RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXX BRANCH OF SERVICE: army

CASE NUMBER: pd1100706 SEPARATION DATE: 20061215

BOARD DATE: 20120717

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SSG/E-6 (19D, Cavalry Scout), medically separated for chronic knee, ankle, shoulder, hand and low back pain (LBP). The CI did not improve adequately with treatment to meet the physical requirements of his Military Occupational Specialty (MOS) or satisfy physical fitness standards. He was issued a permanent P3 H2 profile and referred for a Medical Evaluation Board (MEB). Polyarthralgia was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Hearing loss and headaches, as identified in the rating chart below, were forwarded on the MEB submission as medically acceptable conditions. The PEB adjudicated the polyarthralgia condition with chronic knee, ankle, shoulder and hand pain as unfitting rated 10%, with likely application of the US Army Physical Disability Agency (USAPDA) pain policy. The PEB determined the LBP to be a separately unfitting condition and rated it 10% with application of the Veteran’s Affairs Schedule for Rating Disabilities (VASRD) and with likely application of the USAPDA pain policy. The CI made no appeals, and was medically separated with a 20% combined disability rating.

CI CONTENTION: The CI states: “The rating did not take into consideration all existing conditions such as left and right shoulder strain and bilateral tinnitus when the rating was determined. Also, the rating did not reflect the severity of the disability such as degenerative disk disease, thoracolumbar spine with sciatica, as well as the quantity for severly affected joints and body parts that are continuously affected by pain daily.”

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 right and left shoulder strain conditions as requested for consideration meet the criteria prescribed in DoDI 6040.44 for Board purview; and, are addressed below, in addition to a review of the ratings for the unfitting polyarthralgia and back pain conditions. The remaining conditions rated by the Department of Veterans’ Affairs (DVA) at separation and listed on the DD Form 294 are 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 20061130** | | | **VA (2 Mo. After Separation) – All Effective Date 20061216** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Knee, Ankle, Shoulder and Hand Pain | 5099-5003 | 10% | Active Polyarthralgia, B. Wrists, B. Knees, B. Ankles, R Elbow, Feet & Hands | 5299-5002 | 40%\* | 20070206  20071026 |
| Residuals, Right Shoulder Strain | 5201-5014 | 10% | 20070206 |
| Residuals, Left Shoulder Strain | 5201-5014 | 10% | 20070206 |
| Chronic Low Back Pain | 5299-5237 | 10% | DDD Thoracolumbar spine | 5242 | 20%\*\* |  |
| Hearing Loss | Meets Retention | | Hearing Loss, Right Ear | 6100 | 0% | 20070203 |
| Headaches | Meets Retention | | Mixed Headaches | 8100 | 0% | 20070206 |
| ↓No Additional MEB/PEB Entries↓ | | | Bilateral Tinnitus | 6201 | 10% | 20070203 |
| 0% x 3/Not Service-Connected x 3 | | | 20070203  20070206  20071026 |
| **Combined: 20%** | | | **Combined: 70%** | | | |

\*Initial VARD 20070710 granted ratings for right and left shoulder strain and deferred entitlement to compensation for polyarthralgia, ankle, hand, knee pain. Subsequent VARD 20071129 added active polyarthralgia rated 40% effective 20061216 based on C&P examinations 20070206 and 20071026.

\*\*Initial VARD 20070710 did not grant a SC rating for the back condition. VARD 20071129 added degenerative disc disease of thoracolumbar spine rated 20% effective 20061216 based on C&P examination 20071026.

ANALYSIS SUMMARY: The Disability Evaluation System (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. 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 nor for conditions determined to be service-connected by the DVA but not determined to be unfitting by the PEB. However, the 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 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. The Board utilizes DVA evidence proximal to separation in arriving at its recommendations and DoDI 6040.44 defines a 12-month interval for special consideration to post-separation evidence. The Board’s authority as defined in DoDI 6044.40, however, resides in evaluating the fairness of DES fitness determinations and rating decisions for disability; at the time of separation. Post-separation evidence therefore is probative only to the extent that it reasonably reflects the disability and fitness implications at the time of separation.

Polyarthralgias, Knee, Ankle, Shoulder and Hand Pain. According to the MEB narrative summary (NARSUM) dated 19 October 2006, the CI experienced onset of pain in both feet and lower legs without inciting injury while deployed in August 2005; followed a day later by marked swelling of his feet, knees, hands and wrists. The joint pain responded to treatment with prednisone but upon return to his home base, multiple joint pains recurred but with less swelling than at onset. Review of service treatment record (STR) show the CI first presented to the clinic on 19 October 2005 while deployed to Iraq, for care of swelling and pain of both ankle regions of 5 days duration. At that time, there were no complaints of pain in knees, hands or wrists. A 29 October 2005 clinic appointment states that the CI had a history of intermittent ankle pain and swelling for a year and noted complaint of resolved left wrist swelling (there is a 24 May 2005 clinic entry for left wrist pain with diagnosis of a possible ganglion cyst). Treatment with prednisone improved his ankle pain symptoms sufficiently for him to complete his deployment. The CI took and passed the Army physical fitness test on 3 November 2005 and again on 7 January 2006. Upon return from deployment to his home base, the CI sought follow up care. The family practice clinic appointment on 7 February 2006 recorded complaint of arthralgias of feet, shoulders and wrists. The examiner stated there was no involvement of the knees with the arthralgias condition. At the first rheumatology evaluation, performed on 8 March 2006, the CI reported he had knee problems in Iraq after the initial ankle pain and swelling, but also noted there was a history of knee pain off and on for several years. The CI also reported heel pain and several years of low back and thoracic back pain addressed separately below. The joint examination by the rheumatologist was normal. Follow up rheumatology evaluation on 12 April 2006, with the CI off of medication, recorded complaint of heel pain and LBP. A bone scan, performed on April 2006, was normal, showing no abnormality suggestive of any type of arthritis (inflammatory or degenerative arthritis). Rheumatology follow up on 21 April 2006 noted right heel pain, low back and thoracic pain. Examination of the joints noted right heel tenderness but was otherwise normal. Subsequent follow up appointments with the rheumatologist on 6 July 2006, 8 August 2006, and 10 October 2006 recorded complaints of right greater than left knee pain, right ankle pain, and, low back and thoracic spine pain.

Joint examinations by the rheumatologist on 8 March 2006, 12 April 2006, 21 April 2006, 6 July 2006, 8 August 2006, and 10 October 2006 documented absence of synovitis (no swelling, redness, warmth, limited motion, or tenderness) of all joints. The CI took and passed his Army physical fitness test on 5 May 2006. The CI was disqualified from recruiter school apparently due to exceeding weight standards and reported he was projected to deploy with his unit again. Family practice and primary care clinic appointments documented complaints of pain of the back, knees, ankles, left wrist, and hands. Two references to shoulder pain were made at the 7 February 2006 and the 11 July 2006 family practice clinic appointments. The 11 July 2006 clinic record records, “some shoulder discomfort with vigorous exertion.” Shoulder pain was not specifically mentioned in the MEB NARSUM as a problem. The NARSUM examination was performed on 19 October 2006 and the occupational therapy examination on 12 September 2006 documented normal range-of-motion (ROM) of the shoulders, elbows, wrists and hands. The physical therapy knee ROM examination performed 11 September 2006 showed both knees extended to 0 degrees, the right knee flexed to 125 degrees limited by pain (passively flexed to 140 degrees), and the left knee flexed to 120 degrees limited by pain (passively flexed to 140 degrees). The NARSUM examination recorded bilateral knee extension to 0 degrees, right knee flexion to 115 degrees and left knee flexion to 125 degrees limited by pain. The physical therapy ankle ROM was full with pain reported at zero degrees of dorsiflexion but gait was documented as normal by the neurologist on 10 October 2006. The NARSUM ankle ROM was “full,” “at lower end of ROM for person his age.” The NARSUM physician reported prior examinations showing some finger joint swelling but STR documenting those examinations are not in evidence and all rheumatologist examinations were negative for findings of synovitis (swelling, tenderness, warmth). At the time of the NARSUM there was no joint swelling or redness. Imaging of the joints were normal including X-rays, bone scan, and a MRI of the right knee. Laboratory testing was negative for markers of inflammatory arthritis (negative rheumatoid factor, anti-nuclear antibody, HLA-B27; normal erythrocyte sedimentation rate and C-reactive protein). The rheumatologist concluded that at the time of rheumatology evaluation and with observation between March 2006 and October 2006, there was no evidence of an inflammatory arthritis condition and diagnosed non-specific joint pain (arthralgias), mechanical back pain, and chronic knee pain.

The VA Compensation and Pension examination, performed on 6 February 2007, 2 months after separation, recorded CI complaint of continued joint pain. On examination of the joints there was no redness, abnormal warmth or swelling joints. There was pain reported with range of motion testing. Gait was normal. Examination of the shoulders recorded right shoulder flexion of 130 degrees and abduction of 115 degrees limited by report of pain. The left shoulder flexion and abduction were limited by report of pain to 165 and 155 degrees respectively. The hand examination was normal. Examination of the knees showed no crepitus, deformity, erythema, effusion, instability or tenderness. Tests for meniscus, ligament and patellofemoral pathology were negative. The knees extended to 0 degrees, the right knee flexed to 130 degrees with pain report at 110 degrees, and the left knee flexed to 135 degrees with pain report at 120 degrees. The CI was wearing hinged knee braces for comfort but no internal knee derangement such as torn meniscus, torn ligament or instability for which a brace is typically prescribed was shown. Examination of the ankles revealed no crepitus, deformity, erythema, effusion, instability or tenderness. The ankle ROM was right ankle plantar flexion 40 degrees, dorsiflexion 15 degrees, and left ankle plantar flexion 35 degrees, dorsiflexion 20 degrees with pain report at end ROM. The examination of the feet was reported as normal (no evidence of abnormal weight bearing limited motion, deformities, edema, weakness or instability). X-rays of bilateral wrists, right elbow, bilateral knees, and bilateral ankles were normal. The radiologist specifically noted that changes that are associated with inflammatory arthritis were absent in the wrist x-rays. At the time of the 26 October 2007 C&P examination, 10 months after separation, there was no heat, redness or swelling noted of the joints. ROM for the right elbow, wrists, knees, and ankles were mildly limited by report of pain. By rating decision dated 29 November 2007, the VA adjudicated a service-connected rating of 40% for active polyarthralgia of bilateral wrists, bilateral knees, bilateral ankles, right elbow, feet and hands, effective the day after separation. The VA assigned the 40% rating analogous using diagnostic code 5002, rheumatoid arthritis, and citing the presence of joint pain (polyarthralgia) as reflective of an active disease process. The PEB adjudicated its 10% rating analogously using the 5003 code for degenerative arthritis with application of the USAPDA pain policy.

The Board directs attention to its rating recommendation based on the above evidence. Evaluation and observation over a period of a year did not result in identifying a cause for the CI’s polyarthralgias or diagnosis of a specific medical condition. The NARSUM examiner opined that with time, the CI might develop signs and symptoms that would be identifiable as a rheumatic condition. The VA rated analogously using the diagnostic code for rheumatoid arthritis (5002), an inflammatory arthritis. Other inflammatory arthritis conditions are appropriately rated analogously to this VASRD diagnostic code. Although there was clinical evidence of inflammation at the time of initial onset in October 2005, all subsequent examinations including by a rheumatologist, laboratory testing, and imaging were negative for an inflammatory arthritis condition. The VA adjudicated a 40% rating based on subjective symptoms of joint pain without objective findings, concluding joint pain was an active process productive of definite impairment of health. VASRD diagnostic code 5002 requires there be an active disease process, which in the case of rheumatoid arthritis and other types of inflammatory arthritis, implies ongoing inflammation. There was no evidence of active inflammation of joints by lab testing, bone scanning, or multiple examinations by a rheumatologist. Pain can be a symptom of an active inflammatory joint process; however, the 40% rating under 5002 requires objective examination findings which were absent in this case. Three or more incapacitating episodes in a year due to an active inflammatory arthritis condition also support a 40% rating under this diagnostic code. However, neither an active inflammatory arthritis by objective examination findings, nor incapacitating episodes were documented prior to separation. The 20% rating is based on exacerbations in a “well established diagnosis.” The CI did not have any diagnosis of inflammatory arthritis made by the rheumatologist. Although there were complaints of pain, there were not exacerbations and the CI passed his PT tests despite symptoms. Examination findings in the months prior to separation as well as after separation were consistently negative for objective findings. There were no objective residuals of an inflammatory arthritis. Since there was not an inflammatory arthritis condition diagnosed by the rheumatologist, the PEB’s selection of the 5003 code was reasonable. Although hip pain was not a feature documented in service treatment records or the NARSUM, VA X-rays after separation of the hips demonstrated degenerative changes of the hip joints. There were no incapacitating episodes to support the 20% rating under this diagnostic code, therefore a 10% rating is supported using this diagnostic code. The Board considered whether separate ratings for specific involved joints was supported by the evidence. There was not limitation of motion of any joint to support a rating under any specific joint code. When limitation of motion of involved joints is non-compensable under the appropriate joint specific codes, a 10% rating may be supported for non-compensable limitation of motion that is objectively confirmed by examination findings that may include “satisfactory evidence of painful motion.” Although pain was reported during examinations, the Board also noted the CI passed the Army PT test on three occasions in November 2005, January 2006 and May 2006 (including push-ups, sit-ups and two mile run). After May 2006, rheumatology examinations continued to remain unchanged without objective findings. The Board noted that the VA granted separate ratings for the right shoulder and the left shoulder while the PEB included the shoulders in the polyarthralgia rating. Review of the STR do not show any specific shoulder injury and complaints of shoulder pain were documented only twice. The reference to shoulder pain at the 11 July 2006 family practice clinic appointment, noted “some shoulder discomfort with vigorous exertion.” Shoulder pain was not specifically mentioned in the MEB NARSUM as a problem. The NARSUM examination 19 October 2006 and the occupational therapy examination 12 September 2006 documented normal ROM of the shoulders, elbows, wrists and hands. The occupational therapy examination and MEB NARSUM examination of the shoulders was normal, with normal ROM, and strength of the shoulders was normal on multiple examinations. The rheumatology evaluations never recorded any complaint of shoulder pain, and joint examinations by the rheumatologist were normal. The Board concluded that the evidence of the record does not support separate ratings for each shoulder. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board concluded that there was insufficient cause to recommend a change in the PEB adjudication for the polyarthralgia condition.

Chronic Low Back Pain. The CI had chronic intermittent low back and thoracic back pain for several years which was reported to have worsened in 2006 while the CI was being evaluated and treated for polyarthralgias. There was no specific history of injury. X-rays, MRI, and bone scanning were normal. Rheumatology evaluation performed on 21 April 2006 recorded absence of radicular symptoms. Neurology evaluation October 2006 documented a normal gait, intact reflexes and normal strength. The NARSUM examination documented tenderness of the paravertebral muscles. Thoracolumbar ROM by physical therapy on 11 September 2006 documented flexion 80 degrees, extension 30 degrees, left lateral bending 20 degrees, right lateral bending 15 degrees, left rotation 25 degrees and right rotation of 25 degrees. The physical therapist noted presence of non-organic examination findings that were not otherwise detailed. The VA C&P examination. Performed on 6 February 2007, 2 months after separation, documented a ROM similar to the MEB physical therapy examination (flexion 80 degrees, extension 25 degrees, lateral bending 20 degrees, rotation 20 degrees). Gait was normal and strength was normal. X-rays at the time of the C&P examination showed “slight narrowing” of the L5- S1 disc space, and mild multilevel thoracic spondylosis (degenerative changes). ROM examinations at the time of MEB and the VA C&P examination proximate to the time of separation support the 10% rating adjudicated by the PEB. The 26 October 2007 C&P examination, 10 months after separation documented decreased ROM supporting the 20% rating assigned by the VA. This examination was not proximate to the time of separation, and therefore is not probative with regard to recommendation for disability rating at separation. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board concluded that there was insufficient cause to recommend a change in the PEB adjudication for the back pain condition.

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 polyarthralgia condition was operant in this case and the condition was adjudicated independently of that policy by the Board. In the matter of the polyarthralgia, chronic knee, ankle, shoulder and hand pain condition, and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the chronic back pain condition, and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. There were no other conditions within the Board’s scope of review for consideration.

RECOMMENDATION: The Board, therefore, recommends that there be no recharacterization of the CI’s disability and separation determination, as follows:

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Polyarthralgia, Chronic Knee, Ankle, Shoulder and Hand Pain | 5099-5003 | 10% |
| Chronic Low Back Pain | 5299-5237 | 10% |
| **COMBINED** | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110828, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans’ Affairs Treatment Record

XXXXXXXXXXXXXXXXXX

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 XXXXXXXXXXXXXXXXXXXXXXXXXXX, AR20120013401 (PD201100706)

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 XXXXXXXXXXXXXXXXXXXXXXXX

Deputy Assistant Secretary

(Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA