on examination there was patellofemoral crepitus, a grade 1 Lachman test with mild laxity (<5mm movement; test for ACL laxity), and no side-to-side joint laxity. The VA C&P examiner noted a normal gait and posture. Examination of the knees demonstrated crepitus with “unremarkable” anterior drawer (test for ACL laxity) and McMurray tests. The examiner concluded there were no findings of recurrent subluxation (instability), locking pain, or effusion. A VA clinic exam on 3 February 2005, four months after separation, recorded complaints of stiffness and pain with prolonged walking. On examination, the left knee was stable with a negative Lachman’s test. The left knee condition was reviewed by the action officer and considered by the Board. Although it is possible that impairment from due to the left knee condition was overshadowed by the right knee condition, that possibility is unduly speculative as the basis for a Board fitness recommendation. There was no evidence for concluding that the left knee condition interfered with duty performance to a degree that could be argued as unfitting and subject to service disability rating.

Other Contended Conditions. The CI’s application asserts that compensable ratings should be considered for sleep apnea (OSA), degenerative disease of the thoracolumbar spine, PTSD, diabetes, high blood pressure and high cholesterol. Mild OSA was diagnosed by a sleep study eight months prior to separation. Treatment with a continuous positive airway pressure (CPAP) device was shown to alleviate his condition. The C&P examiner noted that the condition caused no functional impairment or lost work. The services do not routinely find OSA, with or without CPAP requirement, unfitting if symptoms are controlled and functioning is unimpaired. The burden of providing CPAP in field and deployment environments is not considered to be a critical factor with the common availability of portable generators and sanitary facilities. Low back pain occurring intermittently was first reported in 2000 and again prior to separation, at which time X-rays were normal. The C&P examiner noted the condition caused no functional impairment or lost work time. Neither of these conditions was clinically or occupationally significant during the MEB period, neither carried attached profiles and neither was implicated in the commander’s statement. These conditions were reviewed by the action officer and considered by the Board. It was determined that neither could be argued as unfitting and subject to separation rating.

PTSD, diabetes, high blood pressure and high cholesterol were not in the DES file. On the post-deployment health assessment form (18 June 2003), the CI checked “no” in response to screening questions for PTSD. On the MEB history and physical examination form (DD Form 2807-1) the CI checked “no” in response to screening questions for psychological symptoms. Four months after separation, VA service treatment records screening for symptoms of depression and PTSD was negative (3 February 2005). No diabetes was shown or diagnosed in service or at the time of the VA examination. The CI was shown to have mildly elevated lipids in service not requiring treatment. Laboratory findings of elevated cholesterol or lipids are not disabilities that interfere with performance of duties. In the year prior to separation, the CI was shown to have borderline elevated blood pressures on occasion with normal blood pressures at all other visits. His blood pressure was normal at the time of the MEB history and physical examination (115/80). While 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, if the presence of these conditions in the DES was conceded, there is no evidence they could be argued as unfitting and subject to separation rating.

Remaining Conditions. Other conditions identified in the DES file were heartburn, allergies, left wrist pain, neck pain and bilateral shoulder pain. Several additional non-acute conditions or medical complaints were also documented. None of these conditions were clinically or occupationally significant 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. Additionally, bilateral knee residual scarring and tinnitus were noted in the VA rating decision proximal to separation, but were not documented in the DES file. The Board does not have the authority under DoDI 6040.44 to render fitness or rating recommendations for any conditions not considered by the DES.

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 unfitting knee condition was operant in this case and the condition was adjudicated independently of that policy by the Board. In the matter of the unfitting knee condition, erroneously listed as left knee condition on PEB forms rather than right knee, and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the opposite knee condition that was not determined to be unfitting, the Board unanimously agrees that it cannot recommend any findings of unfit for additional rating at separation. In the matter of the OSA and degenerative disease of the thoracolumbar spine, 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. 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 therefore recommends that there be no recharacterization of the CI’s disability and separation determination.

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Chronic Left Knee Pain | 5099-5003 | 10% |
| **COMBINED** | **10%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110127, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

 XXXXXXXXXX

 President

 Physical Disability Board of Review

**DEPARTMENT OF THE ARMY**

ARMY REVIEW BOARDS AGENCY

1901 SOUTH BELL STREET 2ND FLOOR

ARLINGTON, VA 22202-4508

MEMORANDUM FOR Commander, US Army Physical Disability Agency

(TAPD-ZB *I* ), 2900 Crystal Drive, Suite 300, Arlington, VA 22202

SUBJECT: Department Defense Physical Disability Board of Review Recommendation

for AR20110021274 (PD201100032)

I have reviewed the enclosed Department of Defense Physical Disability Board of

Review (DoD PDBR) recommendation and record of proceedings pertaining to the

subject individual. Under the authority of Title 10, United States Code, section 1554a,

I accept the Board's recommendation and hereby deny the individual's application.

This decision is final. The individual concerned, counsel (if any), and any Members of

Congress who have shown interest in this application have been notified of this decision

by mail.

BY ORDER OF THE SECRETARY OF THE ARMY:

End

CF:

( ) DoD PDBR

( ) DVA