RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: ARMY

CASE NUMBER: PD1100216 SEPARATION DATE: 20070417

BOARD DATE: 20120217

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SSG/E-6 (88N, Transportation Management Coordinator) medically separated for chronic neck pain, left shoulder pain and left knee pain. The neck condition began in 1995 as a result of injury. The shoulder and knee conditions began in 2005 and were not a consequence of injury. None of the conditions were associated with a surgical indication. He did not respond adequately to treatment and was unable to fully perform within his Military Occupational Specialty (MOS) or meet physical fitness standards. He was issued a permanent P3 U3 profile and underwent a Medical Evaluation Board (MEB). Degenerative joint disease of the left shoulder and neck, obstructive sleep apnea and left patellofemoral osteoarthritis were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Three other conditions, as identified in the rating chart below, were also identified and forwarded on the DA Form 3947 as medically acceptable conditions. Additional conditions supported in the Disability Evaluation System (DES) file are discussed below, but were not forwarded for PEB adjudication. The PEB adjudicated the chronic neck pain, left shoulder pain and left knee pain conditions as unfitting, rated 0% each. The PEB applied the US Army Physical Disability Agency (USAPDA) pain policy for the shoulder condition. It was determined that the remaining conditions were not unfitting. The CI did not appeal and was medically separated with a 0% combined disability rating.

CI CONTENTION: The CI states: “Diagnosed with PTSD and social anxiety disorder, and anger management issues while at Walter Reed. The doctor who diagnosed me originally transferred and did not refer me to another doctor. The condition has effected me at several jobs, causing termination at one of them. I am currently being treated at the Bessemer CBOC in Alabama.” No additionally contended conditions are in evidence.

RATING COMPARISON:

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| --- | --- |
| **Service IPEB – Dated 20070112** | **VA (2 Mo. After Separation) – All Effective 20070418** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Neck Pain | 5237 | 0% | C4-5 Degenerative Disc Disease | 5242 | 20% | 20070626 |
| Left Shoulder Pain | 5099-5003 | 0% | Left Shoulder Tendonitis | 5024-5203 | 10% | 20070626 |
| Left Knee Pain | 5099-5003 | 0% | Left Knee Degenerative Jt. Dis. | 5003-5261 | 10% | 20070626 |
| Obstructive Sleep Apnea | Not Unfitting | Sleep Apnea | 6847 | 50% | 20070626 |
| Migraine Headaches | Not Unfitting | Traumatic Brain Injury | 8045-8100 | 50% | 20070626 |
| Traumatic Brain Injury | Not Unfitting |
| Left Ulnar Neuropathy | Not Unfitting | Left Ulnar Neuropathy | 8516 | 10% | 20070626 |
| ↓No Additional MEB Entries↓ | Post Traumatic Stress Disorder | 9411 | 70% | 20070628 |
| Sciatica | 8620-5236 | 10% | 20070626 |
| 0% x 2 |  |
| **Combined: 0%** | **Combined: 100%** |

ANALYSIS SUMMARY: The Board notes the CI’s assertion that his psychiatrist did not appropriately refer him to another doctor; however the Board has neither the jurisdiction nor authority to scrutinize or render opinions in reference to asserted service medical care or improprieties in the processing of a case. The Board’s role is confined to the review of medical records and all evidence at hand to assess the fairness of PEB rating determinations, compared to VASRD standards, based on severity at the time of separation. It must also judge the fairness of PEB fitness adjudications based on the fitness consequences of conditions as they existed at the time of separation. The Board further 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.

Chronic Neck Condition. The CI reported ongoing neck pain after sustaining an injury in 1995 when the roof of a van fell on his head during a training exercise. In April 2005 worsened neck pain and headaches necessitated air evacuation from his deployed location in Iraq. 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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| Cervical ROM  | NARSUM ~ 7 Mo. Pre-Sep | VA C&P ~ 2 Mo. After Sep |
| Flexion 0-45⁰ normal | 40⁰ | 40⁰ |
| Extension 0-45⁰ normal | 10⁰  | 15⁰ |
| Combined 340⁰ normal | 195⁰ | 215⁰ |
| Comments | Painful motionAble to bring chin to chest after formal exam c/w full normal flexionRotation limited to L 40⁰, R 45⁰ (nl 80⁰) | Pain at end of motion, not during movement |
| 4.71a Rating | 10% | 10% |

The orthopedic narrative summary (NARSUM) examiner (8 September 2006, seven months prior to separation) reported soreness on awakening that lasted for 30 minutes to two hours, although it did not interrupt his sleep. Sitting for over one to two hours caused pain and he could not work at a computer for longer than 45 minutes. The CI noted “some neck pain 8 to 10 hrs per 24 hour period.” There was “a little” radiation of pain to the left elbow. The exam was silent regarding posture, alignment, muscle tenderness or spasm. Later in the examination session, the CI, on request by the orthopedic surgeon, was able to fully flex his neck touching his chin to his chest, although it was with pain. The examiner noted that “this was clearly more flexion than when I measured him.” The ability to bring the chin to the chest is full flexion of the cervical spine. The orthopedist observed that the CI was “quite muscular” and noted normal strength and absence of atrophy including the upper extremities. Sensory testing was normal in both hands except for slight decrease in two point discrimination of the left small finger (see ulnar neuropathy below). Examination by the neurology NARSUM examiner noted normal muscle strength without muscle atrophy, and intact sensation and deep tendon reflexes (DTR) of the upper extremities. Normal posture, gait, heel and toe walking was also reported. Magnetic resonance imaging (MRI) of the neck revealed mild degenerative disc disease at C4-5 with slight narrowing of the left neuro-foramin without nerve compression. While a prior routine X-ray suggested a possible old fracture of spinous processes of C7-T1, the MRI did not confirm this. Electrodiagnostic studies (EMG) of the left upper extremity, performed to evaluate “neck and shoulder pain with numbness in the left little finger,” were normal. The neurology NARSUM noted that neck pain prevents wear of military equipment, but commented that it “will not preclude him from being functional in most civilian occupations.” The VA Compensation and Pension (C&P) examiner (26 June 2007, two months after separation) reported a history of constant, daily pain that radiated to the head and the left shoulder. There were no incapacitating episodes during the prior year. Physical examination revealed pain during range of motion testing but recorded that pain began at the end ROM. There was pain after repetitive use but no additional loss of motion with repetition. There was no muscle spasm, guarding or tenderness, neck muscle strength was normal on isometric testing, and upper extremity reflexes were normal. Spinal contour, posture, and head position were normal. The PEB and VA chose different coding options for the condition, but this did not bear on rating. The service and C&P examinations were consistent and support the same rating. The PEB noted the ability to touch the chin to the chest with absence of spasm, and examination findings inconsistent with the pathology in arriving at its 0% rating. The VA rated the neck condition 5242 at 20%, however, this is inconsistent with the ROM assessment in the C&P examination which supports only a 10% rating. Painful motion (§4.59) was also an appropriate pathway, but attains a 10% rating. No higher rating can be achieved by application of 5243 (intervertebral disc syndrome) in the absence of any documented episodes of incapacitation. 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 neck pain condition.

The Board also considered if additional disability rating was justified for peripheral nerve impairment. There is little support in the service record for clinically significant radiculopathy. Although the CI complained of radiating pain to the left upper extremity, there was no evidence of radiculopathy on examination such as weakness, reflex changes, dermatomal sensory changes. The MRI showed mild neuroforaminal encroachment without impingement on nerve roots, and electrodiagnostic studies were negative for evidence of radiculopathy. The presence of functional impairment with a direct impact on fitness is the key determinant in the Board’s decision to recommend any condition for rating as additionally unfitting. While the CI may have suffered additional subjective pain from the nerve involvement, this is subsumed under the general spine rating criteria, which specifically states “with or without symptoms such as pain (whether or not it radiates).” Therefore the critical decision is whether or not there was a significant motor weakness which would impact MOS-specific activities. There is no evidence in this case that motor weakness existed to any degree that could be described as functionally impairing. The Board therefore concludes that additional disability rating was not justified on this basis.

Left Shoulder Condition. There are two references regarding a shoulder condition in the available record prior to the MEB process. In 1999 the CI was diagnosed with left rotator cuff tendonitis which was treated conservatively. There were no further clinical visits for it in evidence until January 2005 when he complained of left neck and shoulder pain which was diagnosed as a trapezius muscle strain. The NARSUM examiner reports that he was treated with physical therapy (PT) after an evaluation in April 2005 revealed a possible rotator cuff problem, but these notes are not in evidence. There were two goniometric 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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| Left Shoulder ROM  | NARSUM ~ 7 Mo. Pre-Sep | VA C&P ~ 2 Mo. After Sep |
| Flexion 0-180⁰ normal | 120⁰  | 160⁰ |
| Abduction 0-180⁰ normal | 90⁰  | 160⁰ |
| Comments | Painful motion | Painful motion |
| §4.71a Rating (5201) | 20%  | 10% |

 \*Minor joint; CI right hand dominant

The right hand-dominant CI reported constant pain to the orthopedic NARSUM examiner (8 September 2006) especially when raising his arm near shoulder level. Lying on the shoulder caused pain. The shoulder would sometimes “pop” with movement. Examination showed no tenderness, but “resisted movements in all planes were painful.” Impingement signs were absent. Passive motion was accompanied by “closing eyes, grimacing and muscle contractions.” The endpoint of passive flexion and abduction was “vague” and limited by pain. Impingement signs were absent. The orthopedic surgeon observed that the CI was “quite muscular” and noted normal strength and absence of atrophy about the shoulders. Two weeks before (22 August 2006), the neurology examiner reported that the shoulder would click and that pain occurred with a can-emptying motion (a test for supraspinatus tendon impingement) that was not shown by the orthopedic examiner. However, the neurologist also documented normal symmetric strength of shoulder muscles without atrophy. X-rays were normal. The C&P examiner reported that the shoulder condition began in 2005 and was not associated with known injury. There were no episodes of dislocation or subluxation. Despite a reported series of steroid injections and physical therapy in 2005, symptoms became progressively worse. Flare-ups of pain were reported to occur monthly, lasted for an hour or two, and were of moderate severity. Anti-inflammatory agents provided partial relief. Physical examination showed nearly full active arm elevation in both forward flexion and abduction to 160 degrees with report of pain beginning at 90 degrees. There was no additional limitation of motion after repetitive use and muscle strength was normal. The C&P examiner concluded there would be no significant effects for general occupational effect due to the shoulder. The VASRD §4.71a threshold for compensable ROM impairment is “shoulder level,” i.e., 90 degrees. The PEB coded the shoulder condition 5099-5003, analogous to arthritis and applied the US Army Physical Disability Agency (USAPDA) pain policy in rating. The VA used a combination code, 5024-5203 (tenosynovitis, and impairment of clavicle or scapula), and based its 10% rating on §4.40 (functional loss due to pain). While the limitation of abduction noted on the NARSUM exam supported a 20% rating under the 5201 code, the ROM recorded by the C&P examiner supported only 10%. The clear disparity between these examinations has very significant implications regarding the Board's rating recommendation. The Board thus carefully deliberated the probative value of each evaluation and assigned the higher probative value to the C&P examination, which was also more proximate to separation. The NARSUM examination was silent regarding painful motion thresholds for the ROM values it recorded, but painful motion was present. The Board does believe that the totality of the evidence supports a conclusion that either §4.59 (painful motion) or §4.40 (functional loss) should be applied to achieve the minimal compensable threshold under the analogous 5003 rating. 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 left shoulder condition, coded 5099-5003.

Left Knee Condition. The left knee problem appeared to begin in early 2005. While knee strains occurred in 1994 and 2001, these were minor and of no long-standing consequence. The record was silent regarding any further knee issues until a PT note in April 2005 reported a six week history of left knee pain without associated injury. There were two goniometric 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 – Left Knee | NARSUM ~ 7 Mo. Pre-Sep | VA C&P ~ 2 Mo. AfterSep |
| Flexion (140⁰ normal) | 113⁰ | 110⁰ |
| Extension (0⁰ normal) | 15⁰ | 0⁰ |
| Comments | Extension limited by voluntary contraction of hamstrings  | Painful motion, tenderness and crepitance |
| §4.71a Rating | 20% | 10% |

The orthopedic NARSUM examiner, 8 September 2006, recorded a history of constant pain, knee swelling, popping, giving way, and pain with weight bearing and going over uneven terrain. Gait was noted to favor the left lower extremity due to pain to straighten the knee. The CI held the knee in a stiff and difficult to examine position. There was no effusion. There was tenderness on patellar compression and to palpation of the anterior knee, but examination testing for instability was negative. Muscle atrophy was absent. Limitation of complete extension appeared to be secondary “to contraction of the hamstring muscles” (voluntary muscle action), rather than knee pathology. This was supported by results of routine X-rays which were normal, and an MRI which showed only mild patellofemoral osteoarthritis. Two weeks prior to the orthopedic examination, the neurology NARSUM addendum (22 August 2006) documented normal gait with normal stride length, height, speed and arm swing; findings contrary to the loss of extension reflected in the orthopedic examination. The neurologist also documented the CI turned easily, and that the CI rose from sitting normally. Strength was normal without atrophy. The initial neurology NARSUM also recorded a normal gait. The CI informed the C&P examiner that he experienced intermittent episodes of knee pain throughout his career that worsened in 2005 and progressed to a state of constant pain and stiffness. He reportedly used a knee brace and cane for prolonged walking, though no examiner ever documented the presence of these devices. He could walk greater than one-quarter mile but less than one mile. The knee condition had a moderate impact on exercise and sports, but no effect on other activities such as chores, shopping or traveling. He reported intermittent swelling, giving way and instability, but no episodes of locking, dislocation or subluxation. Flare-ups occurred weekly and lasted a few hours. On examination, the knee fully extended with pain reported between 10 degrees and full extension at 0 degrees. There was no additional limitation of motion after repetitive use. Crepitance and tenderness were noted. Left knee muscle strength, including resisted extension, was normal and muscle bulk was recorded as normal. There were no signs of instability or meniscus abnormalities, and the gait was normal. The C&P examiner concluded no significant effects for general occupational effect due to the knee. The PEB coded the knee condition 5099-5003, analogous to arthritis and cited the non-compensable range of motion and involvement of one joint in its rating rationale. The VA used a combination code, 5003-5261 (degenerative arthritis, limitation of extension); a 10% rating was assumed assigned based on extension limited to 10 degrees, although 0 degrees of active extension was documented on examination. The limitation of extension of 15 degrees as reported in the NARSUM evaluation supports a 20% rating under the 5261 code. As noted above, this loss of extension was attributed to voluntary muscle contraction of the hamstring muscles.

The Board concluded that a loss of extension of this significance was inconsistent the documented pathology and the normal gait reported in the neurology NARSUM addendum two weeks before, and at the time of the C&P examination. The Board concluded the preponderance of evidence, did not support a finding that there was compensable limitation of motion. Despite the questionable application by the VA of limited extension, there was sufficient evidence of painful motion or functional loss to justify a minimal compensable rating under §4.71a. Because the CI complained of giving way and instability, the Board considered 5257 (instability) and 5258 (locking due to dislocated meniscus) coding pathways to a higher rating. However, all examinations were negative for signs of instability and MRI demonstrated no ligamentous or meniscus abnormalities. There was no evidence of torn or dislocated meniscus on MRI to warrant consideration under diagnostic code 5258, “frequent” episodes of locking due to dislocated meniscus. 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 left knee condition, coded 5099-5003.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were obstructive sleep apnea (OSA), migraine headaches, traumatic brain injury (TBI) and left ulnar neuropathy. Moderate OSA was diagnosed on a sleep study in April 2006, and the CI begun on continuous positive airway pressure (CPAP) at night. A follow-up on 13 July 2006 documented that “excellent compliance” with CPAP resulted in the CI feeling “more refreshed and rested.” A neuropsychology note 6 September 2006 reported no sleep disturbances with CPAP use. The C&P examiner stated that the CPAP helped the daytime fatigue. PEBs across 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 deployed environments is not considered to be a critical factor with the common availability of portable generators and sanitary facilities. The OSA was profiled but not implicated in the commander’s statement. Although found medically unacceptable by the MEB, the condition was adjured as not unfitting by the PEB. This condition was thoroughly reviewed by the action officer and considered by the Board. Upon extensive review of the record, there was no indication that this condition significantly interfered with satisfactory performance of MOS requirements to a degree that could be argued as unfitting.

Migraine headaches developed subsequent to a minor head trauma in 1995 when diagnosis of concussion without loss of consciousness (LOC) was made. There is no mention of headaches in the record from Oct 1995 until April 1997 when the CI presented to clinic for care of a headache for several weeks duration and diagnosis of stress headaches was made. The record falls silent again regarding complaint or care for headaches from 1997 until 2001 when the CI underwent a neurology evaluation because he was applying for warrant officer school and a history of concussion was disqualifying for entry into the program. The neurology evaluation 27 September 2001 recorded a history of head injury in 1995 with loss of consciousness for two minutes (primary medical records documented no LOC) with posttraumatic symptoms of chronic daily headache and persistent, well-compensated cognitive difficulty. The neurologist noted the CI was highly motivated and remained functional and able to perform duties without reservations from command. A diagnosis of post concussive headaches was made and the patient treated. In 2001 the CI felt well and was deployed to Kosovo. After one year in theater, headaches worsened and he was air evacuated to Germany, then transferred to Ft Drum where an MEB was initiated. A neurology MEB NARSUM performed June 2002 reported that CI had received none of the treatment recommended prior to deployment to Kosovo and that his symptoms of chronic, well-compensated symptoms fared poorly during the high stress time in theater. Additionally this NARSUM noted the CI to be “very functional.” In October 2002, the CI requested that the MEB for headaches be discontinued, noting that symptoms had improved with treatment to the extent that he was able to do the physical fitness test. The CI presented to clinic on 13 March 2003 requesting a profile for no sit-ups during the PT test due to headache. There are no further service treatment record entries for headache until 2004 while deployed to Kuwait, when he was seen a few times in the clinic in July 2004.

In April 2005, while deployed to Iraq, the CI presented for care of worsened headaches. The treating physician noted a prior profile and referred the CI to Germany for specialty evaluation. Evaluation in Germany documented two to three severe headaches/week. Treatment in Germany did not improve his headaches and the CI was then evacuated to the U.S. in May 2005. A neurology clinic visit December 2005 reported a decrease in headache frequency to approximately one to two per month with a combination of injection therapy (Botox) and oral medications. Again, response to injection therapy was noted as “good” at follow-up neurology evaluation two months before the MEB. At the time of the neurology NARSUM addendum evaluation in August 2006, the CI noted continued improvement, with headaches occurring once a month and responding to oral medication. There is no documentation of prostrating attacks. The examining neurologist concluded “meets retention standards and his diagnosis of migraine headache without prostration is medically acceptable IAW AR 40-501, chapter 3-30.” The MEB determined this condition to be medically acceptable. The CI appealed the MEB findings and presented a clinical scenario in marked contradistinction to the MEB findings. On VA C&P evaluation, CI reported an occasional migraine occurring less than 1-2 times per month. His report to the C&P examiner that he had monthly incapacitating headaches lasting 48 hours formed the basis of the VA 50% rating for traumatic brain injury post concussive headaches (coded 8045-8100). Loss from work was reported as two weeks per 12 months for back pain or migraines. However, service treatment records do not support prostrating headaches in the year prior to separation. This condition was thoroughly reviewed by the action officer and considered by the Board. Upon extensive review of the record, there was no indication that this condition significantly interfered with satisfactory performance of MOS requirements to a degree that could be argued as unfitting. TBI occurred consequent to the same 1995 incident that caused neck pain and headaches. Review of service treatment records at the time of the injury, 17 October 1995, document that the roof of an expandable van compartment roof fell eight to ten inches on his head. He was wearing his Kevlar helmet at the time and there was no loss of consciousness. He complained of mild light headedness. He experienced headache and blurring of vision. Examinations and imaging were normal and he was diagnosed with a concussion with post concussive syndrome. Except for a 1997 encounter for headache, there were no subsequent medical record entries related to this concussion until a September 2001 neurology evaluation for entry into warrant officer school (the past history of concussion was disqualifying for entry into warrant officer school). The neurologist recorded a history of head injury in 1995 with loss of consciousness for two minutes (primary medical records documented no LOC) with post traumatic symptoms of chronic daily headache, and persistent well-compensated cognitive difficulty. The neurologist noted the CI was highly motivated, and remained functional and able to perform duties without reservations from command. Subsequent MRI of the head was normal. Neuropsychological evaluation in 2002 indicated that any brain injury as a result of the incident was mild. While testing showed some isolated cognitive impairment it was concluded to be due to problems with attention most likely linked to emotional distress and not TBI. Repeat neuropsychological testing in 2006 was remarkable only for mild impairment of attention and concentration that was similar to results from the 2002 testing. The examiner concluded that his current neuropsychological profile was not likely a consequence of the mild TBI in 1995.

NCO evaluation reports for the periods October 2002 to September 2003, October 2003 to September 2004, and October 2004 to May 2005 documented good duty performance, and recommendations for promotion and attendance at advanced leadership school. Upon extensive review of the record, there was no indication that this condition significantly interfered with satisfactory performance of MOS requirements to a degree that could be argued as unfitting. Left ulnar neuropathy was manifested by occasional numbness and tingling of the left forearm and hand that responded to an elbow brace. An EMG in 2005 showed mild ulnar neuropathy, but a repeat study in 2006 was normal. Both the orthopedic and neurology NARSUM examiners documented decreased two point discrimination in the left ulnar nerve distribution on the left hand (left little finger). The VA C&P examiner documented decreased light touch on the ulnar aspect of the left hand with intact strength of muscles controlled by the ulnar nerve. Upon extensive review of the record, there was no indication that this condition significantly interfered with satisfactory performance of MOS requirements to a degree that could be argued as unfitting. With the exception noted above of profiled OSA, none of the other conditions were profiled, 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 performance of MOS requirements. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the migraine, OSA, TBI or ulnar neuropathy conditions.

Other Contended Conditions. The CI’s application asserts that a compensable rating should be considered for posttraumatic stress disorder (PTSD), social anxiety disorder and anger management issues. PTSD as a provisional diagnosis was first considered during a psychiatric evaluation on 28 March 2006. At that time the CI complained of a nine month history of “becoming more anxious,” reluctance to be in crowds, irritability and nightmares; however, he described himself as being “happy most of the time.” Symptoms were reported to have started during an organized fireworks display on 4 July 2005. He reported traumatic stressors of seeing fellow soldiers in same vicinity die from direct mortar firing and fearing for his life. After separation, the specific traumatic events described by the CI to VA examiners included assisting in transfer of injured soldiers from ambulance into the hospital in theater after a suicide bombing in a dining facility one hour after the CI had left the facility in December 2004. The CI noted “knowing you were an hour away from death really \*\*\*\*s you up.” Historical records confirm a dining hall bombing at Forward Operating Base Marez in December 2004, however the CI’s NCOER for this period reflects assignment to Joint Base Balad. Additionally the CI reported experiencing a nearby mortar explosion in March 2005. He also reported witnessing friends being killed in a vehicle explosion, although this event was undated. These events were not confirmed in service documentation. At the time of return from deployment, a psychiatric assessment performed 12 May 2005 stated he had no psychiatric issues or psychiatric diagnosis, and was deemed “psychiatrically fit for duty.” During a 5 June 2006 clinic visit, depression was denied. At the time of neuropsychological evaluation and testing in September 2006, the CI endorsed symptoms of PTSD but had no loss of interest in activities, no violent behavior, and was not upset by any problems at home or at work.

Mental status examination noted a dysthymic, anxious mood but with full affect, intact memory, normal thought processes and no paranoid ideations. He was noted to have been divorced since February 2006, however marital problems predated his deployment to Iraq and he was dating someone he had known for a year. Testing revealed mild impairments of attention and concentration, and a longstanding pattern of coping difficulties similar to prior testing in 2002. NCO evaluation reports indicated the CI performed satisfactorily with the mild impairments documented on neuropsychological testing in 2002 that were stable on testing in 2006. There is no evidence that a mental health condition interfered with duty as evidenced by a performance report (2 August 2005) and a commander’s statement (13 December 2006). PTSD or other mental condition was not profiled, or included in the MEB. In his letter of appeal (2 November 2006) regarding the MEB’s findings, the CI made no contention about the PTSD condition on the MEB’s DA Form 3947. The PTSD condition, which includes social anxiety disorder and anger management issues, was reviewed by the action officer and considered by the Board. There was no evidence for concluding that it interfered with duty performance to a degree that could be argued as unfitting. The Board determined therefore that condition was not subject to service disability rating.

Remaining Conditions. Other conditions identified in the DES file were gastroesophageal reflux, irritable bowel syndrome, low back pain and sciatica. Several additional non-acute conditions or medical complaints were also documented. Low back pain with sciatica was reported by the NARSUM examiner to have developed in 1997 and was not a consequence of injury. An L2 profile for no sit-ups was written in 2003. An outpatient note on 5 June 2006 stated the CI’s pain episodes occurred every six to nine months and responded to pain medication and home physical therapy. None of these conditions were clinically or occupationally significant during the MEB period, none except the back pain 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. As discussed above, PEB reliance on the USAPDA pain policy for rating the left shoulder condition was operant in this case and the condition was adjudicated independently of that policy by the Board. In the matter of the chronic neck pain condition, the Board unanimously recommends a rating of 10% coded 5237 IAW VASRD §4.71a. In the matter of the left shoulder pain condition, the Board unanimously recommends a rating of 10% coded 5099-5003 IAW VASRD §4.71a. In the matter of the left knee pain condition, the Board unanimously recommends a rating of 10% coded 5099-5003 IAW VASRD §4.71a. In the matter of the PTSD condition with social anxiety and anger, the Board unanimously agrees that it cannot recommend a finding of unfit for additional rating at separation. In the matter of the OSA, migraine headaches, TBI, and left ulnar neuropathy conditions, the Board unanimously recommends no change from the PEB adjudication as not unfitting. In the matter of the gastroesophageal reflux, irritable bowel syndrome and low back pain with sciatica conditions 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 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** |
| Chronic Neck Pain | 5237 | 10% |
| Left Shoulder Pain | 5099-5003 | 10% |
| Left Knee Pain | 5099-5003 | 10% |
| **COMBINED** | **30%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110324, 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)