IN THE CASE OF: [redacted]

BOARD DATE: 24 April 2024

DOCKET NUMBER: AR20230007622

APPLICANT REQUESTS: physical disability retirement in lieu of physical disability separation wit severance pay through the inclusion of multiple additional Department of Veterans Affairs (VA) diagnostic codes to identify and rate his conditions.

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

- DD Form 149 (Application for Correction of Military Record)
- multiple pages of medical records dated between 21 April 1998 – 17 June 1999
- Commander's Performance Statement, 2 November 1999
- Medical Evaluation Board (MEB) Narrative Summary (NARSUM), 27 December 1999
- partial DA Form 199 (Physical Evaluation Board (PEB) Proceedings, 26 January 2000

FACTS:

1. The applicant did not file within the 3-year time frame provided in Title 10, U.S. Code, section 1552(b); however, the Army Board for Correction of Military Records (ABCMR) conducted a substantive review of this case and determined it is in the interest of justice to excuse the applicant's failure to timely file.

2. The applicant states:

a. The MEB failed to use several diagnostic codes to appropriately assess his disability rating at the time of his discharge. His discharge narrative reason for separation should have been honorable retirement instead of discharge with severance pay.

b. The medical review board failed to use several diagnostic codes when calculating his disability rating. They did not apply diagnostic code 5003. Colonel (COL) [redacted] documented he had osteoarthritis in both knees with the left being worse than the right. A 10 percent disability rating for osteoarthritis should have been granted but was not. Diagnostic code 5010, which is used when chondromalacia is present in the knees, was not used in evaluating his disabilities, even though he was diagnosed with grade II-III

chondromalacia in his right knee and grade III-IV chondromalacia in his left knee. Additionally, diagnostic code 5258 should have been used by the board in determining his disability rating at discharge, as COL [redacted] documented he had an inability to extend his left knee fully, had stiffness, crepitus, "giving way" and swelling at the time of his MEB physical. This warrants a minimum of a 20 percent disability rating for his left knee alone.

c. He also had tears in both his left and right meniscus along with "osteophytes." The board appeared to only address symptomatic issues and not the diseases(s)/infirmities to which they were tied, although the conditions were documented by COL [redacted] in the MEB NARSUM and in his medical records. The MEB results state that his right knee was rated for semilunar cartilage, removal of, symptomatic; left knee rated for semilunar cartilage, removal of, symptomatic. There is no mention of osteoarthritis, which is clearly documented in the board proceedings as well as in his medical records. This diagnosis is rated at 10 percent.

d. These disabilities can and should be rated separately and cumulatively at 40 percent at the time of his discharge. Although the attached documentation states there is an appendix B listing the board members, it was not given to him. The president of the board was a Field Artillery (FA) COL, and the board may not have received the medical review as determined by statute.

e. In honesty, he was not in the proper state of mind at the time of his discharge. He had been so battered over time that he was numb to the situation. He was displaced from his young daughter and wife and had not seen them for several months. He cannot assert that he gave this matter the attention it deserved at the time because his focus was on reuniting with his family. He faults himself for that, but armed with the knowledge he can do this now, he is dedicated to having his service properly identified. He is proud that he served, and the loss of his career was devastating. The is also the fact that the disabilities he had at the time of his discharge have regressed substantially.

3. The applicant enlisted in the Regular Army on 28 December 1993 and was awarded the Military Occupational Specialty (MOS) 95B (Military Police).

4. The applicant provided multiple pages of medical documents, dated between 21 April 1998 – 17 June 1999, which have been provided in full to the Board for review and in pertinent part show:

a. On 21 April 1998, the applicant underwent right knee examination under anesthesia, arthroscopic partial lateral and medical meniscectomies, and debridement of bony ridge. His postoperative diagnoses were right knee complex tear, posterior horn of lateral meniscus; undersurface tear of medical meniscus; posterior horn with bony

ridge; softening of femoral tibial plateau cartilage and undersurface of the patella throughout, tricompartmental; small medical parapatellar plica.

b. On 7 June 1999, he underwent left knee arthroscopy with debridement of loose bodies and degenerative lateral meniscus tear. His postoperative diagnoses were left knee degenerative lateral meniscus tear; grade 3 chondral changes, lateral femoral condyle, and lateral tibial plateau; loose bodies; and grade 4 chondral defect, proximal trochlear groove.

5. A Commander's Performance Statement, dated 2 November 1999, shows:

a. The applicant initially injured his right knee in 1994, during Basic Combat Training (BCT) and Advanced Individual Training (AIT) at Fort McClellan, AL, while completing a station on the obstacle course, with reinjury multiple times during training in 1997. On 28 April 1998, he had arthroscopic knee surgery to repair torn cartilage and a meniscal tear. It was found he had grade I chondromalacia. Upon recovery, he began running and was again active with occasional knee pain but noticed increased left knee swelling and locking at additional Army training and schooling. He was found to have loose bodies floating within the knee joint, a medial meniscal tear, torn cartilage, and a degenerative arthritic condition which will eventually require knee replacement surgery. ON 7 June 1999, he had arthroscopic knee surgery to repair this knee damage and on 20 July 1999, was issued a permanent profile rating of 3, which prohibited him from running to time and distance, all functional activities, and the standard Army Physical Fitness Test (APFT).

b. He was reassigned from his 95B squad leader position since his knee surgeries and now works in the company operations cell, performing duties as a company training noncommissioned officer (NCO). There has been a marked decline in his physical performance since January 1997 and the decline has worsened since June 1999. His inability to perform the physical aspects of his job in the field environment dictated his move out of a leadership position in a line platoon. His performance in the company operations cell has been extraordinarily strong; however, he should be filling a much-needed squad leader position that he cannot fill due to his physical status. He is an NCO who takes care of Soldiers and exceeds the standard during the execution of his daily duties. Yet, he cannot lead from the front because of his weakened knee condition.

6. An MEB NARSUM shows:

a. On 23 November 1999, the applicant underwent medical examination for an MEB. This history of his present illness shows he injured himself in BCT while jumping off and obstacle course and landing on his right knee. He had a rapid effusion and was seen by the physician who checked his ligaments, and they were fine. He had intermittent symptoms with the right knee and noticed he also developed symptoms on

the left knee, favoring the right knee. He had recurrent episodes of locking on the right knee and on 20 April 1998, underwent arthroscopic surgery (by the doctor doing the current examination and writing the NARSUM, COL [redacted]). Preoperatively, a magnetic resonance imaging (MRI) revealed a posterior horn lateral meniscal tear. At the operative procedure, it was noted that he had a complex tear of the posterior horn of the lateral meniscus and a small undersurface tear of the medical meniscus posterior horn with a bony ridge present, softening of the medical femoral and tibial plateau cartilage, a grade II-II chondromalacia patella, and a small medial parapatellar plica. An arthroscopic partial, medial, and lateral meniscectomy was done along with smoothening the medial bony ridge.

b. Post-operatively he did excellently with recovery of his left knee as his right knee took the burden of his activities. He developed swelling of the mechanical symptoms present in the left knee at Basic Noncommissioned Officer Course (BNCOC). He started having locking of his left knee and thus when he returned to Hawaii with the increased problems of pan and locking, he underwent arthroscopic surgery of the left knee on 7 June 1999, where a degenerative tear of the lateral meniscus was noted and debrided. He had multiple loose bodies that were removed from his knees. He had grade III chondromalacia changes of the lateral femoral condyle, lateral tibia plateau, and a grade IV chondral defect at the proximal of trochlear groove. The pre-operative MRI had shown tears of both the medial and lateral menisci. On through examination, there was no tear of the medical meniscus. His lesions were debrided, and the knee was thoroughly washed out.

c. Post-operatively, he had persistent symptoms in the left knee, not fully recovering to the level that he did on the right side. He admits he does not have any episodes of locking. The left knee has some swelling still present. He does have slight giving way. He has noted he has stiffness, particularly with prolonged sitting for more than 20 minutes. When he starts to stand up, he has anterior knee pain, retropatellar and patellar tendon as well as in the level of the tibial tubercle discomfort, to include inability to fully extend his knee. He notes retropatellar crepitus. The stiffness is more of a problem to him as it makes it difficult to start walking his first few steps and he will limp. He notes that he favors the left knee and is doing well with the right knee. He was given a permanent profile due to changes of both knees.

d. On detailed review of systems, he has no other problems.

e. His physical examination showed he had a smooth symmetrical gait. In the left knee, he had a small amount of soft tissue fullness, no effusion, but thicker, soft tissue. In the right knee, no effusion is present. Medial and lateral patellar dimples were easily seen. His patella portals were all well-healed with no keloid formation. His left knee range of motion with the large goniometer measured 10 to 112 degrees. The right knee measured 0 to 122 degrees. Range of motion was checked several times throughout

the examination and remained consistent. He had bilaterally stable ligaments to a Lachman, drawer, adduction, abduction, and pivot shift stressing. McMurray's was negative. His radiograph of 3 May 1999 of the right knee showed a good joint space present in the patellofemoral view as well as the AP and notch views. His radiographs of the left knee dated 3 May 1999 as well as 20 July 1999 and 19 October 1999, showed. anterior inferior and superior patella osteophytes that are small. He has narrowing of the latera joint space. The mild subchondral irregularity marginal osteophytes are present at the lateral joint space as well as the notch.

f. His diagnoses were:

(1) Status post mild osteoarthritic changes, left knee greater than right knee

(2) Status post medical and lateral posterior horn partial meniscectomies, right knee.

(3) Status post lateral posterior horn partial meniscectomy, left knee.

g. The recommendation shows he was referred to the PEB for adjudication under Army Regulation 40-501 (Standards of Medical Fitness), paragraph 3-14b. [Paragraph 3-14 (Miscellaneous conditions of the extremities) provides the miscellaneous causes for referral to an MEB. Paragraph 3-14b specifies arthritis due to trauma, when surgical treatment fails or is contraindicated and there is functional impairment of the involved joints so as to preclude the satisfactory performance of duty.]. He was given a permanent physical profile rating of "3" in factor L (Lower extremities), with restrictions of running at own pace and distance, alternate APFT, and no repeated squatting.

7. The applicant's DA Form 3349 (Physical Profile) and DA Form 3947 (MEB Proceedings) are not in his available records for review and have not been provided by the applicant.

8. A partial DA Form 199 shows:

a. A PEB convened on 26 January 2000, where the applicant was found physically unfit with a recommended combined rating of 20 percent and that his disposition be separation with severance pay.

b. The applicant's unfitting conditions are:

(1) Right knee injury 1994 and reinjured in 1997, status post medical and lateral meniscectomy (April 1998) with findings of grade II-II chondromalacia on arthroscopic examination; stable joint, 0–122-degree range of motion; rated for

semilunar cartilage, removal of, symptomatic; MEB diagnosis 2; VA code 5259; 10 percent rating.

(2) Left knee pain status post arthroscopy (June 1999) with debridement of the lateral meniscus with findings of grade III to IV chondromalacia; stable knee joint with mild limitation in range of motion, 10 -112 degrees; rated for semilunar cartilage, removal of symptomatic; MEB diagnosis 1; VA codes 5261 and 5259; 10 percent rating.

c. The portion of the form reflecting the applicant's concurrence/nonconcurrence is not in the available records for review.

9. Headquarters, 25th Infantry Division (Light) and U.S. Army, Hawaii Orders 046-0005, dated 15 February 2000, honorably discharged the applicant due to disability with severance pay effective 4 March 2000, with a disability rating of 20 percent.

10. The applicant's DD Form 214 (Certificate of Release or Discharge from Active Duty) shows he was honorably discharged on 4 March 2000, under the provisions of Army Regulation 635-40 (Physical Evaluation for Retention, Retirement, or Separation) due to disability with severance pay in the amount of $22,384.80, with corresponding separation code. He was credited with 6 years, 2 months, and 7 days of net active service.

11. In the adjudication of this case, an advisory opinion was provided by the U.S. Army Physical Disability Agency (USAPDA) legal advisor, dated 23 October 2023, which shows:

a. This is an advisory opinion regarding the applicant's request to include several additional VA diagnostic codes to the findings of the PEB completed on 26 January 2000. For the reasons set forth in more detail, below, the request is found to be legally insufficient.

b. On 21 April 1998, and 7 June 1999, COL [redacted] MD (Orthopedics), performed right and left knee arthroscopies, respectively, on the applicant. See Treatment Notes, dated 21 April 1998 and 7 June 1999.

c. The applicant was thereafter referred to an MEB) conducted by Dr. [redacted]. Upon physical exam conducted by Dr. [redacted] on 23 November 1999, the applicant exhibited a smooth symmetrical gait. See MEB Proceedings. There was noted to be no effusion of either knee. Range of motion for the left knee was 10 to 112 degrees; and 0 to 122 degrees for the right knee. He was assessed to have bilaterally stable ligaments. The patellar tracked in the midline, and mild to moderate crepitus was observed. Dr. [redacted] noted mild tenderness to palpation about the lateral joint on the left knee and assessed mild patellofemoral symptoms. There was no abnormality to palpation at the patellar

tendon or tibia tubercle bilaterally. The applicant's musculature was observed to be symmetrical bilaterally, and he demonstrated 5/5 strength upon testing of his toes, ankles, and knees.

d. On 26 January 2000, the PEB found disability of the right knee, status post medial and lateral meniscectomy, with grade II-III chondromalacia, stable joint, and 0-122-degree range of motion. See PEB Proceedings. The applicant was rated for semilunar cartilage, removal of, symptomatic, and VA diagnostic code 5259 was applied. He was assessed a rating of 10 percent for his right knee. The PEB also found disability of the left knee, status post arthroscopy with debridement of the lateral meniscus, with grade Ill-IV chondromalacia, stable joint, and mild limitation in range of motion (10-112 degrees). He was rated for semilunar cartilage, removal of, symptomatic. VA diagnostic codes 5259 and 5261 were applied and he was assessed a rating of 10 percent.

e. The applicant's request for the correction of his military records alleges that the PEB failed use several diagnostic codes (e.g., VA diagnostic code 5003 relating to osteoarthritis of both knees; VA diagnostic code 5010 relating to chondromalacia of both knees; and VA diagnostic code 5258 with respect to purported limitation in extending left knee, with stiffness, crepitus, give away, and swelling) when calculating his disability rating. Accordingly, he believes he should receive a rating of 40 percent instead of the 20 percent rating determined by the PEB.

f. Army Regulation 15-185 (Army Board for Correction of Military Records (ABCMR)), paragraph 2-9, states that, with respect to the allegations of errors related to military records, there is a presumption of administrative regularity. The applicant has the burden of proving an error or injustice by a preponderance of the evidence. The applicant has failed to carry this burden. His initial argument is that the PEB should have applied VA diagnostic code 5003 because Dr. [redacted] "documented that [he] had osteoarthritis in both knees." Of note, during the two surgical procedures performed by Dr. [redacted], he never rendered a diagnosis of arthritis but, rather, noted "mild osteoarthritic changes..." Moreover, Title 38 CFR, Part 4, Schedule for Rating Disabilities (VASRD), Subpart B, notes that VA diagnostic code 5003 is for degenerative arthritis, other than post-traumatic. The VASRD further explains that Code 5003 is specifically used to rate degenerative arthritis established by X-ray findings. In this case, degenerative arthritis was not established by X-ray or otherwise found during surgical procedure or subsequent physical examination.

g. Next, the applicant asserts that the PEB erred because "[d]iagnostic code 5010...is used when chondromalacia is present in the knees ..." However, although Dr. [redacted] noted the presence of chondromalacia in the applicant's right knee, and chondral changes or defects in the left knee, he did not diagnose chondromalacia following the physical exam conducted as part of the MEB proceedings on 23 November 1999.

Interestingly, the VASRD indicates that diagnostic code 5010 is for post-traumatic arthritis and is rated as limitation in motion, dislocation, or other specified instability under the affected joint. Chondromalacia is not expressly referenced as a condition that is rated under the VASRD.

h. Lastly, the applicant states that diagnostic code 5258 should have been applied by the PEB. VA diagnostic code 5258 is for cartilage, semilunar, dislocated, with frequent episodes of "locking," pain, and effusion into the joint. Upon physical exam conducted by Dr. [redacted] on 23 November 1999, the applicant demonstrated a smooth symmetrical gait. Dr. [redacted] noted no effusion of either knee. After performing Lachman's, Drawer, Adduction, Abduction, and Pivot Shift Stressing tests, the applicant was assessed to have bilaterally stable ligaments. The patellar tracked in the midline and mild tenderness to palpation about the lateral joint was noted on the left. Dr. [redacted] assessed mild patellofemoral symptoms and noted no abnormality to palpation at the patellar tendon or tibia tubercle bilaterally. The applicant demonstrated 5/5 strength upon testing of his toes, ankles, and knees. He reported that he had some pain in the left knee when he starts to stand up. Dr. [redacted] noted that the applicant "is doing well with the right knee." He added that the applicant admits that he does not have any episodes of locking. Because the applicant did not experience effusion or locking, and only experienced pain briefly and intermittently, diagnostic code 5258 does not apply to his condition.

i. In assessing the interests of justice, it should also be noted that, whereas only diagnostic code 5259 was applied to the right knee, both codes 5259 and 5261 were applied to the left knee. VA diagnostic code 5259 is for cartilage, semi lunar, removal of, symptomatic. VA diagnostic code 5261 is for limitations in the extension of the leg. Where extension is limited to 10 percent, the VASRD states that a rating of 10 percent is appropriate under diagnostic code 5261. Thus, it is clear that the PEB carefully assessed the slightly diminished range of motion in the applicant’s left knee upon extension, and distinguished it from the right knee condition when it included diagnostic code 5261. Moreover, VASRD, Subpart A, para 4.14 states, "The evaluation of the same disability under various diagnoses is to be avoided. Disability from injuries to the muscles, nerves, and joints of an extremity may overlap to a great extent, so that special rules are included in the appropriate bodily system for their evaluation." As discussed above, it is clear from a review of the record that the PEB correctly applied the diagnostic codes when considering the applicant’s disability case.

j. Based upon the above and without any additional evidence, the applicant’s request to correct his PEB ratings is found to be legally insufficient.

12. On 30 October 2023, the applicant was provided a copy of the USAPDA advisory opinion and given an opportunity to respond.

13. The applicant initially responded via email on 6 February 2024, which has been provided in full to the Board for review. In the email he provided his initial comments to the advisory opinion and stated he did not receive the advisory opinion until late January 2024, due to having moved his residence in September, and therefore requested additional time to respond.

14. The applicant was granted additional time and provided a lengthier rebuttal response on 21 March 2024, which shows:

a. In response to his request being legally insufficient, he provides the following in response. The statute governing military retirement for disability, Title 10 U.S. Code section 1201, is a money-mandating statute because when the requirements of the statute are met, i.e., when the Secretary determines that a service member is unfit for duty because of a physical disability and that disability is permanent and stable and not the result of the member's intentional misconduct or willful neglect, the member is entitled to compensation.

b. The following items, which he will discuss below, make his request legally sufficient:

(1) For bilateral knee disabilities, the VA combines the rating you receive for each knee and adds 10 percent when both limbs are affected. This alone would give him a combined disability of 30 percent.

(2) The major joint rule states that when a veteran has arthritis of the knees, the VA will perform the normal range of motion tests and determine a rating based on diagnostic codes 5260 or 5261. If the VA discovers the veteran has a normal range of motion, but experiences pain, the VA will then refer to diagnostic code 5003 for arthritis.

(3) Dr. [redacted] committed malpractice when he debrided the meniscus in his left knee when they agreed that he would repair and preserve the meniscus in is left knee. This resulted in an inability to fully straighten his left leg, decreased range of motion and flexion, a permanent physical profile, and an inability to perform his duties as an active-duty service member, premature separation from the service, and a medical discharge not leading to retirement.

(4) Failure to use all/correct diagnostic codes and their application during the PEB.

- the board did not use diagnostic code 5003 for osteoarthritis diagnosis/degenerative arthritis (see the MEB diagnosis 1 status post mild osteoarthritic changes left knee greater than right

- the board failed to follow Title 38 CFR and apply a 20 percent rating for arthritis in two major joints
- the board failed to apply diagnostic code 5257 for chondromalacia diagnosis
- the board failed to apply diagnostic code 5261 for right knee range of motion post-surgery, 0-122 degrees with the normal range of motion being 0-140 degrees
- the MEB failed to conduce a full physical to determine his total disability at discharge, to include sleep apnea testing
- in the time between his MEB exam on 23 November 1999 and the signing of his PEB on 26 January 2000, his medical situation worsened, and no re-examination took place

c. During active military service at age 28, he sustained life-long disabilities that affect his everyday life to this day. No, he didn't lose a limb or life, but he lost his ability to do things he loves, like running, walking for distance, cutting grass, household repairs, standing up playing catch with his son, and praying on his knees. These are all things he can't do because of disabilities and injuries he sustained defending his country. Did he mention the pain is unbearable most day. His career was cut short at the age of 28 due to his service-connected disabilities, for which the Army compensated him with $16,000.00 and a disability rating just low enough not to grant him a medical retirement. Moreover, he had to pay back the $16,000.00 over a 3-year period before he could receive disability benefits from the VA. In essence, he never received any compensation for disabilities at discharge, but through no fault of his own, his stellar military career was cut short, and he was not afforded a 20-year career.

d. At the time of his discharge through the MEB/PEB process, his condition was far worse that written in his medical file. He was depressed and didn't know how to handle the situation; however, his medical records say his mental status was fine. He had undiagnosed sleep apnea and a separated shoulder, as evidenced in his medical records, as well as slight hearing loss, yet none of this was included in the process of determining his total disability. What he did not have was a full medical exam at his discharge. Title 38 CFR states that the board can only find information on the current medical status of the individual and not future medical issues that they may have and a more thorough examination should be carried out. So, he asks, why were his knees the only ratable disabilities at the time?

e. COL [redacted] performed surgery on his right knee and was a member of his PEB. The PEB was correct in its use of diagnostic code 5259 for medical and lateral meniscus removal. Not mentioned in the PEB was the bony ridges that COL [redacted] also corrected during his surgery. He also referenced patellofemoral changes, which is a description and not a diagnosis. Patellofemoral pain syndrome is a diagnosis, and a symptom of the disease would be dull pain at the front of the knee passed on the pain syndrome. A vague statement such as this would leave a layman to perceive he just

had a mild condition and that the effect of the “patellofemoral changes” were just a thing. He believes this was done purposely.

f. Patellofemoral pain syndrome falls under VA diagnostic codes 5299-5261. COL [redacted] stated he did not have limitations in range of motion of his knee (diagnostic code 5261) and the patellofemoral pain syndrome (that he referred to as patellofemoral symptoms, a non-diagnosis in any medical document) is assessed at a minimum rating of 10 percent disabling. Further, the normal range of motion of a knee is 0-140 degrees and his range of motion for his right knee was 0-122 degrees, proving he had a loss in range of motion in both knees. Neither the MEB nor the PEB state this evidence and he was not compensated or rated for this. COL [redacted] diagnosed him with osteoarthritis but chose to state he had osteoarthritis changes on the MEB document, which is a description of the disease and not a diagnosis. Again, he focused on symptoms and not the actual disease or disability. Whether osteoarthritis or chondromalacia, diagnostic code 5257 or 5003 (degenerative arthritis) should have been used when calculating his disability rating.

g. He also believes COL [redacted] wrongly opined about the “osteophytes” he found during surgery, with are another symptom of the highest stages of osteoarthritis. He negligently described his conditions as mild or moderate when they were much worse. He had this at the age of 28. This condition was service-connected, debilitating, life lasting, and improperly treated and diagnosed. He was never given steroids as a treatment method or pain medication to manage the disease. Outside of post-operative physical therapy, there was no treatment plan. Dr. [redacted] referred to his knees as those of a 69-year-old and stated he would need a knee replacement in the future. This is also evidenced in his commander’s memorandum to the PEB. Since both his knees were affected and diseased, he should have received an additional 10 percent disability rating.

h. Chondromalacia is the softening, and erosion of cartilage under the knee cap. He was diagnosed with, grade II III (right knee), and grade III IV (left knee). Again, this disease is life long, degenerative in nature as is osteoarthritis, which are the effects of cartilage removal, and constant pain. The surgeon(s) knew he had arthritis in both knees and so did the board. They never used the term arthritis at the PEB. Why? because arthritis in both knees is a 20 percent disabling rating alone. Combined with other meniscus injuries, pain, and reduced range of motion/flexion, the PEB would have been forced to apply a disability rating of 30 percent or greater with these combined service-connected disabilities. He believes the board was fully aware of their word use, and descriptive nature of symptoms versus condition. A layman does not know what chondromalacia changes are, but if an actual diagnosis was used, they would be prompted to ask what the disease entails if they did not know what the disease is. The diagnostic code used for chondromalacia is 5257 and it was not used in the PEB proceedings.

i. This failure to fully disclose his diagnosis was deceitful, and below board. The board failed to provide the fiduciary duties of their position. Since this board had a legal and ethical decision to make, why was the surgeon who performed one of his two surgeries and assisted in the other a member of his medical board? COL or not, any mistakes made during surgery, mistaken post operative treatments and opinions, and evidentiary would not be uncovered during the proceedings because he would have been held liable. This is like having a wronged judge rule on a case involving a person who wronged them. This is not an attack on COL [redacted]'s integrity, but it is an indictment of the process and the results. COL [redacted] should not have been a member of the board, and his and CPT [redacted]'s opinions and actions should have been reviewed by a third-party doctor unrelated to his medical treatment. The second surgery, conducted on my left knee by CPT [redacted], left him unable to straighten his leg out completely, and subsequently he went through the MEB process as he could no longer perform his military duties. COL [redacted] also assisted in this surgery. Again, how can he, with good conscience, determine his level of disability when he was involved in the botched surgery that left him unable to effectively continue his military career?

j. COL [redacted]'s notes/statements post-surgery are as follows: Preoperative physical examination revealed a full range of motion of the left knee pain in both the medial and lateral joint lines with McMurray testing, negative Lachman, negative posterior drawer, and no varus or valgus instability. Preoperative radiographs showed mild to moderate degenerative changes in the patellofemoral medial compartment and lateral compartments of the left knee. Description of Procedure: an examination under anesthesia was carried out, which revealed range of motion from -5 to 130 degrees. CPT [redacted] stated he had full range of motion in my preoperative testing which would indicate that he possessed range of motions of 0-140 degrees. Post Surgery and at the time of his discharge, his range of motion declined to -5 to 130 degrees. His military career was ended due to malpractice.

k. Preoperative MRI shows: the patient is indicated, and given consent, for diagnostic left knee arthroscopy with repair versus debridement as indicated. A 4.2-mm gator shaver was introduced. Inflamed synovial tissue was also debrided from the medial compartment. Inflamed synovial fluid synovial tissue was also debrided from the intercondylar notch, as was hypertrophic ligamentum mucosm. He did not recover fully from this surgery. CPT [redacted] performed the surgery in a manner inconsistent with what he agreed to. Because it is ideal to keep and preserve the entire meniscus, a meniscus tear repair was discussed, agreed upon, and preferred by him. Dr. (CPT) [redacted] took upon himself to stray from his surgery plan which resulted in his knee flexion and extension being compromised, which led to his early departure active-duty military service. This is textbook malpractice (improper, illegal, or negligent professional activity or treatment, especially by a medical practitioner, lawyer, or public official). Further, CPT [redacted] made the following findings: grade IV chondral defect, trochlear groove, mild degenerative changes, medial compartment, Intact anterior cruciate ligament,

moderate degenerative changes, lateral compartment, with grade 3 chondral changes of the lateral femoral condyle and lateral tibial plateau. Damage to the cartilage on the end of the bone is known as arthritis. This could also be described as chondromalacia, which is basically a kind term for arthritis. Any damage to the cartilage is the body in effect is arthritis. Note he was awake for both procedures.

l. During his second surgery, which was performed by Dr. (CPT) [redacted], he was told after the surgery that the camera did not work and that they were unable to provide evidence of the surgery. During the surgery, CPT [redacted] said, "Wow, I almost clipped his ACL." Before this surgery, he was told they were not going to perform a debridement and repair his cartilage. Repairing the cartilage would have preserved more of it, which he believes would have led to a full recovery. By all definitions of the word, this was malpractice. His left knee was diagnosed with osteoarthritis, semilunar cartilage removal of, symptomatic. They removed two large chunks of the cartilage that were floating in the joint. Diagnostic codes 5003, 5261, and 5257 for recurrent subluxation should have all been applied when rating his left knee. Whether the board applied the codes separately or combined, his left knee alone should have met the criteria for medical retirement based on his disability at that time. The board negligently decided not to use all diagnostic codes available and suitable for his disabilities which ended his career in the Army.

m. At the time of his MEB, there were multiple locations that heard MEBs and it was known that boards out of Fort Lewis, WA, had "different" results than others, meaning it was hard to get a reasonable rating from their MEB's. His board went through Fort Sam Houston, TX, and he believes he has proved that many mistakes were made in the process sand that he is entitled to an upgrade to medically retired and receive the benefits of a retired veteran, to include back pay, a permanent identification card, and retirement benefits until he leaves this earth. When these unfortunate errors were made, he lost the opportunity to retire as a proud Army veteran. He wants the records to reflect he gave his all to his country and although we cannot hold those accountable who purposefully created this injustice, this Board can make him whole. He prays this situation is given the respect it deserves, and that justice prevails.

15. 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.

16. MEDICAL REVIEW:

a. The Army Review Boards Agency (ARBA) Medical Advisor was asked to review this case. Documentation reviewed included the applicant's ABCMR application and accompanying documentation, the military electronic medical record (AHLTA), the VA electronic medical record (JLV), the electronic Physical Evaluation Board (ePEB), the Medical Electronic Data Care History and Readiness Tracking (MEDCHART) application, and the Interactive Personnel Electronic Records Management System (iPERMS). The ARBA Medical Advisor made the following findings and recommendations:

b. The applicant is applying to the ABCMR requesting an increase in his military disability rating with a subsequent change in his disability discharge disposition from separated with severance pay to permanent retirement for physical disability. He states:

> "The medical review board failed to use several diagnostic codes when calculating my disability rating. The medical Review board did not apply diagnostic code 5003. COL [redacted] documented that I had Osteoarthritis in both knees with the left being worse than the right.
>
> A 10% disability rating, for osteoarthritis, should have been granted, but was not. Diagnostic code 5010 which is used when chondromalacia is present in the knees, was not used in evaluating my disability rating even though I was diagnosed with grade II-III chondromalacia in my right knee, and grade III-IV chondromalacia in my left knee.
>
> Diagnostic code 5258 should have been used by the board in determining my disability rating at discharge as COL [redacted] documented that I had an inability to extend my left knee fully, had stiffness, crepitus, "giving way," and swelling at the time of my MEB physical. This warrants a minimum of 20% disability rating for my left knee alone. I had tears in both my left and right meniscus along with osteophytes."

c. The Record of Proceedings details the applicant's military service and the circumstances of the case. The applicant's DD 214 for the period of service under consideration shows he entered the regular Army on 28 December 1993 and was separated with $22,384.80 of disability severance pay on 26 June 1999 under provisions in paragraph 4-24b(3) of AR 635-40, Physical Evaluation for Retention, Retirement, or Separation (1 September 1990).

d. On 26 January 2000, the applicant's informal PEB determined he had two unfitting conditions for continued military service: "Right knee injury 1994 and reinjured in 1997,

status post medial and lateral meniscectomy (Apr 98) with findings of grade II-III chondromalacia on arthroscopic examination;" and "Left knee pain status post arthroscopy (Jun 99) with debridement of the lateral meniscus with findings of grade III-IV chondromalacia.

e. The VA Schedule for Rating Disabilities (VASRD) (38 Code of Federal Regulations Book C) is the document used to rate unfitting military disabilities. Paragraph B-1a and B1b of Appendix B to AR 635-40, Physical Evaluation for Retention, Retirement, or Separation (1 September 1990):

> a) Congress established the VASRD as the standard under which percentage rating decisions are to be made for disabled military personnel. Such decisions are to be made according to Title IV of the Career Compensation Act of 1949 (Title IV is now mainly codified in chap 61 of Title 10, United States Code).
>
> b) Percentage ratings in the VASRD represent the average loss in earning capacity resulting from these diseases and injuries. The ratings also represent the residual effects of these health impairments on civil occupations.

f. Using the VA Schedule for Rating Disabilities (VASRD) diagnostic code (DC) 5259 - Cartilage, semilunar [meniscus], removal of, symptomatic - they rated both conditions at 10% for a combined rating of 20% and recommended that he be separated with severance pay.

g. The criteria the VA used for his ratings:

> Right knee: "Stable joint, 0 - 122 degrees range of motion. Rated for semilunar cartilage, removal of, symptomatic."
>
> Left knee: "Stable knee Joint with mild limitation in range of motion, 10 - 112 degrees. Rated for semilunar cartilage, removal of, symptomatic.

h. These are documented in the applicant Medical Evaluation Board narrative summary.

i. The applicant states a 10% rating using DC 5003 – Arthritis, degenerative – should also have been awarded. However, his is not allowed.

j. Within the VASRD, §4.14 of Part 4 of Title 38 states that when symptoms overlap and could be considered under multiple codes, "the evaluation of the same disability under various diagnoses is to be avoided ... and … the evaluation of the same manifestation under different diagnoses are to be avoided." This is known as

"pyramiding," where a Veteran would receive multiple ratings for the same symptoms, e.g. breathing treatment for asthma and obstructive sleep apnea; and concentration problems in a Veteran who has both a mild traumatic brain injury and PTSD. In this case, it would be multiple ratings for a symptomatic knee joint.

k. When presented with a situation where a Veteran's symptoms may be rated under two different VASRD codes, §4.7 - Higher of two evaluations – is brought into play:

> "Where there is a question as to which of two evaluations shall be applied, the higher evaluation will be assigned if the disability picture more nearly approximates the criteria required for that rating. Otherwise, the lower rating will be assigned."

l. The applicant would have received the same 10% if the PEB used DC 5003 instead of DC 5259:

> With X-ray evidence of involvement of 2 or more major joints or 2 or more minor joint groups, with occasional incapacitating exacerbations..... 20
>
> With X-ray evidence of involvement of 2 or more major joints or 2 or more minor joint groups..... 10
>
> Note (1): The 20 pct and 10 pct ratings based on X-ray findings, above, will not be combined with ratings based on limitation of motion.

m. There is no evidence in the MEB narrative summary or other documentation the then 28-year-old Soldier suffered from "occasional incapacitating exacerbations" due to osteoarthritis, thus the 10% rating would have been applied had DC 5003 been used instead of DC 5259.

n. The applicant states DC 5010 - Arthritis, due to trauma, substantiated by X-ray findings - should also have been used, but this would have resulted in the same 10% as the VASRD directs that rater to "Rate as arthritis, general:" There is no separate rating criteria for DC 5010.

o. The applicant states that DC 5258 should also have been applied:

> "Cartilage, semilunar, dislocated, with frequent episodes of "locking," pain, and effusion into the joint..... 20

p. While the record noted he had an effusion (fluid in a joint) and pain, there is no evidence the was experiencing third required criterion - "frequent episodes of locking."

The MEB narrative summary states: “He admits that he does not have any episodes of locking.”

q. Lastly, the applicant notes his “inability to extend my left knee fully.” The record stated his left knee range of motion was 10 – 112 degrees. Range of motion ratings are separate and are added to conditions/diseases affecting the joint. Had the PEB included the rating for the decrease of his left knee extension using DC 5261 - Leg, limitation of extension of -, the rating would have added 10% to his combined military disability rating:

Leg, limitation of extension of:

Extension limited to 45° 50
Extension limited to 30° 40
Extension limited to 20° 30
Extension limited to 15° 20
Extension limited to 10° 10
Extension limited to 5° 0

r. Thus, the applicant’s final military disability rating should have been 30% (10% combined with 10% = 19% + 1.9% (bilateral factor = 10% of 19%) = 20.9% which rounds to 21% combined with 10% = 29% which rounds to 30%)

s. It is the opinion of the ARBA Medical Advisor the applicant should have been permanently retired for physical disability effective 4 March 2000.

BOARD DISCUSSION:

1. After reviewing the application, all supporting documents, and the evidence found within the military record, the Board found that relief was warranted. The Board carefully considered the applicant's record of service, documents submitted in support of the petition and executed a comprehensive and standard review based on law, policy and regulation. Upon review of the applicant’s petition, available military records and medical review, the Board concurred with the advising official finding the applicant should have been permanently retired for physical disability with an effective date of 4 March 2000. The Board determined there is sufficient evidence to support the applicant’s contentions for his records to show physical disability retirement in lieu of physical disability separation wit severance pay through the inclusion of multiple additional Department of Veterans Affairs (VA) diagnostic codes to identify and rate his conditions.

2. The Board noted the advising opine identifying the applicant's final military disability rating should have been 30% (10% combined with 10% = 19% + 1.9% (bilateral factor = 10% of 19%) = 20.9% which rounds to 21% combined with 10% = 29% which rounds to 30%). Based on the preponderance of evidence and opine, the Board determined the applicant's orders #046-0005, dated 15 February 2000 should be amended to reflect a disability rating of 30 % and his DD Form 214 be amended to show his narrative reason as medical retirement, to include amending his separation code and separation authority that coincides with the narrative reason. Therefore, the Board granted relief.

BOARD VOTE:

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

BOARD DETERMINATION/RECOMMENDATION:

The Board determined the evidence presented is sufficient to warrant a recommendation for relief. As a result, the Board recommends that all Department of the Army records of the individual concerned be corrected by

- amending the applicant's orders #046-0005, dated 15 February 2000 to reflect a disability rating of 30 %

- amend his DD Form 214 for the period ending 4 March 2000 to show in
  - item 25 (Separation Authority) which coincides
  - item 26 (Separation Code) JFW
  - item 28 (Narrative Reason for Separation) Medical Retirement

5/6/2024

X [redacted]

CHAIRPERSON

[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, section 1552(b), provides that applications for correction of military records must be filed within 3 years after discovery of the alleged error or injustice. This provision of law also allows the ABCMR to excuse an applicant's failure to timely file within the 3-year statute of limitations if the ABCMR determines it would be in the interest of justice to do so.

2. 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.

3.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.

4. Army Regulation 40-501 provides information on medical fitness standards for induction, enlistment, appointment, retention, and related policies and procedures. Chapter 3 lists the various medical conditions and physical defects which may render a Soldier unfit for further military service and which fall below the standards required for the individuals listed in this chapter. Paragraph 3-14 (Miscellaneous conditions of the extremities) provides the miscellaneous causes for referral to an MEB. Paragraph 3-14b specifies arthritis due to trauma, when surgical treatment fails or is contraindicated and there is functional impairment of the involved joints so as to preclude the satisfactory performance of duty.

5. 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.

6. Title 38, U.S. Code, Part 4, provides the complete Schedule for Rating Disabilities and subpart B provides the Disability Ratings. It states the use of diagnostic code number appearing opposite the listed ratable disabilities are numbers used for the purpose of showing the basis of the evaluation assigned and for statistical analysis in the VA and extend from 5000 to a possible 9999. The Schedule of Ratings – Musculoskeletal system include the following diagnostic codes:

a. 5003 Degenerative arthritis, other than post-traumatic: Degenerative arthritis established by X-ray findings will be rated on the basis of limitation of motion under the appropriate diagnostic codes for the specific joint or joints involved (DC 5200 etc.). When however, the limitation of motion of the specific joint or joints involved is non-compensable under the appropriate diagnostic codes, a rating of 10 pct 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. In the absence of limitation of motion, rate as below:

(1) With X-ray evidence of involvement of 2 or more major joints or 2 or more minor joint groups, with occasional incapacitating exacerbations, 20 percent

(2) With X-ray evidence of involvement of 2 or more major joints or 2 or more minor joint groups, 10 percent

b. 5010 post-traumatic arthritis: rate as limitation of motion, dislocation, or other specified instability under the affected joint. If there are two or more joints affected each rating shall be combined in accordance with section 4.25.

c. 5258 Cartilage, semilunar, dislocated, with frequent episodes of “locking,” pain, and effusion into the joint, 20 percent.

d 5257 Knee, other impairment of:

(1) Recurrent subluxation or instability:

a. Unrepaired or failed repair of complete ligament tear causing persistent instability, and a medical provider prescribes both an assistive device (*e.g.,* cane(s), crutch(es), walker) and bracing for ambulation, 30 percent

b. One of the following: (a) Sprain, incomplete ligament tear, or repaired complete ligament tear causing persistent instability, and a medical provider prescribes a brace and/or assistive device (*e.g.,* cane(s), crutch(es), walker) for ambulation. (b) Unrepaired or failed repair of complete ligament tear causing persistent instability, and a medical provider prescribes either an assistive device (*e.g.,* cane(s), crutch(es), walker) or bracing for ambulation, 20 percent

c. Sprain, incomplete ligament tear, or complete ligament tear (repaired, unrepaired, or failed repair) causing persistent instability, without a prescription from a medical provider for an assistive device (*e.g.,* cane(s), crutch(es), walker) or bracing for ambulation, 10 percent

(2) Patellar instability:

a. A diagnosed condition involving the patellofemoral complex with recurrent instability after surgical repair that requires a prescription by a medical provider for a brace and either a cane or a walker, 30 percent

b. A diagnosed condition involving the patellofemoral complex with recurrent instability after surgical repair that requires a prescription by a medical provider for one of the following: A brace, cane, or walker, 20 percent

c. A diagnosed condition involving the patellofemoral complex with recurrent instability (with or without history of surgical repair) that does not require a prescription from a medical provider for a brace, cane, or walker, 10 percent

d. Note (1): For patellar instability, the patellofemoral complex consists of the quadriceps tendon, the patella, and the patellar tendon.

e. Note (2): A surgical procedure that does not involve repair of one or more patellofemoral components that contribute to the underlying instability shall not qualify as surgical repair for patellar instability (including, but not limited to, arthroscopy to remove loose bodies and joint aspiration).

d.5259 Cartilage, semilunar, removal of, symptomatic, 10 percent

e. 5261 Leg, limitation of extension of:

(1) Extension limited to 45 degrees, 50 percent

(2) Extension limited to 30degrees, 40 percent

(3) Extension limited to 20 degrees, 30 percent

(4) Extension limited to 15 degrees, 20 percent

(5) Extension limited to 10 degrees, 10 percent

(6) Extension limited to 5 degrees, 0 percent

f. Section 4.25 (Combined ratings table) states Table I, Combined Ratings Table, results from the consideration of the efficiency of the individual as affected first by the most disabling condition, then by the less disabling condition, then by other less disabling conditions, if any, in the order of severity. Thus, a person having a 60 percent disability is considered 40 percent efficient. Proceeding from this 40 percent efficiency, the effect of a further 30 percent disability is to leave only 70 percent of the efficiency remaining after consideration of the first disability, or 28 percent efficiency altogether.

The individual is thus 72 percent disabled, as shown in table I opposite 60 percent and under 30 percent.

7. 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.

8. 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.

9. 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//