RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1100995 SEPARATION DATE: 20040218

BOARD DATE: 20120515

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty PFC/E-3 (91K00/Medical Laboratory Specialist), medically separated for chronic pain right hip impingement status post (s/p) labral tear debridement. She developed right hip pain during basic training. She was initially treated conservatively and was able to maintain her physical activities in order to pass physical training. Her hip pain worsened and imaging confirmed a labral tear. She underwent surgical repair and additional conservative treatment including injections, but did not respond adequately to perform within her Military Occupational Specialty (MOS) or meet physical fitness standards. She was issued a permanent L3 profile and underwent a Medical Evaluation Board (MEB). “right hip impingement with chronic pain, status post labral tear debridement” was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Migraine headaches, as identified in the rating chart below, was forwarded on the MEB submission as a medically acceptable condition that existed prior to service (EPTS). The PEB adjudicated the right hip condition as unfitting, rated 0% with specified application of the US Army Physical Disability Agency (USAPDA) pain policy. The USAPDA issued an administrative correction (Revised PEB, DA Form 18) on September 25, 2003 primarily for name change without changing the rating level. The CI had applied for continuance on active Reserve (COAR), and COAR was denied on October 23, 2003. The CI made no appeals, and was medically separated with a 0% disability rating.

CI CONTENTION: “I was discharged with a 0% rating from the Army. A few months later, the VA determined a rating of 40% which was increased to 60% in 2007.”

SCOPE OF REVIEW: The Board wishes to clarify that the scope of its review as defined in DoDI 6040.44 (4.a) is limited to those conditions which were determined by the PEB to be specifically unfitting for continued military service; and, when requested by the CI, those condition(s) “identified but not determined to be unfitting by the PEB.” The right hip condition met the criteria prescribed in DoDI 6040.44 for Board purview; and is addressed below as an unfitting condition. The condition of migraine headaches was considered non-service-connected by the VA, was not part of the VA’s 40% or 60% ratings and is therefore not considered as a contended condition, and is not within the Board’s purview. The other requested conditions of left hip pain, lumbosacral strain and depressive disorder are not within the Board’s purview. 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:

|  |  |
| --- | --- |
| **Service Revised PEB – Dated 20030925** | **VA (6 Mos. After Separation) – All Effective Date 20040219** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Pain Right Hip Impingement s/p Labral Tear Debridement | 5099-5003 | 0% | Right Hip, Residual s/p Operative Anterior Hip Labral Tear Repair with Impingement | 5253 | 20% | 20040802 |
| Migraine Headaches | Not Unfitting | Migraine Headaches | 8100 | NSC | 20040802 |
| ↓No Additional MEB/PEB Entries↓ | Left Hip, Residuals…Impingement | 5252 | 10% | 20040802 |
| Residuals Lumbosacral Strain | 5237 | 10%\* | 20040802 |
| Major Depressive Disorder | 9434 | 10% | 20040802 |
| 0% x 1/Not Service-Connected x 1 additional | 20040802 |
| **Combined: 0%** | **Combined: 40%\*** |

\* Increased 5237 (back) to 40% effective 20060125, based on exam of 20060315 (combined 60%)

ANALYSIS SUMMARY: The Board also 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 Disability Evaluation System (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.

Right Hip Condition (Chronic Pain Right Hip Impingement S/P Labral Tear Debridement). The CI had continued right hip pain following January 2003 surgical repair of a labral tear. Narcotics pain medication, physical therapy and joint injections were not sufficient to allow return to full functioning. A repeat MRI showed only postoperative changes and no evidence of avascular necrosis (AVN) or further tears in the labrum.

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

|  |  |  |
| --- | --- | --- |
| Right Hip (Thigh) ROM | MEB ~7 Mo. Pre-Sep(20030709) | VA C&P ~6 Mo. Post-Sep(20040802) |
| Flexion (0-125⁰) | 105⁰ | 45⁰ |
| Extension (0-20⁰) | 0⁰ | Not provided |
| Abduction (0-45⁰) | Not provided | 10⁰  |
| Adduction (0-45⁰) | Not provided | 0⁰ |
| External Rotation (0-45⁰) | 30⁰ (& internal 20⁰) | Not provided |
| Comment | Tenderness over interior superior iliac spine. No catching; positive impingement sign; negative Tinel’s over lateral femoral cutaneous nerve; compartments soft, leg neurovascularly intact distally without weakness or numbness  | Posture and gait – normal; no increased loss of ROM with repetitive movements; straight leg raising negative; reflexes bilaterally equal; “All of these movements cause pain and she stopped when the pain started.”  |
| §4.71a Rating | 10% | 20% |

The narrative summary (NARSUM) indicated no history of giving way or locking of the hip, although the referenced follow-up orthopedic evaluation, 6 months prior to separation, mentioned subjective complaints of hip popping and “slipping.” Exam demonstrated well healed surgical incisions, with no signs of instability. Tinel’s sign (for nerve entrapment) was negative. There was no objective evidence of “catching.” The ROM of the right hip is summarized above and was missing hip abduction or adduction measurements in both the NARSUM and orthopedic exams.

The VA C&P exam, performed 6 months after separation, indicated that the CI felt that her back problem was related to her hip problems and she did not complain with her back while she was in service. Plain radiographs of the hip were normal. ROMs are summarized above and the examiner stated “all of these movements cause pain and she stopped when the pain started.” The ROM was missing hip extension, internal and external rotation measurements.

While the PEB used coding analogous to 5003 (arthritis code) to rate the hip condition, application of the USAPDA pain policy was specified. The VA coded the hip using 5253, Thigh, impairment of: at 20% for being closest to “limitation of abduction of, motion lost beyond 10⁰.” The Board deliberated over which exam had the highest probative value for rating. Both exams were missing different portions of a comprehensive rating ROM evaluation and they were fairly equidistant from the date of separation. The VA exam demonstrated significantly decreased flexion and the Board noted there was scant evidence of any treatment following from NARSUM through the VA evaluation. Both exams documented pain-limited motion IAW §4.59 (painful motion) and pain-limited motion to achieve a minimum 10% rating for the hip. All factors and ROMs measurements from either exam would rate at most the 10% rating criteria, except for the limited abduction noted on the VA exam which meets the 20% rating level. Since abduction measurement was missing from the service data, there was no evidence to refute that level of hip disability or to indicate any greater level of disability; however, there were some internal inconsistencies in the overall exam picture. In its assignment of probative value to such disparate exams, the Board must acknowledge that VA goniometric examinations may predispose a lowered pain threshold since they are vulnerable to the compelling psychological influence of secondary gain. Upon deliberation the Board agreed in this case that the MEB examination was more consistent with outpatient notes, more reflective of the anticipated severity suggested by the clinical pathology and less vulnerable to the undue influence just elaborated. The Board is therefore relying more heavily on the MEB measurements and the overall disability picture. The Board considered that the evidence of the disability picture more nearly approximates the criteria required for the 10% rating. Coding analogous to 5019 (bursitis) considers the labral debridement, impingement and limited hip motion using the criteria of 5003. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt) and §4.7 (higher of two evaluations), the Board recommends a disability rating of 10%, coded 5099-5019 for the right hip 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, PEB reliance on the USAPDA pain policy for rating the right hip condition was operant in this case and the condition was adjudicated independently of that policy by the Board. In the matter of the right hip condition, the Board unanimously recommends a service disability rating of 10%, coded 5099-5019 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, effective as of the date of her prior medical separation:

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Chronic Pain Right Hip Impingement S/P Labral Tear Debridement | 5099-5019 | 10% |
| **COMBINED** | **10%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20111019, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans’ Affairs Treatment Record

 XXXXXXXXXXXX

 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 XXXXXXXXXXXXXX, AR20120009511 (PD201100995)

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 10% 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 XXXXXXXXXXXXX

 Deputy Assistant Secretary

 (Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA