RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXX BRANCH OF SERVICE: Air force

CASE NUMBER: PD1100852 SEPARATION DATE: 20061128

BOARD DATE: 20120409

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SSgt/E-5 (2W, Aircraft Maintenance), medically separated for chronic elbow pain. The CI initially injured his left elbow while lifting weights in 2000. Later that year, he began to have pain in his right elbow. He was diagnosed with bilateral tendonitis and a left cubital tunnel syndrome; and, underwent a lengthy trial of conservative measures. The conditions could not be adequately rehabilitated to meet the physical requirements of his Air Force Specialty (AFS) or satisfy physical fitness standards. He was consequently issued a permanent U-4 profile and referred for a Medical Evaluation Board (MEB). The condition characterized as “cubital tunnel syndrome/elbow pain” was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AFI 48-123. No other conditions appeared on the MEB’s submission. Other conditions, contended or evidenced in the Disability Evaluation System (DES) file, are addressed below. The PEB adjudicated “chronic elbow pain, associated with triceps tendonitis and cubital syndrome” as unfitting, rated 10%, referencing solely the Veterans Administration Schedule for Rating Disabilities (VASRD). The CI withdrew an initial request for a Formal PEB, and was medically separated with that service disability rating.

CI CONTENTION: **“**I would like to request the PDBR review all medical conditions and not to limit the PDBR review to only conditions deemed unfitting by the PEB. VA determination letter showing 10% ratings for each disability that was deemed unfitting by the PEB. The disabilities were left tricep tendonitis, right tricep tendonitis, and left cubital tunnel (ulnar neuropathy) and combined, should be 30%, not 10%.” He additionally lists all of his currently rated VA conditions. These include those charted below; as well as eczema, cervical strain, and obstructive sleep apnea (OSA) which were service-connected and rated 0% by the VA at separation.

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service PEB – Dated 20060918** | | | **VA (8 Mos. Post-Separation) – All Effective 20061129** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Elbow Pain a/w Triceps Tendonitis and Cubital Tunnel Syndrome | 5306 | 10% | R Elbow Triceps Tendonitis | 5024-5206 | 10% | 20070703 |
| L Elbow Triceps Tendonitis | 5024-5206 | 10% | 20070703 |
| Left Ulnar Neuropathy | 8516 | 10% | 20070703 |
| ↓No Additional MEB/PEB Entries↓ | | | Tinnitus | 6260 | 10% | 20070412 |
| Gastroesophageal Reflux | 7346 | 10% | 20070703 |
| 0% x 3 / Not Service-Connected x 1 | | | 20070703 |
| **Combined: 10%** | | | **Combined: 40%** | | | |

ANALYSIS SUMMARY: The Board acknowledges the CI’s contention that suggests service ratings should have been conferred for other conditions documented at the time of separation. The Board wishes to clarify that it is subject to the same laws for service disability entitlements as those under which the DES operates. The Board further notes that the presence of a diagnosis, in and of itself, is not sufficient to render a condition unfitting and ratable. While the DES considers all of the member's medical conditions, compensation can only be offered for those medical conditions that cut short a career, and then only to the degree of severity present at the time of final disposition. However the Department of Veterans’ Affairs (DVA), operating under a different set of laws (Title 38, United States Code), is empowered to compensate all service-connected conditions and to periodically reevaluate said conditions for the purpose of adjusting the Veteran’s disability rating should the degree of impairment vary over time. The Board further acknowledges the presence of all currently rated conditions by the DVA (elaborated below); 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. This includes conditions which may have had early manifestations during active service, since such sub-clinical conditions cannot be correlated with a fitness determination requisite for a rating.

Combined Vs. Separate Upper Extremity Ratings. It is not clear in the PEB ruling whether the chronic elbow pain rating was for a single elbow or a combined rating for both elbows. The MEB’s narrative summary (NARSUM) yielded a final diagnosis of “left triceps tendonitis,” and the cubital tunnel syndrome submitted on the MEB’s AF Form IMT 618 was diagnosed only for the left upper extremity. The NARSUM elaborated bilateral symptoms, however; and, the PEB’s nomenclature in its adjudication did not specify a left or bilateral rating. Furthermore, the PEB applied VASRD code 5306 (group VI, e.g., triceps muscle disability) which is not amendable to a combined bilateral rating. The Board must apply separate codes and ratings in its recommendations if compensable ratings for each condition are achieved IAW the VASRD. Although the members surmised that the PEB likely intended a rating for the left upper extremity which also subsumed the neuropathy; the failure to so designate it, coupled with the CI’s explicit contention as elaborated above, left the Board in doubt. The members agreed, therefore, that the PEB adjudication should be approached as a consolidated rating which was not compliant with VASRD §4.55 (principles of combined ratings for muscle injuries) or with §4.71a (schedule of ratings—musculoskeletal system). Thus the Board agreed that three separate conditions (in accordance with the CI’s contention and the VA rating decision (VARD) after separation) should be considered for individual ratings: triceps tendonitis of the left elbow, triceps tendonitis of the right elbow, and left cubital tunnel syndrome. 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. A combined rating approach by the PEB (if that be the case here) may well reflect its judgment that the constellation of conditions was unfitting, not a judgment that each condition was independently unfitting. Thus the Board must maintain the prerogative of separate fitness recommendations in this circumstance, and pursued separate fitness and rating deliberations for each condition as follows.

Left Elbow Tendonitis. The CI experienced the onset of left elbow pain in April 2000 while engaged in weight lifting. He was diagnosed with tendonitis of the triceps muscle, and was treated with various courses of physical therapy (PT), transdermal steroids (iontophoresis) and analgesics. There were periods of improvement, but no lasting response to these measures. Magnetic resonance imaging (MRI) revealed no abnormalities. A surgical option was discussed but deferred. The CI was noted to be an avid body builder, and his pain was often exacerbated by weight lifting. A PT note in February 2006 specifically noted concern regarding the aggressive personal weight lifting program, and expressed a hope that the CI’s apprehension around his upcoming nerve conduction study would “entice him to lift in more reasonable moderation.” The NARSUM documented constant pain rated 4-5 of 10, exacerbated by pushing against resistance or lifting > 20 pounds. The only positive physical finding was “mild tenderness to palpation to triceps insertion.” Range-of-motion (ROM) was normal. Normal ROM was corroborated by PT notes and other entries in the service treatment record (STR).

The Board first addressed its fitness recommendation for the left elbow condition. It is clear that the left elbow tendonitis was the primary driver toward MEB proceedings; and, its evaluation and treatment dominated the STR entries during the MEB period. All members readily concluded that it was thus an unfitting condition. The Board then deliberated its rating recommendation for this condition based on the above evidence. The PEB’s choice to rate under the 5306 triceps muscle code was not unreasonable considering the orthopedic diagnosis, although the rating criteria under VASRD §4.56 (muscle injuries) do not lend themselves well to non-penetrating injuries. The PEB’s 10% determination for “moderate” disability is the highest defensible rating under §4.56 criteria based on the evidence in this case. Coding under 5306 also would not permit separate rating for a peripheral neuropathy of the same anatomic territory (IAW VASRD §4.55). The VA coded the condition as 5024-5206 (tenosynovitis rated for limitation of motion at the elbow). This is somewhat enigmatic given the lack of any ROM limitation, but §4.59 (painful motion) was applied to achieve the minimum compensable rating of 10%. With the lack of compensable ROM impairment, bony fractures, or ankylosis in this case; there is no §4.71a elbow or forearm code which would achieve a rating greater than 10%; and, application of §4.59 is requisite (and supported) to achieve the compensable rating. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a service disability rating of 10% for the left elbow tendonitis condition. The action officer recommended, and the Board agreed with, application of the code 5099-5024 (analogous to tenosynovitis) for its clinical compatibility.

Right Elbow Tendonitis. The right elbow pain (and subsequent identical diagnosis) lagged the left elbow condition in onset; but was also exacerbated, if not precipitated, by the weight lifting activity. There are PT notes documenting bilateral treatments; although, several document a dominant severity on the left; and, many were directed only at the left elbow. There were no iontophoresis treatments for the right elbow. The MEB orthopedic consultant addressed only the left elbow. Both the NARSUM and the VA Compensation and Pension (C&P) examination after separation noted that symptoms were more severe on the left. No MRI was obtained for the right elbow, but plain radiographs revealed some mild degenerative changes. The physical exams recorded in the NARSUM and C&P were equivalent to those described for the right elbow, although the VA examiner noted that the single positive exam finding (tenderness over triceps insertion) was worse on the left. All ROM evaluations for the right elbow, as with the left, were normal. The U-4 profile did not specify a diagnosis, and the commander’s statement noted only lifting restrictions without elaboration. The Board deliberated its fitness recommendation for the right elbow in light of the above evidence. It is clear that the left elbow was the dominant condition which forced the MEB, and it is clear that the severity of the right elbow involvement was significantly less than for the left. This notwithstanding, the Board considered that the upper extremity demands for the CI’s AFS were rigorous. It was concluded, however, that if the total impairment was confined to that evidenced for the right arm; the CI could have continued service in his AFS; and, the option had been raised for retraining to a less demanding AFS. Moreover, it must be considered that a significant contribution to the continuing severity of the tendonitis conditions was the body building pursuits which were not linked to AFS requirements. After due deliberation in consideration of the preponderance of the evidence, the Board concluded that there was insufficient cause to recommend the right elbow condition as separately unfitting and subject to service disability rating.

Cubital Tunnel Syndrome. The CI’s application asserts that service rating should be considered for the left cubital tunnel syndrome which clinically equates to an ulnar neuropathy. Symptoms of compression of the ulnar nerve in the left arm, manifested by occasional tingling and numbness on the last three fingers, were first noted by PT in December 2005. The sensory symptoms continued, and in March 2006 an electromyelogram (EMG) was obtained which reported “no electrophysiological abnormalities suggestive of neuropathy.” At the MEB exam, the CI reported “tingling in his fingers a few times a day” and some subjective weakness; although, the examiner stated, “he denies any problems with dropping things he is holding.” The motor and sensory exam findings were normal. The VA examiner recorded detailed and normal neurologic findings for the left ulnar, radial and median nerves; and, specifically noted the absence of hypothenar (ulnar palm) atrophy. Firm Board precedent requires a functional impairment tied to fitness to support a recommendation for addition of a peripheral nerve rating for service disability. The intermittent sensory symptoms had no documented functional consequences, and there were no motor deficits (well established by physical exam and electrophysiologic evidence). The NARSUM confirmed that the CI was not dropping tools, etc.; and, grasp was unaffected. Thus, there is compelling evidence that the peripheral neuropathy was inconsequential to AFS requirements. After due deliberation in consideration of the preponderance of the evidence, the Board concluded that there was insufficient cause to recommend the left ulnar neuropathy as separately unfitting and subject to service disability rating.

Other Contended Conditions. The CI’s application asserts that compensable ratings should be considered for obstructive sleep apnea (OSA), eczema, gastroesophageal reflux disease (GERD), cervical strain and bilateral tinnitus. Initial symptoms of OSA surfaced at the VA examination after separation, and the condition was not diagnosed or treated until well after separation. The first complaint of symptoms related to eczema and GERD in the STR was 7 weeks prior to separation. The VARD after separation stated that neck pain was a long standing complaint in service, but this could not be corroborated by the STR. In entries related to the upper extremity conditions, neck pain was denied. A complaint of tinnitus also did not surface until the VA examination after separation. All of these conditions were reviewed by the action officer and considered by the Board. Some of these conditions were not documented in service; and, none were profiled, implicated in the commander’s statement, or documented in the NARSUM. There is no evidence for concluding that any of them 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.

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. Although the PEB referenced the VASRD in its adjudication, the Board surmised that three conditions may have been inappropriately consolidated for a single rating in conflict with the VASRD; and, the conditions are separately addressed as follows. In the matter of the left elbow tendonitis condition, the Board unanimously recommends a service disability rating of 10%, coded 5099-5024 IAW VASRD §4.71a. In the matter of the right elbow tendonitis condition, the Board unanimously agrees that it cannot recommend a finding of unfit for additional service disability rating. In the matter of the left cubital tunnel syndrome (ulnar neuropathy) condition, the Board unanimously agrees that it cannot recommend a finding of unfit for additional service disability rating. In the matter of the contended OSA, eczema, GERD, cervical strain, and bilateral tinnitus conditions, the Board unanimously agrees that it cannot recommend any findings of unfit for additional disability rating. The Board unanimously agrees that there were no other conditions eligible for Board consideration which could be recommended as additionally unfitting for rating at separation.

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** |
| Triceps Tendonitis, Left Elbow | 5099-5024 | 10% |
| Triceps Tendonitis, Right Elbow | Not Unfitting | |
| Cubital Tunnel Syndrome, Left Upper Extremity | Not Unfitting | |
| **COMBINED** | **10%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110907, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans Affairs Treatment Record

XXXXXXXXXXXXX

President

Physical Disability Board of Review

SAF/MRB

1500 West Perimeter Road, Suite 3700

Joint Base Andrews MD 20762

Dear XXXXXXXXXX

Reference your application submitted under the provisions of DoDI 6040.44 (Title 10 U.S.C. § 1554a), PDBR Case Number PD-2011-00852.

After careful consideration of your application and treatment records, the Physical Disability Board of Review determined that the rating assigned at the time of final disposition of your disability evaluation system processing was not appropriate under the guidelines of the Veterans Administration Schedule for Rating Disabilities. Accordingly, the Board recommended modification of your assigned disability rating without re-characterization of your separation with severance pay.

I have carefully reviewed the evidence of record and the recommendation of the Board. I concur with that finding, accept their recommendation and direct that your records be corrected as set forth in the attached copy of a Memorandum for the Chief of Staff, United States Air Force. The office responsible for making the correction will inform you when your records have been changed.

Sincerely,

XXXXXXXXXXXX

Director

Air Force Review Boards Agency

Attachments:

1. Directive

2. Record of Proceedings

cc:

SAF/MRBR

DFAS-IN

PDBR PD-2011-00852

MEMORANDUM FOR THE CHIEF OF STAFF

Having received and considered the recommendation of the Physical Disability Board of Review and under the authority of Title 10, United States Code, Section 1554a (122 Stat. 466) and Title 10, United States Code, Section 1552 (70A Stat. 116) it is directed that:

The pertinent military records of the Department of the Air Force relating XXXXX, be corrected to show that the diagnosis in his finding of unfitness was Tricep Tenonitis Left Elbow, VASRD Code 5099-5024, rated at 10%; rather than Chronic Elbow Pain a/w Triceps Tendonitis and Cubital Tunnel Syndrome, VASRD Code 5306 rated at 10%.

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Director

Air Force Review Boards Agency