RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXXXXX BRANCH OF SERVICE: army

CASE NUMBER: PD1100246 SEPARATION DATE: 20050806

BOARD DATE: 20120202

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was a mobilized Army National Guard soldier, SGT/E5 (31B, Military Police) medically separated for chronic right ankle pain and bilateral plantar fasciitis. He did not respond adequately to conservative and surgical treatment, and he was unable to perform within his Military Occupational Specialty (MOS). He was issued a permanent L3 profile and underwent a Medical Evaluation Board (MEB). Chronic right ankle pain and chronic bilateral plantar fasciitis were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501, paragraphs 3-14b and 3-13(5) respectively. No other conditions appeared on the MEB’s submission. Other conditions included in the Disability Evaluation System (DES) packet will be discussed below. The IPEB adjudicated the right ankle pain and bilateral plantar fasciitis as unfitting, rated 20% and 0%, respectively, with application of the US Army Physical Disability Agency (USAPDA) pain policy and the VA Schedule for Rating Disabilities (VASRD) respectively. The CI made no appeals, and was medically separated with a 20% combined disability rating. The CI elected disability severance pay in lieu of transfer to the Retired Reserve.

CI CONTENTION: The CI states: “Residuals, right ankle fracture, status post open locks up on me. The carpel tunnel I had turned out to be a Subclavian artery aneurysm. I had 2 surgeries at the VA in Las Vegas, NV. both times the artery collapsed. I was put on an aspirin regiment to thin out my blood. I have nerve damage in both my hands and all of my fingers due to the aneurysm and the hypertension has gotten worst. Had to be put on two medicines for it*.* The Bilateral plantar fascitis has not gotten any better. I still have to wait for a few minutes in the morning to allow my feet to not hurt before I can walk.” He mentions no additionally contended conditions.

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| **Service IPEB – Dated 20050602** | | | **VA (1 & 2 Mo. After Separation) – All Effective Date 20050807** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Right Ankle Pain | 5099-5003 | 20% | Right Ankle Fracture, S/P ORIF | 5271 | 20% | 20051001 |
| Bilateral Plantar Fasciitis | 5399-5310 | 0% | Bilateral Plantar Fasciitis | 5299-5276 | 0% | 20051001 |
| ↓No Additional MEB/PEB Entries↓ | | | IBS | 7319 | 10% | 20051001 |
| 0% x 4 (includes above) / Not Service Connected x 3 | | | 20051001 |
| **Combined: 20%** | | | **Combined: 30%** | | | |

ANALYSIS SUMMARY: The Military Services, by law, can only rate and compensate for those conditions that were found unfitting for continued military service based on the severity of the condition at the time of separation and not based on possible future changes. However, the Department of Veterans’ Affairs (DVA), operating under a different set of laws, can rate and compensate all service connected conditions without regard to their impact on performance of military duties, including conditions developing after separation that are direct complications of a service connected condition. The DVA can also increase or decrease ratings based on the changing severity of each condition over time. 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, as well as the fairness of PEB fitness adjudications at the time of separation. 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. It is noted for the record that the Board has neither the jurisdiction nor authority to scrutinize or render opinions in reference to the CI’s statements in the application regarding suspected missed diagnoses.

Chronic Right Ankle Pain Condition. There were four goniometric range-of-motion (ROM) evaluations in evidence which the Board weighed in arriving at its rating recommendation. These examinations are summarized in the chart below.

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| Goniometric ROM –  R Ankle | PT ~ 4 Mo. Pre-Sep  25 APR 2005 | MEB ~ 3 Mo. Pre-Sep  5 MAY 2005 | PT ~ 3 Mo. Pre-Sep  5 May 2005 | VA C&P ~ 2 Mo. After-Sep  1 OCT 2005 |
| Right Dorsiflexion (20⁰) | 5⁰ | 10⁰ | 15⁰ | 5⁰ |
| Right Plantar Flexion (45⁰) | 55⁰ | 45⁰ | 55⁰ | 10⁰ |
| Comment | w/ pain  Non antalgic gait. | Some joint tenderness | Non antalgic gait | Limitation due to pain with pain throughout motion.  Normal gait at moderate pace. |
| §4.71a Rating | 10% | 10% | 0% | 20% |

The CI had a history of recurrent right ankle injuries incurred during periods of extended active duty including a right ankle fracture (distal fibula) requiring surgery for open reduction and internal fixation in February 2002. In 2004, his unit was scheduled to deploy and he was advised to have the hardware removed to be medically qualified for deployment. In September 2004, right ankle hardware was removed uneventfully and he was mobilized with his unit. However, while in pre-deployment training, he reinjured his right ankle in November 2004 and again December 2004 resulting in persistent duty limiting right ankle pain. Evaluation documented degenerative changes and he was diagnosed with anterior talotibial impingement with a large osteophyte. Following right ankle arthroscopic surgery on 22 March 2005, he continued to experience duty limiting right ankle pain and was restricted from ruck marching and running. At the time of the MEB NARSUM, 5 May 2005, six weeks after surgery, the CI reported his pain was moderate and constant. ROM was reduced in dorsiflexion however the gait was normal indicating functional dorsiflexion. Strength of the lower extremities was normal. A 5 May 2005 physical therapy encounter recorded CI pain report of one to two on a 10 scale (mild) and that the ankle was improving. The CI felt that his limping gait was due to his plantar fasciitis (see below). On examination gait was non-antalgic, dorsiflexion was 15 degrees (improved from five degrees) and plantar flexion 55 degrees. A 9 May 2005 orthopedic examination stated the CI was doing well in therapy 6 weeks post surgery, had a pain score of 4 on a 10 scale, and documented a range of motion examination that was the same as the MEB examination a few days before (dorsiflexion 10 degrees, plantar flexion 45 degrees). A physical therapy examination 15 April 2005, three weeks post surgery documented a non-antalgic gait. At the time of the VA Compensation and Pension (C&P) examination, 1 October 2005, two months after separation, the CI reported constant right ankle pain that worsened with walking, climbing stairs, and standing. The CI stated since the surgery there was no significant instability. On examination there was mild tenderness and swelling on the lateral aspect of the right ankle. There was a marked decreased ROM without a history of recurrent injury to explain the dramatic reduction compared with examinations while on active duty. The CI was observed to ambulate down the hall at a moderate pace with a normal gait which is inconsistent with the marked limitation of motion due to pain reported in the examination. Strength was normal in all extremities. The PEB rated the ankle condition 20% with application of the USAPDA pain policy (moderate constant pain), coded 5099-5003; however, the Board noted the ROMs were consistent with a 10% rating. The VA’s 20% rating, using the limited motion code 5271, was based on the marked decrease in ROM of the post separation C&P examination. The Board concluded there was no evidence to support a higher rating than that adjudicated by the PEB even though the USAPDA pain policy rather than VASRD criteria were employed.

Bilateral Plantar Fasciitis. Plantar fasciitis was diagnosed as a co-existing condition at the time the CI underwent evaluation for his right ankle and is reflected in the duty limiting profile and determined to be unfitting by the PEB. Both the PEB and VA rated the condition 0%. Evidence of the record shows the CI was diagnosed and treated for right plantar fasciitis in August 2004, two months prior to entry on active duty. On 29 July 2004 the CI saw his family physician and reported right foot pain since jumping off of a truck in April of that year. On 2 August 2004, the CI’s civilian podiatrist diagnosed right plantar fasciitis that was caused by jumping out of a truck in March 2004. The CI reported that he experienced a lot of pain in the foot and limping by the end of the day, and on examination, there was extreme pain with palpation. At the time of the MEB NARSUM, 5 May 2005, there was tenderness of the plantar fascia of both feet, and gait was normal. A 5 May 2005 physical therapy encounter recorded CI pain report of one to two on a 10 scale (mild). The CI felt that his limping was due to his plantar fasciitis since his ankle was getting better. On examination the gait was non-antalgic. At the time of the VA C&P examination, 1 October 2005, the CI reported pain and stiffness in the arches of his feet when he first woke up in the morning that lasted five minutes and gradually subsided with activity. His ability to walk was not limited by the condition as the discomfort resolved soon after he started to walk. He experienced discomfort after a prolonged rest but to a lesser degree. He did not take medications for the condition, and had no difficulty with standing or walking. The examiner observed that the CI ambulated down the hallway with a normal gait at a moderate pace. The Board noted that the medical evidence regarding the plantar fasciitis condition following surgery was limited and overshadowed by the right ankle condition. However the C&P examination was close to the date of separation and was consistent with the 0% rating adjudicated by both the PEB and VA. While it appeared the condition was aggravated by service, by the time of the C&P examination two months after separation, it was actually better than the examination of August 2004 prior to entry on active duty. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s rating decision for the bilateral plantar fasciitis.

Other Contended Conditions. The CI’s application asserts that compensable ratings should be considered for hypertension and subclavian artery aneurysm. The CI had treated hypertension controlled with medication that was not disqualifying for military service and did not interfere with performance of duties. The subclavian artery aneurysm was not diagnosed until two years after separation from the Army. VA records record a history of right hand and arm weakness in 1993 while on extended active duty with subsequent diagnosis of carpal tunnel syndrome. A 2 March 2005 service treatment record entry documents complaint of right forearm and hand numbness for three weeks that was diagnosed as carpal tunnel syndrome based on symptoms and a positive examination test for carpal tunnel syndrome. At the time of the C&P examination, two months after separation, the CI reported a diagnosis of carpal tunnel syndrome that was confirmed by electrodiagnostic testing. He reported symptoms consistent with the diagnosis that occurred primarily with typing for more than 15 minutes and that were relieved by stopping. There were no other precipitating or alleviating factors. VA treatment records from October 2007 (two years after separation) document acute thrombosis of the right arm brachial artery due to a right subclavian artery aneurysm. Evaluation disclosed the presence of a cervical rib (a congenital condition that was present on both sides) that was compressing the subclavian artery. The consulting vascular surgeon concluded the cervical rib was the cause of the artery problem. In addition, at the time of surgery, there was a fibrous band that was also discovered to be compressing the artery. Regardless of cause of the right forearm and hand numbness while on active duty, there was no evidence that it prevented performance of duties. 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.

Remaining Conditions. Other conditions identified in the DES file were headaches and carpal tunnel syndrome. 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 irritable bowel syndrome and several other non-acute conditions 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. 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. Although the PEB rated the unfitting right ankle condition using the USPDA pain policy, rating IAW with VASRD guidelines results in a lower rating and the Board therefore unanimously recommends no change in the 20% separation rating. In the matter of the plantar fasciitis condition, and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB rating at separation. In the matter of the hypertension, headaches, carpal tunnel syndrome, 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, as follows:

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Right ankle chronic pain with limited ROM | 5099-5003 | 20% |
| Bilateral Plantar Fasciitis | 5399-5310 | 0% |
| **COMBINED** | **20%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110327 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

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

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation for XXXXXXXXXXX (PD201100246)

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:

Deputy Assistant Secretary

(Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA