RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD11-00614 SEPARATION DATE: 20040705

BOARD DATE: 20120606

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty Soldier, SPC/E-4(91B, Combat Medic), medically separated for pain in the left elbow, left wrist, shoulders (bilateral), and left knee. The CI had left shoulder open surgery in 1999 due to chronic subluxation prior to entering the service; he had right shoulder open surgery in 2002 due to dislocation during an airborne operation; he had a fracture of the left arm (distal radius) with chronic wrist pain and peripheral nerve symptoms. There was no specified single trauma for the left knee condition. The CI underwent numerous specialty consults and therapies for his multiple conditions. Left wrist surgery was recommended, but reasonably declined. The problems with his left elbow, left wrist, shoulders, and left knee could not be adequately rehabilitated and the CI did not improve adequately with treatment including multiple narcotic medication trials to meet the physical requirements of his Military Occupational Specialty (MOS). He was issued a permanent U3/L3 profile and referred for a Medical Evaluation Board (MEB). Chronic left cubital tunnel syndrome, left chronic wrist pain, and chronic left anterior knee pain were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Chronic bilateral shoulder instability was deemed EPTS by the MEB without addressing service aggravation. The MEB forwarded no other conditions for PEB adjudication. The PEB adjudicated “pain left elbow, left wrist, shoulders, and left knee (with sleep disruption and use of narcotic pain medication)” as unfitting, and bundled them as a single unfitting condition rated for pain as moderate and frequent at 10% with application of the US Army Physical Disability Agency (USAPDA) pain policy. The CI appealed to FPEB, but later withdrew his appeal and was then medically separated with a 10% combined disability rating.

CI CONTENTION: “I HAVE A HEART CONDITION THAT WASN'T TAKEN IN COSIDERATION AND I'M STILL HAVING PROBLEMS WITH BMY [*sic*] SHOULDER. I HAVE SEVERAL SURGERYS INCLUDING SLEEP APNEA AND SEVERAL OTHER HEALTH PROBLEMS THAT HAVE NOT BEEN ADDRESSED TO THE FULLEST. I'M PAYIMG FOR MEDS OUT OF POCKET AND NOTRE BURST[*sic*] FOR TRAVEL ASWELL[*sic*] I HAVE PROBLEMS THAT NEED TO BE ATTENDED TOO OR PAID SO THAT, l CAN GET CORRECTED.” [*sic*]

SCOPE OF REVIEW: The Board wishes to clarify that the scope of its review as defined in DoDI 6040.44, Enclosure 3, paragraph 5.e.(2) is limited to those conditions which were determined by the PEB to be specifically unfitting for continued military service; or, when requested by the CI, those condition(s) “identified but not determined to be unfitting by the PEB.” The ratings for unfitting conditions will be reviewed in all cases. The conditions within the Board’s scope are left elbow, left wrist, both shoulders, left knee, and sleep disturbance. The requested heart condition is not within the Board’s purview. Any conditions or contention not requested in this application, or otherwise outside the Board’s defined scope of review, remain eligible for future consideration by the Army Board for the Correction of Military Records (BCMR).

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service PEB – Dated 20040217** | **VA (1 Mos. Pre-Separation) – All Effective Date 20040706** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Pain Left Elbow, Left Wrist, Shoulders (bilateral), and Left Knee; (sleep disruption) | 5099-5003 | 10% | R Shoulder (Major), Recurrent Dislocations w/Chronic Strain | 5299-5202\* | 20%\* | 20040622\* |
| R Shoulder, Post Op. Scar … | 7805 | 0% | 20040622 |
| L Shoulder, Recurrent Dislocations w/Chronic Strain | 5299-5202\* | 20%\* | 20040622\* |
| L Knee Chrondromalacia Patella (CP) w/Laxity | 5257 | 10% | 20040622 |
| L Knee, CP w/Crepitus,  | 5010-5260\* | 10%\* | 20040622\* |
| L Wrist, Post Op. Residuals … | 5215 | 0% | 20040622 |
| L Cubital Tunnel Syn. (L Elbow) ... | 8517 | 0%\* | 20040622 |
| Sleep Disorder | 6847 | NSC | 20040622 |
| ↓No Additional MEB/PEB Entries↓ | Hx of Pericarditis w/LVH & PI | 7002 | 30%\* | 20040622 |
| Major Depression w/Psychotic … | 9434 | 30% | 20040622 |
| R Knee, CP | 5099-5019 | 0%\* | 20040622 |
| TMJ | 9905-5010\* | 10%\* | 20040622 |
| Lumbar Strain, Chronic | 5237 | 10%\* | 20040622 |
| Tinnitus, Bilateral | 6260 | 10% | 20040622 |
| L Ankle, … Surgical Scar | 7804 | 10% | 20040622 |
| 0% X 2 / Not Service-Connected x 5 | 20040622 |
| **Combined: 10%** | **Combined: 90%\*** |

\* DRO of 20050209 referenced VA treatment note of 20041124 and increased original 60% rating: R & L shoulder each changed from 10% to 20% with code from -5203 to -5202; added L knee -5260 at 10%; 7002 (cardiac) increased to 30%; and TMJ increased to 10%. Left cubital tunnel (elbow) 8517 was increased to 10% effective 20050108. Multiple more remote VA coding/rating changes are not charted.

ANALYSIS SUMMARY: The Board acknowledges the CI's contention suggesting that ratings should have been conferred for other conditions documented at the time of separation. The Board wishes to clarify that it is subject to the same laws for disability entitlements as those under which the Disability Evaluation System (DES) operates. The DES is responsible for maintaining a fit and vital fighting force. 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 re-evaluate said conditions for the purpose of adjusting the Veteran’s disability rating should the degree of impairment vary over time. The PEB combined left elbow, left wrist, bilateral shoulder, and left knee pain to include sleep disruption and use of narcotic pain medication as the single unfitting and solely rated condition, coded analogously to 5003. Although this approach complies with AR 635.40 and the USAPDA pain policy in effect at the time, the Board must apply separate codes and ratings in its recommendations, if compensable ratings for each condition are achieved IAW the VASRD. 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 reasonably unfitting and separately compensable (at the time of separation). Not uncommonly this 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.

Left Elbow Condition. As previously elaborated, the Board must first consider whether the left elbow condition remains separately unfitting, having de-coupled it from the combined PEB adjudication. The profile specifically listed left cubital tunnel syndrome as part of the U3 profile restriction. The commander’s statement did not specify conditions other than the shoulders, but profile restrictions may have sheltered this condition. The CI was right-handed. In analyzing the intrinsic impairment for appropriately coding and rating the left elbow condition, the Board is left with a questionable basis for arguing that the left elbow was indeed independently unfitting. The CI had a history of a distal radius fracture onto an outstretched hand and a diagnosis of cubital tunnel syndrome. The CI complained of numbness, tingling and pain of the left fingers. There was a demonstrated 4/5 motor weakness in the left ulnar nerve distribution with positive Tinel’s (nerve irritation sign) at both the elbow (cubital tunnel) and wrist (carpal canal), with a positive elbow flexion test with a non-standard finding of numbness and tingling of all digits (not nerve-specific). There was an electrophysiological study (EMG) which revealed evidence of a left demyelinating sensory neuropathy. The diagnosis was chronic left cubital tunnel syndrome which was not considered operable. There was no significant decrease in elbow range-of-motion (ROM) and no elbow joint pathology. The motor impairment was relatively minor and cannot be linked to significant physical impairment and the sensory component was mild and on the non-dominant hand.

All members agreed that the left elbow pain and wrist/hand symptoms (see below), when considered as an ulnar nerve condition, would have rendered the CI incapable of continued service within his MOS; and, accordingly merits a separate rating. At the VA Compensation and Pension (C&P) exam prior to separation, the CI reported similar symptoms and the VA elbow exam was normal including non-painful ROM to the VA normal ranges. VA records indicated ongoing treatment for this condition and surgical intervention with left ulnar nerve transposition in October 2005. The VA rated their exam at 0% for mild paralysis of the musculocutaneous nerve, with an increased rating to 10% effective on 8 January 2005. This retroactive 10% rating was following the 100% temporary rating (on 20 October 2005) for the surgical intervention and a 10% rating was continued effective on 1 February 2006.

The Board directs attention to its rating recommendation based on the above evidence. There was clear evidence that the nerve involved was the ulnar nerve at the cubital tunnel. Coding would therefore be under the ulnar nerve, 8616 (neuritis) and meet the mild rating level. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a disability rating of 10% for the left elbow (cubital tunnel syndrome) condition coded 8616.

Left Wrist Condition. As previously elaborated, the Board must first consider whether the left wrist condition remains separately unfitting, having de-coupled it from the combined PEB adjudication. The profile specifically listed left wrist TFCC tear [triangular fibrocartilage complex of the wrist affect the *ulnar* (little finger) side of the wrist] as part of the U3 profile restriction. The commander’s statement did not specify conditions other than the shoulders, but profile restrictions may have sheltered this condition, and the CI was recommended for elective surgical correction which he reasonably declined. The wrist and finger symptoms overlap those from the left elbow (see above elbow condition). The MRI imaging of the wrist was inconclusive for TFCC tear, but noted degenerative changes. Bone scan indicated no abnormalities to explain the CI’s symptoms. ROM testing at the VA exam prior to separation indicated full ROM without pain. Functional assessment of the left wrist within a month after separation indicated a fully functional wrist with no pain at rest and pain of 5/10 with use, with a plan for arthroscopic repair and debridement. No wrist surgery was in evidence proximate to separation (see above for ulnar nerve surgery). All members agreed that the left wrist, when considered as a separate condition absent any ulnar nerve condition, would not have risen to the level of being unfitting; however, any wrist and hand symptoms attributable to the ulnar nerve/elbow condition were considered above. After due deliberation in consideration of the preponderance of the evidence, the Board concluded that there was insufficient cause to recommend an unfit determination for the left wrist condition; and, therefore, no additional disability ratings can be recommended (not unfitting).

Left Knee Condition. The Board first considered if the left knee condition, having been de-coupled from the combined PEB adjudication, remained independently unfitting as established above. Chronic left knee anterior knee pain was profiled as L3 without any other condition referable to the lower-extremity profile restrictions. Profile restrictions were for no knee bender, side-straddle hop or jogging in place, allowed aerobic conditioning at own pace for walk, run, swim, or pool; however, also allowed fitness test of walk swim or bicycle. The commander’s statement did not specify the knee condition, but mentioned duty limiting restrictions of no road marching or participation in Airborne operations or physical fitness training.

All members agreed that the left knee condition would have rendered the CI incapable of continued service within his MOS; and, accordingly merits a separate rating. At the MEB exam, the examiner’s history indicated the CI “complains of left anterior knee pain for which no bony or ligamentous pathology has ever been determined. Review of systems indicated a history of bilateral knee pain and swelling, left worse than right, without MRI abnormality or history of surgery. The MEB physical exam noted retropatellar pain with motion and “full active ROM” with no tenderness, effusion or laxity. Referenced formal ROM testing indicated flexion to 125⁰ (140⁰ normal) and extension of 5⁰ of hyperextension (normal 0⁰). X-rays were normal.

At the VA C&P exam prior to separation, the CI reported pain and popping in both knees with a prior indication of knee instability. Exam of the knee showed a normal ROM (0-140⁰) with bilateral crepitus. Tests for instability (Drawer and McMurray’s) were negative. The VA rated this exam at 10% (5257) for chondromalacia patella with laxity. On appeal of this rating the DRO indicated “Treatment reports from VAMC Fayetteville of November 24, 2004 (4 months after separation), notes findings of tender left knee with effusion, negative drawer, positive pivot shift and subluxing patella. X-ray findings on 12 November 2004, revealed a normal left knee. You are shown to have been issued a knee brace.” The brace note is in the available records; however, the source treatment note is not available. The VA added an additional 10% rating (dual rating of the knee) coded 5010-5260 for the left knee based on this evidence.

The Board directs attention to its rating recommendation based on the above evidence. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt) and §4.59 (painful motion), the Board recommends a disability rating of 10% for the left knee condition, coded 5257 for slight knee impairment.

Shoulders (Left and Right) Condition. The Board first considered if the left and right shoulder conditions, having been de-coupled from the combined PEB adjudication, remained independently unfitting as established above. The commander’s statement specifically addressed recurrent bilateral shoulder instability as interfering with duty performance and bilateral shoulder instability was profiled U3. All members agreed that either shoulder instability, would have rendered the CI incapable of continued service within his MOS; and, accordingly merits a separate rating. The CI was right hand dominant. There were two goniometric ROM evaluations in evidence, with documentation of additional ratable criteria, which the Board weighed in arriving at its rating recommendation; as summarized in the chart below.

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| --- | --- | --- |
| Shoulder ROM | MEB ~7 Mo. Pre-Sep | VA C&P ~1 Mo. Pre-Sep |
| Left | Right | Left | Right |
| Flexion (0-180⁰) | 170⁰ | 170⁰ | 160⁰ | 160⁰ |
| Abduction (0-180⁰) | 180⁰ | 180⁰ | 150⁰ | 130⁰ |
| Comments | Instability L 2+ / R 1+ anterior load shift, but no relocation; -tender or effusion; Hx L recurrent dislocation & R less dislocation after surgery, recurrent subluxation (see text) | Painful motion; no tenderness or instability; (see text-VA RX notes 20041124 of visible subluxing)  |
| §4.71a Rating | 20% | 10%-20% | 10% (VA 20%) | 10% (VA 20%) |

The record indicated that the CI had had left shoulder surgery prior to entry into the service (surgery was EPTS). The entry physical did not indicate any painful motion or instability of the left shoulder. The CI had right shoulder surgery following a parachuting injury/dislocation in April 2002 that the CI self-reduced and did not immediately report. At the MEB and specialist exam, the CI reported bilateral shoulder instability with recurrent dislocations on the left and recurrent subluxations on the right and dislocates less frequently after surgery in 2002. The MEB physical exams noted ROMs which were slightly limited, with loose movement noted for each shoulder with the left looser (2+) than the right (1+) as charted above. MRI of the left shoulder showed degenerative changes. The diagnosis was chronic bilateral shoulder instability. The specialist noted severe limitations and a P4 profile for this diagnosis and left elbow, left wrist and left knee pain conditions.

At the VA C&P exam prior to separation, the CI reported that the 2002 parachuting injury had caused bilateral shoulder dislocations that were self-reduced. He complained of recurrent bilateral shoulder dislocations. Exam demonstrated pain-limited ROMs as charted above, with no instability. The diagnosis was “recurrent shoulder dislocations; chronic strain.” The VA DRO noted treatment reports from the VAMC Fayetteville dated 24 November 2004, indicating visible subluxing of both shoulders. MRIs in 2005 demonstrated bilateral mild degenerative changes. VA treatment notes indicated continued complaints and treatment for bilateral shoulder dislocations with additional left shoulder surgery in August 2006, (2 years remote from separation) for left shoulder pain and instability.

The Board directs attention to its rating recommendation based on the above evidence. There was clear evidence that the CI’s first left shoulder surgery was prior to entry into service and the MEB indicated EPTS; however, neither the MEB nor PEB indicated permanent service aggravation as being present or absent. The CI had no left shoulder symptoms prior to the airborne operation injury and left shoulder was in the combined PEB unfit and rated disability description. The VA adjudged permanent service aggravation of the left shoulder. The CI’s history of injuries and recurrent left shoulder dislocations provided reasonable doubt that there was permanent service aggravation of the left shoulder condition and the left shoulder EPTS component for potential deduction was 0%.

The Board deliberated over the probative value of the exams and the post-separation DRO summary of the 24 November 2004 treatment note indicating bilateral visible subluxing. The VA C&P exam had decreased probative value as being an outlier, and for not specifying which tests for instability were applied. The Board determined that the MEB exam had the highest probative value for rating at separation. The Board deliberated on analogous coding using 5003 (arthritis or 5019-5024 which use the same criteria) or 5202 (humerus, other impairment – VA final coding) or 5203 (clavicle or scapula, impairment of – VA initial coding). There was no evidence of shoulder deformity or limitation of movement at shoulder level. The evidence for loose movement of the left shoulder was clear by history of recurrent dislocations and exam findings and met the 20% criteria for 5299-5202 or 5299-5203. The left shoulder EPTS component for potential deduction was 0%. The right shoulder was noted as having recurrent subluxations in service records and dislocations in the VA history prior to separation. Exam findings of 1+ anterior load shift was deliberated as to whether it was sufficient to indicate loose movement (20%), or was closer to no loose movement (10%) in light of the entirety of the record. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a disability rating of 20% for the left shoulder condition, coded 5299-5202; and a disability rating of 10% for the right shoulder condition, coded 5299-5203.

Sleep Condition. Sleep disruption was part of the PEB disability description and sleep apnea was in the CI’s contention. There was no diagnosis of obstructive sleep apnea (OSA) in service and the service record attributed sleep disruption to pain and not a separately diagnosed condition. VA records indicate the CI’s insomnia and sleep issues were considered under their rating for a mental disorder, 9434, major depression with psychotic features, which is outside the scope of the PDBR. Sleep disorder was not profiled; implicated in the commander’s statement; or judged to fail retention standards. Sleep disorder was reviewed by the action officer and considered by the Board. There was no indication from the record that any sleep condition significantly interfered with satisfactory duty performance. After due deliberation in consideration of the preponderance of the evidence, the Board concluded that there was insufficient cause to recommend an unfit determination for the sleep disruption; and, therefore, no additional disability ratings can be recommended.

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 disability was operant in this case and the condition was adjudicated independently of that policy by the Board. In the matter of the “pain left elbow, left wrist, shoulders (bilateral), and left knee; (sleep disruption)” condition, the Board unanimously recommends that the left wrist condition and sleep disorder be determined as not unfitting, and that it be rated for multiple separate unfitting conditions as follows: left elbow condition coded 8616, rated 10% IAW VASRD §4.124a and VASRD §4.71a.; unfitting right shoulder condition coded 5299-5202, rated 10%; left shoulder condition coded 5299-5203, rated 20%; and left knee condition coded 5257, rated 10%. There were no other conditions within the Board’s scope of review for consideration.

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** |
| Right Shoulder (Major) Pain with Recurrent Subluxations | 5299-5203 | 10%  |
| Left Shoulder Pain with Recurrent Dislocations | 5299-5202 | 20% |
| Left Knee Pain  | 5257 | 10% |
| Left Wrist Pain  | Not Unfitting |
| Left Elbow Pain (Cubital Tunnel Syndrome), Including hand  | 8616 | 10% |
| Sleep Disorder | Not Unfitting |
| **COMBINED (w/ BLF)** | **50%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110808, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans’ Affairs Treatment Record

 XXXXXXXXXXXXXX

 President

 Physical Disability Board of Review

SFMR-RB

MEMORANDUM FOR Commander, US Army Physical Disability Agency

(), 2900 Crystal Drive, Suite 300, Arlington, VA 22202

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation

for XXXXXXXXXXXXXX, AR20120011850 (PD201100614)

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 50% 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 50% 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 XXXXXXXXXX

 Deputy Assistant Secretary

 (Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA