ARMY BOARD FOR CORRECTION OF MILITARY RECORDS

RECORD OF PROCEEDINGS

IN THE CASE OF: [redacted]

BOARD DATE: 9 February 2024

DOCKET NUMBER: AR20230006805

APPLICANT REQUESTS: through counsel, reconsideration of his prior request for physical disability retirement in lieu of physical disability separation with severance pay through the inclusion of additional unfitting conditions.

APPLICANT'S SUPPORTING DOCUMENT(S) CONSIDERED BY THE BOARD:

- DD Form 149 (Application for Correction of Military Record)
- Counsel's Brief (15 pages)
- Power of Attorney
- Self-Authored Statement
- Memorandum for Record, subject: [Applicant], dated 22 March 2005
- Radiology Reports, dated between January 2008 – July 2014
- Chronological Statement of Retirement Points, dated 20 October 2015
- Email Correspondence, dated 1 June 2016
- DA Form 7652 (Disability Evaluation System (DES) Commander's Performance and Functional Statement), dated 1 November 2017
- Department of Veterans Affairs (VA) Disability Benefits Questionnaire (DBQ) for hearing loss and tinnitus, dated 17 November 2017
- VA DBQ for post-traumatic stress disorder (PTSD), dated 19 November 2017
- 10 Additional VA DBQs for conditions of artery and vein, shoulder and arm, hip and thigh, knee and lower leg, ankle, neck (cervical spine), back (thoracolumbar spine), headaches, peripheral nerves, and general medical, dated 13 December 2017
- Medical Evaluation Board (MEB) Narrative Summary (NARSUM), dated 18 December 2017
- DA Form 3947 (MEB Proceedings), dated 19 December 2017
- DA Form 3349 (Physical Profile), dated 19 December 2017
- Office of Soldiers' Counsel Memorandum, dated 23 January 2018
- Partial DA Form 5892 (Physical Evaluation Board Liaison Officer (PEBLO) Estimated Disability Compensation Worksheet)
- Enlisted Record Brief (ERB), dated 20 April 2018
- DD Form 214 (Certificate of Release or Discharge from Active Duty) for the period ending 28 July 2018

- Previous DD Form 149, dated 20 April 2020
- Record of Proceedings for Army Board for Correction of Military Records (ABCMR) Docket Number AR20200009009, dated 29 April 2021
- Medical Documents (215 pages)

FACTS:

1. Incorporated herein by reference are military records which were summarized in the previous consideration of the applicant's case by the ABCMR in Docket Number AR20200009009 on 29 April 2021.

2. Counsel's 15-page brief has been provided in full to the Board for review. In summary, Counsel states:

a. The applicant requests correction his military records to reflect a disability retirement or in the alternative, referral to the legacy DES. The applicant is requesting he be granted a disability retirement for the following conditions:

- peripheral arterial disease of the right lower extremity
- left foot neuropathy
- PTSD
- right acromioclavicular joint osteoarthritis with degenerative arthritis
- left and right hip pain with limited extension
- left ankle tendonitis
- right ankle tendonitis
- cervical strain
- degenerative arthritis of the spine
- right shin splint
- right and left hip limited flexion
- right hip impairment

b. The applicant was initially referred to the Integrated DES (IDES) for bilateral hip pain, but it was discovered he had many other medical issues that required a review to determine if he was medically fit for continued service. The MEB Proceedings of 19 December 2017, found the applicant unfit for service based on injuries to his right and left hips. The Army incorrectly and unjustly stated he met retention standards for his shoulders/arms, lower extremity injuries, neck, spine, and back injuries, headaches, right and left hearing loss, and PTSD. The applicant want through a VA review when he was evaluated for medical separation from the Army.

c. Counsel provides numerous pages detailing the differences between the VA DBQs for each contested condition and the corresponding Army MEB determinations,

all of which have been provided in full to the Army Review Boards Agency (ARBA) Medical Advisory Official and to the Board for review.

d. Regulatory guidance required Soldiers to attend all medical and administrative appointments during the DES process, with which the applicant fully complied; yet the MEB failed to properly evaluate the applicant for his multiple conditions, both individually and in the aggregate. All of the applicant's diagnosed conditions required referral to DES per Army Regulation 40-501 (Standards of Medical Fitness). The rationale used to support the determination that the applicant was fit for continued service for his PTSD and numerous other conditions was deeply flawed and simply one-sided, to deny him medical assistance from the Department of Defense. The NARSUM gives an incomplete summary of his purportedly fitting conditions, that is formulated into a one-sided argument to deny the applicant.

e. This honorable Board previously voted in favor of relief when an applicant has presented evidence showing the presence of a medical condition that calls into question the ability of the applicant to perform his or her military duties at the time of separation when certain conditions were not afforded consideration during the separation processing. Examples of such instances are Docket Numbers AR20170000508, AR20150000040, AR20180013251, wherein the Board referred those applicant's records to DES processing after evidence presented showed the applicants suffered impairments hindering the performance of their duties which were not appropriately considered at the time of their separation processing.

f. For the reasons set forth above, the applicant respectfully requests the Board overturn its previous decision and grant his requested relief to be medically retired or in the alternative, referred to the legacy DES for consideration of a finding of unfitness for his conditions of peripheral arterial disease of right lower extremity and left foot neuropathy, PTSD, right acromioclavicular joint osteoarthritis with degenerative arthritis, left and right hip pain and limited extension, left and right ankle tendonitis, cervical strain, degenerative arthritis of the spine, right shin splint, right and left hip limited flexion, and right hip impairment.

3. The applicant states:

a. He injured both his hips during on his 2005-2006 deployment in Afghanistan, when he fell down the side of a mountain during an operation. He had a medic look him over, but did not receive any treatment.

b. Over the years, he neglected to get an evaluation until the pain started affecting him more and more. In 2011, he finally had surgery on his right hip to repair a significant labral tear. Working through the rehabilitation and physical therapy, he was able to continue working with pain still present. He received multiple steroid shots over the

years, but over time, he seemed to sustain several tears in both hips. He has tried many types of rehabilitation, but nothing has completely worked for him and is condition has only worsened.

c. Multiple magnetic resonance imaging (MRIs) show that he has tears in both hips and he cannot stand or sit for long periods of time without having pain or numbness in his legs. He is currently on medication for muscle spasms and for the numbness. The bilateral hip pain is something he has tried to overcome throughout his years of service. It has tome to the point in his life and career that weight bearing equipment and rucking with heavy, large amount of weight has made it unbearable at times.

d. The numbness in his legs is called peripheral arterial disease and has affected the back of his knees and caused foot numbness. He has trouble at night with an arthritic type of pain in both legs and feet. He sleeps on the couch with a large body pillow that he uses to elevate his legs and when the pain worsens, he has a transcutaneous electrical nerve stimulation (TENS) unit that he utilizes at night. For pain management he has received a platelet-rich plasma (PRP) injection into his right hip to see if that will improve his pain and help long term. He is also on medication for the numbness and muscle spasms and provides a comprehensive list of his medication, which has been provided in full to the Board for review.

e. His PTSD has been something he has dealt with since his first deployment to Iraq in 2003-2004. He has used resources such as Military One Source, behavioral health, and even talked with a chaplain. He has had problems getting to sleep, staying asleep, and has recurring nightmares. His PTSD has disrupted his marriage and he has even attacked his wife in the past. This has been something that has been very difficult to deal with and at times hard to explain to a therapist.

f. He has bilateral hip injuries with poor vascular blood flow to his legs, that have progressed over the years. This is something he has dealt with for a very long time. He is not one to sit on a physical profile and milk the system, but it has come to the point that this injury is affecting his everyday life. He has jumped out of planes with the 82nd Airborne Division, was part of the invasion of Iraq in 2003 -2004, deployed to Afghanistan in 2005 – 2006, and deployed to Central America in support of Operation Enduring Freedom. He was selected by the Department of the Army to be a Drill Sergeant and has gone wherever Uncle Sam asked him to go. The reason he brings this up is because he wants the Board to understand if he would have been able to ride this out to reach his 20 years, he would have, but he needed to take a step back and look at the best interest of his health and that his ability to perform his duties was very limited due to his pain. He is requesting an increase to his disability percentages and to be given the opportunity to be medically retired from the U.S. Army.

4. The applicant completed 3 years, 9 months, and 8 days of honorable service in the Regular Army (RA) prior to enlisting in the U.S. Army Reserve (USAR) on 8 July 2001. He was twice ordered to active duty as a member of the USAR, with service in the following imminent danger pay areas:

- Iraq, from 28 February 2003 through 3 March 2004
- Afghanistan, from 2 February 2005 through 31 January 2006

5. The applicant provided a witness statement/memorandum for record from Sergeant First Class (SFC) G____, dated 22 March 2005, which shows the applicant was assigned as the force protection officer of a tactical human intelligence team assigned to Special Forces A Detachment at Camp Eggers, Asadabad, Afghanistan. He acted as an assistance information manager for the information collection effort and played an integral part in the recovery of several munitions caches.

6. The applicant was discharged from the USAR on 21 January 2007 and enlisted in the RA for a second time on 26 November 2007.

7. The applicant deployed to Honduras from 16 October 2016 through 16 April 2017.

8. Multiple Radiology Results, dated between January 2008 – July 2014, which have been provided in full to the Board and the ARBA Medical Advisor for review, show hip arthrogram, foot and ankle imaging, right hip MRI, chest x-ray, and c-spine series results.

9. A DA Form 7652, dated 1 November 2017, shows the applicant's commander provided a performance and functional statements indicating the applicant's medical condition, which was unspecified on this form, prevents him from performing the skills and duties of his primary military occupational specialty (PMOS) 31B (Military Policeman). His medical condition prevents him from conducting law enforcement duties as prescribed under the duties of his PMOS, thus his medical condition greatly affects the unit's ability to conduct its primary mission.

10. A VA DBQ pertaining to hearing loss and tinnitus, signed and dated by a VA audiologist on 17 November 2017, shows after examination on 17 November 2017, the applicant was diagnosed with hearing loss and tinnitus, both of which impact ordinary conditions of daily life, including ability to work.

11. A VA DBQ pertaining to PTSD, signed and dated by a VA psychologist on 19 November 2017, shows:

a. After examination on 16 November 2017, the applicant was diagnosed with PTSD as he meets multiple criteria. He participated in combat activity in Iraq and

displays multiple symptoms of PTSD, including anxiety, suspiciousness, chronic sleep impairment and memory loss.

b. The applicant was assessed with occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks, although generally functioning satisfactorily, with normal routing behavior, self-care, and conversation.

12. An MEB NARSUM, signed and dated by the MEB Clinical Social Worker on 15 December 2017, and the MEB physician on 18 December 2017, provided in full to the Board for review, shows in part:

a. Included among the multiple sources and references for the NARSUM were the applicant's current DA Form 3349, Commander's Statement, multiple VA DBQ examinations (including behavioral health, auditory, and general medical), electronic and service medical records, numerous imaging records (including MRI, arthrogram, and radiographs).

b. The applicant failed medical retention standards under the provisions of Army regulation 40-501 for the following diagnoses (Dx), which are interrelated and fail in combination:

- right hip recurrent labral tears with surgical residuals (Dx 1)
- left hip labral tear with chondromalacia (Dx 2)

c. His chronic bilateral hip pain conditions failed medical retention standards as they were not expected to significantly improve or resolve over the next 3 years, were stable, per the Commander's Statement he could not perform in his PMOS, and the conditions required significant permanent physical profile functional activity restrictions.

d. The following diagnoses (all VA diagnosed) met retention standards:

- PTSD (Dx 3)
- right sensorineural hearing loss (Dx 4)
- left sensorineural hearing loss (Dx 5)
- tinnitus (Dx 6)
- right leg peripheral artery disease (Dx 7)
- left leg peripheral artery disease (Dx 8)
- right shoulder acromioclavicular joint osteoarthritis (Dx 9)
- left shoulder acromioclavicular joint osteoarthritis (Dx 10)
- right shin splints (Dx 11)
- left shin splints (Dx 12)
- right knee iliotibial band syndrome (Dx 13)

- left knee iliotibial band syndrome (Dx 14)
- right ankle tendonitis (Dx 15)
- left ankle tendonitis (Dx 16)
- cervical strain with muscle spasm (Dx 17)
- thoracolumbar degenerative arthritis with lumbar muscle spasm (Dx 18)
- right foot neuropathy (Dx 19)
- left foot neuropathy (Dx 20)

e. The rationale for these diagnoses meeting medical retention standards is listed in full in the MEB NARSUM, was, in effect, none of the conditions are listed in the Commander's Statement, the applicant did not have a permanent physical profile limiting functional activities for these conditions or significantly interfered with satisfactory duty performance.

13. Numerous additional VA DBQs, all signed and dated by the same VA Advanced Practice Registered Nurse Practitioner on 13 December 2017, after examination of the applicant on 30 November 2017, have been provided in full to the Board and ARBA Medical Advisor for review and reflect the VA assessment and diagnosis of the applicant pertaining to conditions related to hearing loss and tinnitus, artery and vein, shoulder and arm, hip and thigh, knee and lower leg, ankle, neck (cervical spine), back (thoracolumbar spine), headaches, peripheral nerves, and general medicine.

14. A DA Form 3947 shows:

a. An MEB convened on 19 December 2017, where the applicant's following conditions were found to not meet retention standards:

- right hip recurrent labral tears with surgical residuals (Dx 1)
- left hip labral tear with chondromalacia (Dx 2)

b. The following conditions were found to meet retention standards:

- PTSD (Dx 3)
- right sensorineural hearing loss (Dx 4)
- left sensorineural hearing loss (Dx 5)
- tinnitus (Dx 6)
- right leg peripheral artery disease (Dx 7)
- left leg peripheral artery disease (Dx 8)
- right shoulder acromioclavicular joint osteoarthritis (Dx 9)
- left shoulder acromioclavicular joint osteoarthritis (Dx 10)
- right shin splints (Dx 11)
- left shin splints (Dx 12)

- right knee iliotibial band syndrome (Dx 13)
- left knee iliotibial band syndrome (Dx 14)
- right ankle tendonitis (Dx 15)
- left ankle tendonitis (Dx 16)
- cervical strain with muscle spasm (Dx 17)
- thoracolumbar degenerative arthritis with lumbar muscle spasm (Dx 18)
- right foot neuropathy (Dx 19)
- left foot neuropathy (Dx 20)

c. The applicant was referred to the Physical Evaluation Board (PEB)

15. A physical profile is used to classify a Soldier's physical disabilities in terms of six factors or body systems, as follows: "P" (Physical capacity or stamina), "U" (Upper extremities), "L" (Lower extremities), "H" (Hearing), "E" (Eyes), and "S" (Psychiatric) and is abbreviated as PULHES. Each factor has a numerical designation: 1 indicates a high level of fitness, 2 indicates some activity limitations are warranted, 3 reflects significant limitations, and 4 reflects one or more medical conditions of such a severity that performance of military duties must be drastically limited. Physical profile ratings can be either permanent or temporary.

16. A DA Form 3349 shows the applicant was given the following permanent physical profile ratings, effective 19 December 2017:

- unilateral hearing loss (right), H2
- hip pain/injury (bilateral), L3

17. An Office of Soldiers' Counsel memorandum, dated 23 January 2018, shows:

a. Soldiers' MEB Counsel requested appeal of the MEB findings pertaining to the applicant and that the MEB find the following conditions fail retention standards:

- PTSD
- right and left sensorineural loss with significant changes in hearing thresholds
- bilateral feet neuropathy

b. The applicant's PTSD precents/impairs successful performance of his military duties. AHLTA (Armed Forces Health Longitudinal Technology Application) medical note, dated 7 December 2015, shows the applicant's exposure to traumatic events, recurring nightmares from hand-to-hand combat, hypervigilance, and exaggerated startle response. These symptoms impair his ability to perform his job.

c. The applicant's hearing loss prevents/impairs successful performance of his military duties. AHLTA medical note, dated 9 February 2015, shows a history of asymmetrical hearing loss. The applicant currently wears a hearing aid in his right ear. As a Military Policeman exposed to gunfire and loud noises, it would be impossible to perform assigned duties without endangering himself or other Army personnel.

d. The applicant's feet prevent/impair successful performance of his military duties. AHLTA medical note, dated 14 December 2017, shows the feet have some discoloration and become numb and cold whether sitting or standing. It may be a consequence of hip surgery, but it will interfere with physical duties as a Military Policeman.

18. The response to the MEB Soldiers' Counsel memorandum of appeal is not in the applicant's available records for review.

19. A VA DES Proposed Rating, dated 9 February 2018, shows the VA recommended establishing service-connection for the following conditions with the following ratings, for the purpose of entitlement to VA benefits:

- peripheral arterial disease of the right lower extremity and right foot neuropathy involving the right external cutaneous nerve of the thigh, 40 percent
- peripheral arterial disease of the left lower extremity, and left foot neuropathy with involvement of the left external cutaneous nerve of the thigh, 40 percent
- PTSD, 30 percent
- right acromioclavicular joint osteoarthritis with degenerative arthritis, 20 percent
- left acromioclavicular joint osteoarthritis with degenerative arthritis, 20 percent
- right hip trochanteric pain syndrome, femoral acetabular impingement syndrome, iliopsoas tendinitis and limitation of extension, 10 percent
- left hip trochanteric pain syndrome, femoral acetabular impingement syndrome, iliopsoas tendinitis and limitation of extension, 10 percent
- left ankle tendonitis, 10 percent
- right ankle tendonitis, 10 percent
- cervical strain, 10 percent
- degenerative arthritis of the lumbar spine, 10 percent
- left shin splint with iliotibial band syndrome, 10 percent
- right shin splint with iliotibial band syndrome, 10 percent
- tinnitus, 10 percent
- limited flexion of the right hip, 0 percent
- impairment of the left hip, 0 percent
- impairment of the right hip, 0 percent
- right sensorineural hearing loss, 0 percent
- service-connection for migraines is not proposed

20. A DA Form 199 (Informal PEB Proceedings) shows:

a. An informal PEB convened on 27 March 2018, where the applicant was found physically unfit with a recommended rating of 20 percent and that his disposition be separation with severance pay.

b. The applicant's following conditions were found unfitting:

(1) right hip recurrent labral tears with surgical residuals (MEB Dx 1); 10 percent. Informal reconsideration was offered to add the following as unfitting conditions: limitation of flexion of the left hip (VA rated 0 percent), limitation of flexion of the right hip (VA rated 0 percent), impairment of the left hip (VA rated 0 percent), impairment of the right hip (VA rated 0 percent). After review by the applicant and counsel, the applicant accepted the informal reconsideration offer.

(2) left hip labral tear with chondromalacia (MEB Dx 2), 10 percent.

(3) limitation of flexion of right hip (MEB Dx 1); 0 percent

(4) impairment of the right hip (MEB Dx 1); 0 percent

(5) limitation of flexion of the left hip (MEB Dx 2); 0 percent

(6) impairment of left hip (MEB Dx s); 0 percent

c. MEB Dxs 3-20 were not found unfitting. None are listed on the DA Form 3349 as preventing the applicant from performing any functional activities and there is no evidence to indicate any performance issues due to these conditions.

d. On 4 April 2018, the applicant signed the form indicating he had been advised of the findings and recommendations of the informal PEB, he concurred and waived a formal hearing of his case, and did not request reconsideration of his VA ratings.

21. The applicant's DD Form 214 shows he was honorably discharged under the provisions of Army Regulation 635-40 (Physical Evaluation for Retention, Retirement or Separation) due to disability with severance pay, combat related (enhanced), with corresponding separation code JEA and reentry code 3, on 28 July 2018. He was credited with 10 years, 8 months, and 3 days of net active service this period; 6 years, 4 months, and 22 days of total prior active service; and 4 years, 5 months, and 12 days of total prior inactive service.

22. A VA letter, dated 23 August 2018, shows the applicant was granted a combined service-connected disability rating of 100 percent effective 29 July 2018.

23. The applicant previously applied to the ABCMR in April 2020, requesting disability retirement in lieu of disability separation with severance pay, through the inclusion of additional unfitting conditions. In the adjudication of that application, the Army Review Boards Agency (ARBA) medical advisor provided an opinion that neither an increase in the applicant's military disability rating nor referral back to the IDES was warranted.

24. On 29 April 2021, the Board denied the applicant's request, determining the evidence presented did not demonstrate the existence of a probable error or injustice and that the overall merits of the case were insufficient as a basis for correction of his records.

25. The Army rates only conditions determined to be physically unfitting at the time of discharge, which disqualify the Soldier from further military service. The Army disability rating is to compensate the individual for the loss of a military career. The VA does not have authority or responsibility for determining physical fitness for military service. The VA may compensate the individual for loss of civilian employability.

MEDICAL REVIEW:

1. The Army Review Boards Agency (ARBA) Medical Advisor reviewed the supporting documents, the Record of Proceedings (ROP), and the applicant's available records in the Interactive Personnel Electronic Records Management System (iPERMS), the Health Artifacts Image Management Solutions (HAIMS) and the VA's Joint Legacy Viewer (JLV). The applicant requests Army medical disability retirement instead of separation with severance pay. This is a request for reconsideration of a previous Board decision (board date 29Apr2021).

2. The ABCMR ROP summarized the applicant's record. The applicant first served in the regular Army starting 19970930 with some breaks including a break to attend school 20010707. Per Enlisted Record Brief (ERB), he completed 4 deployments: Iraq 20030228-20040303; Afghanistan 20050202-20060120; Belgium 20090301-20111031; and Honduras 20161016-20170416. He entered his final period of service 26Nov2007. His primary MOS was 31B Military Police. He was honorably discharged with disability severance pay on 28Jul2018 under provisions of AR 635-40, chapter 4 (Physical Evaluation for Retention, Retirement, or Separation).

3. The applicant underwent 19Dec2017 MEB proceedings which determined Right Hip Recurrent Labral Tears with Surgical Residuals and Left Hip Labral Tear with Chondromalacia did not meet retention standards of AR 40-501 chapter 3. He was referred for a PEB for fitness determination.

a. The PEB convened 27Mar2018 found Right Hip Recurrent Labral Tears with Surgical Residuals (MEB diagnosis 1 or Dx 1) under DC 5019-5251 at 10% and Left Hip Labral Tear with Chondromalacia (MEB Dx 2) under DC 5019-5251 at 10%, unfitting for

continued service. The total combined rating was 20% with recommended disposition separation with severance pay. Under Informal Reconsideration, the PEB added Limitation of Flexion of Right Hip (MEB Dx 1) under DC 5019-5252 at 0%; Impairment of Right Hip (MEB Dx 1) under 5019-5253 at 0%; Limitation of Flexion of Left Hip (MEB Dx 2) under DC 5019-5252 at 0%; and Impairment of Left Hip (MEB Dx 2) under 5019-5253 at 0%. These conditions were added as a correction to the original PEB convened 15Feb2018 to ensure inclusion of all ratings for the right hip joint and all ratings for the left hip joint were designated as unfitting for continued service in combination. The case was adjudicated as part of the Integrated Disability Evaluation System (IDES); therefore, the PEB applied individual ratings for each condition as they were proposed by the VA in the memorandum dated 09Feb2018.

b. Review of the PEB proceedings showed the applicant has already received the 3 total allowable ratings for both the right and left hip conditions 5251 (limited extension), 5252 (limited flexion), and 5253 (other hip motion). For background, he underwent right hip laparoscopic osteochondroplasty (17Sep2012 Washington University in St Louis, School of Medicine Orthopedics). The 30Nov2017 Hip and Thigh Conditions DBQ exam showed decreased but functional ROMs for flexion and extension for both right and left hips—there was no schedularly compensable limitation of motion for any hip motion for either hip (his loss of motion was below the level of what was compensable). However, there was evidence of pain with motion and evidence of pain with weight bearing for both hips. He did not have arthritis in either hip. He received a 10% rating for both hips for pain that limited extension of the hip (Painful motion, in accordance with §4.59). Although he also had pain with hip flexion and 'other hip motion', 10% had already been applied for pain for each hip under hip extension (DC 5251) and could not be used for rating criteria again for the same hip (§4.14 Avoidance of pyramiding).

4. Through counsel, and in his application, the petitioner requested for the following conditions to be reviewed: Peripheral Arterial Disease of Right Lower Extremity; Left Foot Neuropathy; PTSD; Right Acromioclavicular Joint Osteoarthritis with Degenerative Arthritis/Shoulder Arms; Right and Left Hip Pain with Limited Extension; Right and Left Ankle Tendonitis; Cervical Strain/Neck Spine Injuries; Degenerative Arthritis of Spine/Lumbar Spine Injuries; Right Shin Splint; Right and Left Hip Pain with Limited Flexion; Right Hip Impairment; Lower Extremity Injuries; and Headaches. For relevance, this review will focus mainly on the status of the conditions at the time of the MEB and through discharge from service. The right and left hip conditions were reviewed in the section above. This section will cover conditions that were determined by the MEB to MEET retention standards of AR 40-501 chapter 3.

a. Right and Left Foot Numbness. The VA rated these conditions together to avoid pyramiding (§4.14 Avoidance of pyramiding). Accordingly, the conditions were reviewed together.

(1) Peripheral Arterial Disease of Right Lower Extremity. This was a VA diagnosis. During the 30Nov2017 Artery and Vein Conditions DBQ exam, the applicant complained of numbness in both feet since 2015. The applicant did not present to the Army for this complaint until December 2017. He did not have pain or paresthesia attributable to this condition. To help determine if the numbness was arterial or neurologic, a resting Doppler was completed. The VA examiner reported Right ABI (Ankle-Brachial Index) score 1.17 and Left ABI score 1.11 as "abnormal" and concluded this was "concerning for arterial occlusion" (Resting Doppler Arterial Flow Study Form, dated 30Nov2017). It is noted that ABI scores between 1.0 and 1.4 are generally regarded as normal. The scores were regarded as normal by the MEB physician. The repeat 18Jan2018 Right ABI and Left ABI scores were both 1.15 (normal). The 18Jan2018 arterial duplex study/ultrasound was also normal demonstrating that no hemodynamically significant stenosis was present in either iliac artery. Based on exam and test results, a Tripler vascular surgeon assessed that findings were negative for any lower extremity arterial pathology (30Jan2018 Tripler-Shafter AMC). To rule out a pelvic mass causing positional paresthesia, a pelvic MRI was obtained which was also negative (18Jan2018 pelvic MRI). The work up also included left and right foot films which showed no acute osseous abnormality and no significant degenerative change (01Dec2017 Cerner Imaging Exam Report). After discharge from service a VA vascular specialist assessed that there was "no evidence of clinically significant peripheral artery disease, with normal perfusion to digital level of lower extremities bilaterally" (11Apr2019 Vascular Surgery, North TX VAMC). They recommended consideration of EMG (electromyography) for further evaluation of his neuropathic symptoms.

(2) Left Foot Neuropathy. Right and Left Foot Neuropathy was diagnosed by the VA. Again, Army evaluation of this condition began in December 2017. In the 30Nov2017 Peripheral Nerves Conditions DBQ, the VA examiner determined that the neuropathy condition was due to peripheral arterial disease and referenced the 30Nov2017 Artery and Vein Conditions DBQ. *It should be noted this determination was made in November 2017, before arterial occlusion was excluded by repeat and more definitive testing. It should also be noted that the same examiner completed both DBQs)*. *And finally, based on information in the 30Nov2017 Peripheral Nerves Conditions DBQ, the VA service-connected Peripheral Arterial Disease of the Right and Left Lower Extremity condition at 40% for each side based on 'claudication on walking between 25 and 100 yards on a level grade at two miles per hour'. However, claudication was not found to be present during the December 2017 Army evaluation.* The applicant was also seen by orthopedics at Schofield Barracks on 03Jan2018 and no cause was identified for the foot numbness complaint. After the applicant was discharged from service, a lower leg EMG was completed: Nerve conduction studies were normal. The EMG revealed electrodiagnostic evidence of possible old injury to the tibialis anterior [muscle] and/or deep peroneal nerve (04Nov2019 Physical Medicine Rehab Consult N. TX VAMC). However, the specialist assessed that in the absence of

other findings (for example the applicant's exam was normal—showed no focal weakness), this was of unclear significance.

Rationale/Opinion. The applicant reported numbness in his feet began in 2015. There was no documentation in clinical records that issues related to this symptom had significantly impacted performance. Conditions thought to be associated with this symptom were not profiled. The exam showed normal lower extremity motor, sensory and neurologic exams. Evidence was insufficient to support that either peripheral artery disease or peripheral neuropathy conditions failed medical retention standards IAW AR 40-501 Chapter 3-30.j and 3-41.e.(1)(2)(3).

b. Right Acromioclavicular Joint Osteoarthritis with Degenerative Arthritis/Shoulder Arms condition. The VA diagnosed both Right and Left Acromioclavicular Joint Osteoarthritis and Degenerative Arthritis.

The applicant's first complaint of right and left shoulder popping and grinding, was documented in the 30Nov2017 Shoulder and Arm Conditions DBQ. During the exam, both right and left shoulder ROMs exceeded those required (forward elevation to 90 degrees, or abduction to 90 degrees) for referral for a MEB (per AR 40-501 chapter 3-12b(1)). The exam did not show objective evidence of localized tenderness or pain on palpation of the joint; or evidence of pain with weight bearing for either shoulder. Shoulder weakness, instability, dislocation, or labral pathology was also not demonstrated. The 01Dec2017 Cerner Imaging Exam Reports of the right and shoulder films showed no acute osseous findings. There were moderate degenerative changes of the acromioclavicular joint with well-maintained glenohumeral joint for both shoulders. The applicant first presented to Army providers for shoulder complaints on 13Feb2018 (Tripler AMC). He reported left shoulder pain, popping and clicking. The 27Feb2018 Tripler AMC left shoulder MRI showed a small SLAP tear; mild rotator cuff tendinosis; mild edema within the supraspinatus and teres minor muscles; and mild degenerative changes of the acromioclavicular joint with minimal subacromial subdeltoid bursitis (Tripler AMC). In the 15Mar2018 Schofield Barracks Orthopedics Clinic exam, the left shoulder demonstrated 160 degrees of forward elevation (normal is 180); and the right shoulder was to 170 degrees of forward elevation. The applicant endorsed having 'mild' left shoulder pain. Diagnosis: Left Shoulder Subacromial Bursitis. Physical therapy was offered.

Rationale/Opinion. Medical records did not document complaints that symptoms associated with this condition significantly interfered with duty performance. The right and left shoulder condition did not fail conservative therapy. The applicant rated the pain as mild. The exam showed bilateral functional ROM and normal strength. A shoulder condition was not profiled. Evidence was insufficient to

support that right or left shoulder conditions failed medical retention standards IAW AR 40-501 Chapter 3-12, 3-14.c and 3-41.e.(1)(2)(3).

c. Right Ankle Tendonitis (VA diagnosis); Left Ankle Tendonitis (Lower Extremity Injuries)

The applicant was first seen for left ankle symptoms in 2010 at which time he reported having injured the left ankle 4 years prior while down range in Afghanistan. He had not previously sought care. There were no treatment visits for an ankle condition during the 2 years prior to discharge from service. The 30Nov2017 Ankle Conditions DBQ exam showed right ankle dorsiflexion to 10 degrees (normal is 20) and plantar flexion to 45 degrees (normal). Left ankle dorsiflexion was to 10 degrees; and plantar flexion was to 25 degrees. There was no objective evidence of localized tenderness or pain on palpation of the joint; nor was there evidence of pain with weight bearing for both right and left ankles. Strength was 5/5 (normal) and there was no evidence of joint instability for both ankles. Films in December 2017 for both right and left ankle showed no acute osseous finding and no significant degenerative change (01Dec2017 Cerner Imaging Exam Reports).

Rationale/Opinion. Medical records did not document complaints that symptoms associated with this condition significantly interfered with duty performance. The exam showed normal lower extremity motor, sensory and neurologic exams. This condition was not profiled. The condition met retention standards IAW AR 40-501 Chapter 3-13, 3-14.n and 3-41.e.(1)(2)(3)

d. Cervical Strain; Degenerative Arthritis of Spine (Neck Spine Injury).
A cervical spine series was completed for trauma to rule out fracture with normal results (21Apr2008 Ft Leonard Wood). There was no accompanying clinical visit available for review. The 30Nov2017 Neck (Cervical Spine) Conditions DBQ exam showed neck flexion to 45 degrees (normal); and extension to 30 degrees (45 degrees is normal).

There was no objective evidence of localized tenderness or pain on palpation of the cervical joint; nor was there evidence of pain with weight bearing. The 01Dec2017 Cerner Imaging Exam Report for cervical spine indicated radiographs of the cervical spine were normal.

Rationale/Opinion. There were no treatment records with principal diagnosis neck/cervical pain/injury in JLV while the applicant was in service. This condition was not profiled. This condition met retention standards IAW AR 40-501 Chapter 3-39.h and 3-41.e.(1)(2)(3).

e. Right Shin Splint (VA diagnosis); Right Knee Iliotibial Band Syndrome and Left Knee Iliotibial Band Syndrome (Lower Extremities Injuries)

(1) The applicant was seen 20Sep2017 for his first complaint of left knee pain, present for 3 weeks. There was no known injury/trauma. Diagnosis: Patellofemoral Disorders, Left Knee. Knee self-care instruction was given and a 30-day profile. He also attended group therapy for knee pain (10Oct2017 Physical Therapy Tripler AMC). 30Nov2017 Knee and Lower Leg DBQ exam demonstrated right knee flexion was 0 to 120 degrees (normal is 0 to 140 degrees); and extension was 120 to 0 degrees (normal is 140 to 0 degrees). Left knee flexion was 0 to 110 degrees; and extension was 110 to 0 degrees. There was no objective evidence of localized tenderness or pain on palpation of the knee joint; nor was there evidence of pain with weight bearing for either knee. Strength testing was 5/5 (normal) for both knees. The left knee demonstrated mild lateral instability. The right knee demonstrated no instability.

(2) In addition to Bilateral Iliotibial Band Syndrome, the applicant also reported right and left shin pain. The pain was intermittent with running. The examiner assessed that the bilateral condition did not impact ROM for the knee or ankle joints. The 01Dec2017 Cerner Imaging Exam Reports indicated radiographs for the right and left knees showed no acute osseous abnormality and the joint spaces were well-maintained.

Rationale/Opinion. Medical records did not document complaints that symptoms associated with this condition significantly interfered with duty performance. The exam showed normal lower extremity motor, sensory and neurologic exams. These conditions were not profiled. Right Knee Iliotibial Band Syndrome and Left Knee Iliotibial Band Syndrome met retention standards IAW AR 40-501 Chapter 3-13, 3-14.n and 3-41.e.(1)(2)(3); and Right Shin Splints met retention standards IAW AR 40-501 Chapter 3-13, 3-14 and 3-41.e.(1)(2)(3).

f. Thoracolumbar Degenerative Arthritis (Lumbar Spine Injury).

30Nov2017 Back Conditions DBQ exam showed back forward flexion to 80 degrees (normal is 90); and extension to 30 degrees (normal). There was no objective evidence of localized tenderness, or pain on palpation of the back joint; nor was there evidence of pain with weight bearing. The motor, sensory and neurologic exams were normal. There was no radicular pain or other signs/symptoms of radiculopathy. Muscle strength was normal. Of note, 30Nov2019 lumbar MRI (North Texas VAMC), over 1 year after discharge from service, demonstrated minimal degenerative disc changes and no central stenosis.

Rationale/Opinion. There were no treatment notes found with principal diagnosis of lumbar (or back) for pain/injury/trauma while the applicant was in service. This condition was not profiled. Based on records available for review, this

condition met retention standards IAW AR 40-501 Chapter 3-39.h and 3-41.e.(1)(2)(3).

g. BH Condition: PTSD

(1) 05Dec2013 PHA there were some positive responses to BH oriented questions, and he endorsed recent family stress.

(2) 02Dec2015 BH Schofield Barracks. The applicant was referred by his PCP for assessment for “recurring dreams, trouble sleeping". He reported that he only slept 5 to 7 hours per day. PCL-5 score was 10 (consistent with low PTSD symptoms reported). GAD score was 0 (anxiety syndrome unlikely). PHQ2 score was 0 (depression syndrome unlikely). Harmful alcohol consumption was not detected.

(3) NCO Evaluation Reports 20161019-20170414, 20160508-20161018 and 20150508-20160517, indicated that his overall performance ‘exceeded standard’ or ‘far exceeded standard’ and the senior rater rated the applicant’s overall potential as ‘highly qualified’.

(4) 16Nov2017 Initial PTSD DBQ. Examiner assessed that due to the applicant’s BH condition there was occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks although generally functioning satisfactorily with normal routine behavior, self-care and conversation. Combat stressors: Deaths of 4-5 friends (killed in action) and he and a friend engaged in hand-to-hand combat with two insurgents while guarding an ammo depot.

(5) BH review on 23Jan2018 by Tripler MEB: The BH specialist found that the “preponderance of the evidence supports the conclusion that this condition meets psychiatric retention standards”.

(6) The applicant did participate in individual BH counseling for sleep issues from December 2015 to January 2016, which he found helpful: “He reported improved sleep efficiency” (08Jan2016).

(7) 23Jan2018 BH Schofield Barracks. The applicant was referred again by his PCP for assistance with chronic nightmares (rule out Nightmare Disorder) and potential stress-related symptoms during the MEB proceedings for his hip condition. PCL-5 score was 14 (consistent with low PTSD symptoms reported). GAD2 score was 1 (anxiety syndrome unlikely). PHQ2 score was 0 (depression syndrome unlikely).

Harmful alcohol consumption was again not detected.

Rationale/Opinion. The condition did not require sleep medication or psychotropic agents. There were no suicide ideation/attempts, psychosis, recurrent emergency room visits or psychiatric hospitalizations for his BH condition. Medical records did not document complaints that symptoms associated with this condition significantly interfered with duty performance. His permanent profile showed S1. Based on evidence available for review, this condition met retention standards IAW AR 40-501 Chapter 3-33.a.b.c. and Chapter 3-41.e.(1)(2)(3).

5. Headaches. This condition was NOT reviewed by the MEB. Neither the VA nor the

Army diagnosed a headache or migraine condition. The VA rendered the opinion: "There is no diagnosis because there is no pathology to render a diagnosis".
In the 30Nov2017 Headaches DBQ, the applicant reported his headaches started after in 2006, after deployment. The headaches were associated with nausea, sensitivity to light and sound and last less than 24 hours. He reported that he was taking Topamax for his headaches. However, there were no Army or VA treatment notes for a headache condition. Topamax was not in the applicant's JLV medication profile. No private treatment records were submitted for this review.

Rationale/Opinion. There was no documentation found for headache/migraine complaints while the applicant was in service. There was no evidence the condition had failed conservative therapy; and there was no documentation in treatment records that a headache/migraine condition had impacted performance. This condition met retention standards of AR 40-501, chapter 3-30 g.j.

6. The mere presence of a service incurred condition does not equate to unfitness. Despite that applicant's multiple orthopedic conditions, he remained active and passed his most recent APFT 16Feb2017 with score 275 (NCO Evaluation Reports 20161019-20170414) and APFT in August 2017 score 270 (Enlisted Record Brief 20180126). The MEB determined that due to the applicant's chronic bilateral hip pain conditions, he was unable to effectively and safely perform certain required functional activities without worsening and exacerbating his symptoms. Independent medical review did not find an additional condition which failed medical retention standards. Based on review of available records, the ARBA Medical Reviewer did not find that there were other conditions which failed retention standards of AR 40-501 chapter 3. In addition, the ARBA Medical Reviewer did not find that the was error in the VA rating determination for the hip conditions. JLV search today showed the 6 hip ratings are the same today. Referral for further medical discharge processing is not warranted at this time.

BOARD DISCUSSION:

After reviewing the application, all supporting documents, and the evidence found within the military record, the Board found that relief was not warranted. The applicant's contentions, the military record, and regulatory guidance were carefully considered. The Board concurred with the medical advisor's review finding no other conditions existed at the time of separation which would have failed medical retention standards. Additionally, there was no error in the rating determination provided by the VA; therefore, a referral to the IDES is not warranted.

BOARD VOTE:

Mbr 1	Mbr 2	Mbr 3	
:	:	:	GRANT FULL RELIEF
:	:	:	GRANT PARTIAL RELIEF
:	:	:	GRANT FORMAL HEARING
[redacted]	[redacted]	[redacted]	DENY APPLICATION

BOARD DETERMINATION/RECOMMENDATION:

The evidence presented does not demonstrate the existence of a probable error or injustice. Therefore, the Board determined the overall merits of this case are insufficient as a basis to amend the decision of the ABCMR set forth in Docket Number AR20200009009 on 29 April 2021.

[redacted]

I certify that herein is recorded the true and complete record of the proceedings of the Army Board for Correction of Military Records in this case.

REFERENCES:

1. Title 10, U.S. Code, chapter 61, provides the Secretaries of the Military Departments with authority to retire or discharge a member if they find the member unfit to perform military duties because of physical disability. The U.S. Army Physical Disability Agency is responsible for administering the Army physical disability evaluation system (DES) and executes Secretary of the Army decision-making authority as directed by Congress in chapter 61 and in accordance with DOD Directive 1332.18 (Discharge Review Board (DRB) Procedures and Standards) and Army Regulation 635-40 (Physical Evaluation for Retention, Retirement, or Separation).

a. Soldiers are referred to the disability system when they no longer meet medical retention standards in accordance with Army Regulation 40-501 (Standards of Medical Fitness), chapter 3, as evidenced in a Medical Evaluation Board (MEB); when they receive a permanent medical profile rating of 3 or 4 in any factor and are referred by an Military Occupational Specialty (MOS) Medical Retention Board (MMRB); and/or they are command-referred for a fitness-for-duty medical examination.

b. The disability evaluation assessment process involves two distinct stages: the MEB and Physical Evaluation Board (PEB). The purpose of the MEB is to determine whether the service member's injury or illness is severe enough to compromise his/her ability to return to full duty based on the job specialty designation of the branch of service. A PEB is an administrative body possessing the authority to determine whether or not a service member is fit for duty. A designation of "unfit for duty" is required before an individual can be separated from the military because of an injury or medical condition. Service members who are determined to be unfit for duty due to disability either are separated from the military or are permanently retired, depending on the severity of the disability and length of military service. Individuals who are "separated" receive a one-time severance payment, while veterans who retire based upon disability receive monthly military retired pay and have access to all other benefits afforded to military retirees.

c. The mere presence of a medical impairment does not in and of itself justify a finding of unfitness. In each case, it is necessary to compare the nature and degree of physical disability present with the requirements of the duties the Soldier may reasonably be expected to perform because of his or her office, grade, rank, or rating. Reasonable performance of the preponderance of duties will invariably result in a finding of fitness for continued duty. A Soldier is physically unfit when a medical impairment prevents reasonable performance of the duties required of the Soldier's office, grade, rank, or rating.

2. Army Regulation 635-40 establishes the Army Disability Evaluation System and sets forth policies, responsibilities, and procedures that apply in determining whether a

Soldier is unfit because of physical disability to reasonably perform the duties of his office, grade, rank, or rating. Only the unfitting conditions or defects and those which contribute to unfitness will be considered in arriving at the rated degree of incapacity warranting retirement or separation for disability.

a. Disability compensation is not an entitlement acquired by reason of service-incurred illness or injury; rather, it is provided to Soldiers whose service is interrupted and who can no longer continue to reasonably perform because of a physical disability incurred or aggravated in military service.

b. Soldiers who sustain or aggravate physically-unfitting disabilities must meet the following line-of-duty criteria to be eligible to receive retirement and severance pay benefits:

(1) The disability must have been incurred or aggravated while the Soldier was entitled to basic pay or as the proximate cause of performing active duty or inactive duty training.

(2) The disability must not have resulted from the Soldier's intentional misconduct or willful neglect and must not have been incurred during a period of unauthorized absence.

c. The percentage assigned to a medical defect or condition is the disability rating. A rating is not assigned until the PEB determines the Soldier is physically unfit for duty. Ratings are assigned from the Department of Veterans Affairs (VA) Schedule for Rating Disabilities (VASRD). The fact that a Soldier has a condition listed in the VASRD does not equate to a finding of physical unfitness. An unfitting, or ratable condition, is one which renders the Soldier unable to perform the duties of their office, grade, rank, or rating in such a way as to reasonably fulfill the purpose of their employment on active duty. There is no legal requirement in arriving at the rated degree of incapacity to rate a physical condition which is not in itself considered disqualifying for military service when a Soldier is found unfit because of another condition that is disqualifying. Only the unfitting conditions or defects and those which contribute to unfitness will be considered in arriving at the rated degree of incapacity warranting retirement or separation for disability.

3. Title 10, U.S. Code, section 1201, provides for the physical disability retirement of a member who has at least 20 years of service or a disability rating of at least 30 percent. Title 10, U.S. Code, section 1203, provides for the physical disability separation of a member who has less than 20 years of service and a disability rating of less than 30 percent.

4. Title 38, U.S. Code, section 1110 (General – Basic Entitlement) states for disability resulting from personal injury suffered or disease contracted in line of duty, or for aggravation of a preexisting injury suffered or disease contracted in line of duty, in the active military, naval, or air service, during a period of war, the United States will pay to any veteran thus disabled and who was discharged or released under conditions other than dishonorable from the period of service in which said injury or disease was incurred, or preexisting injury or disease was aggravated, compensation as provided in this subchapter, but no compensation shall be paid if the disability is a result of the veteran's own willful misconduct or abuse of alcohol or drugs.

5. Title 38, U.S. Code, section 1131 (Peacetime Disability Compensation – Basic Entitlement) states for disability resulting from personal injury suffered or disease contracted in line of duty, or for aggravation of a preexisting injury suffered or disease contracted in line of duty, in the active military, naval, or air service, during other than a period of war, the United States will pay to any veteran thus disabled and who was discharged or released under conditions other than dishonorable from the period of service in which said injury or disease was incurred, or preexisting injury or disease was aggravated, compensation as provided in this subchapter, but no compensation shall be paid if the disability is a result of the veteran's own willful misconduct or abuse of alcohol or drugs.

6. Title 10, U.S. Code, section 1556 requires the Secretary of the Army to ensure that an applicant seeking corrective action by the Army Review Boards Agency (ARBA) be provided with a copy of any correspondence and communications (including summaries of verbal communications) to or from the Agency with anyone outside the Agency that directly pertains to or has material effect on the applicant's case, except as authorized by statute. ARBA medical advisory opinions and reviews are authored by ARBA civilian and military medical and behavioral health professionals and are therefore internal agency work product. Accordingly, ARBA does not routinely provide copies of ARBA Medical Office recommendations, opinions (including advisory opinions), and reviews to Army Board for Correction of Military Records applicants (and/or their counsel) prior to adjudication.

//NOTHING FOLLOWS//