RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1200179 SEPARATION DATE: 20040128

BOARD DATE: 20120823

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty CPL/E-4 (91W, Combat Medic), medically separated for a left hip condition, a bilateral knee condition and a posttraumatic migraine headache condition. The CI did not respond adequately to conservative treatment for the left hip, right knee and the migraine headache condition and did not respond to operative treatment for the left knee condition to meet the physical requirements of his Military Occupational Specialty (MOS) or satisfy physical fitness standards. He was issued a permanent P3/L3 profile and referred for a Medical Evaluation Board (MEB). Chronic left hip pain, bilateral knee pain, and migraine headaches were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. One other condition, as identified in the rating chart below, was forwarded on the MEB submission as a medically acceptable condition. The PEB adjudicated the left hip condition and bilateral knee condition, bundling them together, and the chronic posttraumatic migraine headaches condition as unfitting, rated 10% and 10% respectively, with application of the US Army Physical Disability Agency (USAPDA) pain policy. The remaining condition was determined to be not unfitting. The CI made no appeals, and was medically separated with a 20% disability rating.

CI CONTENTION: The CI attached a 2 page statement pleading to his application which was reviewed by the Board and considered in its recommendations.

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 condition left knee partial anterior cruciate ligament tears as requested for consideration meets the criteria prescribed in DoDI 6040.44 for Board purview; and, is addressed below, in addition to a review of the ratings for the unfitting conditions. The other requested conditions for the right eye and left fibula fracture 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 Correction of Military Records.

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service PEB – Dated 20031126** | **VA (7 Mos. Pre-Separation) – All Effective Date 20040129** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Post Traumatic Migraine Headaches | 8045-9304 | 10% | Chronic Post Traumatic Migraine Headaches | 8100 | 30% | 20030610 |
| Chronic Pain Left Hip and Bilateral Knees | 5009-5003 | 10% | Tenosynovitis Left Hip | 5024 | 10% | 20030610 |
| Left Knee Partial Anterior Cruciate Ligament Tear | Not Unfitting | Chondromalacia Patellae with Posterior Cruciate Ligament Tear, Left Knee | 5257 | 10% | 20030610 |
| ↓No Additional MEB/PEB Entries↓ | Chondromalacia Patellae with Meniscal Tear, Right Knee | 5299-5257 | 20% | 20030610 |
| Post Traumatic Optic Neuropathy | 6099-6080 | 10% | 20030617 |
| Chronic Adjustment Disorder with Mixed Anxiety and Depressed Mood | 9449 | 10% | 20030613 |
| **Combined: 20%** | **Combined: 70%** |

ANALYSIS SUMMARY: The Board acknowledges the CI’s assertions that “inaccuracies and omissions within the narrative summary (NARSUM) did not portray an accurate picture of my injuries to the PEB.” It is noted for the record that the Board has neither the jurisdiction nor authority to scrutinize or render opinions in reference to asserted service improprieties in the disposition of a case. The Board’s role is confined to the review of medical records and all evidence at hand to assess the fairness of the PEB rating determinations, compared to Veterans Administration Schedule for Rating Disabilities (VASRD) standards, based on severity at the time of separation. It must also judge the fairness of the PEB fitness adjudications based on the fitness consequences of conditions as they existed at the time of separation. The Board also acknowledges the sentiment expressed in the CI’s application, i.e., that the gravity of his condition and predictable consequences which merit consideration for a higher separation rating. 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 Veterans’ Affairs (DVA). 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. Post-separation evidence therefore is probative only to the extent that it reasonably reflects the disability and fitness implications at the time of separation.

Posttraumatic Migraine Headaches Condition. The CI began having headaches since 1998 after being struck with the butt of an M-16 rifle to the right face while in advanced individual training. He was treated for a maxilla fracture with dental involvement that required several dental procedures and had a residual visual field defect of his right eye. He also had residual mild headaches which responded to over the counter medications, and had typical symptoms of severe migraine headaches 3-4 per week and would relief these severe headache with rest, in a dark room, for up to 1-2 days. A magnetic resonance imaging (MRI) in October 2000 was normal. The commander’s statement corroborated the traumatic facial injury and residual migraine headaches and further documented that he had migraine headaches 2-3 times a month which caused him to be put on 24 to 48 hour quarters.

At the MEB exam, the CI described his typical migraine as building from a mild headache to a more severe headache and the pain would escalate to 10 of 10in severity (usually R sided) associated nausea, dizziness, photophobia and phonophobia. With Maxalt (migraine abortive medication) use he noticed that within 2-3 hours his symptoms had nearly completely resolved. He reported an average of one severe migraine per month for which he took the Maxalt and an average of 1-2 mild headaches each week for which he took the over the counter aspirin or Tylenol. He denied taking preventative medication currently or in the past. He reported while deployed to Iraq from January to March 2003 he experienced an increase of his migraine headaches, three times per month, with increased duration and intensity of pain. The MEB physical exam noted normal neuromuscular findings to include memory and other cognitive functions. The neurologist diagnosed chronic migraine headache and episodic tension-type headache, and further opined he continued to have prostrating and disabling headache episodes lasting up to several hours, which significantly limited his ability to perform military duties. A neurology note, completed by a different neurologist, a year prior to the MEB corroborated the MEB diagnosis, treatment and frequency of migraine headaches. At the VA Compensation and Pension (C&P) exam performed 7 months prior to separation, the CI reported headache attacks every 7 days that would last for 4 hours and he had to stay in bed and was unable to do anything which resulted in 4 days per month of time lost from work. The C&P physical exam demonstrated normal neuromuscular findings to include normal behavior, affect, and intact memory.

The Board directs attention to its rating recommendation based on the above evidence. A significant issue confronted in this case is the probative value of the CI’s stated history as it relates to the severity of symptoms. The Board’s recommendation must incorporate a probative value judgment between the disparate evidence from the service file and the VA’s C&P examination. The probative value judgment has to acknowledge a normal tendency to maximize symptoms in the context of VA rating evaluations with their attendant secondary gain pressure, but the Board concedes the validity of all evidence unless contradicting evidence can be cited. There are two service treatment record (STR) entries by different neurologists who both reported one severe headache a month with an improvement of symptoms within 2-3 hours of Maxalt use. Therefore the Board considers the MEB exam and the STR more accurate for its permanent rating recommendation. The PEB and VA chose different coding options for the condition, which had significant implications on the rating for the Board to consider. The PEB chose to code analogously to 8045 code [residuals of traumatic brain injury (TBI)] which falls under §4.124a (schedule of ratings–neurological conditions) and convulsive disorders with the 9304 code (dementia due to head trauma) which falls under §4.130 (schedule of ratings–mental disorders). The Board agreed while the evidence clearly did not support dementia the evidence did support a head injury which clinically is synonymous to a mild TBI. Therefore the Board agreed the PEB was consistent with applying the 8045 code to classify the disabling migraine headaches and the Board notes that the maximum allowable for this code is 10% for the CI’s separation date. The VA coded 8100 (migraine) and rated 30%. The Board notes it was not until September 2008 when a Fast Letter was published which allows an evaluator to adjudicate all residuals of a TBI and to rate each residual under the appropriate diagnostic code. Therefore the Board agreed based on the time of separation the 8100 code could not be considered for a higher rating. There was no other viable approach to a higher rating for the posttraumatic migraine headache which was countenanced by the VASRD. 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 posttraumatic migraine headache condition.

Chronic Pain Left Hip and Bilateral Knees. The PEB rated left hip pain and bilateral knee pain under the single analogous 5003 (degenerative arthritis) code. This coding approach is countenanced by AR 635-40 (B.24 f.), but IAW DoDI 6040.44 the Board must apply only VASRD guidance to its recommendation. The Board must therefore apply separate codes and ratings in its recommendations if compensable ratings for each joint 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. Since §4.71a criteria are met for separate joint ratings in this case, the Board is pursuing separate rating and fitness evaluations as follows.

Left Hip Condition. The CI began with an insidious onset of left hip pain in October 2001 which had worsened with time. He had functionally improved with conservative rehabilitation, rest, and use of nonsteroidal anti-inflammatory medications. 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; as summarized in the chart below.

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| --- | --- | --- |
| Left Hip (Thigh) ROM | VA C&P ~7 Mo. Pre-Sep | NARSUM ~6 Mo. Pre-Sep |
| Flexion (0-125⁰) | 115⁰ | 110⁰ |
| Extension (0-20⁰) | >20⁰ | #⁰ |
| External Rotation (0-45⁰) | 30⁰ | 25⁰ |
| Abduction (0-45⁰) | 40⁰ | 45⁰ |
| Adduction (0-45⁰) | 25⁰ | WNL |
| Comment | Normal gait, painful motion |  |
| §4.71a Rating\* | 10% | 10% |

\*Conceding painful motion 4.59

At the MEB exam, the CI reported hip pain 6 of 10 intensity worsened with prolonged walking and improved with rest and nonsteroidal medications. The MEB physical exam documented a normal gait, normal rise from a chair, pain at the extremes of motion in all directions, and normal distal neurological and vascular findings. X-rays and MRI of the left hip were normal. At the VA C&P exam performed 7 months prior separation, the CI reported the left hip pain started after his knee problems developed. He reported a tight sensation of left hip with audible clicking sound and pain after sitting >20 minutes, rated 8 of 10 intensity with use of Naprosyn (an anti-inflammatory medication) twice a day, Flexeril (muscle relaxant medication), rest, ice and stretching for relief of symptoms. He lost 2 days per month from work due to hip pain. The C&P physical exam noted an abnormal gait; favoring the left hip and right knee, and tenderness of the anterior left hip region at the insertion of hip flexor tendons.

The Board directs attention to its rating recommendation based on the above evidence. The Board first considered if the left hip, having been decoupled from the combined PEB adjudication, remained independently unfitting as established above. All members agreed that the left hip, as an isolated condition, would have rendered the CI incapable of continued service within his MOS, and accordingly merits a separate rating. There was evidence in the profile, and in the commander’s statement to distinguish the left hip from the bilateral knees in terms of duty impairment. The Board notes that both the MEB and VA exams were complete, well documented, and compliant with VASRD §4.46 (accurate measurement) and similar in terms of ratable data and therefore the Board assigns both exams equal probative value. The PEB assigned a rating based on slight and constant pain with application of the USAPDA pain policy. The VA assigned a 10% evaluation coded 5024 (tenosynovitis) based on evidence of painful and non compensable limited motion of a major joint and further documented this was not a permanent assignment. The Board agreed the painful limited ROMs met the minimum 10% criteria IAW §4.59. There was no other viable approach to a higher rating or additional rating for the left hip which was countenanced by the VASRD. 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 left hip condition.

Right and Left Knee Condition. The contended condition left knee partial anterior cruciate ligament tears, adjudicated as not unfitting by the PEB, is considered in the discussion below. In September 2000, the CI sustained a left knee injury while running, and had an immediate effusion and the inability to fully straighten his left knee. He underwent definitive operative care with a diagnostic arthroscopy, ten days after injury, with resolution of pain after resecting a Cyclops lesion of the posterior cruciate ligament. He had some improvement in his left knee pain overall. In 2002, he noted a spontaneous increase of pain in both knees, 6 of 10 in intensity, worse with deep knee bends, squats, stairs, and prolonged sitting. At the time of the MEB he was using braces on both knees to decrease the amount of pain that he had. The commander’s statement specifically detailed deployment pain of the left hip, right knee and that he had suffered a broken left leg during his 6 month deployment in Kosovo. The commander also documented the CI declined an MEB despite being diagnosed with the chronic chondromalacia of the right and left patella causing pain and opted to deploy to Kuwait in December 2002. While there he injured his right knee while loading casualty into an ambulance and was diagnosed with a medial meniscus tear (MMT) and redeployed. The battalion surgeon recommended the CI undergo an MEB. The commander further documented the CI was working in his MOS and had made every effort to rehabilitate himself, however his migraines, knees and hip prevented him from continuing on as a combat medic. The permanent profile specifically identified the right and left knee with the L3 profile with the following limitations; no running, jumping or marching and able to walk, swim or bike at own pace and distance. There were two ROM 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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| L/R Knee ROM | VA C&P MEB – 7 Mo. Pre Sep | MEB –6 Mo. Pre Sep |
| Left | Right | Left | Right |
| Flexion 0-140⁰ normal | 140⁰ | 140⁰ | 135⁰ | 135⁰ |
| Combined 240⁰ normal | 0⁰ | 0⁰ | 0⁰ | 0⁰ |
| Comments | No instability | Normal gait, No instability |
| §4.71a Rating\* | 10% | 10% | 10% | 10% |

\*Conceding painful motion §4.59

At the MEB exam, the CI reported constant bilateral knee pain, 6 of 10 intensity of pain, worsened with deep knee bends, squats, stairs, and prolong sitting and had some relief with use of knee braces. The MEB physical exam documented the left knee exam had normal neurologic and vascular findings negative ligament and meniscal testing however there was a remarkably positive patellar grind test. The right knee exam had normal neurologic and vascular findings, and negative ligament testing with slight tenderness to palpation over the medial collateral ligament. However the right knee meniscal testing was positive and the patellar grind test was markedly positive. There was no obvious effusion, and no point tenderness to palpation anywhere about either knee. X-rays of the right and left knee were normal with the exception of slight peaking of the intercondylar eminence on the left. A post-operative MRI completed in 2002 of the left knee demonstrated chondromalacia and a torn PCL. At the VA C&P exam the CI reported stiffness of the left knee in the morning with increasing pain throughout the day, worsened with standing and deep knee bends and swelling in the evening causing him to miss 2 days of work a month. He reported injuring his right knee while in Iraq in 2002, with residual severe pain with bending, standing and walking. The C&P physical exam documented tenderness of the right medical joint line and left lateral aspect of the knee with a positive retropatellar apprehension sign for both knees, negative objective DeLuca observations for either knee. The right knee demonstrated positive meniscal testing and moderate ligament instability. The left knee demonstrated and a slight lateral instability with ligament testing and negative meniscal testing. A MRI of the right knee completed 7 months after separation, well within the DoDI 6040.44 defined 12-month interval for special consideration of post-separation VA evidence, revealed fraying or degenerative tear of the medial meniscus and normal ligament structures to include the collateral ligaments.

The Board directs attention to its rating recommendation based on the above evidence. The Board first considered if each knee, having been decoupled from the combined PEB adjudication, remained independently unfitting as established above. All members agreed that either knee, as an isolated condition, would have rendered the CI incapable of continued service within his MOS, and accordingly merits a separate rating. There was evidence in the profile and the commander’s statement distinguishing one knee from the other in terms of duty impairment. The Board notes that both the MEB and VA exams were complete, well documented, and compliant with VASRD §4.46 (accurate measurement) and similar in terms of ROM ratable data however there were discrepancies with the outcomes of specific orthopedic maneuvers for ligament and meniscal testing between the MEB and the VA exam with very significant implications regarding the Board's rating recommendation. The Board thus carefully deliberated its probative value assignment to these conflicting evaluations, and carefully reviewed the STR for corroborating evidence in the 12-month period prior to and after separation. Clearly the right knee MRI reflects meniscal derangement only which brings speculation to the VA exam which implies instability from ligament derangement. The MEB exam did not reflect ligament instability of the right knee and was performed by an orthopedic specialist. Therefore, based on all evidence and associated conclusions just elaborated, the Board is assigning preponderant probative value to the MEB evaluation.

The PEB and VA chose different coding options for the condition, but this did not bear on rating. The PEB decision reflected application of the USAPDA pain policy for rating, and its 10% determination was not consistent with §4.71a standards. The PEB’s chosen code 5003 specifies that, in the presence of degenerative arthritis established by X-ray findings, when “the limitation of motion of the specific joint or joints involved is noncompensable under the appropriate diagnostic codes, a rating of 10% is for application for each such major joint or group of minor joints affected by limitation of motion, to be combined, not added under diagnostic code 5003. Limitation of motion must be objectively confirmed by findings such as swelling, muscle spasm, or satisfactory evidence of painful motion.” There was noncompensable ROM impairment of each knee, and the Board agreed that there was adequate documentation of painful motion of each joint in the pre-separation data to merit application of a minimal compensable rating under this code for each knee. The Board also considered code 5259 (cartilage, semilunar, removal of, symptomatic) applicable to the underlying pathology, of the right knee which likewise results in a 10% rating. The Board considered the VA choice of coding each knee with 5257 (knee impairment of with recurrent subluxation or lateral instability) or analogous to 5257, and agreed the evidence did not support instability of the right knee and could not support the 20% rating assigned by the VA for the right knee instability. The evidence did reflect a torn posterior cruciate ligament of the left knee however there was no objective evidence of recurrent subluxation or lateral instability to meet the higher 20% rating. Finally the Board considered code 5014 (osteomalacia) which is clinically appropriate for both knees however this code defaults to the 5003 code and does not yield a higher rating. There was no VASRD compliant coding or rating approach that would yield higher than a minimal compensable rating for either knee. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends that the bilateral knee condition be rated for two separate unfitting conditions as follows: right knee coded 5259-5014 and for left knee 5257-5014 for clinical specificity subsuming painful motion and noncompensable loss of flexion, each rated 10%.

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 left hip, bilateral knees and post traumatic migraine headaches was operant in this case and the conditions were adjudicated independently of that policy by the Board. In the matter of the chronic posttraumatic migraine headaches condition, IAW VASRD §4.124a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the left hip and bilateral knee condition, the Board unanimously recommends that it be rated for three separate unfitting conditions as follows: left hip coded 5024 and rated 10%, left knee coded 5257-5014 and rated 10%; and, right knee coded 5259-5014 and rated 10%; all 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; and, that the discharge with severance pay be recharacterized to reflect permanent disability retirement, effective as of the date of his prior medical separation:

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| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Chronic Post Traumatic Migraine Headaches | 8045-9304 | 10% |
| Tenosynovitis Left Hip | 5024 | 10% |
| Chondromalacia Patellae with Posterior Cruciate Ligament Tear, Left Knee | 5257-5014 | 10% |
| Chondromalacia Patellae with Meniscal Tear, Right Knee | 5259-5014 | 10% |
| **COMBINED (w/ BLF)** | **40%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20120130, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans’ Affairs Treatment Record

 XXXXXXXXXXXXXXXXXX

 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 XXXXXXXXXXXXXXXXXXXXXXX, AR20120016854 (PD201200179)

1. Under the authority of Title 10, United States Code, section 1554(a), I approve the enclosed recommendation of the Department of Defense Physical Disability Board of Review (DoD PDBR) pertaining to the individual named in the subject line above to recharacterize the individual’s separation as a permanent disability retirement with the combined disability rating of 40% effective the date of the individual’s original medical separation for disability with severance pay.

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.

 a. Providing a correction to the individual’s separation document showing that the individual was separated by reason of permanent disability retirement effective the date of the original medical separation for disability with severance pay.

 b. Providing orders showing that the individual was retired with permanent disability effective the date of the original medical separation for disability with severance pay.

 c. Adjusting pay and allowances accordingly. Pay and allowance adjustment will account for recoupment of severance pay, and payment of permanent retired pay at 40% effective the date of the original medical separation for disability with severance pay.

 d. Affording the individual the opportunity to elect Survivor Benefit Plan (SBP) and medical TRICARE retiree options.

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 XXXXXXXXXXXXXXXXXXXXXXXXX

 Deputy Assistant Secretary

 (Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA