RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: Army

CASE NUMBER: PD1100313 SEPARATION DATE: 20020531

BOARD DATE: 20120223

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SPC/E-4 (71L, Administration Specialist) medically separated for a bilateral knee and low back pain condition and obstructive sleep apnea (OSA). The CI’s bilateral knee pain began in November 1995; and, the back pain and OSA conditions surfaced as clinical issues during the MEB process. Despite a variety of treatment modalities, the CI’s pain did not respond adequately to treatment to fully perform within his Military Occupational Specialty (MOS) or meet physical fitness standards; and, the OSA required ongoing treatment with a continuous positive airway pressure (CPAP) device. He was issued permanent P3 and L3 profiles and referred for a Medical Evaluation Board (MEB). Bilateral knee pain, mechanical low back pain, and OSA were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable conditions IAW AR 40-501. Two other conditions, as identified in the rating chart below, were forwarded by the MEB as medically acceptable conditions. Other conditions included in the Disability Evaluation System (DES) file will be discussed below. The PEB adjudicated the bilateral knee pain and low back pain as one unfitting condition, rated 10% referencing the US Army Physical Disability Agency (USAPDA) pain policy; and, OSA as unfitting, rated 0% citing criteria from Department of Defense Instruction (DoDI) 1332.39. The CI made no appeals and was medically separated with a 10% combined disability rating.

CI CONTENTION: The CI states: “I received at a rating from VA of 80% but only received 20% from the military, [SIC] Please look into this according to VASRD instead of DoDI 1332.39. I believe my rating should be a minimum of 30% or more from the military. He elaborates no specific contentions regarding rating or coding and mentions no additionally contended conditions.

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service IPEB – Dated 20020326** | **VA (1 Mo. After Separation) – All Effective 20020601** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Pain, Low Back & Bilateral Knees  | 5099-5003 | 10% | R Retropatellar Pain Syndrome  | 5024 | 10% | 20020717 |
| L Retropatellar Pain Syndrome  | 5024 | 10% | 20020717 |
| Lumbar Strain | 5295 | 10% | 20020717 |
| OSA | 6847 | 0% | Sleep Apnea Syndrome | 6847 | 50% | 20020717 |
| Ocular Contusion Right Eye | Not Unfitting | Bilateral Retinal Holes with Retinal Detachment Left Eye | 6008 | 0% | 20020715 |
| Resolved Retinal Tear Right Eye | Not Unfitting |
| ↓No Additional MEB/PEB Entries↓ | Tinnitus | 6260 | 10% | 20020719 |
| Epicondylitis Right Elbow | 5010 | 10% | 20020717 |
| GERD | 7346 | 10% | 20020717 |
| Reactive Airways Disease | 6699-6602 | 10% | 20020717 |
| 0% x 1/Not Service Connected x 0 | 20020717 |
| **Combined: 10%** | **Combined: 80% (Incorporating BLF)** |

ANALYSIS SUMMARY:

The PEB combined the low back and bilateral knee pain as a single unfitting condition, coded analogously to 5003 and rated 10%; relying on the USAPDA pain policy and possibly AR 635-40 for not applying separately rated 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. VASRD criteria for separate ratings of the lumbar spine and each knee are met in this case; and, therefore the conditions will be addressed separately as below. When the Board judges that two or more separate ratings are warranted in such cases; however, it must satisfy the requirement that each “unbundled” condition was unfitting in and of itself. Most commonly this combined rating 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. Thus the Board must exercise 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.

Lumbar Spine Condition. The Board first considered whether the lumbar condition remains separately unfitting, having de-coupled it from a combined PEB adjudication. In analyzing the intrinsic impairment for appropriately coding and rating the low back condition, the Board is left with a questionable basis for arguing that the lumbar condition was indeed independently unfitting. This condition did not appear to be of clinical significance until it was determined that a medical board would be convened. The orthopedic examiner in the Sports Medicine Clinic who initially evaluated the CI (eight months prior to separation) noted that the CI presented with a complaint of low back pain for four years, but that he had “never complained to physician prior to today;” which implies that the condition was not of clinical or occupational significance prior to that time. Additionally, the narrative summary (NARSUM) documents the examiner’s opinion that the CI “will continue with anti-inflammatory medications and conservative therapy for treatment of his musculoskeletal low back pain, and he will have exacerbations in the future, but nothing that should limit his duty in the military, with regards to his spine.” The NARSUM further documented that the CI “feels that as long as he can get up several times a day and walk around and take substantial breaks, he is able to tolerate the duties that are performed in his MOS.” The only positive findings on the NARSUM examination were mildly decreased spine extension to 10⁰ and paraspinal tenderness. The range-of-motion (ROM) and neurologic findings were normal, and there was no evidence for radiculopathy. The VA Compensation and Pension (C&P) examination (two months after separation) documented a normal lumbar spine examination with no pain, muscle spasm, or tenderness; normal ROM with no limitations due to pain, fatigue, weakness, lack of endurance, or incoordination; no ankylosis; normal neurological examination; normal gait and posture; and no signs of radiculopathy. The Department of Veterans’ Affairs (DVA) examiner opined that the back would have minimal functional effect on the veteran’s usual occupation and on daily activity. The VA rating justification for a compensable rating quoted “characteristic painful or limited motion;” a conclusion specifically refuted by the examiner’s documentation. The VA examiner quoted service magnetic resonance imaging (MRI) findings, as described by the CI, which diagnosed disc disease. The single MRI report in evidence (seven months prior to separation) was normal; specifically confirming the absence of positive disc or nerve findings. After due deliberation, the Board agreed that the evidence does not support a conclusion that the lumbar spine impairment, as an isolated condition, would have rendered the CI incapable of continued service within his MOS; and, accordingly cannot recommend a separate service rating for it.

Bilateral Knee Condition(s). All of the limitations attributed to knee impairment applied to the CI’s ability to perform his soldiering skills, as opposed to the skills specifically required for his MOS. Based on MOS-specific skills, it could be argued that neither of the knee conditions would have been considered unfitting. Left knee pain was the condition for which the MEB was originally initiated; and, that documentation established functional limitations severe enough to warrant a determination of unfitting by the PEB, i.e., that the CI “could be maintained on active duty if he was not required to run, jump, or march, or walk for long distances. As this is not compatible with most military MOS’s, he may be unable to be maintained on active duty.”

Historically, the left knee was clinically worse than the right. Pain in both knees began in 1995, and was related to physical activity as opposed to specific trauma or injury. The CI underwent periods of activity modification, physical therapy, and anti-inflammatory medications without success. Arthroscopic surgery on the left knee (1996) revealed chondromalacia within the patellofemoral space, which was debrided; although, the surgery did not result in improvement of the subjective symptoms (primarily pain with activity such as going up and down stairs, running, marching, or jumping). The NARSUM examination documented minimal limitation of ROM; flexion for each knee was measured at 130⁰ (normal 140⁰). There was some joint tenderness and a positive patellar apprehension test referable to the left knee; no positive physical findings for the right knee; and, a normal gait. Neither joint displayed an effusion, physical signs of cartilage disease, locking, or instability to stress maneuvers. The VA C&P examination (two months after separation) documented qualitatively normal ROM for both knees (“not limited by pain”); and, no fatigue, weakness, or lack of endurance (no DeLuca deductions). The only positive finding by the VA was crepitus in both knees; there was no joint tenderness, effusion, cartilage signs, instability, or gait disturbance. Both the MEB and VA radiographs were normal for both knees.

The Board first deliberated if each knee could be considered as separately unfitting, meriting individual service ratings. There is a strong argument that the right knee alone would not have rendered the CI incapable of continued service within his MOS; since the predominant severity of symptoms and physical signs (by the MEB exam at least) lay with the left knee; and, since the left knee alone was the indication for MEB referral with no change in acuity for either knee during MEB proceedings. Upon further deliberation; however, it was decided that separate fitness adjudications for each knee was moot to service rating; since it was agreed by all members that the knees did not achieve separate compensable ratings IAW VASRD $§$4.71a. The VA conferred separate ratings under the code 5024 (tenosynovitis) which defaults to rating under 5003 (degenerative arthritis) criteria. Although the VA rating decision cited painful motion in its identical narrative for each joint, this conclusion is in conflict with both the MEB and VA exam documentation. For either joint there was no ROM limitation, instability, locking, or frequent effusion to support a compensable rating under any of the specific joint codes for the knee. Therefore the appropriate 5003 rating (via 5024) would be 10% for two major joints, not separate 10% ratings for each joint. Since the left knee alone, or both knees combined, would achieve the same rating (10%), the Board agreed that the more practical recommendation was to rate both knees as a single unfitting condition. The Board therefore recommends that the bilateral knee condition be rated in a combined fashion, coded 5024-5003, at 10%.

Obstructive Sleep Apnea. The CI was first seen for his OSA condition in October 2001 (three months after MEB referral) due to a history of snoring, restless sleep, and nocturnal awakenings. A sleep study was performed in November 2001, and the findings were consistent with moderate OSA. Different potential therapies were discussed, and the CI opted for CPAP therapy; which was well tolerated and resulted in good control of the condition. He was noted at the time of the sleep study to be well controlled on CPAP and to tolerate it well. Both his profile and failure to meet retention standards were premised solely on the requirement to have access to electricity when sleeping. The PEB’s fitness determination in this case did precede the evolution to current practice by all of the service PEBs regarding fitness implications of OSA. Routinely, OSA is not considered unfitting solely on the basis of field and operational impediments to the use of CPAP. There is no evidence in this case that OSA was associated with any unfitting impairments otherwise. However, IAW DoDI 6040.44 (with subsequent legal opinion and precedent), the PEB’s adjudication of OSA as unfitting is not subject to a contrary fitness recommendation on the Board’s part. Although the PEB’s rating adjudication was acceptable by DoDI 1332.39 standards, the Board must base its rating recommendation on the standards of the VASRD in effect. As the requirement for CPAP was established, the Board recommends an OSA rating of 50% IAW VASRD §4.97.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were ocular contusion and resolved retinal tear of the right eye. The ophthalmology addendum to the NARSUM documented that these conditions were the result of eye trauma in April 1997 that required surgery (retinal cryopexy) to repair the tear. The only residual from the injury and the surgery was a small isolated visual field defect. The MEB ophthalmologist documented a stable examination and recommended an annual eye exam as followup. The ocular conditions were profiled, but, there were no limitations specifically related to this condition other than a requirement to wear protective eyewear as appropriate. Additionally, these conditions were not 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.

Remaining Conditions. Other conditions identified in the DES file were right elbow pain and chronic cough associated with gastroesophageal reflux disease (GERD). Several additional non-acute conditions or medical complaints were also documented. The chronic cough and GERD were clinically active during the MEB period, but the pulmonologist managing the CI’s care specifically stated that no MEB and no profile was indicated for them. None of the other conditions were of clinical or occupational significance during the MEB period, and none carried attached profiles. 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, tinnitus and reactive airway disease 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. PEB reliance on the USAPDA pain policy for rating the knees and lower back conditions, and on DoDI 1332.39 for rating the OSA condition, were operant in this case; and, the conditions were adjudicated independently of that policy and regulation by the Board. In the matter of the lumbar spine condition, the Board unanimously agrees that it cannot recommend a finding of unfit for additional rating at separation. In the matter of the bilateral knee condition, the Board unanimously recommends a combined rating of 10% as a single unfitting condition, coded 5024-5003 IAW VASRD §4.71a. In the matter of the obstructive sleep apnea condition, the Board unanimously recommends a rating of 50% coded 6847 IAW VASRD §4.97. In the matter of the ocular contusion and resolved retinal tear of the right eye, the Board unanimously recommends no change from the PEB adjudications as not unfitting. In the matter of the right elbow pain, the chronic cough associated with GERD, 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.

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** |
| Obstructive Sleep Apnea | 6847 | 50% |
| Patellofemoral Pain Syndrome, Bilateral Knees | 5024-5003 | 10% |
| Chronic Low Back Pain  | Not Unfitting  |
| **COMBINED**  | **60%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110315, 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 60% 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 60% 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)