RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1200017 SEPARATION DATE: 20030815

BOARD DATE: 20120524

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SPC/E-4 (91W10, Medic), medically separated for right ankle condition after an inversion injury. She did not respond adequately to conservative and operative treatment and was unable 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 ankle joint ROM <10 degrees and right talus early avascular necrosis were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. No other conditions appeared on the MEB’s submission. The PEB adjudicated right ankle pain as unfitting, rated 20%; with likely application of the US Army Physical Disability Agency (USAPDA) pain policy. The CI made no appeals, and was medically separated with a 20% combined disability rating.

CI CONTENTION: “I feel that the rating I recieved should be changed because my foot was never properly taken care of while I was still active. I was still having lots of problems after the surgery with pain, swelling and range of motion. My foot got so bad, that in 2007 I had to have another surgery on my right Achilles Tendon done by Dr Lance Weaver. After the surgery I went to PT for rehab, but I still have very limited range of motion. It was also found during my VA exam that I have pes valgus, bilateral feet which was service connected.” She elaborates no specific contentions regarding rating or coding and mentions no additionally contended conditions.

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 pes valgus, bilateral feet condition is 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 Correction of Military Records (BCMR).

RATING COMPARISON:

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| **Service IPEB – Dated 20030423** | **VA (5 Mo. After Separation) – All Effective Date 20030816** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Rt Ankle Pain | 5271 | 20% | Tarsal Tunnel Release, Rt Ankle w/ Talus Avascular Necrosis | 5283-5271 | 10% | 20040129 |
| ↓No Additional MEB/PEB Entries↓ | Pes Valgus, Bilateral Feet | 5299-5276 | 10% | 20040129 |
| **Combined: 20%** | **Combined: 20%** |

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impairment with which her service-connected condition continue to burden her. It is a fact, however, that the Disability Evaluation System (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. This role and authority is granted by Congress to the Department of Veteran’s Affairs (DVA). The DVA, operating under a different set of laws (Title 38, United States Code), is empowered to compensate all 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. The Board utilizes VA evidence proximate 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 rating determinations for the disability existing at the time of separation. Post-separation evidence therefore is probative only to the extent that it reasonably reflects the disability at the time of separation.

Right Ankle Condition. The CI had an inversion injury of her right ankle which led to persistent pain around the medial malleolus and subsequent tarsal tunnel release by podiatry for definitive care. She continued to have persistent pain and was additionally diagnosed with an avascular necrosis of talus and was referred for a MEB. Prior to her surgery she was better able to perform her job and after surgery she was on indoor desk duty only. She was not able to pass the army physical fitness test or alternate event, stand for 15 minutes per hour, wear the back pack or load bearing equipment for long periods of time but she was able to road march one mile and wear her Kevlar and her protective mask. 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.

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| Goniometric ROM – Right Ankle | MEB 6 Mo Pre-Sep | VA C&P-5 Mo After -Sep |
| Dorsiflexion (0-20) | 0⁰ | 0⁰ |
| Plantar Flexion (0-45) | 40⁰ | 40⁰ |
| Comment | Splinting on dorsiflexion due to pain, no crepitus, stance abnormal, unable to do heel raise | Cautious gait, unable to heel or toe walk,  |
| §4.71a Rating\* | 20% | 20% |
| §4.124a Rating\* | 10% | 10% |

\* Ratings may overlap and are not independent

At the MEB exam, the CI reported continued daily pain 4 on a scale of 1-10 currently with 8 being the worse, stiff right ankle, only able to walk on the lateral side of the right foot with numbness and tingling of the heel and lateral foot area since surgery. She reported being able to walk on a treadmill for only one mile before her foot swelled, her boots caused pain and when the temperature is cold, and her foot turns colors and takes a while to warm up. Hercurrent medications included Desipramine (antidepressant used for pain) and Depoprovera. The MEB physical exam demonstrated normal vascular exam, negative Tinel's at the tarsal tunnel, tenderness to palpationat surgical site, decreased sensation at the bottom of her heel and a tingling sensation at the bottom of her fifth toe. The skin exam revealed a well healed surgical scar at the right medial tarsal tunnel area approximately 10cm (3.9 inch) in length; temperature and turgor were normal, no excessive sweating and no discolorations. The subtalar joint had 20 degrees of inversion without pain, 10 degrees of eversion with pain, the toe joints had full ROM and there was no crepitus noted. On stance, she did not allow the second and third toes to touch the ground, they were dorsiflexing and she stated that this was involuntary. She was unable to bring the medial column to plantigrade. On rising to tiptoe, she was rolling her foot to the lateral aspect to avoid normal weight bearing to the medial column and she was unable to do a heel rise. X-rays did not reveal any changes to the talar body. The magnetic resonance image (MRI) from the German economy did show small splotches of increased intensity to the inferior talar body not involving the subtalar joint and not involving the ankle joint. The examiner opined she had a neuropathy to the right posterior tibial nerve leading to numbness of the right heel and the talar body changes on the most recent MRI may be early avascular necrosis changes, which are not visible on x-ray.

At the VA Compensation and Pension (C&P) exam after separation, the CI reported pain, worse in the morning and with stairs, involving the right foot with limited mobility of the upper ankle joint, and a feeling of coldness in the right foot and the area of the inner malleolus. She was taking pain medication. The C&P physical exam was similar to the MEB exam in addition demonstrated a cautious gait with no use of orthopedic aids, on stance, feet showed a significant pes valgus deformity, considerable signs of callous over the lateral portion of the right heel on the plantar side. Walking on toes and heels could not be demonstrated. The Achilles tendon showed a slight sensitivity to pressure on the right side in the distal attachment area over the calcaneus but was stable on both sides and no motor deficits. X-rays were normal and ultrasounds revealed normal achilles tendons and synovitis of the tendon of the right posterior tibial muscle. The examiner diagnosed chronic tendinitis of the right posterior tibial tendon after tarsal tunnel release and repeated inversion trauma of the foot.

The Board directs attention to its rating recommendation based on the above evidence. The Board notes that both the MEB and VA exams were complete, well documented, and similar in terms of ratable data; and, therefore assigns them equal probative value. PEB and VA chose different coding options for the condition, but this did not bear on rating. The PEB’s DA Form 199 reflected application of the USAPDA pain policy for rating, but its 20% determination was consistent with §4.71a standards. The PEB chose to rate right ankle pain, subsuming limited ankle ROM and avascular necrosis, and was generous in allowing 20%, the highest evaluation for the 5271 code (ankle, limited motion of). The VA chose to code tarsal tunnel release, right ankle with talus avascular necrosis to 5271 and analogous to 5283 (tarsal, or metatarsal bones, malunion of, or nonunion of) and rated 10% for moderate limited motion and symptoms. The Board agreed pain was the predominant disability and further agreed when considering pain it was difficult to discern if the avascular necrosis (musculoskeletal) or the tarsal tunnel (neurologic) was the predominant clinical pathology for creating the right ankle pain and agreed both were likely. Therefore when considering higher ratings and to avoid pyramiding IAW VASRD 4.14 the Board looked at rating residual chronic right ankle pain either IAW §4.71a or §4.124 not both. The Board looked for higher ratings using analogous 5284 code (foot injuries, other) and the 8625 (neuritis and the posterior tibial nerve [tarsal tunnel]) code but there was insufficient evidence to justify a higher rating under these codes. Board precedent is that a functional impairment tied to fitness is required to support a recommendation for addition of a peripheral nerve rating at separation. The sensory component in this case had no functional implications and there was no motor impairment. Since there was no evidence of functional impairment in this case, the Board cannot support a recommendation for additional separate rating based on peripheral nerve impairment. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board concluded that there was insufficient cause to recommend a change in the PEB adjudication for the right ankle condition; since, the applied code achieved the maximal rating allowed by the VASRD.

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. The Board did not surmise from the record or PEB ruling in this case that any prerogatives outside the VASRD were exercised. As discussed above, PEB reliance on the USAPDA pain policy for rating right ankle condition was operant in this case and the condition was adjudicated independently of that policy by the Board. In the matter of the right ankle condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. There were no other conditions within the Board’s scope of review for consideration.

RECOMMENDATION: The Board, therefore, recommends that there be no recharacterization of the CI’s disability and separation determination, as follows:

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Right Ankle Pain | 5271 | 20% |
| **COMBINED** | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20111230, 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 XXXXXXXXXXXXXX, AR20120010149 (PD201200017)

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 and hereby deny the individual’s application.

This decision is final. The individual concerned, counsel (if any), and any Members of Congress who have shown interest in this application have been notified of this decision by mail.

BY ORDER OF THE SECRETARY OF THE ARMY:

Encl XXXXXXXXXXXXX

 Deputy Assistant Secretary

 (Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA