RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD11-00786 SEPARATION DATE: 20090324

BOARD DATE: 20120807

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was a Reserve SSG/E-6 (68K/Medical Laboratory Specialist), medically separated for chronic left (non-dominant) shoulder pain and left elbow cubital tunnel syndrome with chronic left elbow pain. The CI, who is right handed, developed left shoulder pain in September 2004 while lifting and pulling soldiers during training. The elbow pain condition with cubital tunnel syndrome appeared in February 2007, 6 months after arthroscopic shoulder surgery was completed in September 2006. The left shoulder pain and left elbow cubital tunnel syndrome with left elbow pain conditions could not be adequately rehabilitated and became chronic. The CI did not improve adequately with treatment to meet the physical requirements of his Military Occupational Specialty (MOS) or satisfy physical fitness standards. His permanent P3U3 profile was updated and changed to U3 and he was referred for a Medical Evaluation Board (MEB). Obstructive sleep apnea (OSA) and gallbladder dysfunction conditions, noted in the rating chart below, were also identified and forwarded by the MEB as medically acceptable. The Physical Evaluation Board (PEB) adjudicated the chronic left shoulder pain and left elbow cubital tunnel syndrome with chronic left elbow pain conditions as unfitting, rated 10% and 10%, with application of the Veteran’s Affairs Schedule for Rating Disabilities (VASRD). The CI appealed this decision and requested a Formal PEB (FPEB). However, he subsequently waived the formal hearing and he was then medically separated with a 20% disability rating.

CI CONTENTION: “Condition should have been rated higher, based on the severity of the conditions.”

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. In this case the chronic left shoulder pain and the left elbow cubital tunnel syndrome meet the criteria prescribed in DoDl 6040.44 for Board purview and is addressed below. OSA and gallbladder dysfunction are outside the Board’s scope of review, but remain eligible for future consideration by the Army Board for the Correction of Military Records (ABCMR).

RATING COMPARISON:

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| --- | --- | --- | --- | --- | --- | --- |
| **Service PEB – Dated 20081022** | | | **VA (12 months Post-Separation) – All Effective Date 20090325** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Left (Non-Dominant) Shoulder Pain | 5099-5003 | 10% | S/P Decompression Surgery of the Left Shoulder, Due to  Impingement Syndrome with Limited ROM | 5201 | 20% | 20091103 |
| Left Elbow Cubital Tunnel Syndrome With Chronic Left Elbow Pain | 8716 | 10% | Status Post, Left Ulnar Nerve Transposition Due To  Cubital Tunnel Syndrome | 8599-8515 | 10% | 20091103 |
| Obstructive Sleep Apnea | Not Unfitting | | Obstructive Sleep Apnea | 6847 | 50% | 20091103 |
| Gallbladder Dysfunction | Not Unfitting | | No VA Entry | | | |
| ↓No Additional MEB/PEB Entries↓ | | | Hiatal Hernia/GERD with Gastritis (Also Claimed as Ulcer) | 7399-7346 | 10% | 20091103 |
| Cervical Strain | 5237 | 10% | 20091103 |
| 0% x 2/Not Service-Connected x 1 | | | 20091103 |
| **Combined: 20%** | | | **Combined: 70%** | | | |

ANALYSIS SUMMARY: The Disability Evaluation System (MDES) 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 Department of Veterans’ Affairs (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.

The CI, who is right handed, developed left shoulder pain in September 2004 while lifting and pulling Soldiers during training. In September 2006 left shoulder arthroscopy was performed and included subacromial space bursectomy and decompression with thermal capsulorrhaphy. An initial permanent P3U3 profile issued for the shoulder pain and OSA in December 2006 and a MEB was initiated. On 6 March 2007 a PEB determined the shoulder pain was unfitting and applied a 10% disability rating. The PEB also determined the OSA was not unfitting. The CI appealed and a FPEB was initiated but it was recessed in April 2007 so that left upper extremity electrodiagnostic assessment and a current shoulder range-of-motion (ROM) evaluation could be obtained. The CI had developed left forearm numbness and tingling as well as intermittent tingling in the fourth and fifth fingers of his left hand. On 30 April 2007 left shoulder flexion was approximately 150 degrees. On 3 May 2007 EMG and nerve condition velocity revealed a minor left ulnar neuropathy at the elbow and mild lower brachial plexopathy, chronic. The FPEB was recessed a second time in June 2007 and more information about the shoulder ROM and ulnar neuropathy was requested. A MEB narrative summary (NARSUM) addendum was completed on 31 July 2007 and the CI’s permanent P3U3 profile was updated to include the chronic numbness and tingling of the left forearm and 4th and 5th digits. All three conditions; chronic left shoulder injury, OSA, and left brachial plexopathy and left ulnar neuropathy at the elbow were forwarded to the PEB in August 2007. However, in October 2007 the PEB proceedings were terminated because the CI was scheduled to have ulnar nerve release surgery in December 2007. In July 2008 the permanent profile was changed to U3 with all three conditions retained. On 11 August 2008 a new MEB NARSUM was completed and the case was referred to the PEB.

Left Shoulder Condition. There were two goniometric ROM evaluations in evidence, which the Board weighed in arriving at its rating recommendation; as summarized in the chart below.

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| --- | --- | --- | --- |
| Goniometric ROM- Left Shoulder | MEB ~8 Months  Pre-Separation  (20080731) | Ortho ~6 Months  Pre-Separation  (20080911) | C&P ~7 Months  Post-Separation  (20091103) |
| Flexion (180⁰) | 140⁰ (138⁰) | Full | 90⁰ |
| Abduction (180⁰) | 135⁰ | Full | 100⁰ |
| Comments | Pain at limits of ROM; rotator cuff signs negative; slight tenderness to palpation; normal strength and reflex exam. | Some noted weakness at left biceps, triceps, and wrist flexion; decreased sensation on medial aspect of the arm and the 4th and 5th digits; 3+ reflexes on left | ROM limited by pain, weakness and lack of endurance; tenderness to palpation and guarding but no instability |
| §4.71Rating | 10% | 0% | 20% |

CI developed pain in his left shoulder in 2004 while lifting during training. An MRI of the left shoulder in 2005 revealed tendinitis but no anatomic injury. An MRI arthrogram in June 2006 revealed tendinitis and bursitis. In September 2006, the CI underwent arthroscopic subacromial bursectomy and decompression as well as thermal capsulorrhaphy. This resulted in temporary but not sustained improvement in painful shoulder symptoms despite extensive physical therapy. The MEB NARSUM evaluation, performed approximately 8 months prior to separation noted the CI had constant pain rated 5-6/10 that rarely would increase to 10/10 for a moment or two. He could run and walk without difficulty but could not swim or do significant overhead lifting or upper body exercises or pushups because of pain. He reported taking narcotic pain medication once or twice weekly for pain. Both flexion and abduction of the left shoulder were limited at a noncompensable level as recorded in the chart above. An outpatient orthopedic examination in September 2008 documented a full ROM as noted in the ROM chart above but it does not appear that a goniometer was used and no actual measurements are recorded. This examiner also noted weakness, decreased sensation, and hyperreflexia in the elbow and forearm.

The VA C&P examination performed approximately 7 months after separation is not contained in the record and could not located after appropriate inquiries by the Board. However, this document is extensively quoted in the VA Rating Decision Document (VARD). The VARD recorded decreased ROM of the shoulder secondary to pain, weakness, and lack of endurance with lack of endurance having the most functional impact. The ROM was not additionally limited by fatigue or incoordination after repetitive use. No instability, weakness, or subluxation was reported.

The PEB rated the shoulder condition for painful ROM analogous to code 5003, arthritis, at 10% disability based on painful motion. The VA rated the shoulder condition as 5201, arm limitation of motion, nondominant side at 20% disability based on flexion limited to the shoulder level (90 degrees).

The Board directs attention to its rating recommendation based on the above evidence. The MEB and C&P evaluations occurred in similar temporal proximity to date of separation, with one 8 months prior to separation and one 7 months after separation. The C&P examination documented limitations of motion that were significantly worse than those reported by the MEB. Both exams appear to be complete. However, the VA exam was performed after separation from service and there is no indication that this level of limitation of motion was present at the time of separation. Additionally, the totality of the evidence, including the September 2008 orthopedic examination, supports the lower rating. After 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 left shoulder pain condition.

Left Elbow Condition. 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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| --- | --- | --- | --- |
| Goniometric ROM Left Elbow | MEB ~8 Months  Pre-Separation  (20080731) | Ortho Consult  ~6 Months  Pre-Separation  (20080911) | VA C&P ~8 Months  Post-Separation  (20091103) |
| Flexion (0-145⁰) | 145⁰ | Full | 95⁰, 90⁰ with repeated motion |
| Extension (0°) | 0° |  | 85°, no change with repeated motion |
| Supination (85°) |  |  | 60°, no change with repeated motion |
| Pronation (80°) |  |  | 60°, no change with repeated motion |
| Comment | No limit by pain; hypoesthetic area extending from extensor surface down laterally to the 4th and 5th digits in the ulnar nerve distribution; decreased light touch and pinprick sensation of the left 4th and 5th digits; negative Tinel’s sign; normal muscle strength; tenderness to palpation at medial epicondyle; normal reflexes in upper extremities | Altered sensation on medial aspect of the arm and over the 4th and 5th digits; some noted weakness of biceps, triceps, and wrist flexion; 3+ reflexes at left C5, C6, and C7. | ROM additionally limited by pain, fatigue, weakness, and lack of endurance but not incoordination after repetitive use; weakness, tenderness, and guarding of movement; no edema, instability, abnormal movement, effusion, redness, heat deformity, malalignment, or drainage. No neurologic exam. |
| §4.71a Rating |  |  |  |
| 5206 | 0% | 0% | 20% |
| 5207 | 0% | 0% | 20% |
| 8716/8515 | 10% | 10%/20% | VA rated 10% |

CI reported tingling in the left arm and hand 6 months after the arthroscopic shoulder procedure in 2007. Nerve conduction study (NCV) completed in May 2007 revealed a minor ulnar neuropathy at the elbow and diagnosis of cubital tunnel syndrome (fibrous band in the elbow blocking the ulnar nerve) was made. In December 2007 surgical release of the cubital tunnel was performed. Post-operatively, symptoms of numbness, tingling and pain improved then recurred. The MEB NARSUM, completed approximately 8 months prior to separation, noted pain in the left elbow and forearm and numbness and tingling in the left forearm and hand. The pain was reported as 4-5/10. Functional impairments are noted above. On physical examination a slight tenderness was reported around the elbow. A hypoesthetic area extending down the little finger side of the arm to the 4th and 5th fingers in the sensory distribution of the ulnar nerve was noted. Tinel’s sign was negative at the elbow. An outpatient orthopedic examination in September 2008 also documented decreased sensation in the ulnar nerve distribution. Additionally it noted weakness at the elbow and wrist and hyperreflexia at the elbow. The provider referred him for repeat EMG/NCV testing and the CI was supposed to follow-up after the testing. No EMG/NCV test report is available for review but at a visit performed on 29 December 2008, this provider stated the EMG was negative. Another visit to a different provider on 10 February 2009 documented daily pain with weak biceps and triceps reflexes, a weakly positive Tinel test over the ulnar nerve and a positive Lhermitte sign on the left side in the ulnar nerve distribution. No sensory loss was noted and muscle strength was not addressed. Quoting the C&P exam from 7 months after separation, the VARD reported the CI to have weakness, stiffness, swelling, lack of endurance, and tenderness. The history documented flare-ups of pain with physical activities that were alleviated by rest. Treatment was anti-inflammatory medication. On examination, the elbow had no edema, instability, abnormal movement, effusion, redness, heat, deformity, malalignment, or drainage. No peripheral neurologic evaluation was documented.

Although the PEB and the VA utilized different coding, both determined a 10% disability rating was appropriate. The PEB used code 8716, ulnar nerve neuralgia and the VA used code 8515m median nerve paralysis. Although the median nerve was not affected in this case, both codes warrant the same 10% disability rating for mild incomplete paralysis of the nondominant side. The PEB rating was based on elbow pain associated with forearm numbness and tingling. The VA rating was based on functional limitations of the elbow due to pain, fatigue, weakness, and lack of endurance after left ulnar nerve transposition surgery.

The Board directs attention to its rating recommendation based on the above evidence. The MEB and C&P evaluations occurred in similar temporal proximity to date of separation, with one 8 months prior to separation and one 7 months after separation. Although the VA utilized a peripheral nerve code, the actual C&P was missing and the VARD did not include a neurologic exam. The Board must therefore rely on the MEB NARSUM examination and other outpatient visits that occurred prior to separation in determining the appropriate rating recommendation. All evaluations noted pain and variously documented sensory, motor, and reflex abnormalities. There is no indication of either worsening or improving symptoms over time between the MEB NARSUM and the date of separation. All evaluations easily support a 10% rating for neuritis as described in VASRD §4.123 based on mild incomplete paralysis. The orthopedic examination of performed on 11 September 2008 could possibly support a 20% rating for moderate incomplete paralysis. However, evaluations both before and after this one but prior to separation support a 10% rating. Although the ROM measurements on the VA C&P examination would support a combined 40% disability rating with 20% each for limitation of flexion and extension of the elbow, no limitation of motion or painful motion was documented on any evaluation prior to 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 left elbow cubital tunnel syndrome with chronic 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. 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 chronic left shoulder pain condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the left elbow cubital tunnel syndrome condition and IAW VASRD §4.124a, the Board unanimously recommends no change in the PEB adjudication.

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 Left Shoulder Pain | 5099-5003 | 10% |
| Left Elbow Cubital Tunnel Syndrome with Chronic Elbow Pain | 8716 | 10% |
| **COMBINED** | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110913, 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 XXXXXXXXXXXXXXXXXXXXXXXXXXXXX, AR20120015301 (PD201100786)

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 XXXXXXXXXXXXXXXXXXXXXX

Deputy Assistant Secretary

(Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA