RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1200090 SEPARATION DATE: 20070508

BOARD DATE: 20121011

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SGT/E-5, (92A20/Automated Logistical Specialist), medically separated for chronic pain right ankle/foot and right shoulder, patellar tendonitis of the right knee and bursitis of the right hip. Her physical medicine and rehabilitation (PMR) physician thought it unlikely that the CI would reach a deployable state within one year even with further rehabilitation and that she should also need a Medical Evaluation Board (MEB) to ensure that she was not reactivated once separated and in the Inactive Reserves. Her expiration of term of service (ETS) date of 5 February 2007 was extended to 5 May 2007 to allow for the MEB which met on 7 February 2007. Right ankle/foot, right shoulder, right knee and right hip conditions did not improve adequately with treatment to meet the physical requirements of her Military Occupational Specialty (MOS) or satisfy physical fitness standards. She was issued a permanent U3/L3 profile and referred for a MEB which determined these conditions to be medically unacceptable and forwarded the conditions to the Physical Evaluation Board (PEB). The MEB forwarded no other conditions for PEB adjudication. The PEB adjudicated the right ankle/foot/shoulder, patellar tendonitis of the right knee and bursitis of the right hip as unfitting, rated 10%, 0% and 0%, respectively, with application of the US Army Physical Disability Agency (USAPDA) pain policy, which has since been rescinded. The CI made no appeals, and was medically separated with a 10% disability rating.

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

SCOPE OF REVIEW: The Board wishes to clarify that the scope of its review as defined in the Department of Defense Instruction (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.

RATING COMPARISON:

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| --- | --- | --- | --- | --- | --- | --- |
| **Service IPEB – Dated 20070308** | | | **VA (6 Mo. After Separation\*) – All Effective Date 20070509** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Examination** |
| Chronic R Ankle/Foot and Shoulder Pain | 5099-5003 | 10% | Rt Ankle Repetitive Sprain | 5299-5271 | 20%\*\* | 20071108 |
| R Shoulder Tendonitis | 5099-5014 | 10% | 20071108 |
| Patellar Tendonitis R knee | 5024 | 0% | Patellar Tendonitis R Knee | 5099-5014 | 10% | 20071108 |
| Bursitis R Hip | 5019 | 0% | Bursitis R Hip | 5019-5252 | 40%\*\* | 20071108 |
| ↓No Additional MEB/PEB Entries↓ | | | Residual Scar Abd C-Section | 7804 | 10% | 20071108 |
| 0% x 1/Not Service Connected x 4 | | | 20071108 |
| **Combined: 10%** | | | **Combined: 70%** | | | |

\*The original VARD did not have any C&P examinations on which to base recommendations; the above conditions were determined to be service connected at 0% based on the STRs. The VARD cited above is based on the C&P six months after separation. \*\*Subsequently, the VA reduced the ankle and hip to 10% each effective 20081201, based on the 6 March 2008 C&P, ten months after separation.

ANALYSIS SUMMARY: The Disability Evaluation System (DES) is responsible for maintaining a fit and vital fighting force. 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. The DES has neither the role nor the authority to compensate members for anticipated future severity or potential complications of conditions resulting in medical separation nor for conditions determined to be service-connected by the Department of Veterans’ Affairs (DVA) but not determined to be unfitting by the PEB. However 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 his degree of impairment vary over time. The Board’s role is confined to the review of medical records and 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 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 6044.40, 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.

The CI sought intermittent care for various musculoskeletal complaints throughout her active military career beginning in 2001 during basic training associated with strenuous military duties without specific trauma while on active duty. The CI underwent her scheduled separation medical examination on 9 September 2006, 5 months before her projected ETS. Complaints of right shoulder pain, back pain, and knee pain were noted, but not ankle pain. Beginning 15 September 2006, evaluation for “long term right hip pain and shoulder pain” was initiated including magnetic resonance imaging (MRI) of both and evaluation in the Physical Medicine and Rehabilitation (PMR) clinic. The CI was referred into the DES in December 2006, 2 months before her scheduled ETS by her PMR physician who believed the multiple musculoskeletal complaints and inability to tolerate strenuous military duties would cause a problem if the CI was recalled to active duty from the Reserves for deployment. On 9 January 2007, her ETS was extended to 5 May 2007 to allow for completion of the MEB and PEB. Despite her various conditions, NCO evaluation reports (NCOERs) document excellent duty performance as an automated logistics technician through June 2006. The NCOERs also document that the CI passed her physical fitness tests in 2004, 2005 and in May 2006. The commander’s letter, dated 19 January 2007, prepared by a new commander (of the CI’s newly assigned unit) reported she was not able to wear military gear, participate in combat training, or deploy as a result of her physical limitations outlined in the permanent U3 L3 profile issued 3 weeks before.

Chronic Right Foot / Ankle and Shoulder Pain. The PEB combined the right ankle and right shoulder as a single unfitting condition, coded analogously to 5003 and rated 10%. PEBs often combine multiple conditions under a single rating when those conditions considered individually are not separately unfitting and would not cause the member to be referred into the DES or be found unfit because of physical disability (DoDI 1332.38, paragraph E3.P3.4.4.; “Overall Effect”). This approach by the PEB reflects its judgment that the constellation of conditions was unfitting, not a judgment that each condition was independently unfitting. When combining conditions in this manner, the PEBs concluded that there was no need for separate fitness adjudications. When considering a separate rating for each condition, the Board first must satisfy the requirement that each unbundled condition was unfitting in and of itself based on a preponderance of evidence. When the Board recommends separate fitness recommendations in this circumstance, its recommendations may not produce a lower combined rating than that of the PEB. The Board first unbundled the right ankle and shoulder conditions and considered them separately.

Right Ankle/Foot Condition. The CI first presented for medical evaluation of bilateral ankle pain performed on 12 June 2000, 17 days after accession. No trauma was noted and the examination was unremarkable other than bilateral tenderness, but without edema, effusion or erythema indicative of acute injury. Overuse was diagnosed. At an appointment for knee pain on 28 March 2001, she disclosed that she had sustained a right ankle injury 5 years previously (over 2 years before accession) when her foot was caught in a car wheel; this was treated with casting for a month and hospitalization. The Board noted that the CI failed to disclose either the injury or hospitalization on her accession examination or pre-screen and also during the MEB process. It also noted that she did not disclose a prior-to-service 6 week hospitalization for Hepatitis B on the accession examination. On 19 March 2002, she was again seen for right ankle pain as well as right knee pain and reported pain in both since the ankle injury 5 years previously. She also endorsed some discomfort of the left ankle secondary to compensating for the right side. No diagnosis was made. There were no further service record encounters for ankle pain noted in the available records until the fall of 2006. She then reported persistent ankle pain for 6 years since basic training. At a 1 November 2006 PMR appointment, 3 months prior to her original ETS, the ankles were non-tender with normal motion, and gait was normal. The examiner noted “lateral instability” of the right ankle without further detail. On 3 November 2006 at a physical therapy (PT) encounter, the CI reported that she sustained an inversion injury during basic combat training, but did not seek medical care at that time and was able to complete training. On examination, gait and strength were normal. There was no ankle joint instability to anterior drawer testing or talar tilt. On 6 December 2006 at a PT appointment, the physical therapist documented that the right ankle pain had resolved and that “she continues to run and workout despite her profile.” Her gait was normal. The CI was seen by the PMR physician on 13 December 2007 for shoulder, hip and knee pain and entered into the DES system as noted above. The physician also noted that the CI should improve with further rehabilitation and that she should be able to “sustain work as a civilian police officer” which the CI wanted to pursue after separation The 21 December 2006 PT appointment also documented that the right ankle pain had resolved. At the MEB examination the examiner noted tenderness to palpation (TTP) over the lateral malleolus, painful inversion and eversion, and normal range-of-motion (ROM). In the MEB narrative summary (NARSUM), dictated by the PMR physician on 7 February 2007, but based on a 1 November 2006 examination, the CI reported that her pain dated to an ankle sprain during basic training with recurrent milder sprains since the initial injury. No mention was made of the prior-to-service car incident. Review of the records does not show any contemporaneous entries documenting a sprain. Gait was normal and non-antalgic. Examination was remarkable for lateral instability. The examiner did not comment on whether the ankle was symptomatic at the time of the examination. The Board considered if the ankle condition was separately unfitting when considered alone. The CI complained of progressive pain in her right ankle since an initial, undocumented sprain in basic training. While ROM of the ankle was reduced on both the MEB NARSUM and initial C&P, it was normal on the MEB separation physical and second C&P. The latter exam was well away from the physical stresses of military life. Lateral instability was noted by one examiner, but not the others. Gait was normal. Imaging done post-separation was normal. The CI had passed the PT test in 2004, 2005, and May 2006. Although she had been on a profile allowing modified physical fitness training for 3 months in the fall of 2006, she had resumed running and was noted to be asymptomatic by the physical therapist. The final two notes in the record note that the ankle pain had resolved or essentially resolved. After due deliberation and in consideration of the preponderance of evidence, the Board concluded that the right ankle condition was not separately unfitting.

Right Shoulder Condition. In December of 2001, the CI fell on her right side and complained of right shoulder pain. She next sought care in September 2004 for right shoulder pain which was thought to be aggravated by carrying a heavy pack. She noted a one year history of pain since carrying a heavy pack during training in 2003. There were no additional visits until September 2006 when she was seen for shoulder pain, again reporting that pain had been present since 2003. MRI of the right shoulder was normal. She was seen several times during the fall of 2006 for shoulder girdle pain diagnosed as myofascial pain. Use of medications by the CI was inconsistent and she declined injections. PT was beneficial, but uncomfortable. At a 1 November 2006 PMR visit, she stated that the shoulder pain was “particularly unbearable” when wearing a ruck sack. The record did note that her neck and shoulder had improved from PT sufficiently to allow her to work at the computer without pain. It goes on to note that she had received no “real therapy” up to that point. A PT encounter performed on 7 December 2006 annotated increased pain after a rear end motor vehicle crash that morning. In the 13 December 2006 PMR note, the visit at which the MEB was recommended, the examiner opined that her myalgias and myositis symptoms would improve with time if the CI remained diligent in rehabilitation. On 18 January 2007, a PT documented that the CI reported that the shoulder pain was increasing and spreading to the left shoulder, but without additional trauma or explanation for the increase in symptoms. At the MEB examination, the examiner recorded no limitation in ROM and normal strength of the right shoulder. Tenderness was noted over the trapezius and rhomboid muscles. The NARSUM documented pain with arm elevation (“painful arc”) with tenderness to palpation of the right levator scapula associated with crepitus. She was diagnosed with myofascial pain of the right shoulder. Neurological examination was normal.

The Board first considered if the shoulder condition was separately unfitting. The Board noted that the treating PMR physician wanted to prevent reactivation of the CI after separation and determined that she should enter the DES process when the CI was already within 2 months of the end of her service commitment and due to separate. She placed the CI on a permanent L3 profile that same day (13 December 2006). It limited her physical fitness training and marching; however, the physician noted that the CI would probably be successful in her pursuit of a career as a civilian police officer after separation. The Board noted that this can be a strenuous occupation itself. A temporary L3 profile 3 months earlier had restricted her from running and sit-ups due to right hip pain, but, according to the 6 December 2006 PT note, the CI continued to run and work out. There were no other profiles in the record other than for pregnancy. The record documents right shoulder pain in 2001 after a fall; however, there were no further medical encounters for her right shoulder until 2006, indicating there was no significant residual injury at that time other than a note in 2004 in which the CI complained of progressive pain since an overuse injury in training in 2003 secondary to carrying a heavy pack. Despite this, the CI passed PT tests in 2004, 2005 and May 2006. An MRI of the right shoulder was normal. PT was beneficial, but did not resolve her symptoms. The PMR physician who initiated the MEB opined that her symptoms would improve with diligent rehabilitation and a PT note the prior month noted that she had not yet received adequate therapy. The VA Compensation and Pension (C&P) examination, performed 10 months after separation and removed from the physical stresses of military life, documented normal strength and ROM measurements. There was no pain with motion, although there was supraspinatus tenderness. After due deliberation and in consideration of the preponderance of evidence, the Board concluded that the right shoulder condition was not separately unfitting.

Right Knee Condition. There were three goniometric 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.

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| Goniometric ROM  Right Knee  Degrees | MEB ~ 3 Mo. Pre-Sep  (20070207) | VA C&P ~ 6 Mo. After-Sep  (20071108) | VA C&P ~ 10 Mo. After-Sep  (20080304) |
| Flexion (140 normal) | 130 | 120 | 120 |
| Extension (0 normal) | 0 | 0 | 0-70 |
| Comment | Limited by pain; Contralateral unaffected L knee the same | Tenderness in patellar borders; Lachman and McMurray negative | Pain begins at 110 with flexion. At 70 with flexion |
| §4.71a Rating | 0% | 0% | 0% |

The CI developed non-traumatic knee pain in 2001 diagnosed as retro-patellar pain syndrome (RPPS), but reported that it was similar to an episode of knee pain during basic training 2 years earlier. She was seen again in March 2002 for right knee pain which she reported had been present since the car accident 5 years earlier, prior to service. The records then fall silent until September 2006 when she sought care for multiple musculoskeletal complaints including right knee pain. A 6 December 2006 PT noted annotated that “she continues to run and workout despite her profile.” At the MEB examination, the examiner noted FROM (full range-of-motion), without tenderness, edema or effusion. Pain was elicited by flexion. Strength was normal. The NARSUM noted an unremarkable examination other than tenderness of the infra-patellar tendon. Gait was normal. At the initial C&P examination, the CI reported 6-7/10 pain of the knee, ankle and hip with stiffness, but no instability. She had flare-ups with continued weight bearing and ambulation in excess of one mile. No assistive devices were used and gait was normal. There was tenderness along the patellar borders and mild end-range (of motion) pain. Lachman and McMurray tests were normal consistent with normal menisci and ligamentous stability. At the second C&P examination, the CI noted stiffness, pain and occasional swelling as well as progressive worsening of her condition. Her gait and strength were normal without atrophy or spasm. Motion was reported to be painful. An MRI showed a possible old, healed fracture of the right proximal fibula vice a normal variant. The Board considered the right knee condition for rating. The PEB coded the knee 5024, tenosynovitis, and rated it at 0%. The VA rated it at 10% for painful limited motion, coded 5099-5014, analogous to osteomalacia. The CI complained of progressive pain of insidious onset starting after an injury during basic training. However, in 2002 she reported that she had ankle and knee pain since the car incident. Other than this visit and a visit a year earlier in 2001, no other records appeared in the record solely related to the knee.

At the 6 December 2006 PT appointment she was noted to be able to “run and workout” despite being on a profile. Her gait was consistently normal and examination unremarkable other than peri-patellar tenderness. Although ROM was reduced, it was not to a compensable level. Moreover, ROM was noted to be full, but painful, on the MEB examination and the examiner for the NARSUM noted that it was symmetric with the unaffected side, both slightly decreased from VA normal values. The second C&P examiner noted slightly reduced, painful ROM, but imaging was normal other than possible old trauma. The Board noted that the only history of trauma was the car accident prior to service and that the CI had reported that her knee had been painful since then. The Board considered a rating of 10% for painful motion under VASRD §4.59. It noted that while there was a subjective complaint of pain with motion, this did not overcome the objective findings of a normal gait and essentially normal examination supported by the history provided by the CI that she continued to run and work-out despite her profile. The Board also noted that she continued to pass her physical fitness tests in 2004, 2005 and May 2006 (as documented on the three NCOERs prior to separation). Therefore, it was determined that VASRD §4.59 was not applicable. 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 knee condition.

Right Hip Condition. There were three goniometric 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.

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| Goniometric ROM  R Hip (Thigh)  Degrees | MEB ~ 3 Mo. Pre-Sep  (20070207) | VA C&P ~ 6 Mo. After-Sep  (20071108) | VA C&P ~ 10 Mo. After-Sep  (20080304) |
| Flexion (125) | 115 | Under 10 | 125 |
| Extension (10-20) | 5 | 25 | 0-15 |
| Abduction (45) | 30 | 25 | 45 |
| Adduction (45) | - | 20 | 30 |
| Comment | Pain limited; left identical | Cont pain w/ repetitive use |  |
| §4.71a Rating | 0% | 40% | 10% awarded |

The CI presented to the clinic in August 2000, with left hip pain after running. No diagnosis was made and she was treated conservatively. There were no additional visits for either hip until September 2006 when she was seen for right hip pain noting that pain had been present since she had carried a heavy pack in 2003. MRIs of the hip were normal. Over the next few months, the CI had multiple visits for right hip pain. Use of medications was inconsistent and she declined injections. PT was beneficial, but uncomfortable. On 6 December 2006 it was annotated that “she continues to run and workout despite her profile.” The MEB physical examiner noted full ROM with tenderness to palpation over the right greater trochanter and pain with adduction and internal rotation. The MEB NARSUM noted pain over the anterior hip flexors and painful ROM. Gait was normal. At the initial C&P examination, the CI reported 6-7/10 pain and stiffness of the right hip, ankle and knee aggravated by ambulation and weight bearing. Posture and gait were normal. There was lateral trochanteric tenderness and all motion was painful. At the second C&P examination, the CI reported continued pain and stiffness of the hip. She was noted to be able to walk over a mile and to bear weight. Gait and strength were normal. Tenderness was documented, but the location not specified. No other abnormalities were noted. The Board considered the right hip condition for rating. The PEB coded the hip 5019, bursitis, and rated it at 0%. The VA rated it at 10% for painful limited motion, coded 5099-5014, analogous to osteomalacia, although she was initially rated at 40% based on the first VA examination. The CI complained of progressive pain since an overuse injury in training in 2003 secondary to carrying a heavy pack; however, there are no entries in the record specific for right hip pain prior to September 2006, 9 months prior to separation and 5 months prior to projected ETS. She was noted to have been poorly compliant with medications, secondary to a miscommunication, and to have not had adequate treatment. Despite this, her gait was normal and she was able to continue to run, contrary to her profile restrictions. It was noted that PT was beneficial and that the second C&P documented essentially normal ROM for the hip. As it did with the knee, the Board considered a rating of 10% for painful motion under VASRD §4.59. It noted that while there was a subjective complaint of pain with motion, this did not overcome the objective findings of a normal gait and essentially normal examination supported by the history provided by the CI that she continued to run and work-out despite her profile. The Board also noted that she continued to pass her physical fitness tests in 2004, 2005 and May 2006 (as documented on the three NCOERs prior to separation). Therefore, it was determined that VASRD §4.59 was not applicable. 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 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 ankle and shoulder conditions was operant in this case and these conditions were adjudicated independently of that policy by the Board. In the matter of the ankle and shoulder conditions the Board determined that they are not separately unfitting. The Board does not recommend a rating less than that adjudicated by the PEB, and accordingly, the Board unanimously concluded that there was insufficient cause to recommend a change in the PEB adjudication for the right ankle and shoulder conditions. In the matter of the knee condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the hip 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** |
| Chronic Pain Right Ankle/Foot and Right Shoulder | 5099-5003 | 10% |
| Patellar Tendonitis Right Knee | 5024 | 0% |
| Bursitis Right Hip | 5019 | 0% |
| **COMBINED** | **10%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20120109, 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 22202-3557

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation for XXXXXXXXXXXXXXXXXXXXXX, AR20120019266 (PD201200090)

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 XXXXXXXXXXXXXXXXXXX

Deputy Assistant Secretary

(Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA