RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1100353 SEPARATION DATE: 20081019

BOARD DATE: 20120419

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was a National Guard SPC/E-4 (11B / Infantryman), medically separated for left shoulder pain and left knee degenerative joint disease (DJD). The CI injured his left shoulder during combative training in July 2007. He was diagnosed with a complete rotator cuff tear and underwent surgical repair in October 2007. Despite surgery and physical therapy rehabilitation, the CI continued to experience pain and weakness that limited his ability to lift or work above shoulder height with the left upper extremity. The CI was diagnosed with left knee DJD after he injured his left knee during a road march in July 2007. He was treated with physical therapy, but continued to experience knee pain that limited his ability to walk up and down stairs and prohibited running. The CI did not respond adequately to treatment and was unable to perform within his Military Occupational Specialty (MOS) or meet physical fitness standards. He was issued a permanent P3U3L3 profile and underwent a Medical Evaluation Board (MEB). Diabetes mellitus, chronic left shoulder pain (status-post rotator cuff repair), and chronic left knee pain (due to DJD) were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Hypertension and obesity were forwarded on the MEB submission as medically acceptable conditions. The PEB adjudicated the left shoulder pain and left knee DJD conditions as unfitting, rated 10% and 10% respectively; with application of the Veterans Administration Schedule for Rating Disabilities (VASRD). The CI rebutted the findings of the PEB, requesting the addition of hypertension, back pain and erectile dysfunction as unfitting conditions, and requesting further evaluation for hearing loss and blurry vision due to diabetes. The PEB response noted that the diabetes condition (adjudicated as not unfitting) existed prior to service (EPTS) and thus any residuals would also be EPTS. The CI appealed to the Formal PEB (FPEB), contending for the addition of thoracic back pain as an unfitting condition. The FPEB determined that there was no evidence that the thoracic back pain limited duty performance and adjudicated the diabetes condition as not separately unfitting. There was no change in the final rating and the CI was medically separated with a 20% combined disability rating.

CI CONTENTION: “I was rated below what my injuries were. Also, I started to have back problems while on active duty, but was told to late in the process to continue any further action. My diabetes flared out of control while on active duty.” He elaborates no specific contentions regarding rating or coding and mentions no additionally contended conditions. Note: Application was signed by surviving spouse; CI certificate of death 20110429 for immediate cause of hypertensive cardiovascular disease was in the record.

RATING COMPARISON:

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| **Service FPEB – Dated 20080819** | **VA (4 Mos. After Separation) – All Effective Date 20081020** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Left Shoulder Pain | 5099-5003 | 10% | Left Shoulder Injury | 5202 | 20% | 20090205 |
| Surgical Scars, Left Shoulder | 7804 | 10% | 20090205 |
| Left Knee DJD | 5003 | 10% | Left Knee Injury | 5262 | 10% | 20090205 |
| Diabetes Mellitus, Type 2 | Not Unfitting | Diabetes Mellitus w/Retinopathy | 7913 | NSC | 20090210 |
| Hypertension | Not Unfitting | Hypertension | 7101 | NSC | 20090210 |
| Obesity | Not Unfitting | No VA Entry | 20090210 |
| Thoracic Back Pain | Not Unfitting | Back Injury | 5237 | NSC | 20090205 |
| ↓No Additional MEB/PEB Entries↓ | 0% x 1/Not Service-Connected x 6 | 20090210 |
| **Combined: 20%** | **Combined: 40%** |

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impairment with which his service-incurred condition had burdened him. The Board wishes to clarify that it is subject to the same laws for service disability entitlements as those under which the Disability Evaluation System (DES) operates. The DES has neither the role nor the authority to compensate service members for anticipated future severity or potential complications of conditions resulting in medical separation. That role and authority is granted by Congress to the Department of Veterans’ Affairs (DVA), operating under a different set of laws (Title 38, United States Code). The Board evaluates DVA evidence proximal to separation in arriving at its recommendations, but its authority resides in evaluating the fairness of DES fitness decisions and rating determinations for disability at the time of separation. The Board also acknowledges the CI's contention suggesting that service ratings should have been conferred for other conditions documented at the time of separation. 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. The DVA, however, is empowered to compensate service-connected conditions and to periodically re-evaluate said conditions for the purpose of adjusting the Veteran’s disability rating should the degree of impairment vary over time.

Left Shoulder Pain. The CI was left hand dominant. He injured his left shoulder during combative training exercises in July 2007. His pain persisted despite physical therapy and he was subsequently diagnosed with a complete tear of the left rotator cuff. Following arthroscopic repair of the left rotator cuff in October 2007, the CI had significant improvement in his range of motion. The narrative summary (NARSUM) indicated “he still has pain in his left shoulder and says he feels pain with any attempts at doing exercises above shoulder height with his left arm. He says also that he notices he has fairly good range-of-motion (ROM) but it does hurt when he performs range of motion exercises.”

There were three comprehensive shoulder evaluations, two with ROM measurements, in evidence which the Board weighed in arriving at its rating recommendation. These examinations were an orthopedics post-operative evaluation, the MEB NARSUM exam (with physical therapy ROM measurements) and the VA Compensation and Pension (C&P) exam. The exam findings are summarized in the chart below.

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| Goniometric ROM – Left Shoulder | Ortho ~ 6 Mo. Pre-Sep(20080404) | MEB ~4 Mo. Pre-Sep(20080619) | VA C&P ~4 Mo. After-Sep(20090205) |
| Flexion (0-180) | “FROM” | 170⁰ | 180⁰ |
| Abduction (0-180) | “FROM” | 150⁰ | 180⁰ |
| Comment: Surgery 20071017 | 4-/5 strength on external rotation and abduction. | External rotation limited to 40 degrees; 5/5 biceps and triceps strength; painful motion | Weakness and pain from 90 – 180 degrees; external rotation limited to 45 degrees and painful; no Deluca; tenderness biceps groove |
| §4.71a Rating | 10% | 10% | 10%-20% (VA - 20%) |

Pre-operative plain films of the left shoulder (6 July 2007 – pre-op) noted mild arthritic changes and a pre-operative MRI arthrogram (20 September 2007) documented partial tears of the supraspinatus and subscapularis tendons. Surgery included subacromial space bursectomy and arthroscopic subacromial decompression as well as rotator cuff repair and tendon debridement.

The orthopedics evaluation noted full ROM, but documented slight weakness (4-/5) on external rotation and on abduction. The MEB exam documented painful limitation of flexion, abduction and external rotation, but did not comment on rotator cuff muscle strength. A physical therapy note (2 June 2008) from 3 weeks prior to the MEB exam showed full active ROM for flexion and abduction with resisted tests of flexion and abduction at 90 degrees of 4-/5 (indicating slight weakness). Restriction was no lifting over 20 pounds with the left upper extremity. At the VA C&P exam, the history indicated a rotator cuff repair with distal clavicle resection. The findings for flexion and extension ROM were: “abduction and forward flexion are 0-180 degrees with weakness and pain from 90-180 degrees. There are no additional limitations following repetitive use other than increased pain without further loss of motion. There are no flare-ups. There is no effect of incoordination, fatigue, weakness or lack of endurance on his joint function.” The diagnosis was “left shoulder impingement status post rotator cuff repair with biceps tendonitis.”

The PEB and the VA applied different codes and arrived at different ratings for the left shoulder condition. The PEB coded analogous to degenerative arthritis and rated 10% based upon periarticular pathology with painful limitation of motion of flexion 170 and abduction 150 degrees (beyond 90 degrees). The VA coded for other impairment of the humerus and rated 20% for “infrequent episodes of dislocation of the scaphohumeral joint with guarding of arm movements only at the shoulder level.”

The Board directs attention to its rating recommendation based on the above evidence. There were no symptoms or evidence of an unfitting peripheral nerve impairment and there was no evidence that left shoulder surgical scars interfered with duty performance to a degree that could be considered unfitting. The Board considered application of the 5202 coding (humerus, other impairment of) used by the VA (20%-Moderate). The CI had subacromial decompression which may be analogous to clavicular resection for analogous coding of 5202. Analogous coding for rotator cuff pathology under 5203 (impairment of clavicle or scapula) or 5304 (group IV, moderate) was also considered. The crux of the rating is if the CI’s ROMs were considered limited or guarded at 90 degrees due to weakness and pain at 90 degrees abduction, or if the pain and weakness with tenderness equated to a moderate (20%) functional impairment under 5202. The Board considered VASRD §4.40 (Functional loss) and the phrase “weakness is as important as limitation of motion, and a part which becomes painful on use must be regarded as seriously disabled.” The CI had full active flexion and abduction ROM of the left shoulder, and displayed pain and weakness (service 4-/5; VA unspecified) beyond 90 degrees without additional limitation of ROM with repetitive use. The 20 pound lifting restriction for the CI’s dominant (“major” IAW §4.71a.) hand was also considered. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s coding or rating decision for the left shoulder condition.

Left Knee Degenerative Joint Disease. The CI injured his left knee during a three mile march during training in July 2007. Despite treatment with physical therapy his pain persisted, restricting his ability to use stairs, run or meet physical fitness standards. Although it was noted that the CI would eventually require arthroplasty, it was not felt that the left knee would require surgical intervention in the foreseeable future. There were two comprehensive knee evaluations, with ROM measurements, in evidence which the Board weighed in arriving at its rating recommendation. These examinations were the MEB NARSUM exam and the VA C&P exam. The exam findings are summarized in the chart below.

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| Goniometric ROM –Left Knee | MEB ~4 Mo. Pre-Sep(20080619) | VA C&P ~ 4 Mo. After-Sep(20090205) |
| Flexion (140⁰ normal) | 110⁰ | 130⁰ |
| Extension (0⁰ normal) | 0⁰ | 0⁰ |
| Comment | Normal gait; painful flexion | No flare-ups; normal gait; Pain and crepitus throughout range; tenderness; small effusion; no instability; Neg Lachman’s |
| §4.71a Rating | 10% | 10% (VA 20% w/reduction to 10% for EPTS) |

Both exams documented a normal gait, knee joint tenderness and painful limitation of knee flexion. The VA exam additionally noted crepitus and a small effusion. There was no evidence of instability and Lachman’s was negative. Plain filmsdocumented prominent arthritic changes.

The PEB and the VA utilized different coding and rationale, but arrived at the same final rating recommendation for the condition. The PEB coded for degenerative arthritis and rated at 10% for painful limitation of motion. The VA coded for impairment of the tibia and fibula and rated their exam at 20% for moderate knee disability with a 10% deduction for pre-service disability (the CI’s 1983 VARD had determined that the left knee injury had EPTS) for a final 10% service-connected disability.

Neither the MEB nor the VA exam documented compensable ROM impairment of the left knee under 5260, limitation of flexion, coding. The MEB and VA evaluations documented the absence of mechanical instability, locking or frequent effusions. There were no symptoms or findings of an unfitting peripheral nerve impairment. With a normal gait and no flare-ups, the CI’s knee impairment was adjudged to be at the slight versus the moderate knee disability level under the 5262 coding. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s coding or rating decision for the left knee degenerative joint disease condition.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were hypertension, obesity and diabetes mellitus. Additionally, the condition of thoracic back pain, which developed after the MEB and IPEB proceedings, was addressed by the FPEB. The condition of obesity does not constitute a physical disability IAW DoDI 1332.38. The condition of hypertension was fairly well controlled on medication. There was no diagnosis of any associated end-organ damage, this condition was not noted as failing retention standards and it was not implicated in the commander’s statement. The CI developed thoracic back pain a month prior to the FPEB proceedings, and he petitioned for this to be added as an unfitting condition. There was scant documentation in the service treatment records (STRs) on the thoracic back pain condition and there was insufficient evidence that this condition resulted in any duty limitations. The FPEB noted that the thoracic back pain condition was of recent onset and likely transient. With respect to the thoracic back pain condition, the Board notes that it is not uncommon for members to be separated for an established unfitting condition with pending treatment issues for conditions unrelated to the reason for a MEB. The service’s responsibility in such cases is to assure that there are no safety concerns with transfer of care, not to see all conditions through to their maximal resolution. When assessing the fitness implications of these collateral conditions, the PEB acknowledges that the member is not remaining on active duty for other reasons. It must therefore anticipate the typical clinical course and expected impact on long-term MOS performance. The Board must judge the fairness of the PEB’s fitness adjudication in such cases on the basis of that principle, not on the particulars in effect on the day of separation. The conditions of hypertension and thoracic back pain were reviewed by the action officer and considered by the Board. There was no indication from the record that either 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 the hypertension or thoracic back pain conditions.

The CI was initially diagnosed with diabetes in 2004. He had a diagnosis of mildly symptomatic, new onset type II diabetes mellitus in February 2008 after a January 2008 ophthalmology exam found evidence of diabetic retinopathy. At the time of the February 2008 diagnosis, the CI complained of blurry vision, malaise, polydipsia and a recent five pound weight loss. His fasting glucose was 267, the glycated hemoglobin (HgA1c) level was 13.3%, and he was spilling 4+ glucose in his urine. The endocrinologist noted likely beta cell failure that required initial treatment with an intensive insulin regimen for a period of three to 6 months. At the time of endocrinology reevaluation in June 2008, the CI’s blood sugars were under better control and the HgA1c had decreased to 8.2. In response to the CI’s improving diabetes control, the endocrinologist initiated a plan to transition off of insulin therapy and onto oral medications. At the time of the MEB exam, it was noted that the CI’s diabetes control was improving and that his insulin therapy was being discontinued. He had not had any problems with insulin reaction and denied any problems with his oral diabetes medication. The MEB examiner noted that the CI had been previously diagnosed with diabetes in 2004 and in 2006, but had not followed up with treatment. The STRs documented that while activated in March 2005, the CI had been placed on a permanent P2 profile for diabetes treated with oral medication.

The VA exam 4 months after separation, on 10 February 2009, indicated the CI was taking insulin, and had not been hospitalized or had any activity restrictions due to diabetes. There were no peripheral nerve findings (some ocular findings with record of diabetic retinopathy). Blood glucose was 299 mg/dl (70-109), HgA1c was 11.7% (4.2-5.8), and there was glucose and microalbumin in the urine. The diagnosis was diabetes mellitus type II with poor control. VA review indicated “STRs from July 16, 1980 through March 30, 1983 and from May 14, 2007 to October 19, 2008 show diabetes mellitus on medication at entrance examination on May 20, 2007.” The VA rating was “not service-connected, not aggravated by service:” “Although the veteran was treated for diabetes mellitus during service, there is no evidence of aggravation beyond normal progression of the disease during service. There must be objective evidence of worsening of a pre-existing condition in order to establish service-connection by aggravation. There is no evidence that the condition permanently worsened as a result of service.”

The diabetes mellitus requiring oral medication condition was designated by the MEB as not meeting AR 40-50 standards, although that fact does not establish whether or not a condition is unfitting. The PEB arrives at that determination through a performance-based assessment. 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 as discussed above. The PEB noted that the CI’s diabetes mellitus condition was improving and that he was being treated with oral medications. As there was no longer a requirement for insulin, the PEB concluded “there is no reason that this should interfere with the performance of his duties.” The endocrinology clinic notes confirmed improvement of the diabetes condition and the STRs (on 28 July 2008) confirmed that the CI was no longer being treated with insulin. There was no documentation of duty limiting impairment due to the medications or the diabetic retinopathy. The VA record within 4 months prior to separation indicated the CI’s diabetes required insulin and was in poor control. This may indicate worsening after separation or that the CI’s in-service transition to oral medications was only transiently effective (akin to a honeymoon period). After due deliberation in consideration of the preponderance of the evidence, the Board concluded that there was insufficient cause to recommend a change in the PEB adjudication for the diabetes mellitus condition.

Remaining Conditions. The condition of left shoulder scars due to the arthroscopic rotator cuff surgery was identified in the VARD proximal to separation but was not documented as causing any duty limitations in the STRs. By precedent, the Board does not recommend separation rating for scars unless their presence imposes a direct limitation on fitness. Several additional non-acute conditions or medical complaints were also documented. None of these conditions were significantly clinically or occupationally active 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. 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. The Board did not surmise from the record or PEB ruling in this case that any prerogatives outside the VASRD were exercised. In the matter of the left shoulder condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication at separation. In the matter of the left knee degenerative joint disease condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication at separation. In the matter of the diabetes mellitus (type II), hypertension and thoracic back pain conditions, the Board unanimously recommends no change from the PEB adjudications as not unfitting. In the matter of the left shoulder surgical scar condition 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, 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** |
| Left Shoulder Pain | 5099-5003 | 10% |
| Left Knee DJD | 5003 | 10% |
| **COMBINED** | 20% |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20120209, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans Affairs Treatment Record

 XXXXXXXXXXX

 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 XXXXXXXXXXXX, AR20120008206 (PD201100353)

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’s spouse, 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:

Encl XXXXXXXXXXX

 Deputy Assistant Secretary

 (Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA