RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1100833 SEPARATION DATE: 20030420

BOARD DATE: 20120416

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SFC/E-7 (91W, Healthcare Specialist), medically separated for chronic neck, back, shoulder, knee, tibial, hip, and shoulder pain; and obstructive sleep apnea (OSA) with good response to continuous positive airway pressure device (CPAP). The CI was initially referred to a Medical Evaluation Board (MEB) for excessive daytime sleepiness and other sleep related symptoms. His condition was determined to be OSA requiring CPAP which decreased the CI’s symptoms. The CI had a long history of multiple joint chronic pain and profile restrictions limiting field duty and fitness testing. He was evaluated by orthopedics and rheumatology and treated conservatively. He did not respond adequately to treatment and was unable to perform within his Military Occupational Specialty (MOS) or meet physical fitness standards. He was issued a permanent P3/U3/L3 profile and underwent an MEB. OSA requiring use of CPAP, chronic cervical strain, low back pain (LBP), bilateral shronic tibial pain, patellofemoral syndrome, bilateral hip pain, and right shoulder bursitis were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Five other conditions, as identified in the rating chart below, were forwarded on the MEB submission as medically acceptable conditions. The PEB adjudicated the “chronic neck, back, shoulder, knee, tibial, hip and shoulder pain” as a single unfitting condition rated at 20% with specified application of the USAPDA pain policy; and adjudicated the OSA condition as unfitting, rated 0% with application of DoDI 1332.39. The CI made no appeals, and was medically separated with a 20% combined disability rating.

CI CONTENTION: “PTSD Diagnosed within 12 months of discharge. Report Enclosed. My MEB/PEB were not done consistent w/NDAA2008; Dept. of Veterans Affairs Rating Schedule for pain(s) nor did it take into regard the totality of circumstances. Notably, numbers 8-I0 (a-c) which further led to orders #077-0100 "Additional instructions" letters a-c. Additionally, SM DD 214 would need amended to reflect changes consistent with new exam and (please see continuation of contention”. The contention continuation and a MFR (fax) from the CI’s spouse for expedited processing including a letter to Congressman John Dingell are in the record. They address mental health issues, PTSD, TBI, migraines, 10 A/C, pain, worsening, and treatment for Hodgkin’s Lymphoma (cancer) and medical insurance coverage.

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service PEB – Dated 20030220** | | | **VA (15 Mo. Pre-Separation) – All Effective Date 20030421** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Neck, Back, Knee, Tibia, Hip, Shoulder Pain | 5099-5003 | 20% | R. Shoulder Tendonitis | 5024 | 10% | 20020107 |
| Lumbar Spondylosis w/DDD L5-S1 … | 5010-5292 | 10% | 20020107 |
| L. Knee Patellar Tendonitis | 5250 | 0% | 20020107 |
| R. Knee Patellar Tendonitis | 5250 | 0% | 20020107 |
| Cervical Spine Strain | 5290 | 0% | 20020107 |
| Bilateral Hip Pain | 5252 | Not Service Connected | |
| Obstructive Sleep Apnea | 6847 | 0% | OSA, Sleep Paralysis | 6847 | 50% | 20020107 |
| Tinnitus | Not Unfitting | | Tinnitus | 6260 | 10% | 20020116 |
| Vascular Headache | Not Unfitting | | Tension Headaches … | 8045-8100 | *10%\** | *20020107* |
| 30%\* | 20040721 |
| R. Ankle Pain | Not Unfitting | | R. Ankle Pain | 5271 | Not Service Connected | |
| Bilateral Plantar Fasciitis | Not Unfitting | | Bilateral Pes Planus; Bilateral Plantar Fasciitis | 5284-5276 | 10%\* | 20020116 |
| Fatty Liver, Enzymes … | Not Unfitting | | Fatty Liver, Enzymes … | 7345 | Not Service Connected | |
| ↓No Additional MEB/PEB Entries↓ | | | Subungual Onychomycosis | 7813-7806 | 10% | 20020107 |
| 0% x 8 (incl above) | | | 20020107 |
| **Combined: 20%** | | | **Combined: 80%\*** | | | |

\*VA Decision Review Officer Decision dated 20031219 adjudicated a 10% rating for Bilateral Pes Planus; Bilateral Plantar Fasciitis reversing original NSC determination for both conditions *((no new exam info*)); original 10% for tension headaches 8045-9304 (“as symptomatic of brain trauma”) retroactively increased to 30% based on exam of 20040721.

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 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 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. 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. We note that the applicant asks the Board for specific correction of records and specified consequential entitlements. By law the Board authority is limited to making recommendations on correcting disability determinations. The actual correction of records and consequential entitlement determinations is the responsibility of the applicable Secretary and accounting service. The applicant's request will of course remain with the application as it is processed.

Chronic Neck, Back, Knee, Tibia, Hip, Shoulder Pain Condition. The PEB combined chronic neck, back, knee, tibia, hip, shoulder pain as a single unfitting condition, coded analogously to 5099-5003 [arthritis, degenerative (hypertrophic or osteoarthritis)] with specified application of the USAPDA pain policy. Although this approach complied with Army rules 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 VASRD §4.71a. 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 unfitting in and of itself. 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. The MEB indicated the knees, hips, and tibial conditions were bilateral, but that the shoulder condition was right shoulder bursitis only. There was no indication in the record that the left shoulder was functionally impaired.

The commander’s comments indicated duty limitations of inability to “run, lift patients on litters, lift medical equipment, and stand for long periods of time.” Profile limitations were “Run at own pace and distance; No LBE; No Kevlar; No APFT.” The orthopedic narrative summary (NARSUM) indicated the CI had passed the APFT a roundFebruary 2002 and detailed the orthopedic history with neck pain of 9 years on and off, lower back pain of 12 years with episodic right leg pain radiation undergoing work-up/evaluation, right hip pain of 6-months controlled by medication, right ankle pain of 11 years with symptoms controlled, bilateral shin splints of 11 years with symptoms under control, bilateral plantar fasciitis since 1996 with symptoms under control, bilateral knee (PFS) since 1995 with symptoms under control and profile-restricted, right shoulder pain of 6 years and bilateral upper extremity and inability “to wear helmet or wear backpack or LPE” stemming from a motor vehicle accident (LOD indicated hand, wrist, and concussion due to Humvee accident of 13 May 1991.

Orthopedic exam indicated right shoulder with pain-free range-of-motion (ROM) to 180° (normal 180°) of abduction/forward flexion with no tenderness; back exam was forward flexion to 80° (normal 0-90°) with tenderness; hip exam was normal; knees were stable with no tenderness and pain-free symmetric ROM of “0 to 135-140 degrees” (normal 0-140°); there was bilateral non-tender tibial bowing; right ankle was pain-free ROM of 45° plantar flexion (normal) and “dorsiflexion up to neutral” (normal 20° [earlier VA exam was 20°]); bilateral foot exam indicated non-tender pes planus. All extremities were neurovascularly intact. The rheumatology exam indicated right shoulder pain with palpation, right sacroiliac joint (back) tenderness, and groin pain with hip ROM testing. There was bone scan evidence of “acromioclavicular degenerative joint disease which is most likely the cause of his shoulder pain.” There was no evidence of a systemic inflammatory autoimmune disorder, and the rheumatologist opined “his other areas of joint pain are most likely related to his history of patellofemoral pain syndrome and pes planus as well as due to over use and mechanical abnormalities.”

The VA history and exams of January 2001 were reviewed, but were more remote from separation (April 2003) than the NARSUM exams of August and September 2002 which carried a higher probative value. The VA exams provided compensable musculoskeletal exams only for the right shoulder (VA 10%; PEB not unfitting), back (VA 10%), and bilateral feet (VA 10% bilateral pes planus & bilateral plantar fasciitis; PEB not unfitting).

As previously elaborated, the Board must first consider whether neck, knees, tibia and hip conditions remain separately unfitting, having de-coupled them from a combined PEB adjudication. In analyzing the intrinsic impairment for appropriately coding and rating the neck, knees, tibia and hip conditions, the Board is left with a questionable basis for arguing that any of the chronic neck, knee, or tibia conditions or relatively mild hips condition were indeed unfitting. There was discussion concerning if any of the relatively mild and longstanding musculoskeletal symptoms rose to the level of being unfitting; however, the PEB unfitting 20% for multiple musculoskeletal pain conditions (including back and right shoulder) was administratively final. The Board considered the overall profile and commander restrictions to align the musculoskeletal conditions which most likely contributed to those duty limitations. There was overlap between the neck and right shoulder duty limitations, but the neck exam was not to a compensable level, so all neck/shoulder limitations/symptoms were attributed to the shoulder condition. After due deliberation, the Board agreed that evidence does not support a conclusion that the neck, knees, tibia and hip conditions remain separately unfitting, or even as combined, would have rendered the CI incapable of continued service within his MOS; and, accordingly cannot recommend a separate service rating for the neck, knees, tibia or hip conditions.

The Board considered that the duty restrictions from the back with radiating pain condition and the right shoulder condition were the predominant duty limiting components of the combined PEB adjudication. All members agreed that the back and right shoulder conditions adversely impacted the CI’s ability to continue in his MOS. Independent rating of the back condition including slight limited motion, tenderness and radiating pain would be 10% IAW the 2003 VASRD (prior to the 26 September 2003 change in spine rating criteria) §4.71a. with coding of 5299-5292 (spine, limitation of motion of, lumbar). Independent rating of the right shoulder would be 10% conceding both §4.59 (painful motion) and §4.40 (functional loss) as the ROM was to normal limits.

After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), in regards to the chronic neck, back, knee, tibia, hip, shoulder pain joint conditions combined under a single 5003 rating by the PEB, the Board recommends individual ratings as follows: chronic neck as not unfitting; back as unfitting rated at 10%, knees as not unfitting; tibia as not unfitting; hips as not unfitting; left shoulder as not unfitting; and right shoulder as unfitting rated at 10%.

OSA With CPAP Condition. The PEB’s DA Form 199 assigned a 0% rating under DODI 1332.39 for OSA “with good response to C-PAP.” The pulmonary NARSUM addendum indicated that a full polysomnogram confirmed the diagnosis of OSA and that CPAP was required and used, and the CI had “excellent relief” of his excessive daytime somnolence with CPAP. The commander’s statement on 16 October 2002 stated the CI “remains excessively somnolent in the daytime.” Profile restrictions on 10 February 2003 included no firearms and no driving in military vehicles. Although it appears that the PEB based the fitness adjudication solely on field impediments to the use of CPAP, there was additional evidence of impairment as noted. Contemporary PEBs across all of the services no longer consider OSA to be unfitting solely on the basis of restriction from field duty. However, the Board, by legal opinion and firm precedent, does not make contrary recommendations to a PEB determination that a condition was unfitting. VASRD §4.100 mandates a minimum rating of 50% under 6847 for OSA requiring a breathing assistance device. In consideration of this evidence, and IAW DoDI 6040.44, the Board must recommend a service disability rating of 50% for the OSA condition.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were tinnitus, vascular headache, right ankle pain (“pain is intermittent”), bilateral plantar fasciitis (“pain is intermittent”), and fatty liver with elevated liver enzymes. None of these conditions were profiled, specifically implicated in the commander’s statement or noted as failing retention standards. The CI had no difficulty understanding speech; there was no evidence of prostrating headaches pre-separation; the right ankle and bilateral plantar fasciitis conditions may have been sheltered by the limitations primarily attributed to the back condition, but this would be undue speculation; and the liver condition is an abnormal lab and imaging finding and not a physical disability. All were reviewed by the action officer and considered by the Board. There was no indication from the record that any of these conditions significantly interfered with satisfactory duty performance. All evidence considered there is not a preponderance of evidence in the CI’s favor supporting recharacterization of the PEB fitness adjudication for any of the stated conditions.

Other Contended Conditions. The CI’s application asserts that compensable ratings should be considered for PTSD (and other mental disorders), TBI and migraine headaches. The PEB vascular headaches (substantively similar to migraine headaches) were discussed above. Although there was no diagnosis of TBI prior to separation in the DES file, the record indicated a history of concussion and the VA diagnosis 15 months prior to separation was tension headaches as related to brain trauma coded as 8045-9304 for brain disease due to trauma, purely subjective symptoms. However, as discussed, there was no evidence of prostrating headaches and there were no other TBI-related symptoms that rose to the level of being unfitting at the time of separation. The CI was not profiled for any mental disorder (profile was S1) and the only axis I diagnosis in evidence proximate to separation was OSA. PTSD was not noted in the DES file. The Board acknowledges the presence of PTSD as a currently rated condition by the VA, but notes that the scope of its recommendations does not extend to conditions which were not diagnosed or in evidence at the time of medical separation. All of these conditions were reviewed by the action officer and considered by the Board. There was no evidence for concluding that any of the conditions interfered with duty performance to a degree that could be argued as unfitting. The Board determined therefore that none of the stated conditions were subject to service disability rating.

Remaining Conditions. Other conditions identified in the DES file were tenia pedis (fungal infection in the feet (VA 10% for toenail fungal infection: subungual onychomycosis). 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 was/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. Hodgkin’s lymphoma was not in the DES file or diagnosed proximate to separation. 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. As discussed above, PEB reliance on the USAPDA pain policy for rating the multiple joint conditions and on DoDI 1332.39 for rating OSA was operant in this case and the conditions were adjudicated independently of that instruction and policy by the Board. In the matter of the combined chronic neck, back, knee, tibia, hip, shoulder pain condition, the Board unanimously recommends that each joint be separately adjudicated as follows: an unfitting chronic back pain condition coded 5292 and rated 10%; an unfitting right shoulder condition, coded 5024-5003 and rated 10%, both IAW VASRD §4.71a.; and not unfitting chronic neck, knees, tibia and hips and left shoulder conditions. In the matter of the OSA condition, the Board unanimously recommends a disability rating of 50%, coded 6847 IAW VASRD §4.97. In the matter of the tinnitus, vascular headache, right ankle pain, bilateral plantar fasciitis, and fatty liver with elevated liver enzymes conditions, the Board unanimously recommends no change from the PEB adjudications as not unfitting. In the matter of the TBI condition or any other medical conditions eligible for Board consideration, the Board unanimously agrees that it cannot recommend any findings of unfit for additional disability rating.

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:

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Obstructive Sleep Apnea with CPAP | 6847 | 50% |
| Chronic Back Pain | 5292 | 10% |
| Chronic Right Shoulder Pain (*Left Not Unfitting*) | 5024-5003 | 10% |
| Chronic Neck Pain | NOT UNFITTING | |
| Chronic Knee Pain | NOT UNFITTING | |
| Chronic Tibia Pain | NOT UNFITTING | |
| Chronic Hip Pain | NOT UNFITTING | |
| **COMBINED** | **60%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110812, 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 XXXXXXXXXXX, AR20120008204 (PD201100833)

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 60% 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 60% 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 XXXXXXXXXXXXX

Deputy Assistant Secretary

(Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA