RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXX BRANCH OF SERVICE: army

CASE NUMBER: PD1100771 SEPARATION DATE: 20030917

BOARD DATE: 20120418

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SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SGT/E-5 (37F2P/Psychological Operations Specialist), medically separated for left shoulder pain with multidirectional instability. The CI initially presented with left shoulder instability and pain in May 1999 while he was in basic training. After a week of physical therapy (PT) his shoulder had full range-of-motion (ROM) without pain and he was able to return to duty. The CI reinjured his shoulder in April 2001 while performing an airborne operation. In December 2001 he had an MRI which revealed a dislocated shoulder with a labral tear. The CI underwent an arthroscopic repair and debridement surgical repair in May 2002 after conservative measures failed to significantly improve his condition. Despite surgery and aggressive physical therapy (PT) his pain did not improve and he did not respond adequately to treatment. The CI was unable to perform within his Military Occupational Specialty (MOS) or meet physical fitness standards. He was issued a permanent U3 profile and underwent a Medical Evaluation Board (MEB). The MEB forwarded “left shoulder multidirectional instability” on DA Form 3947 to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. No other conditions appeared on the MEB’s submission. Other conditions included in the Disability Evaluation System (DES) packet will be discussed below. The PEB adjudicated “left (non-dominant) shoulder pain with multidirectional instability” condition as unfitting, rated 10%, with application of the US Army Physical Disability Agency (USAPDA) pain policy. The CI made no appeals, and was medically separated with a 10% combined disability rating.

CI CONTENTION: “The full extent of the injuries sustained while in service was not included in this rating. Mr. M--- is currently rated at 90% service-connected disability by the VA, with service-connection established on all disabilities. The 10% finding of the PEB considered damage to his left shoulder joint. Mr. M--- also suffers from nerve damage to his left arm and spine, 7 damaged spinal discs, Traumatic Brain Injury resulting from multiple head wounds suffered in service, High Blood Pressure, Left Knee Osteoarthritis and serious hearing loss. These are all service connected disabilities to Mr. M--- as his VA records and in service medical records will show.”

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service PEB – Dated 20030602** | | | **VA (2 Mo. Pre Separation) – All Effective Date 20030918** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Left Shoulder Pain with Multidirectional Instability | 5099-5003 | 10% | Postoperative Residuals of Injury, Degenerative Joint Disease Left Shoulder and residual scars | 5003 | 10%\* | 20030711 |
| ↓No Additional MEB/PEB Entries↓ | | | Osteoarthritis Right Knee | 5003 | 10% | 20030711 |
| 0% x 4/Not Service-Connected x 3 | | | 20030711 |
| **Combined: 10%** | | | **Combined: 20%\*\*** | | | |

\*Increased to 20% effective 20070613, with combined rating increased to 40%.

\*\*increased to 60% effective 20081126 with increase of rating for hearing loss increased to 30%. Also increased to 90% effective 20100317 with rating for hypertension increased to 10% and addition of amnestic disorder due to TBI.

ANALYSIS SUMMARY: The Board acknowledges the CI's contention suggesting that service ratings should have been conferred for other conditions documented at the time of separation and for conditions not diagnosed while in the service but later determined to be service-connected by the Department of Veterans’ Affairs (DVA). 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. 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 6040.44, 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.

Left Shoulder with Multidirectional Instability Condition. There were four goniometric ROM in evidence, with documentation of additional ratable criteria, which the Board weighed in arriving at its rating recommendation.

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| ROM – Lt Shoulder | MEB  ~ 6 Mo. Pre-Sep  (20030331) | MEB NARSUM  ~ 4 Mo. Pre-Sep  (20030508) | VA C&P  ~ 2 Mo. Pre-Sep  (20030711) |
| Flexion (0-180) | 180⁰ | 170⁰ | 180⁰ |
| Abduction (0-180) | 180⁰ |  | 180⁰ |
| External Rotation (0-90) | 50⁰ | 35⁰ | 0°-75°-90⁰ |
| Internal Rotation (0-90) | 70⁰ | at T12 level | 0°-90⁰ |
| Comment | TTP (tender to palpation); positive apprehension(instability; pain w/ abduction; distal NV intact | 50% posterior subluxation with spontaneous reduction; 25% anterior subluxation with spontaneous reduction; positive apprehension; TTP posterior and anterior shoulder | DeLuca effects from 75° to 90° of external rotation; mild ROM decrease; motor 5/5, sensation intact, DTR normal; normal outline, no atrophy |
| §4.71a Rating 5003 | 10% | 10% | 10% |
| §4.71a Rating 5202 | 20% | 20% | Instability not addressed |

The CI had a well documented history in the service treatment record (STR) of left shoulder pain. In May 1999 the CI had a dislocation of the left shoulder and was referred to physical therapy (PT). In April 2001 the CI reinjured the left shoulder suffering another dislocation and was found to have a weak rotator cuff. He was again seen in September 2001 for left shoulder pain and follow-up for this complaint continued on a monthly basis. An MRI done in December 2001 demonstrated a posterior shoulder dislocation complicated by a glenoid impaction fracture and posterior (reverse) Bankhart lesion with resulting neuropraxia and nerve injury to the teres minor muscle. In February 2002 an EMG indicated no evidence of neuropathy. The CI was evaluated by orthopedics and underwent a left shoulder arthroscopic repair and debridement (Bankhart repair) in May 2002. In September 2002, 4 months after surgery, examination by orthopedics noted improved ROM with full flexion and abduction to 170 degrees. In October 2002 PT noted pain throughout the upper trapezius muscle and numbness at the anterior brachial muscle with pressure anteriorly and difficulty performing overhead activity. In October and December 2002 the CI was noted by orthopedics to have left shoulder posterior instability with pain. An outpatient note from January 2003 documents a discussion of options and notes the CI did desire any further surgeries. A permanent profile was issued and the MEB process was started. The CI was placed on a permanent U3 profile in February 2003 for left shoulder pain with subtle instability with restrictions of no airborne operations; no pushups or pull ups; no sit-ups with arms across chest and running only at own pace and distance. The commanders statement in March 2003 was specific to the limitations caused by the left shoulder instability and that fact that the CI could not perform within his MOS. At the MEB history and physical examination, 6 months prior to separation, there was TTP, and positive apprehension test and pain with abduction. The MEB NARSUM examination 4 months prior to separation indicated left shoulder posterior and anterior pain with decreased strength and instability with overhead movements. The VA Compensation and Pension (C&P) examination 2 months prior to separation indicated that the CI still had difficulties when he raised his arm to do work above the shoulder level and he had pain on external rotation.

The PEB coded the left shoulder pain with multidirectional instability as 5099 analogous to 5003 arthritis, degenerative (hypertrophic or osteoarthritis) rated 10% and the VA coded 5003 and rated at 10%. Both the PEB and VA rating was likely with application of §4.59 painful motion. The VA later increased the disability rating to 20% effective 20070613 based on a later C&P examination completed 30 August 2007 which documented left shoulder abduction limited to 90 degrees by pain. The CI had TTP and pain on abduction on the MEB exam and on the VA C&P exam the CI still complained of pain on external rotation with mild limited ROM. Under this coding schema, all available evidence supports a 10% rating. However, the CI had shoulder instability and also had a history of multiple shoulder dislocations prior to his surgery. The MEB NARSUM examination documented subluxation both posteriorly and anteriorly and was diagnosed with multidirectional instability. This could be coded under 5202 humerus, other impairment of for recurrent dislocation of at scapulohumeral joint with infrequent episodes and guarding of movement only at the shoulder level. This warrants a 20% rating for either the dominant or nondominant side. A higher rating under this code requires fibrous union of the joint and this was not present. After lengthy discussion, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a separation rating of 20% for the left shoulder pain with multidirectional instability coded as 5202.

The VA also later service-connected left arm nerve injury as associated with and secondary to the left shoulder condition and applied a 10% rating for 8517 moderate incomplete paralysis of the musculocutaneous nerve effective 13 June 2007, the date of his claim. A 30 August 2007 VA C&P examination noted both decreased sensation in the distribution of a small cutaneous nerve in the left upper medial forearm and a generalized mild weakness of the left upper extremity with strength noted at 4/5. The examiner noted the left arm nerve damage was at least as likely as not related to the left shoulder condition. However, the examiner at a 14 January 2009 VA C&P examination noted the CI had subsequently had an MRI in August 2008 that showed a herniated nucleosus pulposis between the fifth and sixth cervical vertebrae with disc protrusion worse on the left. Also an EMG in September 2008 showed a left C5 radiculopathy with denervation noted in the C5 innervated muscles. This examiner opined the left arm nerve damage was less likely than not caused by the left shoulder condition and that it was more likely than not caused by the MRI cervical spine and EMG abnormalities. The VA denied service-connection for the cervical degenerative disc disease and for left-sided cervical radiculopathy but continued the rating for left arm nerve damage secondary to the left shoulder condition. Additionally, there is no evidence that any neurologic abnormality existed in the left arm prior to separation from service. The MEB history and physical performed in March 2003, MEB NARSUM examination performed in May 2003, and the initial VA C&P examination performed on 11 July 2003 all reported normal neurologic examinations. Whenever muscle weakness is noted it is described as give way weakness or deceased strength due to pain and not a true motor abnormality. While the commander’s letter mentions noticeable muscle atrophy, the VA exam specifically mentions a normal shoulder outline that was symmetric with the right shoulder. Also, while the EMG performed in September 2008 clearly shows a nerve injury, the EMG performed in February 2002 was normal. As there is no evidence any nerve impairment existed prior to separation, the Board cannot support a recommendation for additional rating based on left arm peripheral nerve impairment.

Other Contended Conditions. The CI’s application asserts that compensable ratings should be considered for damage to seven spinal discs, traumatic brain injury, osteoarthritis of the left knee, high blood pressure and hearing loss. The damage to seven spinal discs, traumatic brain injury, and osteoarthritis of the left knee conditions 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. High blood pressure and hearing loss were mentioned in the DES. Both of these conditions were reviewed by the action officer and considered by the Board. Neither was significantly clinical during the MEB period, carried attached profiles, or was implicated in the commander’s statement. At the time of the MEB NARSUM, the blood pressure was controlled with medication. A normal hearing test was documented on 31 October 2002 and no other service audiograms are available for Board review. However, the VA C&P audiology examination performed 14 July 2003 did document significant loss so the hearing loss was present prior to separation in September 2003. This examination also noted that speech recognition testing with the Maryland CNC word list revealed a result of 92% in each ear. There is no evidence for concluding that either condition interfered with satisfactory duty performance to a degree that could be argued as unfitting. The Board, therefore, has no reasonable basis for recommending any additional unfitting conditions for separation rating.

Remaining Conditions. Other conditions identified in the DES file are right knee pain/osteoarthritis and previous head injury. Both of these conditions were treated while in service and considered resolved at the time of the MEB NARSUM examination. One head injury was noted in August and September 2000. No diagnosis of traumatic brain injury was made and the latest visit documented in the record in September 2000 listed resolved head injury as the diagnosis. The latest visit for right knee pain documented in the record available for review is from June 2000. A history of knee injuries was noted in the MEB NARSUM examination but no examination was performed. Neither of these conditions was significantly clinical during the MEB period, neither carried an attached profile, and neither was implicated in the commander’s statement. These conditions were reviewed by the action officer and considered by the Board. It was determined that neither could be argued as unfitting and subject to separation rating. Additionally sinusitis and mild levoscoliosis of the thoracic spine were noted by the VA proximal to separation but were not documented in the DES file. Right unilateral periodic tinnitus was service-connected in 2007 but was 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.

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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 left shoulder was operant in this case and the condition was adjudicated independently of that policy regulation by the Board. In the matter of the left shoulder pain with multidirectional instability condition, the Board unanimously recommends a 20% rating, coded 5202 IAW VASRD §4.71a. In the matter of the left arm radiculopathy or nerve damage, hypertension, high frequency hearing loss, right knee pain/osteoarthritis, and previous head injury conditions, the Board unanimously agrees that it cannot recommend any findings of unfit for additional rating at separation.

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RECOMMENDATION: The Board recommends that the CI’s prior determination be modified as follows, effective as of the date of his prior medical separation:

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Left Shoulder Pain with Multidirectional Instability | 5202 | 20% |
| **COMBINED** | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110914, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans Affairs Treatment Record

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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 XXXXXXXXX, AR20120008232 (PD201100771)

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:

Encl XXXXXXXXXX

Deputy Assistant Secretary

(Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA