RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1200070 SEPARATION DATE: 20051215

BOARD DATE: 20120629

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty Soldier, SGT/E-5(96D2O, Imagery Analyst), medically separated for chronic neck pain and right knee pain. Both conditions began while on deployment to Iraq in 2004. The knee condition was the result of injury; neither condition was associated with a surgical indication. He did not respond adequately to conservative treatment and was unable to meet the physical requirements of his Military Occupational Specialty (MOS) or satisfy physical fitness standards. He was issued a permanent U3/L3 profile and referred for a Medical Evaluation Board (MEB). The MEB forwarded neck pain secondary to degenerative joint disease and spondylosis at C4-6, and right knee pain secondary to osteochondral defect of the medial femoral condyle as medically unacceptable IAW AR 40-501. Four other conditions, as identified in the chart below, were also forwarded by the MEB. The Physical Evaluation Board (PEB) adjudicated the chronic neck pain and right knee pain as unfitting, rated 10% and 0%, with likely application of the US Army Physical Disability Agency (USAPDA) pain policy. The remaining conditions were determined to be not unfitting. The CI made no appeals and was medically separated with a 10% disability rating.

CI CONTENTION: The CI elaborated no specific contention in his application.

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 – Dated 20050826** | **VA (2 Mos. Pre-Separation) – All Effective Date 20051216** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Neck Pain | 5237 | 10% | Cervical Degen. Disc Disease | 5242 | 10% | 20051021 |
| Right Knee Pain | 5010 | 0% | Right Knee Osteochondral Defect | 5260-5010 | 10% | 20051021 |
| Left Wrist Pain | Not Unfitting | Left Wrist DJD | 5214-5010 | 10% | 20051021 |
| Mild Asthma | Not Unfitting | Reactive Airway Disease | 6602 | 10% | 20051021 |
| Right Shoulder DJD | Not Unfitting | Right Shoulder DJD | 5201-5010 | 10% | 20051021 |
| L5-S1 Degen. Disc Disease | Not Unfitting | Lumbar Degen. Disc Disease | 5242 | 10% | 20051021 |
| ↓No Additional MEB/PEB Entries↓ | Tinnitus | 6260 | 10% | 20051021 |
| Muscular Tension Headaches | 8100 | 10% | 20051021 |
| 0% X 1 / Not Service-Connected x 6 | 20051021 |
| **Combined: 10%** | **Combined: 60%** |

ANALYSIS SUMMARY:

Chronic Neck Pain. The narrative summary (NARSUM) performed on 26 July 2005 (5 months prior to separation) notes the CI first developed neck pain in March 2004 while deployed. There was no reported injury, and the pain was thought to be due to wearing a Kevlar helmet. He did not seek medical care until that summer, at which time he was given pain medication. The CI complained of constant, dull aching in the lower neck that worsened with carrying more than 20 pounds, performing sit-ups or wearing a helmet. In December 2004 after return from deployment, X-rays revealed cervical spine spondylosis. The MEB exam showed flexion, extension, left rotation and right rotation to be “within normal limits,” but specific measurements were not provided. Right side bending was 25⁰ (normal 0-45⁰), and left side bending was 29⁰; both were limited by pain. Mild interspinous tenderness at C5-C6 was present. The examination was silent regarding upper extremity neurologic symptoms, gait or spinal contour. Normal strength, sensation and deep tendon reflexes (DTR) of the right upper extremity, and normal strength of the left upper extremity were documented. Magnetic resonance imaging (MRI) showed degenerative osteophytes at C4-C5 with mild effacement of the thecal sac and ventral surface of the spinal cord, and mild left C6 neuroforaminal narrowing.

The VA Compensation and Pension (C&P) examiner on 21 October 2005, 2 months prior to separation, comingled discussion of the neck condition with that of lower back pain. A history of “repetitive neck strains and microtrauma” was reported, but “no significant injury” was noted. Daily pain was present. Lifting heavy objects or doing repetitive impact activities exacerbated his pain and limited his involvement in sports or hobbies. He could walk three and one-half miles before pain caused him to stop. He denied use of a brace, flare-ups, history of incapacitation or missed work due to pain. Bilateral ring finger tingling that was positional and resolved with shaking his hands was reported. Physical examination revealed a “slight antalgic gait complaining of neck and back pain.” Inspection of the spine was “grossly unremarkable.” Tenderness of the lower cervical region was present but muscle spasm was absent. Cervical range-of-motion (ROM) showed flexion of 0-45⁰ and combined of 305⁰ (normal 340⁰). Function was not limited by pain. No radicular symptoms were produced during the examination. Muscle strength, DTRs and sensation were all intact.

The PEB and VA chose different coding options for the condition, but this did not bear on rating. The PEB’s 10% rating under the 5237 code (cervical strain) was based on the presence of tenderness and IAW VA Schedule for Rating Disabilities (VASRD) standards; however, the DD Form 199 statement that there was no significant loss of ROM may have reflected application of the USAPDA pain policy, since the necessary ROM measurements were not provided. The VA’s use of the 5242 code (degenerative arthritis of the spine) was equally applicable in this case and its 10% rating was also appropriate. Painful motion (§4.59) or pain with use (§4.40) were appropriate pathways to a 10% rating in the setting of non-compensable limitation of motion. The Board debated if the “slight antalgic gait” reported by the C&P examiner warranted a higher rating, since under the spine formula “muscle spasm or guarding severe enough to result in an abnormal gait or abnormal spinal contour” justifies a 20% rating. The Board considered that near-normal cervical ROM, along with the absence of muscle spasm or guarding, was inconsistent with gait problems due to a neck condition. Board members agreed therefore that a higher rating was not justified on this basis. The Board also considered rating intervertebral disc disease under the alternative formula for incapacitating episodes, but could not find sufficient evidence which would meet even the 10% criteria under that formula. The Board further deliberated if additional disability was justified for the history of bilateral ring finger sensory symptoms. MRI showed mild effacement of the thecal sac and ventral surface of the spinal cord, and mild left C6 neuroforaminal narrowing. Examiners however recorded normal neurologic findings, including muscle strength. The presence of functional impairment with a direct impact on fitness is the key determinant in the Board’s decision to recommend any condition for rating as additionally unfitting. There is no evidence in this case of functional impairment attributable to peripheral neuropathy. 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 neck pain condition.

Right Knee Pain. The CI injured his knee in January 2004 when he struck it on a turret hatch. According to his first sergeant’s statement on 25 August 2005, the injury caused subsequent swelling, bruising and weeks of severe pain. A MEB consultant on 20 May 2005, 7 months prior to separation, reported buckling episodes due to pain, but stated that there had been no locking or giving way. Examination revealed moderate patellofemoral crepitus, “full ROM” and no instability. Moderate anteromedial joint line tenderness was present. There was no effusion, but slight synovitis was noted. The NARSUM examiner reported that there was a constant, dull pain that worsened with stair climbing and running, and improved with rest and elevation. The NARSUM examination was remarkable for “full ROM” without providing specific measurements. Gait was not mentioned. Effusion was absent and there was no varus, valgus, anterior or posterior instability. Slight synovitis, moderate patellofemoral crepitus and anteromedial joint line tenderness were noted. Although there are few clinical entries regarding the knee, several radiologic studies were ordered for evaluation of pain, one of which stated: “complains of locking.” X-rays and MRI confirmed the presence of an osteochondral defect in the medial femoral condyle. The C&P examiner reported that the CI experienced occasional knee swelling, but no feelings of instability. He did not require any assistive devices or braces. Running aggravated the knee pain, but walking three and a half to four miles did not. Examination revealed no swelling or tenderness. As previously mentioned, a slight antalgic gait was observed. He was able to squat from the standing position, achieving 135⁰ of flexion. This maneuver resulted in pain from 90⁰ to 135⁰. Flexion in the supine position was 120⁰ (normal to 140⁰) and extension 0⁰ (normal is 0⁰). Repetitive movement did not result in additional limitation.

The Board directs attention to its rating recommendation based on the above evidence. The PEB and the VA used the 5010 code (arthritis due to trauma), although the VA added the 5260 code (limitation of flexion). The PEB’s 0% rating reflected likely application of USAPDA pain policy. The Board agreed that examination findings of synovitis, crepitus and tenderness justified a 10% rating with application of §4.40 or §4.59. Because of the pathology in this case (osteochondral defect), the Board also considered a pathway to a higher rating under the 5258 code (dislocated semilunar cartilage). However, the CI’s meniscus was not dislocated and frequent episodes of knee locking required for a 20% rating under this code were not in evidence. The Board considered rating under the code for instability (5257, other impairment of knee) but concluded there was no support for using this code. 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 right knee 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 chronic neck pain and right knee pain was likely operant in this case and the condition was adjudicated independently of that policy by the Board. In the matter of the neck pain condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the right knee pain condition, the Board unanimously recommends a disability rating of 10%, coded 5010 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 his prior medical separation:

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Chronic Neck Pain | 5237 | 10% |
| Right Knee Pain | 5010 | 10% |
| **COMBINED** | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20120110, 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 XXXXXXXXXXXXXXXXXXXXXX, AR20120011976 (PD201200070)

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 XXXXXXXXXXXXXXXXXXX

 Deputy Assistant Secretary

 (Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA