RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1100346 TDRL START DATE: 20000402

BOARD DATE: 20120124 TDRL END DATE: 20021203

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was a Reserve member, CPT/O-3 (35C, Imagery Intelligence), medically separated for “chronic pain, neck due to C5-6 degenerative disc disease (DDD) and right shoulder, status post subacromial decompression.” The CI reported insidious onset of neck, right shoulder, and arm pain in 1995. She also developed numbness in her right thumb and index finger. Radiologic studies of the cervical spine revealed disc herniation at C5-6 without neuroforaminal compromise, and an osteophyte at that level impinging the right C5-6 foramen. Orthopedic and radiological evaluation of the right shoulder revealed a partial rotator cuff tear (supraspinatus tendon) and an acromial spur. Her treatment included medications, physical therapy (including cervical traction), and right shoulder surgery (subacromial decompression), with incomplete relief. She did not respond adequately to treatment and was unable to perform within her Military Occupational Specialty (MOS). She was issued a permanent U3 profile and underwent a Medical Evaluation Board (MEB). “Cervical spondylosis at C5-6 with mild right C6 radicular deficit and mild to moderate C6 radicular pain syndrome” and “status post right subacromial decompression for right shoulder pain with persistent right shoulder pain and mild to moderate loss of range of motion of the right shoulder” were forwarded to the Informal Physical Evaluation Board (IPEB) IAW AR 40-501. Six other conditions, as identified in the rating chart below, were forwarded on the MEB submission. Other conditions included in the Disability Evaluation System (DES) file are discussed below. The IPEB adjudicated the cervical spondylosis and right shoulder pain conditions as unfitting, rated 20% and 10% respectively, with application of the Veterans’ Administration Schedule for Rating Disabilities (VASRD). The CI was placed on Temporary Disability Retired List (TDRL) with ratings as reflected in the chart below. A second IPEB, after approximately 29 months of TDRL, combined the neck and shoulder into a single pain condition and adjudicated the combined condition as unfitting, rated 0% with application of the US Army Physical Disability Agency (USAPDA) pain policy. The CI appealed for a Formal PEB (FPEB) which reaffirmed the IPEB decision. The CI was then medically separated with a 0% disability rating. The CI also appealed to her Congressional representatives, and the USAPDA responded to those representatives reaffirming the FPEB decision.

CI CONTENTION: “The Rating is not an accurate representation of my condition. My original disability rating was 30% in February 2000 when I was placed on the Temporary Disability Retirement List. This disability rating was changed to 0% after my 1st annual examination in 2002. I feel that the medical examinations conducted during thisperiod were not thorough and were more superficial that comprehensive. I am a Disabled Veteran, (though not an Iraq or Afghanistan Veteran). In the course of my time in the military I injured my right shoulder and neck. My shoulder required surgery in 1998. By 2000, (due to my shoulder and neck injury,) I could not wear heavy combat gear and was considered "non deployable." I was medically retired from the Army in 2000 for Cervical Spondylosis at C5/C6 with Mild Radicular Deficit, Mild to Moderate Right C6 Radicular Pain and also for Pain Right Shoulder Post Subacromial Decompression with some decrease in range of motion. The disability rating determined at this time for my neck was 20% and my shoulder was 10% for a total disability rating of 30%. I was placed on the "Temporary Medical Retirement List" (TDRL). This is a five year program that military members are placed on if they have an injury considered at least 30% disabling but at the time not considered stabilized enough where a permanent degree of severity can be determined. Each year I was to be reevaluated. At which time, my status would be determined as; Unchanged, Worse, or Improved. After one (1) year I was found to be "Improved" and thus, my disability was reduced from 30% to 0% and I was discharged. On 24 July 2001, I reported for my first annual physical at Fort Gordon Georgia. The doctor, Major M-------- advised me that he felt that I would not improve to the point that I would ever be placed back on active duty and that he was going to recommend to the board that I be removed from TDLR. At no time did he tell me that I that I had significantly improved in any way. In late June or early July, I received a phone call from Mrs. L----- from the Fort Gordon Physical Evaluation Board Liaison Officer (PEBLO) office, who informed me that my physical from July was not complete and that the Physical Evaluation Board (PEB) wanted additional information. On August 30 2001, I reported for my appointment. The doctor then advised me that I needed a nerve conduction test and it would be scheduled at the first opportunity. Approximately 3-4 weeks later I returned to have this test. Prior to my test my appointed doctor explained that another doctor would be conducting the test. I was told that this doctor was learning how to conduct the test and operate the equipment. He proceeded without any oversight as the first doctor had left the room. When the test was completed I saw an orthopedic doctor; Major B------ had x-rays taken of my shoulder and neck and examined me. At this time he did not provide any information as to the status of my condition. I received a letter (dtd 11 September 2002) from the PEB advising me that my name was being removed from the Temporary Disability Retired List and that my disability rating had been reduced to 0%. The letter also stated my diagnosis as: Chronic Neck Pain due to C5-6 Degenerative Disc Disease and Right Shoulder, Status Post Subacromial Decompression. This was rated as slight/intermittent. I filed a rebuttal of the PEB findings on 17 September 2002. On 20 September 2002, (3 days after I filed my rebuttal), I received a letter from the PEB stating that they found no change was warranted. I appealed this decision and a formal hearing was scheduled for 22 October 2002. I then requested to have the hearing rescheduled to allow time for a series of comprehensive tests, (to include a MRI, as one was not done during my annual medical evaluation) whereas, to provide additional objective medical information to present to the PEB. The request to reschedule the hearing was denied. On 3 December 2002, I received orders from the U.S. Army Physical Disability Agency removing me from the TDRL and discharging me from the service due to permanent physical disability. I believe that the examinations conducted for my annual re-evaluation for the TDRL were not complete enough to properly assess my condition, as well as, conflicting examinations and continued medical duress because of my disabilities. 1. An MRI was never done on my neck or shoulder at the reevaluation. X-rays do not provide enough detail and were not the only diagnostic method used to originally diagnose my condition. (I did have current MRI reports available however, the doctors refused to review them) 2. The nerve conduction test I underwent in 2001 was conducted by a doctor who was not proficient in the use of the equipment or at administering the test. It was administered with no medical supervision at any time. 3. I continue to have varied medical issues due to my physical disabilities. I have been treated by the VA and my family doctor as well as a chiropractor for my disabilities. I have been periodically prescribed Darvocet and Lidoderm Lidocaine Patches for management of pain associated with my disabilities. 4. The Veteran Administration (VA) has rated me disabled, specifically 20% for my neck and 20% for my shoulder (70% Combined Rating). 5. Previous examination findings stating my condition would not improve.” She elaborates no specific contentions regarding coding, and mentions no additionally contended conditions.

RATING COMPARISON:

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| --- | --- |
| **Final Service FPEB – Dated 20021022** | **VA\* – All Effective Date 20000402** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| **On TDRL – 20000402** |  | **TDRL** | **Sep.** |
| Cervical Spondylosis… | 8599-8510 | 20% |  | Chronic Neck Pain w/ Mod Lim. of Motion Due to Cervical DDD w/ Disc Bulge at C5-6 | 5003-5290 | 20% | 20000912 |
| Right Shoulder Pain… | 5099-5003 | 10% |  | Chronic Impingement Syn., R. Shoulder… | 5003-5201 | 20% | 20000912 |
| Chronic Pain, Neck due to C5-6 DDD and R. Shoulder s/p (surgery)… | 5099-5003 |  | 0% |
| History of Plantar Fasciitis | Not Unfitting | Plantar Fasciitis…w/ Heel Spurs… | 5299-5276 | 10% | 20000912 |
| Seasonal Rhinitis | Not Unfitting | Allergy Disease…  | 6513-6522 | 0% | STR\* |
| History of Blurry Vision w/o Identified Etiology | Not Unfitting | Migraine Headaches (Claimed as Migraine w/ Blurring of Vision) | 8100 | 0%\* | 20000912 |
| Gastroesophageal Reflux | Not Unfitting | GERD Requiring Daily Medication | 7399-7346 | 10% | 20000912 |
| Right Hand, Hx of Fracture x2 | Not Unfitting | R Wrist Limited Motion, Residual Navicular Fracture, … | 5099-5010 | 10% | 20000912 |
| L. Breast, Hx of Cyst …  | Not Unfitting | L. Breast, Scar … | 7805 | 0% | STR\* |
| ↓No Additional MEB/PEB Entries↓ | Chronic Lower Back Pain w/ Mod Limitation of Motion Due To DDD, L3-4 & L4-5, w/ Disc Bulges | 5292 | 20% | 20000912 |
| Kidney Stones, by History | 7509 | 10% | STR\* |
| Residuals of Injury, R Leg Sural N | 8599-8521 | 10% | 20020320 |
| 0% x 1 / Not Service Connected x 2 | 20000912 |
| **Combined: 0%** | **Combined: 70%** |

\*Migraine HA 8100 increased to 10% from 20050228. VA rating based on exam most proximate to date of permanent separation. STR = Service Treatment Record.

ANALYSIS SUMMARY: The Board acknowledges the CI’s assertions of procedural and medical practice improprieties surrounding her final PEB. It is noted for the record that the Board has neither the jurisdiction nor authority to scrutinize or render opinions in reference to asserted Service improprieties in the disposition 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. There was no contention for change of the initial TDRL entry PEB determination, nor any apparent use of non-VASRD criteria for TDRL-entry rating. The Board determined that the TDRL-entry ratings were fair and equitable. The final FPEB rated the right shoulder and neck conditions under a single analogous 5003 (degenerative arthritis) code. This coding approach was countenanced by AR 635-40 (B.24 f.) and the USAPDA pain policy; however, IAW DoDI 6040.44, the Board must apply only VASRD guidance to its recommendation. The Board must therefore apply separate codes and ratings in its recommendations if compensable ratings for each joint/area are achieved IAW VASRD §4.71a. or other VASRD coding. If 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. Since §4.71a criteria are met for separate joint ratings in this case, the Board is pursuing separate rating and fitness evaluations as follows.

Right Shoulder Pain. The record indicates the CI was right hand dominant. The CI had shoulder surgery and abnormal imaging and the shoulder joint pathology was separate from any radiculopathy due to the cervical spine condition, although there was likely some overlap of symptoms. There were three shoulder examinations proximate to TDRL exit, including goniometric range-of-motion (ROM) evaluations, in evidence which the Board weighed in arriving at its rating recommendation. These exams are summarized in the chart below.

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| --- | --- | --- | --- |
| Goniometric ROM – R Shoulder | TDRL Ortho ~ 16 Mo. Pre-TDRL Exit | TDRL Ortho ~ 5 Mo. Pre-TDRL Exit | Civilian Ortho ~ 2 Mo. Pre-TDRL Exit |
| Flexion (180) | 175⁰ | 120⁰ | 120⁰ |
| Abduction (180) | 180⁰ | 130⁰ | 60⁰ |
| Comment: Surgery ~ 51 Mo. pre-TDRL exit | TTP R trapezius, ER to 45⁰, IR to C6, strength 5/5 | Positive Neer’s; positive apprehension, IR to T10, ER to 60⁰, strength 5/5, sensation intact to light touch throughout upper extremities, neg Hawkins’, neg relocation sign | Painful motion, TTP, pos impingement, pos Speed’s, pos cross-shoulder adductor, IR & ER full, no atrophy, ligaments stable |
| §4.71a Rating | 10% | 10% | 20% |

The VA C&P exam, 27 months pre-TDRL exit, indicated abduction less than 90° (meeting the 20% criteria), and was only slightly more limited in ROM than the pre-TDRL MEB exam documenting 100° of abduction. Neither exam was considered proximate to TDRL-exit. The first orthopedic TDRL reevaluation, 16 months pre-TDRL exit, reported slight limitation of forward flexion (abduction was full), tenderness of the right trapezius, and normal (5/5) upper extremity muscle strength. Shoulder radiographs were essentially normal. The second orthopedic TDRL reevaluation, five months pre-TDRL exit, noted more significant ROM deficits, and positive Neer’s (impingement) and apprehension (anterior glenohumeral instability) signs. Negative findings included normal strength (5/5), normal sensation, and negative Hawkins’ (impingement) and relocation (anterior glenohumeral instability) signs. Radiographs showed a small amount of spurring under the acromion.

An additional (civilian) orthopedic exam, obtained by the CI after the TDRL IPEB (five days prior to the FPEB and apparently not provided to the FPEB), diagnosed impingement syndrome and indicated a dramatic reduction in abduction (meeting the 20% criteria under 5201). There was tenderness, painful motion, positive impingement sign, positive Speed’s test (biceps tendon instability or tendinitis), and positive cross-shoulder adductor (acromioclavicular joint arthritis) sign. There was no muscle atrophy or ligament/capsular instability. Right shoulder plain radiographs were normal. The examining orthopedic surgeon accomplished an AC joint injection for pain relief within one week after this exam. A civilian neurology exam two days prior to this orthopedic exam, noted slight deltoid muscle weakness (-5/+5) and patchy sensory loss to pinprick in the right upper extremity. MRI demonstrated tendinopathy of the supraspinatus tendon and clavicle spurring producing some compromise of the subacromial space

The Board considered multiple rating options, including the use of analogous muscle codes reflecting the weakness seen in the pre-TDRL MEB exam and pre-FPEB neurology exam; however, there was no history of muscle injury and the CI’s intermittent weakness was most likely due to pain or guarding. Analogous coding to 5203 (clavicle or scapula, impairment of) was not appropriate based on the pathology. The CI’s shoulder impairment was principally due to the rotator cuff pathology, with degenerative osteophytes impinging the subacromial space; therefore analogous coding to 5019 (Bursitis), 5024 (Tenosynovitis), or 5201 (Arm, limitation of motion) was predominate.

It is obvious that there is a clear disparity between these examinations, with significant implications regarding the Board's rating recommendation. The Board thus carefully deliberated its probative value assignment to these conflicting evaluations, and carefully reviewed the file for corroborating evidence in the 12-month period prior to final separation. In assigning probative value to these somewhat conflicting examinations, the Board notes that the five-month pre-TDRL exit measurements are consistent with other collateral physical findings and corroborating evidence. The two-month pre-TDRL exit exam was performed after the TDRL IPEB, after the CI’s rebuttal to that IPEB, and just prior to the FPEB. There is not a reasonable accounting for progressively impaired ROM in the fairly short interval between the two examinations (just three months apart). The later ROM evaluation relies on subjective pain thresholds which are plainly associated with financial incentive, thus intrinsically subject to some loss of objectivity. Therefore, based on all evidence and associated conclusions just elaborated, the Board majority assigned preponderant probative value to the five-month pre-separation orthopedic evaluation. After due deliberation, considering all of the evidence and mindful of VASRD §4.59 (painful motion), the Board majority recommends a final separation rating of 10% for the right shoulder condition, coded 5099-5003 for pain-limited arm motion.

Neck Condition. The first IPEB rated the neck condition for the associated radiculopathy, using analogous coding to a peripheral nerve code, 8510, paralysis of the upper radicular group (fifth and sixth cervical nerves) IAW §4.124a. This was supported by the pre-TDRL neurosurgery NARSUM, which noted slight weakness of the brachioradialis, wrist extension, and finger extension (all 4/5), and mild hypesthesia of the thumb and index finger. The VA C&P exam, with slightly different findings, and complete ROM measurements, was rated by the VA under a musculoskeletal system code as 5003-5290 at 20% IAW §4.71a., absent any peripheral nerve rating. Subsequent TDRL evaluations, 16 and 27 months later (16 and 5 months pre-TDRL exit), revealed normal muscle strength, and the latter one reported a return of normal sensory function and a normal electrophysiologic study (EMG conducted the same day as the exam).

The neck condition must be rated IAW 2002 VASRD standards, following VASRD changes of 23 September 2002 to criteria of 5293 intervertebral disc syndrome, and before the VASRD change of 26 September 2003 when the current spine criteria became effective. As noted above, there may have been some overlap of symptoms from the right shoulder joint condition.

There were three neck examinations proximate to separation, including goniometric ROM evaluations, in evidence which the Board weighed in arriving at its rating recommendation. These exams are summarized in the chart below.

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| Goniometric ROM – Cervical | TDRL Ortho ~ 16 Mo. Pre-TDRL Exit | TDRL Ortho ~ 5 Mo. Pre-TDRL Exit | Civilian Neuro ~ 2 Mo. Pre-TDRL Exit |
| Flex (0-45) | ROMs not documented | “Full” | “↓ROM” |
| Ext (0-45) |
| R Lat Flex (0-45) |
| L Lat Flex (0-45) |
| R Rotation (0-80) |
| L Rotation (0-80) |
| COMBINED (340) |
| Comment | TTP R trapezius w/ increased tone; C-spine nontender w/ no bony [abnormalities]; decreased sensation right index finger & thumb, but 2 pt discrimination normal (<5 mm); motor 5/5; gait non-antalgic | TTP, pain w/ axial compression, strength 5/5 | Right deltoid muscle strength “-5/+5,” patchy sensory loss to pinprick (R arm), cervical spasm |
| Post-September 2002 §4.71a Rating | - | 10% | 10%-20% |
| §4.124a Rating | 10% | 0%-10% | 10%-20% |

\* §4.71a and §4.124a ratings have significant overlap and are not independent

The VA exam, 27 months pre-TDRL exit, showed reduced cervical ROMs, painful motion, tenderness, decreased strength, slowed motions, and limited endurance. Muscle spasm was specifically denied. The neurology C&P performed the same day reported thumb and fifth finger opposition somewhat limited, but no further muscle weakness or paresis, and hypesthesia in the C6 distribution (but also noted a positive Tinel’s sign of the radial nerve, suggesting peripheral nerve entrapment as the cause). The first TDRL orthopedic evaluation, 16 months pre-TDRL exit, reported the cervical spine was nontender with no bony abnormalities. There was tenderness of the right trapezius with increased tone but no mention of muscle spasm. The examiner also noted decreased sensation over the right index finger and thumb, but two-point discrimination was normal (<5 mm), motor function was normal (5/5), and gait was non-antalgic. Radiographs of the cervical spine were without significant degenerative change. A VA C&P exam, 8.5 months pre-TDRL exit for unrelated migraines and right leg/knee issues, indicated mild decrease of right hand grip strength. The second TDRL orthopedic NARSUM, five months pre-TDRL exit, noted “full” cervical ROM, tenderness to palpation, and pain with axial compression of the spine. Motor and sensory function was normal throughout the upper extremities, and nerve conduction studies of the right upper extremity, performed the same day as the orthopedic exam, were normal, with no evidence of radiculopathy. Radiographs revealed degenerative disc disease of the cervical spine. An additional (civilian) neurology exam, obtained by the CI after the TDRL IPEB (seven days prior and apparently not provided to the FPEB), with follow-up exam the following week (the day after the FPEB) reported right deltoid muscle weakness “-5/+5,” patchy sensory loss to pinprick in the right upper extremity, and cervical spasm. The follow-up exam the following week reported reduced ROM (without measurements). MRI revealed straightening of the normal cervical curvature (suggesting spasm), and a C5-6 “disc spur complex.”

There was no evidence of incapacitating episodes requiring physician-prescribed bed rest, so coding under 5245 for intervertebral disc syndrome was not appropriate. The VA exam, 27 months pre-TDRL exit, was remote from final separation, therefore deemed to have a lower probative value than more proximate exams. The Board majority also deemed the civilian neurology exam, two months pre-separation, to have a lower probative value than the TDRL orthopedic evaluation, for reasons elaborated under the shoulder discussion above; however, the Board also noted that the civilian neurology exam could rate either 10% or 20% for the neck condition, while the TDRL orthopedic exam would rate 10% under §4.71a. All exams proximate to separation suggest the CI’s neck condition had improved from the pre-TDRL evaluations.

After due deliberation, considering all of the evidence and mindful of VASRD §4.59 (painful motion), the Board recommends a final separation rating of 10% for the cervical spine condition, coded 5290 reflecting the mild limitation of cervical spine motion.

Neck Condition (Radiculopathy). The final TDRL NARSUM indicated that the pre-TDRL peripheral nerve impairment had resolved with normal nerve conduction studies. The VA exam finding of mild decrease of right hand grip strength 8.5 months prior to TDRL-exit and the neurologic exam two months prior to TDRL-exit indicating mild (-5/+5) right deltoid muscle weakness with patchy sensory loss to pinprick in the right upper extremity. The deltoid muscle weakness reported in the neurology exam was most likely attributable to the shoulder condition, as it was not associated with any corroborating radicular findings. The earlier reported positive Tinel’s sign (VA exam 27 months pre-TDRL exit) further questions the original PEB diagnosis of radiculopathy, in favor of peripheral nerve entrapment (radial or median nerve). The grip weakness reported in the VA exam was not specific to a cervical nerve distribution and may also be attributed to either the peripheral nerve entrapment or the CI’s history of right hand fractures which were not unfitting (VA rated 10% with limited motion).

The preponderance of evidence indicated there was no nerve impairment significant enough to interfere with performance of MOS duties at TDRL-exit. This leaves no grounds for a Board recommendation of an additionally unfitting neuropathy. All evidence considered, there is not reasonable doubt in the CI’s favor supporting addition of any upper extremity radiculopathy as an unfitting condition for separation rating.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were a history of plantar fasciitis (VA 10%), seasonal rhinitis, history of blurry vision without identified etiology, gastroesophageal reflux disease (VA 10%), history of fracture of right hand x2 (VA 10%), and history of resection of benign cyst of the left breast. Of these conditions, only plantar fasciitis was profiled (L2; run at own pace and distance, but may take the three-event Army physical fitness test). None of these conditions were 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 duty requirements. 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 headaches (VA 0%, later 10%), “dizziness or fainting spells,” sinusitis, hearing loss (separation audiogram normal), chronic cough, kidney stone or blood in urine (VA 10%), low back pain (VA 20%), nerve injury (VA 10% for residuals of right leg sural nerve injury), easy fatigability, and right knee arthritis status post arthroscopy (1986; VA 0%). Several additional non-acute conditions or medical complaints were also documented. None of these conditions were 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. 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, FPEB reliance on the USAPDA pain policy for rating the neck and right shoulder conditions was operant in this case and the conditions were adjudicated independently of that policy by the Board. In the matter of the neck and right shoulder condition, for a separation rating after TDRL, the Board unanimously recommends that it be rated as two separate unfitting conditions with rating, by a vote of 2:1, as follows: a cervical spine condition coded 5290 and rated 10%; and, a right shoulder condition coded 5099-5003 and rated 10%; both IAW VASRD §4.71a. The single voter for dissent (who recommended the conditions be rated as two separate unfitting conditions as follows: the right shoulder condition coded 5003-5201 and rated at 20%; and the cervical spine condition coded 5290 and rated 10%) did not elect to submit a minority opinion. In the matter of the plantar fasciitis, seasonal rhinitis, blurry vision, gastroesophageal reflux disease, fracture of right hand x2, and benign cyst of the left breast conditions, the Board unanimously recommends no change from the PEB adjudications as not unfitting. In the matter of the low back pain, history of kidney stone, right sural nerve injury, 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, effective as of the date of her prior medical separation:

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| **UNFITTING CONDITION** | **VASRD CODE** | **PERMANENT****RATING** |
| Right Shoulder Pain, S/P Surgery | 5099-5003 | 10% |
| Cervical spondylosis at C5/C6 w/ mild radicular deficit and mild/moderate R. C6 radicular pain | 8599-8510 |  |
| Neck Pain With DDD, C5-6 | 5290 | 10% |
| **COMBINED** | **20%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110423, 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 XXXXXXXXXXXXXXXXX (PD201100346)

1. 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 to modify the individual’s disability rating to 20% without recharacterization of the individual’s separation. This decision is final.

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.

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:

 Deputy Assistant Secretary

 (Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA