RECORD OF PROCEEDINGS
PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXX
CASE NUMBER: PD1200366
BOARD DATE: 20121211

BRANCH OF SERVICE: ARMY
SEPARATION DATE: 20030327

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SGT/E-5 (91A20/Biomedical Maintenance Technician), medically separated for chronic pain neck, patellar rated as constant, slight. The CI had experienced neck and bilateral knee pain intermittently for over 4 years when the two conditions began to worsen sometime in 2001. There was no injury or acute trauma to either area that was identified as the cause of his pain. Over the year prior to separation, the CI's neck pain demanded the most medical attention including non-steroidal anti-inflammatory medications and extensive physical therapy (PT). When the CI's chronic neck and left knee pain could not be adequately rehabilitated to meet the physical requirements of his Military Occupational Specialty (MOS) or satisfy physical fitness standards, he was issued a permanent L3/U3 profile duty and referred for a Medical Evaluation Board (MEB). The MEB forwarded degenerative joint disease (DJD) of the neck, DJD secondary to a bipartite patella as unfitting conditions for Physical Evaluation Board (PEB) adjudication along with the following medically acceptable conditions: retropatellar knee pain, mild intermittent asthma, low back pain with recurrent spasms, muscle contracting headaches with neck pain, left ear tinnitus and intermittent radicular symptoms, as identified in the rating chart below. The PEB designated the neck and knee conditions as; chronic pain neck, patellar, and adjudicated them together as unfitting and rated for pain at 10%, with specified application of the US Army Physical Disability Agency (USAPDA) pain policy. The remaining conditions were determined to be not unfitting and therefore not rated. The CI made no appeals, and was medically separated with a 10% disability rating.

CI CONTENTION: "During the MEB, the member was given a low rating and was medically discharged only to receive a severance pay and no medical retirement. The member sustained all injuries while on active duty. The member was given his disability rating on only one medical injury instead of all injuries received during active duty."

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. The conditions retropatellar knee pain, mild intermittent asthma, low back pain with recurrent spasms, muscle contracting headaches with neck pain, left ear tinnitus and intermittent radicular symptoms as requested for consideration meet the criteria prescribed in DoDI 6040.44 for Board purview; and, are addressed below, in addition to a review of the ratings for the unfitting conditions. 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 Correction of Military Records.

RATING COMPARISON:

Service IPEB – Dated 20021224			VA (4.5 Mos. Post-Separation) – All Effective Date 20030328			
Condition	**Code**	**Rating**	**Condition**	**Code**	**Rating**	**Exam**
Chronic Pain Neck, Patellar	5099-5003	10%	DJD C-Spine	5242*	30%	20030813
			DJD Lt Knee	5260	10%	20030813
			DJD Rt Knee	5260	10%	20030813
			Lateral Instability Lt Knee	5257	20%	20030813
Mild, Intermittent Asthma	Not Unfitting		Bronchial Asthma	6602	0%	20030813
Low Back Pain w/ Recurrent Spasms	Not Unfitting		DJD L-Spine	5242*	20%*	20030813
Muscle Contracting Headaches w/ Neck Pain	Not Unfitting		Chronic Muscle Tension Headaches	8199-8100	10%	20030813
Lt Ear Tinnitus	Not Unfitting		Tinnitus	6260	10%	20030813
Intermittent Radicular Symptoms	Not Unfitting		NO VA ENTRY			
Retropatellar Knee Pain	Not Unfitting					
↓No Additional MEB/PEB Entries↓			0% x1			
Combined: 10%			**Combined: 70%**			

*VARD dated 20040106 penciled in VASRD code 5290 & 5292 for DJD C spine & L spine respectively. VASRD code 5242 did not exist until the 38 CFR 7–1–04 Edition; DJD L-Spine effective date 20030331

ANALYSIS SUMMARY: The Board acknowledges the CI's contention that suggests 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 disability entitlements as those under which the Disability Evaluation System (DES) operates. While the DES considers all of the member's medical conditions, compensation can only be offered for those medical conditions that cut short a 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 his 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. We also note that the applicant asks the Board for specific correction of records and specified consequential entitlements, "no medical retirement." By law the Board authority is limited to making recommendation 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. The Board will review 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 PEB combined DJD of the neck and DJD secondary to a bipartite patella as a single unfitting condition, coded analogously to 5003 and rated 10%. The PEB relied on the USAPDA pain policy and did not apply separately compensable VASRD codes. 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.

Neck Condition. The Board first considered if the chronic neck pain, having been de-coupled from the combined PEB adjudication, remained independently unfitting as established above. The commander's statement directly implicated neck pain as causing duty limitations and the inability to participate in both Common Task Training and the alternate fitness test. It contains the statement "…he is a highly motivated soldier with the desire and dedication of performing his job as a 91A20 but does not possess the capability due to the physical requirements to maintain his MOS." The CI had an average of at least two medical visits a months for his neck pain within the year prior to separation which was also noted in the commander's statement as the CI occasionally missed work due to these problems. All members agreed that the chronic neck pain, as an isolated condition, would have rendered the CI incapable of continued service within his MOS, and accordingly merits a separate service rating.

There were two range-of-motion (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.

Cervical ROM	NARSUM ~5 Mo. Pre-Sep	VA C&P 4.5 Mo. Post-Sep	VA Urgent Care Clinic
Flex (45° Normal)	45°	10°	-
Ext (0-45)	20°	5°	-
R Lat Flex (0-45)	45°	15°	-
L Lat Flex (0-45)	45°	10° (12°)	-
R Rotation (0-80)	80°	5°	-
L Rotation (0-80)	80°	5° (4°)	-
COMBINED (340°)	315°	50°	-
Comment	Diffuse Neck Tenderness W/ Trigger Points Neg- Spurling's Test & Adsons Maneuver No Hoffman's Sign Normal Strength & Reflexes 0/4 Waddel's	Pos. Painful Motion + Mild Paravertebral Muscle Spasm Decreased DTRs Bilat. Arms Depressed Pin Prick & Vibratory Sense Bilat. Arms Pos. Fatigability of C-Spine on Repetitive Motion	Neck: Tenderness at C5 and C6. Good, But Slow, Cervical ROM
7-1-02 Edition §4.71a Rating	Slight	Severe	Slight
Current §4.71a Rating	10%*	30%	N/A

*IAW §4.59 Painful motion.

At the MEB exam prepared 6 months prior to separation, the CI noted "I get numbness in my left arm every now and then" on the DD Form 2807-1. The MEB physical exam noted "tender cervical area." The narrative summary (NARSUM) prepared almost 5 months prior to separation noted that the CI presented to the Orthopedic Clinic with a 1-2 year history of neck pain. He had been evaluated in the past and was told that he had some disc bulging and DJD in his neck. He stated that he was in constant pain at his neck. He rated the neck pain as 7/10. He had no significant history of trauma and reported no history of fractures in his neck. He did not have any surgical procedures on his neck. He stated that his major problem was that he cannot perform activities related to the PT test because he could not walk or run the PT test and he had a difficulty with sit ups because of his neck pain. He did state that he intermittently got left arm pain. All significant physical examination findings are summarized in the cervical ROM chart above. Magnetic resonance imaging (MRI) of the cervical spine was performed approximately 6 months prior to separation and the impression was: (1) mild bilateral foraminal narrowing at C6/7 due to osteophyte (2) minimal disc bulge C5/6. An electromyography (EMG) and nerve conduction study of the left upper extremity was performed approximately 5 months prior to separation and the conclusion was: "1. normal study. 2. No electrodiagnostic evidence of denervation of sampled muscles on needle EMG, sample represents contributions from nerve root levels C5 to T1. 3. No electrodiagnostic evidence of mono or polyneuropathy."

At the VA Compensation and Pension (C&P) exam performed 4.5 months after separation, the CI reported DJD involving the cervical spine with bilateral foraminal stenosis and with herniated disk at C4-5 with cervical radiculopathy involving both upper extremities. The CI stated that in 1998 he started having pain in the cervical spine and his pain started gradually and had gotten worse. He gave no history of acute trauma to the cervical spine. This pain radiated down both upper extremities with tingling and numbness of both upper extremities. He had pain on a daily basis that lasted 1.5 days and sometimes longer and it interfered with his occupation and daily activities. Because of the pain, he had a lack of endurance and chronic fatigue on a daily basis. He took Motrin as needed and got minimal or no relief with that medication. Subsequently, an MRI was done and he was diagnosed with DJD involving the cervical spine with bilateral foraminal stenosis and a herniated disk at C4-5. The CI had no surgery of the cervical spine, just intensive medical treatment. All pertinent physical exam findings are summarized in the cervical ROM chart above.

The Board directs attention to its rating recommendation based on the above evidence. The PEB "bundled" the chronic neck and knee pain together, coded analogously as 5099-5003 and rated them at 10% for pain specifically citing the USAPDA pain Policy. As noted in the analysis summary section, this was common practice at the time however; this Board must apply separate ratings if the "un-bundled" condition was separately unfitting. The Board determined that the CI's neck pain was separately unfitting and the rating recommendation discussion will follow below. Additionally, there was a significant change in the VASRD guidance concerning rating disabilities of the spine during the time period the CI's disability case was being processed by the DES and VA. The Board is required to make its rating recommendation based on VASRD guidance if effect at the time of separation. The VA applied VARSD code 5242, a code that came into existence later in 2003, then penciled in code 5290; Spine, limitation of motion of, cervical, on the VA rating decision document dated 6 January 2004. The VA rated the neck disability at 30% utilizing guidance present in the "newer" 23 September 2003 VASRD. That 30% rating was assigned based on a forward flexion of the cervical spine of 15 degrees or less as the VA examination showed the ROM measurements as summarized in the chart above. However, under the VASRD in effect at the time of separation, a 30% would also be assigned based on a characterization of the limitation of motion as severe.

It is obvious that there is a clear disparity between these examinations, with very significant implications regarding the Board's rating recommendation. The ROM values reported by the VA examiner, 5 months after separation, are significantly worse than those reported by the NARSUM dated 5 months before separation. The Board thus carefully evaluated these conflicting evaluations, and reviewed the file for corroborating evidence. This review yielded one subjective mention of the CI's cervical ROM that occurred during a VA urgent care visit 7 months after the C&P examination and it stated, "Tenderness at C5 and C6. Good, but slow, cervical ROM." The ROM measurements in the C&P exam represent an 85% decrease in the total ROM of the cervical spine and if still present 7 months later would not be qualified as "good." Considering the slightly abnormal NARSUM exam performed 5 months before separation and the "Good, but slow, cervical ROM" comment made by a VA medical provider 12 months after separation, it is likely that the severely abnormal C&P examination performed between these two exams was performed when significant muscle spasm was present, as was documented on that exam. Additionally, review of the service treatment records (STR) reveals that the CI experienced "good and bad days" based on the presence or absence of cervical muscle spasm and paraspinal trigger points. These intermittent muscle spasms also correlated with the CI's upper extremity radicular symptoms that were also intermittently present. These intermittent radicular symptoms did not result in any persistent, duty limiting functional impairment and completely resolved when the muscle spasm was not present. Therefore, the intermittent radicular symptoms were adjudged not to be separately unfitting and will be evaluated in conjunction with the CI's neck condition. In evaluating these somewhat conflicting

examinations, the NARSUM measurements are consistent with the diagnostic and clinical pathology in evidence and with the exam performed 12 months after separation. The presence of paravertebral cervical muscle spasm during the C&P examination accounts for the progressively impaired ROM in the fairly short interval between the MEB and VA examinations. As discussed earlier, the CI's neck pain also had waxing and waning muscle spasms that, when present, significantly increased his neck pain while likely also decreasing the ROM. The presence of muscle spasm was documented on that exam. Each of these examinations was performed equidistant from the date of separation, one before and the other after. Recognizing that the CI's level of neck disability was always consistent with "slight" and did occasionally raise to the "severe" level, the Board will not assign preponderant probative value to a specific examination but seek to recommend a disability rating that will most accurately reflect the waxing & waning nature of the CI's neck disability and the level of disability present the majority of the time.

The 2002 Veterans Administration Schedule for Rating Disabilities (VASRD) coding and rating standards for the spine, which were in effect at the time of separation, were modified on 23 September 2002 to add incapacitating episodes (5293 Intervertebral disc syndrome), and then changed to the current §4.71a rating standards on 26 September 2003. The 2002 standards for rating based on ROM impairment were subject to the rater's opinion regarding degree of severity, whereas the current standards specify rating thresholds in degrees of ROM impairment. When older cases have goniometric measurements in evidence, the Board reconciles (to the extent possible) its opinion regarding degree of severity for the older spine codes and ratings with the objective thresholds specified in the current VASRD §4.71a general rating formula for the spine. This promotes uniformity of its recommendations for different cases from the same period and more conformity across dates of separation, without sacrificing compliance with the DoDI 6040.44 requirement for rating IAW the VASRD in effect at the time of separation. For the reader's convenience, the 2002 rating code under discussion in this case is excerpted below for later reference during conclusions regarding recommendation:

5290 Spine, limitation of motion of, cervical:
Severe 30
Moderate 20
Slight 10

Furthermore, the Board policy of reconciling recommendations under the older 5290 rating schedule with current §4.71a based recommendations (when reasonable to do so) was considered. The NARSUM exam documents ROM measurements that are non-compensable IAW Current §4.71a standards; however there was evidence of painful motion. As delineated in the VASRD, IAW §4.59 Painful motion, the CI's chronic painful neck is entitled to at least the minimum compensable rating for the joint 10% in this case, which would be consistent with a slight, 10%, rating IAW the rating standards in effect at the time of separation. The C&P examination documented in the chart above is consistent with a severe, 30% rating IAW current §4.71a standards and the rating standards in effect at the time of separation. As described above, the waxing and waning nature of this condition over time would result in days with slight, moderate, or severe limitation of motion. The Board determined that, more likely than not, the CI had fewer days with either a moderate or severe limitation of motion of his neck than days with a mild limitation of motion. There was no evidence of a ratable peripheral nerve impairment or documentation of incapacitating episodes that would provide for additional or higher rating. 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 neck pain condition.

Knee Condition. The Board first considered if the chronic knee pain having been de-coupled from the combined PEB adjudication remained independently unfitting and in addition, if each knee independently was separately unfitting as the MEB and PEB documents were sufficiently

vague as to leave that in question for the Board. The NARSUM documents that one of the CI's major limitations was his inability to walk or run the PT test. Of the three core documents used to garner information regarding fitness determinations, the physical profile, commander's statement and the NARSUM, two specifically mention the left knee while none mention the right knee as causing duty limitations. The NARSUM specifically documents only left knee pain as a chief complaint, along the CI's neck pain as discussed above. The CI's permanent L3 profile prepared 3 months prior to separation annotates only the left knee pain as causing limitations in the CI's ability to perform the fitness test. The right knee was not mentioned in any of these documents. All members agreed that only the left knee, as an isolated condition, would have rendered the CI incapable of continued service within his MOS, and accordingly merits a separate rating.

There were two 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.

Left Knee ROM	NARSUM ~5 Mo. Pre-Sep	VA C&P 4.5 Mo. Post-Sep
Flexion (140° Normal)	130°	110°
Extension (0° Normal)	0°	0^0
Comment	No varus/valgus laxity at 0^0 or 30^0 No effusion + patellofemoral tenderness on patellar grind No Lachman's or Ant./Post Drawer Normal McMurray's Painful motion well documented in STR	Pain with Motion; + crepitation 2+ swelling 2+ Laxity w/ lateral instability + decrease ROM w/ repetitive motion + Mild gait abnormality w/ wt. bearing
7-1-02 Edition §4.71a Rating	10%*	Code 5260 at 10%
	N/A	Code 5257 at 20%
Current §4.71a Rating	10%*	10%*

*IAW §4.59 Painful motion.

At the MEB exam prepared 6 months prior to separation, the CI noted, "I have arthritis in both knees which swells up on occasion." The MEB physical exam noted "+ facet pain both knees." The NARSUM prepared almost 5 months prior to separation noted that the CI presented to the Orthopedic Clinic with a 1-2 year history of left knee pain. He had been evaluated in the past and was told that he had some DJD in his left knee. He stated that he was in constant pain due to his left knee rated at 8/10. He had no significant history of trauma and reported no history of fractures. He did not have any surgical procedures on his knees in the past. He stated that his major problem was that he cannot perform activities related to the PT test because he could not walk or run the PT test and he had a difficulty with sit ups because of his neck pain. All significant physical examination findings are in the left knee ROM chart above.

At the C&P exam the CI reported DJD involving both knees with retropatellar pain syndrome of both knees. The CI stated that in 1997, he started having pain in both knees. The pain started gradually and has persisted. There was no history of acute trauma to the knees. He had been treated medically for the knee pain and has had no surgical procedures to the knees. The pain in both knees had worsened with daily pain that lasted 3 hours and sometimes all day. He had increased pain in both knees with any kind of prolonged standing, prolonged walking and when going up or down a flight of stairs. The pain interfered with his occupation and daily activities and experiences a lack of endurance and chronic fatigue on a daily basis. He had swelling of the knees and periodically, had giving out of the left knee. He takes Motrin and Tylenol extra strength as needed. He got minimal or no relief with the medication prescribed. All pertinent physical exam findings are summarized in the left knee ROM chart above. Plain film X-ray revealed the left knee showed bipartite patellar change without deformity of the articulating

surface of the patella. The patellofemoral joint is normal. The tibio-femoral joint was also normal in appearance. No fluid was seen. Although the primary report for the bilateral knee MRI performed on 6 May 2004 was not present for review, a VA treatment note dated 22 July 2004 contains the following statement, "Patient informed of the normal MRI on the right knee and was informed that the left knee showed degeneration of the posterior horn of the medial meniscus."

The Board directs attention to its rating recommendation based on the above evidence. The PEB "bundled" the chronic neck and knee pain together, coded analogously as 5099-5003 and rated them at 10% for pain specifically citing the USAPDA pain Policy. As noted in the analysis summary section, this was common practice at the time however; this Board must apply separate ratings if the condition was separately unfitting. The CI's left knee pain was determined to be separately unfitting and the rating recommendation discussion will follow below. The VA applied VASRD code 5260; Leg, limitation of flexion of, to each of the CI's painful knees and rated them each at 10% IAW with VASRD §4.59. The Board recognizes the documented painful motion present in the CI's left knee and IAW VASRD §4.14 Avoidance of pyramiding, a separate rating for retropatellar knee pain cannot be considered. The NARSUM evaluation of the CI's left knee reveals non-compensable ROM measurements, a knee without any laxity on examination and tenderness to patellar grind. There is no specific mention of painful motion in the NARSUM; however, the STR provides ample evidence for that conclusion. 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 knee pain condition.

The left knee was additionally coded with 5257, knee, other impairment of: Recurrent subluxation or lateral instability, and rated at 20%, moderate, by the VA. The C&P exam findings documented in the left knee ROM chart above are significantly worse than those documented in the NARSUM; with instability being the sole factor responsible for these poorer findings. To determine the appropriate level of disability, the Board carefully reviewed the STR for corroborating evidence in the 12-month period prior to separation. This review yielded no evidence of subluxation or instability complaints by the CI and no other exams showing knee laxity. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board concluded that the evidence available for review does not support the presence of left knee instability prior to separation. Therefore, no additional rating can be assigned.

Contended PEB Conditions. The contended conditions adjudicated as not unfitting by the PEB were retropatellar knee pain, mild intermittent asthma, low back pain with recurrent spasms, muscle contracting headaches with neck pain, left ear tinnitus and intermittent radicular symptoms. The Board's first charge with respect to these conditions is an assessment of the appropriateness of the PEB's fitness adjudications. The Board's threshold for countering fitness determinations is higher than the VASRD §4.3 (reasonable doubt) standard used for its rating recommendations, but remains adherent to the DoDI 6040.44 "fair and equitable" standard. The intermittent radicular symptom condition was addressed in the neck condition section and the retropatellar knee pain condition was addressed in the knee condition section above. The CI's low back pain had been intermittently profiled and was mentioned in the commander's statement along with the CI's back condition but was not annotated in the permanent profile 4 months prior to separation. MRI examination of the lumbar spine was normal. The CI's low back with recurrent spasm condition was not judged to fail retention standards and was considered by the Board. There was no indication from the record that the CI's low back pain significantly interfered with satisfactory duty performance. The mild intermittent asthma, muscle contraction headaches and left eat tinnitus conditions were not profiled, implicated in the commander's statement or judged to fail retention standards. All were reviewed and considered by the Board. There was no indication from the record that any of these conditions significantly interfered with satisfactory duty performance.

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 chronic pain neck, patellar was operant in this case and the condition was adjudicated independently of that policy by the Board. In the matter of the chronic pain neck condition, the Board unanimously recommends a disability rating of 10%, coded 5290 IAW VASRD §4.71a. In the matter of the chronic pain knee condition, the Board unanimously recommends a disability rating of 10%, coded 5260 IAW VASRD §4.71a. In the matter of the contended retropatellar knee pain, mild intermittent asthma, low back pain with recurrent spasms, muscle contracting headaches with neck pain, left ear tinnitus and intermittent radicular symptoms conditions, the Board unanimously recommends no change from the PEB determinations as not unfitting. 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 his prior medical separation:

UNFITTING CONDITION	VASRD CODE	RATING
Chronic Pain Neck	5290	10%
Chronic Pain Knee	5260	10%
	COMBINED	**20%**

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20120416, w/atchs
Exhibit B. Service Treatment Record
Exhibit C. Department of Veterans' Affairs Treatment Record

XXXXXXXXXXXXXXXX, DAF
President
Physical Disability Board of Review

SFMR-RB

MEMORANDUM FOR Commander, US Army Physical Disability Agency
(TAPD-ZB / XXXXXXXX), 2900 Crystal Drive, Suite 300, Arlington, VA 22202-3557

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation for XXXXXXXXXXXXXX AR20130000148 (PD201200366)

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 20% 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

XXXXXXXXXXX
Deputy Assistant Secretary
(Army Review Boards)

CF:
( ) DoD PDBR
( ) DVA