RECORD OF PROCEEDINGS
PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXX CASE: PD-2022-00072
BRANCH OF SERVICE: ARMY SEPARATION DATE: 20060317

SUMMARY OF CASE: Data extracted from the available evidence of record reflects this covered individual (CI) was an active duty E4, Food Service Specialist, medically separated from the Temporary Disability Retired List (TDRL) for "asthma," "chronic right knee pain," and "chronic right shoulder pain," rated 10%, 0%, and 0%, respectively, with a combined disability rating of 10%.

CI CONTENTION: Should have been medically retired. The complete submission is at Exhibit A.

SCOPE OF REVIEW: The panel's scope of review is defined in DoDI 6040.44. It is limited to review of disability ratings assigned to those conditions determined by the Physical Evaluation Board (PEB) to be unfitting for continued military service, and when specifically requested by the CI, those conditions identified by the Medical Evaluation Board (MEB), but determined by the PEB to be not unfitting or non-compensable. Any conditions outside the panel's defined scope of review, and any contention not requested in this application, may remain eligible for future consideration by the Board for Correction of Military Records. The panel's authority is limited to assessing the fairness and accuracy of PEB rating determinations and recommending corrections when appropriate. The panel gives consideration to VA evidence, particularly within 12 months of separation, but only to the extent that it reasonably reflects the severity of disability at the time of separation.

RATING COMPARISON:

SERVICE PEB – 20060301			VARD – 20050916			
Condition	**Code**	**Rating**	**Condition**	**Code**	**Rating**	**Exam**
Asthma	6602	10%	Asthmatic Bronchitis	6602	10%	20050829
Chronic Right Knee Pain	5003	0%	Degenerative Joint, Right Knee	5260	10%	20050829
Chronic Right Shoulder Pain	5099-5003	0%	Residuals of Right Shoulder Injury	5201	10%	20050829
COMBINED RATING: 10%			**COMBINED RATING OF ALL VA CONDITIONS: 50%**			

ANALYSIS SUMMARY:

Asthma. According to the service treatment record (STR) and MEB narrative summary (NARSUM), the CI began to experience chronic shortness of breath (SOB) and chest tightness with exertion in February 2004. A pulmonary function test (PFT) performed on 9 February 2004 was consistent with mild airway obstruction, and he was diagnosed with probable asthma and started on an albuterol metered dose inhaler (inhaled bronchodilator) as needed. He continued to experience SOB and chest tightness in his work environment and with running. Subsequently, a positive methacholine challenge test confirmed the asthma diagnosis, and an Advair™ inhaler (inhaled bronchodilator/anti-inflammatory combination) was added to his regimen. An evaluation by an allergist found multiple environmental and food allergies and the CI was assessed to have allergic asthma. He was separated and placed on the TDRL on 15 February 2005.

At the 29 August 2005 VA Compensation and Pension (C&P) examination, 7 months before separation, the CI reported continued SOB with any exertion. The VA examiner noted that a PFT in service showed a forced expiratory volume in one second (FEV-1) of 79% predicted, which was "identical to his pulmonary function test on presentation to the pulmonary clinic in February 2004." The CI's inhaled medications included Combivent™ (bronchodilator combination), albuterol, and Advair™.

During the 25 November 2005 MEB TDRL re-evaluation examination, 4 months prior to separation, the CI reported persistent asthma. A PFT showed FEV-1 of 84% predicted and FEV-1/forced vital capacity (FVC) of 99% predicted at baseline and FEV-1 of 94% predicted and FEV-1/FVC of 102% predicted after bronchodilator, with a significant positive response to bronchodilator treatment. He was prescribed Advair™ 250 mg twice daily and an albuterol inhaler. There was no evidence in the STR that asthma exacerbations were frequent enough to require monthly visits to a physician.

The panel directed attention to its rating recommendation based on the above evidence. The PEB removed the CI from TDRL with a permanent disability disposition of separation with severance pay at 10%, citing an "FEV-1 of 94% after treatment, requiring intermittent bronchodilator." The VA rated the asthmatic bronchitis 10%, coded 6602, citing "FEV-1 of 71 to 80 percent predicted, or FEV-1/FVC of 71 to 80 percent or intermittent inhalational or oral bronchodilator therapy." Panel members noted that the C&P and TDRL reevaluation examiners reported a prescription of inhaled anti-inflammatories. Additionally, the TDRL re-evaluation documented daily use of inhaled medications. Thus, the panel agreed that the VASRD §4.97 threshold for a 30% rating was reasonably satisfied in this case based on daily bronchodilator and/or inhalational anti-inflammatory medication use. A 60% rating was not justified in the absence of at least monthly visits to a physician for required care of exacerbations, or intermittent (at least three per year) courses of systemic corticosteroids. After due deliberation, considering all the evidence and mindful of VASRD §4.3 (reasonable doubt), the panel recommends a disability rating of 30% coded 6602 for the asthma at the time of TDRL removal.

Right Knee. According to the STR and MEB NARSUM, the CI suffered a twisting injury to his right knee while running in January 2004 and underwent a medial meniscal debridement in July 2004. Following surgery, clicking, popping and mechanical symptoms improved as did his medial joint line pain, and he participated in post-operative physical therapy.

At the VA C&P examination, the CI reported worsening knee pain rated at 5/10. The examiner recorded right knee range of motion (ROM) from 0- 120 degrees (normal 140) and painful ROM. The examiner documented tenderness all around the knee, with a small amount of fluid, and slight crepitus with flexion, but no laxity or instability. There was no additional loss of motion with repetition and no additional limitation during flare-ups.

During the MEB TDRL reevaluation examination, the CI reported recurrent pain despite some post-surgical improvement. After attempts at physical activity, he experienced increased pain and swelling. Physical findings showed mild diffuse tenderness throughout the anterior aspect of the knee, and ROM from 0-140 degrees without crepitus. The knee was stable in all planes and meniscal pathology testing was negative. Knee X-rays showed mild degenerative changes.

The panel directed attention to its rating recommendation based on the above evidence. The PEB rated the right knee condition 0% coded 5003 (degenerative arthritis) citing normal ROM, and X-rays that revealed early degenerative joint disease. The VA rated the right knee condition 10%, coded 5260 (leg, limitation of flexion), citing painful motion. Panel members agreed that there while there was no compensable limitation of flexion or extension (5260 or 5261), a 10% rating was supported for VA evidence of symptoms of status post meniscal

surgery coded as 5259 (cartilage, semilunar, removal of) or, alternatively, for painful motion with functional loss (based on §4.59, §4.40 and §4.45), coded 5299-5260 (analogous to limitation of flexion). There was no fracture, nonunion or malunion of the femur or tibia to support consideration under the respective codes for knee impairment related to long bone conditions (5255, 5262); and no history or evidence of dislocated meniscus or loose body causing frequent locking with recurrent effusions (5258) following the knee arthroscopy for a higher rating under this code. After due deliberation, considering all the evidence and mindful of VASRD §4.3 (reasonable doubt), the panel recommends a disability rating of 10%, coded 5259, for the right knee condition at the time of TDRL removal.

Right Shoulder. According to the STR and MEB NARSUM, the CI's right shoulder condition began in December of 2003 when he notice progressively worsening pain after doing some heavy lifting. The shoulder pain continued, primarily with overhead activities, but he denied instability or dislocations. Shoulder X-rays in April 2004 were normal, but an orthopedic assessment noted osteolysis of the distal clavicle. Physical therapy, activity modification and medications did not resolve the condition, and while a steroid injection provided complete relief, it only lasted a few days. The CI was offered surgery for a distal clavicle resection, but declined.

At the VA C&P examination, the CI reported pain rated at 6/10 and aggravated by overhead activity, lifting more than 10 pounds, or laying on his shoulder. On examination, right shoulder flexion was to 120 degrees (normal 180) and abduction to 110 degrees (normal 180), both with painful motion. There was no additional loss of motion with repetition. The examiner noted tenderness in the bicipital groove and about the acromioclavicular (AC) joint.

During the MEB TDRL reevaluation examination, the CI reported pain mainly about the AC joint, which was worsened by activity and overhead use. Physical findings revealed forward flexion to 180 degrees and abduction to 160 degrees, with tenderness directly over the AC joint. Testing for AC joint pathology was positive but tests for impingement, bicipital tendonitis, and instability were negative. Shoulder X-rays were normal.

The panel directed attention to its rating recommendation based on the above evidence. The PEB rated the right shoulder condition 0%, analogously coded 5099-5003 (degenerative arthritis) citing "normal ROM, not requiring daily narcotics." The VA rated the right shoulder condition 10%, coded 5201 (arm, limitation of motion), citing painful and limited motion. The VASRD §4.71a threshold for rating for ROM impairment is "at shoulder level" (approximately 90 degrees from the side), and the examinations in evidence demonstrated motion above this level. However, panel members agreed a 10% rating was justified for degenerative arthritis of the AC joint with painful motion, analogously coded 5099-5003. There was no humerus malunion or recurrent dislocation and no clavicle/scapula dislocation or nonunion of the to justify higher ratings under those respective codes (5202 or 5203). After due deliberation, considering all the evidence and mindful of VASRD §4.3 (reasonable doubt), the panel recommends a disability rating of 10%, coded 5099-5003, for the right shoulder condition at the time of TDRL removal.

BOARD FINDINGS: In the matter of the asthma, the panel recommends a disability rating of 30%, coded 6602 IAW VASRD §4.97. In the matter of the right knee condition, the panel recommends a disability rating of 10%, coded 5259 IAW VASRD §4.71a. In the matter of the right shoulder condition, the panel recommends a disability rating of 10%, coded 5099-5003 IAW VASRD §4.71a. There are no other conditions within the panel's scope of review for consideration.

The panel recommends the CI's prior determination be modified as follows; and, that the discharge with severance pay be re-characterized to reflect permanent disability retirement, effective the date of medical separation:

CONDITION	VASRD CODE	PERMANENT RATING
Asthma	6602	30%
Chronic Right Knee Pain	5259	10%
Chronic Right Shoulder Pain	5099-5003	10%
	COMBINED	**40%**

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20220729, w/atchs
Exhibit B. Service Treatment Record
Exhibit C. Department of Veterans Affairs Record

AR20230008662, XXXXXXXXXX

XXXXXXXXXXX

Dear XXXXXXXXXX:

I accept the recommendation of the Department of Defense Physical Disability Board of Review (DoD PDBR) to re-characterize your separation as a permanent disability retirement with the combined disability rating of 40% effective the date of your medical separation for disability with severance pay. Enclosed is a copy of the Board's recommendation and record of proceedings for your information.

The re-characterization of your separation as a disability retirement will result in an adjustment to your pay providing retirement pay from the date of your original medical separation minus the amount of severance pay you were previously paid at separation.

The accepted DoD PDBR recommendation has been forwarded to the Army Physical Disability Agency for required correction of records and then to the U.S. Defense Finance and Accounting Service to make the necessary adjustment to your pay and allowances. These agencies will provide you with official notification by mail as soon as the directed corrections have been made and will provide information on your retirement benefits. Due to the large number of cases in process, please be advised that it may be several months before you receive notification that the corrections are completed and pay adjusted. Inquiry concerning your correction of records should be addressed to the U.S. Army Physical Disability Agency, 1835 Army Boulevard, Building 2000, JBSA, Fort Sam Houston, TX 78234.

A copy of this decision has also been provided to the Department of Veterans Affairs and to the counsel you listed on your application.