RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: Army

CASE NUMBER: PD1100642 SEPARATION DATE: 20081227

BOARD DATE: 20120316

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty member, E-5/SGT (92Y/Supply NCO) medically separated for chronic right knee pain secondary to pes anserine bursitis*.* The CI began experiencing knee pain in 2000 during basic training. The CI underwent an initial arthroscopic meniscal repair in 2002 and was reoperated again in 2006. The procedure provided little relief of her knee pain. In 2006 the CI was diagnosed with pes anserine (PA) bursitis and underwent removal of the pes anserinus bursa. Despite extensive physical therapy and medications, the CI did not respond adequately to treatment and was unable to perform within her Military Occupational Specialty (MOS) or meet physical fitness standards. The CI was issued a permanent L3 profile and underwent a Medical Evaluation Board (MEB). The MEB forwarded “chronic right knee pain secondary to pes anserine bursitis” on DA Form 199 to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. History of tibial stress fractures and migraine headaches identified in the rating chart below, were forwarded on the MEB submission as medically acceptable conditions. The PEB adjudicated “chronic right knee secondary to pes anserine bursitis” condition as unfitting, rated 10%, with application of the Veterans Administration Schedule for Rating Disabilities (VASRD). The CI made no appeals, and was medically separated with a 10% combined disability rating.

CI CONTENTION: The CI states: “I feel that my 10% rating was in error, I feel that my Pes Anserine Bursitis is and was a lot worse than this rating implies. I feel that I should have been medically retired due to this condition.”

RATING COMPARISON:

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| --- | --- |
| **Service PEB – Dated 20080905** | **VA (4 Mo. Pre-Separation) – All Effective Date 20081228** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Right Knee Pain secondary to Pes Anserine Bursitis | 5019 | 10% | Right Knee Pes Anserinus Bursitis, Post Bursectomy with Shin Splints and Scarring | 5262 | 10% | 20080811 |
| History of Tibial Stress Fractures | Not Unfitting |
| Migraine Headaches | Not Unfitting | Migraine Headaches | 8100 | 30%\* | 20080811\* |
| ↓No Additional MEB/PEB Entries↓ | Tenosynovitis, Right Wrist | 5024 | 10% | 20080811 |
| Tenosynovitis, Left Wrist | 5024 | 10% | 20080811 |
| Cervical Strain | 5237 | 20%\* | 20080811\* |
| Lumbar Sprain | 5237 | 10% | 20080811 |
| 0% x 2/Not Service Connected x 2 | 20080811 |
| **Combined*:* 10%** | **Combined: 60%\*** |

\* Originally Migraine coded 8100 rated at 0% later changed to 30%, and cervical strain coded 5237 rated at 10% changed to 20% effective 20081228 (combined rating changed from 40% to 60%) following exam of 20100811 per DRO de novo review, VARD dated 20101102 [*VA memo of 20101115 stated effective date was 20091228*].

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impairment with which his service-incurred condition continues to burden 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 further acknowledges the CI’s contention for service ratings for other conditions documented at the time of separation, and notes that its recommendations in that regard must comply with the same governance.

Right Knee Condition. There were two goniometric range-of-motion (ROM) evaluations and one non goniometric ROM evaluation 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 Knee | Medical Clinic ~ 5 Mo.Pre-Sep | MEB ~ 4 Mo. Pre-Sep | VA C&P ~ 4 Mo. Pre-Sep |
| Flexion (140⁰ normal) | 5⁰-42⁰7⁰-48⁰8⁰-48⁰ | See PT - Medical Clinic | 0⁰-120⁰ pain at 110⁰-120⁰\* |
| Extension (0⁰ normal) | -5⁰-7⁰- 8⁰ | 0-20⁰\* |
| Comments  | Pain with repetition; unable to fully squat on floor; quad strength limited by pain; able to climb stairs | Slightly antalgic gait favoring right; varus deformity; no instability; Tender over PA; strength 5/5; “1+ Lachman’s and 1+ posterior drawer with good endpoints”  | \* Loss of motion due to pain, fatigue, weakness.\*\*Loses 20-25⁰ of motion on repetitive use due to pain/fatigue; Slightly antalgic gait; entire knee tender; guarding, grinding; no instability |
| §4.71a Rating\* | 10% | 10%\* | 10% |

 \*Conceding §4.59 (painful motion) and §4.40 (functional loss)

The CI had a long history of well documented right knee pain in the service treatment record (STR). The CI initially presented with right swelling and pain in September 2000 during Basic Training and was diagnosed with right patellofemoral syndrome. In 2001, the CI had an x-ray which showed a tibial stress fracture that healed with non surgical treatment. The right knee worsened and in 2002 the CI underwent right knee arthroscopy where a small lateral meniscal tear was found and treated. In June 2004, the CI was seen again for mild right knee swelling with tenderness at a localized area of the right medial knee termed the “pes anserinus.” The clinical diagnosis was inflammation of the bursa of this area (pes anserine bursitis - PAB). An MRI done in 2004 indicated no internal derangement. The CI was referred to physical therapy (PT) for a four week treatment course. In 2006, the CI underwent MRI demonstrating an “inflamed pes bursa” and a second right knee arthroscopy with removal of the pes bursa was undertaken. The CI was seen by orthopedics in February 2008 for continued right knee pain. The examiner noted unresolved pain after the second knee surgery; increased pain with heavy activity involving the legs including running and heavy lifting; popping and catching and burning pain in the area. Physical findings included mild swelling with tenderness over the pes area of the knee, mild patellar grind and tenderness over the patellar tendon. A recommendation for physical therapy with emphasis on hamstring stretching and other therapeutic modalities was made. The CI was seen in follow-up by orthopedics in April 2008. At this exam, the knee showed signs of worsening with tenderness along the entire course of the medial tibia, but concentrated near the surgical scar overlying the PA. No instability was present. The diagnosis was “medial sided tibial pain of uncertain etiology.” Normal routine x-rays, bone scan, MRI ruled out bony, ligamentous, arthritic and inflammatory etiologies. The CI was seen in the PT/Medical Clinic in July 2008 five months prior to separation and was found to have a limited ROM, inability to ascend stairs or jump without pain, limited quad strength and inability to fully squat. The MEB examination four months prior to separation documented pain interfering with sleep, stair climbing, carrying any weight, squatting, bending and kneeling, and limitations while playing with her children. Physical exam findings were a slightly antalgic gait with varus deformity. The VA Compensation & Pension (C&P) examination indicated that the CI used a knee brace intermittently along with medication, showed deformity, giving way, pain, stiffness, weakness, locking one to three times a month, and joint flare-ups every one to two months requiring rest for one to two days and required activity limitation. Physical exam findings were an antalgic gait and ROM limited by pain. CI was able to stand for 15 to 30 minutes and walk one quarter mile without pain. The NARSUM refered to, and attached, the PT ROMs from July 2008.

The PEB and the VA chose different coding options, but this did not bear on the rating. The PEB coded the chronic right knee pain secondary to pes anserine bursitis 5019 (bursitis) and rated it at 10%. The VASRD stipulates that the diseases under diagnostic codes 5013 through 5024 (in which code 5019 is categorized) will be rated on limitation of motion of affected parts, as arthritis, degenerative, coode 5003. At a clinic evaluation one month prior to the NARSUM, flexion of the knee was as recorded as 42⁰, 48⁰ and 48⁰ and extension of the knee at -5⁰,-7⁰,-8⁰ on three consequative observations. A rating of 10% would be achieved under code 5260 (flexion), for limitation to 45⁰ (measured 42⁰), with no other ROM meeting the compensable limit under the specific joint code. The right knee was tender and demonstrated pain-limited motion on the preponderance of examinations. The Board adjudged that IAW §4.14 (avoidance of pyramiding) dual rating of the knee was not achievable.

The VA coded the right knee pes anserinus bursitis, post bursectomy with shin splints and scarring under code 5262 (tibia and fibula, impairment of) rated at 10% for slight knee disability. This was based on “pain with slight limitation of motion” and was supported by the findings of the C&P evaluation where slightly reduced but noncompensable flexion of the right knee, normal extension with deteoriation upon repetition (Deluca) and a slightly antalgic gait were noted. A rating of 20% under Code 5262 requires moderate degree of knee or ankle disability. The minimally positive (1+) Lachmans and posterior drawer tests at the military exam were noted to have good endpoints and the VA exam documented no objective knee instability. Subjective history of locking and give way was attributable to pain and/or patellar tracking/grinding rather than internal meniscal pathology. After extensive review of the DES record, the Board was unable to find any route to achieve a combined disability rating higher than 10% under any applicable code and no extant pathology which would merit additional rating. The Board opined that optimal coding would be 10% under code 5099-5262, to encompass all of the CI’s knee pathology, however this would not offer any rating advantage to the CI. Following due deliberation, considering the totality of the evidence, the Board concluded that there is no VASRD basis for recommending a higher rating than the 10% conferred by the PEB in this case.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were history of tibial stress fractures and migraine headaches. The tibial stress fractures condition was considered above in rating the CI’s unfitting knee condition. Neither of these conditions were profiled, implicated in the commander’s statement or noted as failing retention standards. Both 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 performance of MOS/AFSC duty requirements. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for either of the stated conditions.

Remaining Conditions. Other conditions identified in the DES file were: alopecia, congenital varus deformity lower left extremity, tenosynovitis right wrist, tenosynovitis left wrist, umbilical hernia, shin splints and posterior vitreous detachment (eye). 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. Cervical strain and lumbar sprain and several other non-acute conditions were noted in the VA rating decision (VARD) 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. In the matter of chronic right knee pain secondary to pes anserine bursitis and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB rating of 10%. In the matter of the history of tibial stress fractures and migraine headaches conditions, the Board unanimously recommends no change from the PEB adjudications as not unfitting. In the matter of the alopecia, congenital varus deformity lower left extremity and left and right wrist tenosynovitis conditions, 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** |
| Chronic Right Knee Pain Secondary to Pes Anserine Bursitis | 5019 | 10% |
| **COMBINED** | **10%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110818, 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

I have reviewed the enclosed Department of Defense Physical Disability Board of Review (DoD PDBR) recommendation and record of proceedings pertaining to the subject individual. Under the authority of Title 10, United States Code, section 1554a, I accept the Board’s recommendation and hereby deny the individual’s application.

This decision is final. The individual concerned, counsel (if any), and any Members of Congress who have shown interest in this application have been notified of this decision by mail.

 BY ORDER OF THE SECRETARY OF THE ARMY:

Encl

 Deputy Assistant Secretary

 (Army Review Boards)