RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXXXX BRANCH OF SERVICE: ArmY

CASE NUMBER: PD1100890 SEPARATION DATE: 20070927

BOARD DATE: 20120705

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty 1LT/O-2 (88A/Transportation Corps Officer), medically separated for chronic left (non-dominant) shoulder pain and chronic low back pain (LBP). 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 U3/L4 profile and underwent a Medical Evaluation Board (MEB). Chronic LBP and chronic left shoulder pain were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Three other conditions, as identified in the rating chart below, were forwarded on the MEB submission as medically acceptable conditions. An initial PEB determined each condition was unfitting and rated each at 0%. However, after range-of-motion (ROM) measurements from physical therapy were submitted, a Reconsideration PEB (RPEB) adjudicated the chronic left shoulder pain condition and chronic LBP condition as unfitting, rated 10% and 0% respectively; with application of the Veterans Administration Schedule for Rating Disabilities (VASRD). The CI made no further appeals and was medically separated with a 10% combined disability rating.

CI CONTENTION: “Chronic LBP suffered while deployed to OIF was rated for no mechanical loss of motion which I suffer from and has now progressed to shooting pain down my legs with tingling and limited mobility. Combined with the restricted motion in my left shoulder, my quality of life is poor making jobs I was trained for in the military impossible to keep.”

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. 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:

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| **Service PEB Reconsideration – Dated 20070713** | **VA (<1 Mo. Pre-Separation) – All Effective Date 20070929** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Left Shoulder Pain(Non-dominant) | 5201 | 10% | Acromioclavicular Hypertrophy with Impingement and Minimal Tendinopathy Left Shoulder (Dominant) | 5299-5203 | 10%\* | 20070920 |
| Chronic Low Back Pain | 5237 | 0% | Moderate Spinal Canal Stenosis, Board-Based Disk Bulging and Small Central Disk Protrusion and Facet Degenerative Changes of the Lumbar Spine | 5237 | 10%\* | 20070920 |
| Retropatellar Pain Syndrome Bilateral | Not Unfitting | Retropatellar Pain Syndrome Right Knee | 5099-5014 | 10% | 20070920 |
| Retropatellar Pain Syndrome Left Knee | 5099-5014 | 10% | 20070920 |
| Hypertension | Not Unfitting | Hypertension | 7101 | 0% | 20070920 |
| Hypercholesterolemia | Not Unfitting | Hyperlipidemia | 7099-7005 | NSC | 20070920 |
| ↓No Additional MEB/PEB Entries↓ | 0% x 3/Not Service-Connected x 4 | 20070920 |
| **Combined: 10%** | **Combined: 40%\*\*** |

\*Increased to 20% effective 20110406.

\*\*Increased to 60% effective 20110406 when 5299-5203 and 5237 increased to 20% each and addition of 8520 Right Lower Extremity neuropathy at 10% effective 20110406.

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application, i.e., that the gravity of his condition and predictable consequences merit consideration for a higher separation rating. The Board wishes to clarify that it is subject to the same laws for disability entitlements as those under which the Disability Evaluation System (DES) operates. 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. 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 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.

Chronic Left Shoulder Pain Condition. The CI injured his left shoulder in February 2005 during Officer Candidate School (OCS) when he fell to the ground with a 35 pound weapon. The MEB narrative summary (NARSUM) completed on 8 June 2007, noted his shoulder pain was exacerbated by minor physical activities and was described as throbbing, nagging, and constant. His pain continued despite treatment with nonsteroidal anti-inflammatory medications, Tramadol, and narcotic pain medications in addition to physical therapy. A magnetic resonance imaging (MRI) was obtained in August 2005 when the shoulder pain persisted despite physical therapy. This study documented severe tendinopathy of the supraspinatus tendon extending to the conjoined tendon as well as AC joint hypertrophy and edema. No clear evidence of a labral tear was noted. A second MRI study completed in January 2007 noted minimal acromioclavicular hypertrophy and lateral outlet impingement with minimal tendinopathy. No tear or osteochondral lesion was noted. Orthopedic consultation was obtained in May 2007 and while surgical treatment was discussed, the CI and the surgeon decided to try steroid injections first. An outpatient visit note from May 2007 documents a steroid injection was given that resulted in more than 80% relief before leaving the clinic. No further follow-up visits are in the record available for review. At the time of the NARSUM in early June 2007, the left shoulder pain had returned. The CI was issued a permanent U3 profile and the MEB was completed.

A VA Compensation and Pension (C&P) examination completed on 20 September 2007, approximately a week prior to separation, reported a similar clinical history. It also included information about an initial Toradol injection and treatment with a sling. He was unable to perform push-ups and was noted to have adhesions. The VA examiner opined that with repetitive use and motion, the CI would develop mild to moderate physical limitation that would be mostly manifested by pain and might also be manifested by lack of endurance. The examiner noted mild acromioclavicular hypertrophy with impingement and minimal tendinopathy with residuals of pain and stiffness of the left shoulder as the diagnosis.

Pertinent physical examination findings including ROM measurements are noted in the chart below. While the NARSUM exam included ROM values, the examiner acknowledged in an addendum that he had not used a goniometer, but had visually estimated the values. Therefore, these values are not included in the chart. The ROM measurements obtained by physical therapy in June 2007 were noted to have been done with a goniometer and these are included in the chart below.

There were two ROM evaluations in evidence, with documentation of additional ratable criteria, which the Board weighed in arriving at its rating recommendation.

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| Date of Separation: September 27, 2007 |
| ROM – Left Shoulder | ME PT Exam, p. 37~4 Months Pre-Separation(20070601) | MEB, p. 35~2 Months Pre-Separation(20070711) | VA C&P, p. 162<1 Month Pre-Separation(20070920) |
| Flexion (0-180) |  75⁰, 75°, 80° (78°) | NA | 100⁰ |
| Abduction (0-180) | 80° (78°), 80°, 75⁰ | NA | 110⁰ |
| Comment | ROM restricted due to a soft tissue adhesion mechanical type limitation; complaints of "throbbing pain" pointing to rotator cuff. | Positive Apley Scratch Test and Drop Arm with stress test; normal motor, sensory and reflex exams.No goniometer used, NARSUM Physician refers ROM to MEB PT exams since PT utilized instrument to measure ROMs | Pain and stiffness at 95° of flexion and 100° of abduction; +1 crepitus with ROM; No effusion or swelling; mild to moderate pain and stiffness during examination; normal reflexes, no motor or sensory examination. |
| §4.71a Rating | 20% | NA | 10% |

A PEB on 3 July 2007 determined the CI’s left shoulder condition was unfitting and rated it at 0% with application of the US Army Physical Disability Agency (USAPDA) pain policy. This was presumably based on the ROM estimates provided by the NARSUM examiner. However, the examiner submitted a NARSUM addendum dated 11 July 2007 stating he had not used a goniometer but had visually estimated the ROM measurements noted in the NARSUM. Upon review of this information, a RPEB determined the left shoulder condition should be rated at 10%, noting the presence of mechanically restricted abduction to 80 degrees due to soft tissue adhesions. The VA also applied a 10% rating based on limitation of ROM noted on the VA C&P examination. Although the VA rating decision stated the left shoulder was the dominant side, the VA C&P examinations noted the CI was right hand dominant. The VA later increased this rating to 20% effective on 6 April 2011, more than 3 years after separation. This increase was based on a C&P examination from May 2011 which documented a much more limited left shoulder flexion and abduction. This clearly shows a worsening of the condition over time and is not relevant for rating at the time of separation.

It is obvious that there is a clear disparity between the service and VA examinations, with very significant implications regarding the Board's rating recommendation. The Board thus carefully deliberated its probative value assignment to these conflicting evaluations, and carefully reviewed the service file for corroborating evidence in the 12-month period prior to separation. The only other ROM estimates available for review are those provided by the NARSUM examiner which he acknowledged were visual estimates, not goniometric measurements. However, the estimate of 80 degrees of abduction of the left shoulder is similar to the value actually measured by the physical therapist using a goniometer. The NARSUM exam did not include an estimate for left shoulder flexion but did note limitations in external rotation and pain with flexion, extension, internal rotation, and adduction. The NARSUM exam also noted positive Apley scratch test which is also indicative of limited ROM. The NARSUM examination corroborates the limited ROM measurements provided by physical therapy. Abduction of the shoulder to less than 90 degrees meets the minimal compensable level under VASRD 5201 and warrants a 20% rating. The VA C&P examination appears to be less comprehensive and did not include the Apley scratch test. Therefore, even though the VA C&P examination was closer in time to the date of separation, the Board determined this exam had less probative value than the physical therapy and MEB examinations. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a disability rating of 20% for the chronic left shoulder pain condition.

Chronic Low Back Pain Condition. The CI developed LBP while deployed to Iraq. However, his pain progressed over time and by the time of the MEB NARSUM examination in June 2007, he reported constant and severe pain, which was rated at 10/10 at its worst, radiated down his lower extremities, and was aggravated by minimal activities. It was also aggravated by standing for more than thirty minutes, weight bearing in excess of 25 pounds, spine flexion and extension, and exercises that required the use of back muscles. His pain did not respond to conservative treatment with NSAIDs, Tramadol, or narcotic pain medication or physical therapy and surgical treatment was not recommended. Additionally the service treatment record documents a lumbar epidural steroid injection on 27 July 2007 but no follow-up visits are in the record available for review and this procedure is not mentioned in the VA C&P examination in September 2007. The MEB NARSUM examination noted decreased thoracolumbar ROM but did not provide any actual measurements and as noted in the NARSUM addendum dated 11 July 2007, the examiner did not use a goniometer. The goniometric measurements provided by physical therapy are noted in the chart below. The physical therapist only recorded the average value of presumably three measurements for each ROM measured and that is what is recorded in the chart. The physical therapist also noted that all ROM was limited by pain. The VA C&P examination noted a similar clinical history and also noted the CI continued to have back pain. However, this examination noted the CI had declined an offer of corrective surgery and the NARSUM stated he was not a surgical candidate. The VA examiner opined the CI would have a total function loss equated to flexion limited to 75 degrees and he will have mild physical impairment during flare-ups. With repetitive use and motion of his lumbar spine, he would likely develop mild physical limitation that was mostly manifested by pain.

An MRI of the lumbar spine completed in January 2007 documented mild to moderate spinal canal stenosis at L2-3 and L3-4. At L4-5 a small broad-based disc bulge with thickening of the ligamentum flavum and facet arthropathy all contributed to narrowing of the bilateral lateral recesses and there was moderate spinal canal stenosis and contact of the bilateral L5 nerve roots. At L5-S1 there was moderate spinal canal stenosis from a combination of a broad-based disc bulge with a small central disc protrusion and facet degenerative change with ligamentum flavum thickening. There was no significant neuroforaminal stenosis at any level. A second MRI performed on 17 March 2007 had similar findings but also noted a small broad-based disc bulge at L3-4. A consult to a Pain and Spine Center in July 2007 noted the CI’s pain was constant, radiated down his left leg, and was rated at 7/10 on average but could be as low as 4/10 and as high as 10/10. This examination noted normal gait, decreased flexion of the spine, and normal motor, sensory, and reflex examinations in both lower extremities. This examiner noted the CI was a good candidate for surgery but the immediate plan was for lumbar epidural steroid injections and one injection administered on 27 July 2007 and is documented in the record.

There were two ROM evaluations in evidence, with documentation of additional ratable criteria, which the Board weighed in arriving at its rating recommendation.

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| Date of Separation: September 27, 2007 |
| Goniometric ROM - Thoracolumbar | MEB p. 35 (20070711)PTROM Exam ~4 Months Pre-Separation(20070531) | VA C&P, p. 163<1 Month Pre-Separation(20070920) |
| Flex (0-90) | 50⁰ | 70⁰ (pain at 65°) |
| Ext (0-30) | 15⁰ (17⁰) | 25⁰ (pain and stiffness at 20°) |
| R Lat Flex (0-30) | 15⁰ | 25⁰ (pain and stiffness at 20°) |
| L Lat Flex 0-30) | 15⁰ (17⁰) | 25⁰ (pain and stiffness at 20°) |
| R Rotation (0-30) | 20⁰ | 25⁰ (pain and stiffness at 20°) |
| L Rotation (0-30) | 20⁰ (18⁰) | 25⁰ (pain and stiffness at 20°) |
| COMBINED (240) | 135⁰ | 195⁰ |
| Comment | No paraspinal muscle spasm; normal gait; normal motor, sensory, and reflex examinations; positive straight leg raising on the left; moderate restriction of flexion, extension, and rotation; three of eight Waddell’s signs were positive: non-anatomic tenderness, mild lower spine pain with axial loading; distracted straight leg raise. | No antalgia; no muscle spasm; no abnormal curvature; negative straight leg raise testing; no increase in pain or stiffness with repeated motion; mild pain and stiffness during exam; reflex exam was normal and no mention of sensory or motor exam. |
| §4.71a Rating | 20% | 10% |

On 3 July 2007, the PEB determined the CI’s back pain condition was unfitting and rated it at 0% with application of the US Army Physical Disability Agency (USAPDA) pain policy. Upon review of new information, an RPEB also determined the back pain condition should be rated at 0%, noting pain limited motion without spasm or localized tenderness. This 0% rating was based on “no mechanical loss of motion.” This is in contradiction with VASRD §4.71a which specifies for 5003 that “satisfactory evidence of painful motion” constitutes limitation of motion and specifies application of a 10% rating “for each such major joint or group of minor joints affected by limitation of motion.” The VA applied a 10% rating based on limitation of ROM noted on the VA C&P examination. The VA later increased this rating to 20% effective 6 April 2011, more than 3 years after separation. This increase was based on a C&P examination from May 2011 which documented a much more limited thoracolumbar spine flexion. This clearly shows a worsening of the condition over time and is not relevant for rating at the time of separation.

It is obvious that there is a clear disparity between the service and VA examinations, with very significant implications regarding the Board's rating recommendation. The Board thus carefully deliberated its probative value assignment to these conflicting evaluations, and carefully reviewed the service file for corroborating evidence in the 12-month period prior to separation. While there is documentation of decreased ROM on multiple visits during this time period, there are no other goniometric measurements available for review. Additionally 3/8 Waddell’s signs were positive on the NARSUM examination. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a disability rating of 10% for the chronic LBP 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, the 3 July 2007 PEB relied on the USAPDA pain policy for rating the chronic left shoulder pain. However, it appears the RPEB on 13 July 2007 did not. In the matter of the chronic left shoulder pain condition, the Board, by simple majority, recommends a disability rating of 20%, coded 5201 IAW VASRD §4.71a. The single voter for dissent (who recommended no recharacterization of the 10% disability rating) did not elect to submit a minority opinion. In the matter of the chronic LBP condition, the Board unanimously recommends a disability rating of 10%, coded 5237 IAW VASRD §4.71a. There were no other conditions within the Board’s scope of review for consideration.

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:

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Chronic Left Shoulder Pain (Non-Dominant) | 5201 | 20% |
| Chronic Low Back Pain | 5237 | 10% |
| **COMBINED** | **30%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110923, 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 XXXXXXXXXXXXXXXXXX, AR20120012297 (PD201100890)

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 30% 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 30% 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 XXXXXXXXXXXXXXXX

 Deputy Assistant Secretary

 (Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA