RECORD OF PROCEEDINGS
PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXX
BRANCH OF SERVICE: ARMY

CASE: PD-2022-00075
SEPARATION DATE: 20050102

SUMMARY OF CASE: Data extracted from the available evidence of record reflects this covered individual (CI) was an active duty E4, Infantryman, medically separated for "chronic low back pain [LBP]" and "stress related pelvic girdle enthesopathies, knee pain, ankle and foot pain," rated 10% and 0%, respectively, with a combined disability rating of 10%.

CI CONTENTION: "I am service connected through the VA for more conditions that should have been included during my Med Board." 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 PEB to be unfitting for continued military service, and when specifically requested by the CI, those conditions identified by the 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 - 20040927			VARD – 20050805			
Condition	**Code**	**Rating**	**Condition**	**Code**	**Rating**	**Exam**
Chronic LBP	5237	10%	Degenerative Disc Disease, Lumbar Spine	5242	20%	20050615
Stress Related Pelvic Girdle Enthesopathies, Knee Pain, Ankle, and Foot Pain	5099-5003	0%	Right Knee Retropatellar Pain Syndrome	5260	10%	20050615
			Left Knee Retropatellar Pain Syndrome	5260	10%	20050615
			Left Foot Plantar Fasciitis, and Degenerative Arthritis of Great Toe	5024-5284	10%	20050615
			Right Foot Plantar Fasciitis	5024-5284	0%	20050615
Cognitive Disorder, Not Otherwise Specified	Not Unfitting		PTSD with Cognitive Disorder	9411	50%	20050615
Bilateral Occipital Neuralgia	Not Unfitting		Residuals of Closed Head Injury with Posttraumatic Cephalgia	8100	0%	20050615
Migraine Headaches, Post Traumatic	Not Unfitting					
Bilateral Hearing Loss	Not Unfitting		Hearing Loss, Bilateral	6100	0%	20050615
COMBINED RATING: 10%			**COMBINED RATING OF ALL VA CONDITIONS: 80%**			

ANALYSIS SUMMARY:

LBP. According to the service treatment record (STR) and MEB narrative summary (NARSUM), the CI's back condition began in September 2001 after falling out of a truck. Lumbar spine X-rays in February 2003 were normal, but a lumbar MRI in April 2003 showed degenerative disc disease (DDD) at L5-S1 and central disc protrusion with probable compromise of the S1 nerve

roots. Repeat lumbar spine X-rays in September 2003 were normal. There were no surgical options and physical therapy (PT) and epidural injections had not resolved the back pain.

During the 20 November 2003 MEB examination (recorded on DD Forms 2807-1 and 2808), 13 months prior to separation, the CI reported back pain, and the physical examination indicated an abnormal spine. A repeat lumbar spine MRI in June 2004 showed persistent DDD with resolution of the disc protrusion. Thoracolumbar (TL) range of motion (ROM) measurements, performed by PT in May 2004, showed flexion of 40 degrees (normal 90) and combined ROM of 105 degrees (normal 240). All planes of motion were painful after three repetitions. The 8 September 2004 MEB NARSUM examination, 4 months before separation, noted complaints of LBP radiating to the lower extremities (LEs). The CI reported morning stiffness and pain exacerbated by prolonged sitting, standing, bending and lifting. Electrodiagnostic studies were attempted, but the CI could not tolerate the procedure. Physical findings showed normal gait and tenderness.

At the 15 June 2005 VA Compensation and Pension (C&P) examination, 5 months after separation, the CI reported daily LBP. Physical examination showed an antalgic gait, but the CI did not use any assistive device for ambulation. The spine was normal in appearance without muscle spasm. Measured TL ROM showed flexion of 55 degrees, but the CI stopped due to fear of aggravation; extension was declined. Left and right lateral flexion were each to 20 degrees (normal 30), and left and right rotation were each to 30 degrees (normal), with pain. No repetitive motion was performed due to the CI's fear of exacerbating his back condition.

The panel directed attention to its rating recommendation based on the above evidence. The PEB rated the back condition 10%, coded 5237 (lumbar spine strain), citing flexion limited to 40 degrees by pain. The VA rated the back condition 20%, coded 5242 (degenerative arthritis of the spine), based on the C&P examination, citing forward flexion greater than 30 degrees but not greater than 60 degrees. Panel members agreed that a 20% rating, but no higher, was justified for limitation of flexion (greater than 30 degrees but not greater than 60 degrees) as reported on the MEB NARSUM and VA examinations. The panel also agreed that code 5242 provided a more accurate diagnostic description of the back condition. There was no evidence of intervertebral disc syndrome which resulted in incapacitating episodes requiring physician-prescribed bed rest to warrant consideration of rating under that alternate VASRD formula. After due deliberation, considering all the evidence and mindful of VASRD §4.3 (reasonable doubt), the panel recommends a disability rating of 20% for the back condition, coded 5242.

<u>Stress Related Pelvic Girdle Enthesopathies, Knee Pain, Ankle, and Foot Pain</u>. The PEB combined the MEB referred conditions of pelvic girdle enthesopathies, bilateral greater trochanteric (GT) and ischial bursitis (from here forward referred to as "hip pain"), bilateral patellofemoral syndrome (PFS), bilateral medial tibial stress syndrome (MTSS), bilateral plantar fasciitis (PF), bilateral pes cavus, and left 1st metatarsophalangeal (MTP) joint degenerative joint disease (DJD) as a single condition, coded 5099-5003, and characterized as "stress related pelvic girdle enthesopathies, knee pain, ankle, and foot pain," with apparent application of the US Army Physical Disability Agency pain policy and AR 635-40 B24.f. This approach by the PEB not uncommonly reflected its judgment that the constellation of conditions was unfitting, and there was no need for separate fitness adjudications. The panel's initial charge in this case was therefore directed at determining if combining conditions under a single rating was justified in lieu of separate ratings. When considering a separate rating for each condition, the panel considers each bundled condition to be reasonably justified as separately unfitting unless a preponderance of evidence indicates the condition would not cause the member to be referred into the disability evaluation system (DES) or be found unfit because of physical disability.

The panel majority noted that the CI was only referred to the PEB for back pain, which was also the only condition implicated by the commander. Only after a MEB was required did the CI

undergo evaluations by physical medicine, podiatry and orthopedics. He had never previously complained of hip, knee, ankle or foot issues, nor were these conditions identified in any prior STR examination. At a 24 November 2003 physical medicine visit, the specialist diagnosed multiple pelvic girdle enthesopathies and tendinopathies that failed retention standards, but did not implicate bilateral hip, knee, ankle or foot conditions as not meeting retention standards. The podiatry consult on 17 December 2003 diagnosed symptomatic pes cavus that failed retention standards. The orthopedic consult on 24 December 2003, indicated no objective findings of the knees and ankles, but noted mild bilateral PF, which failed retention standards "as substantiated by his commander." In September 2004, the MEB physician added LE pain to the CI's physical profile at the MEB. This updated MEB NARSUM indicated that all the conditions above failed retention standards.

The panel majority carefully considered the retention standards the CI had been determined to fail. The podiatrist indicated that the CI's foot conditions failed retention standards IAW AR 40-501 3-13b.(3), which lists "pes cavus when moderately severe…and which prevents the wearing of footwear." However, there was no STR documentation that the CI could not wear military footwear. The MEB NARSUM indicated that bilateral PF also failed retention standards IAW AR 40-501 3-13b.(5), which lists "refractory to treatment, prevents performance of military duties, or prevents wear of military footwear." However, the podiatrist indicated the CI had not received any treatment for foot pain and had no limitations on military footwear.

The remaining conditions added at the time of the MEB NARSUM were cited to fail retention standards according to AR 40-501 3-41e.(1), which refers to conditions resulting in interference with satisfactory performance of duties "as substantiated by the individual's commander or supervisor." However, the only condition implicated in the commander's statement was the CI's back condition. The MEB listed all the remaining conditions with the retention standards cited as above. The sole exception was the bilateral PFS, where the retention standard was changed to AR 40-501 3-41e.(2), which lists conditions "not mentioned elsewhere in this chapter" for which "the individuals health or well-being would be compromised" by remaining in the military. However, knee conditions are indeed mentioned elsewhere in the chapter and the appropriate retention standards (3-13 and 3-14) list specific criteria for failing, and none of which were evident in the record. In addition, the PEB bundled these conditions into a single condition which also included ankle pain. After deliberations, the panel majority concluded the ankle pain was interchangeable with the MTSS, which is supported by the December 2003 bone scan finding of increased uptake in the distal tibias.

The panel majority conceded that the pelvic girdle and hip conditions would be difficult to discriminate from the back condition due to overlapping physical limitations, and concluded they were reasonably considered unfitting when separated from the combined adjudication.

Next the panel majority considered the remaining unbundled conditions. Of central importance, there was no evidence that the CI sought treatment for the PFS, MTSS, PF, pes cavus or left 1st MTP DJD prior to initiation of the MEB, and thus, the majority determined that the PFS, MTSS/ankles and foot conditions could not have impacted duty performance. Because of the back condition, the CI was already on a restrictive profile at the time and was not performing his full duties. In accordance with DoDI 1332.38 (in effect at the time of the CI's MEB), "adequate performance of duties until the time the Service member was referred to the DES, may support a finding of fit for duty even though medical evidence indicates questionable physical ability to continue to perform duty." In this case, the majority agreed that, when taken together, the lack of evaluation and treatment notes in the record for these conditions prior to the MEB; the lack of profiles for these conditions prior to the MEB; and the questionable determinations that the PFS, MTSS/ankle and feet conditions failed retention standards, support the conclusion that none of these conditions were unfitting at separation, even if they may have become unfitting in the future. After due deliberation, the panel concluded there

was not a preponderance of evidence to overcome the presumption that the pelvic girdle and hip conditions were reasonably considered unfitting when separated from the combined adjudication. However, based on the evidence of record, the panel majority concluded that there was a preponderance to overcome the presumption that PFS, MTSS/ankle pain, PF, and 1st MTP DJD were reasonably considered unfitting and no additional disability ratings for these conditions are warranted. The dissenting member thought each of the bundled conditions was reasonably considered unfitting when separated from the PEB's combined adjudication.

The panel next turned to its rating recommendations for the unfitting pelvic girdle enthesopathies and hips, which are considered together due to the overlap in VASRD rating criteria. At the MEB examination, the CI did not report any pelvic pain, and the LEs were checked as "normal" upon physical examination. The December 2003 pelvis X-rays were normal, and the MEB NARSUM examiner noted that the CI attributed symptomatic pain to both hips but not the pelvic girdle. Physical findings showed a normal gait and no LE muscle atrophy, but no focused examination of the pelvis or hips was documented. At the VA C&P examination, the CI did not report any specific pelvic or hip pain, and the examiner noted an antalgic gait with complaint of back pain. The VA did not service connect any condition of the pelvis or hips, nor did it appear the CI claimed these conditions.

Pelvic Girdle Enthesopathies. Sacroiliac pain is subsumed in the panel's rating recommendation for the TL spine IAW VASRD §4.66 (sacroiliac joint). According to VASRD §4.67 (pelvic bones), pelvic fractures, and by inference other pelvic injuries, are rated based on specific residuals, such as posture, limitation of motion of the spine or hips, or related nerve injury. In this case, limitation of motion of the spine or an abnormal gait are subsumed under the TL spine rating. There was no record of a hip examination in the 12 months prior to separation, and therefore no basis for the panel to recommend higher than a 0% rating under any applicable VASRD code for the pelvic girdle conditions. After due deliberation, considering all the evidence and mindful of VASRD §4.3 (reasonable doubt), the panel recommends a disability rating of 0% for the right and left pelvic girdle conditions, coded 5299-5252 (analogous to limitation of hip flexion).

Bilateral Hip Pains. With no hip examinations in evidence proximate to separation, the panel had no basis to recommend a rating higher than 0% for either hip condition. After due deliberation, considering all the evidence and mindful of VASRD §4.3 (reasonable doubt), the panel recommends a disability rating of 0% for the right and left hip conditions, coded 5299-5255 (analogous to femur impairment).

<u>Contended PEB Conditions: Bilateral Occipital Neuralgia; Post-Traumatic Migraine Headaches (HAs); Cognitive Disorder; and Bilateral High Frequency Hearing Loss</u>. The panel's main charge is to assess the fairness of the PEB determination that the contended conditions were not unfitting.

Bilateral Occipital Neuralgia and Migraine HAs. These conditions were not profiled or implicated in the commander's statement and did not fail retention standards. There was no performance-based evidence from the record that either of these conditions significantly interfered with satisfactory duty performance at separation. After due deliberation, the panel concluded there was insufficient cause to recommend a change in the PEB fitness determinations for the bilateral occipital neuralgia and migraines HAs, so no additional disability ratings are recommended.

Cognitive Disorder. The cognitive disorder was profiled and judged to failed retention standards, but was not implicated in the commander's statement. The sole profile limitation due to the condition was no assignment where psychiatric, neurological or neuropsychological care was not available. Neuropsychological testing in December 2003 led to diagnoses of cognitive disorder, not otherwise specified, and psychological factors affecting medical

condition. The summary stated "there are a number of confounding factors in [the CI's] clinical presentation that include a preexisting history of attention deficit disorder, chronic pain, and possible current attempts to appear worse than he is. Also, his head injury was of a mild nature and occurred almost 2 years ago…nevertheless a pattern of neurocognitive deficits of a mild nature are felt to be genuine." At the 1 March 2004 psychiatric MEB consult, 10 months prior to separation, the CI reported memory problems, HAs and light sensitivity since February 2002 after he suffered a head injury while wrestling in the dorms. He reported losing consciousness for 1-3 minutes and went to sick call the next day where he "appeared to be alright." The mental status examination was normal except for the examiner documenting that the CI did "manifest some difficulty with concentration" and was "somewhat vague about recall of dates." During the 14 September 2004 psychiatric MEB addendum update, 4 months before separation, the CI continued to report problems with memory, HAs, light sensitivity and sleep difficulties. The psychiatric examiner noted he had not missed any duty due to the cognitive disorder, but had reported some decreased performance in college courses. There was no performance-based evidence from the record that the cognitive disorder significantly interfered with satisfactory duty performance at separation. Panel members agreed there was not a preponderance of evidence to overcome the PEB's not unfitting determination. After due deliberation, the panel concluded there was insufficient cause to recommend a change in the PEB fitness determination for the cognitive disorder, so no additional disability rating is recommended.

Hearing Loss. The CI's hearing loss was profiled at the time of the MEB but not implicated in the commander's statement. At a 7 November 2003 audiology evaluation, the CI reported he had not noticed any problems with his hearing. However, tests indicated his hearing levels did not meet retention standards, and the results of a functional hearing test (SPRINT) placed him in the "separation from service" category. At an ear, nose, and throat visit on 21 November 2003, the CI reported he had trouble hearing since a live fire incident without hearing protection. However, he was also surprised by the audiogram results. He was subsequently approved for hearing aids. There was no performance-based evidence in the record that the member's hearing, with use of hearing aids, impaired his duty performance. After due deliberation, the panel concluded there was insufficient cause to recommend a change in the PEB fitness determination for the hearing loss, so no additional disability rating is recommended.

BOARD FINDINGS: In the matter of the low back condition, the panel recommends a disability rating of 20%, coded 5242 IAW VASRD §4.71a. In the matter of the stress related pelvic girdle enthesopathies and knee, ankle, and foot pain, the panel majority recommends the following disability ratings: 0% each for each unfitting right and left pelvic girdle enthesopathies, coded 5299-5252; 0% for each unfitting right and left hip condition, coded 5299-5255, all IAW VASRD §4.71a; and not unfitting knee, ankle and foot conditions. The single voter for dissent submitted the appended minority opinion. In the matter of the contended bilateral occipital neuralgia, migraines headaches, cognitive disorder and hearing loss, the panel recommends no change from the PEB determinations as not unfitting. 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, effective the date of medical separation:

CONDITION	VASRD CODE	PERMANENT RATING
Chronic Low Back Pain	5242	20%
Right Pelvic Girdle Enthesopathies	5299-5252	0%
Left Pelvic Girdle Enthesopathies	5299-5252	0%

Right Greater Trochanteric and Ischial Bursitis	5299-5255	0%
Left Greater Trochanteric and Ischial Bursitis	5299-5255	0%
	COMBINED	**20%**

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20220408, w/atchs
Exhibit B. Service Treatment Record
Exhibit C. Department of Veterans Affairs Record

Minority Opinion:

This minority opinion relates only to the panel's unbundling of the PEB "stress related pelvic girdle enthesopathies, knee pain, ankle and foot pain" conditions. The minority voter agrees with the panel majority regarding the recommendation to increase the rating of the back condition to 20%, coded 5242, and disagrees with recommending no change of the PEB's not unfitting determinations for any of the contended conditions.

Unbundling discussion. As noted above each bundled condition is reasonably justified as separately unfitting unless a preponderance of evidence indicates the condition would not cause the member to be referred into the DES or be found unfit because of physical disability.

In this case the CI was referred for the back condition. Then as summarized above, he was diagnosed with additional musculoskeletal conditions of the pelvis and LEs and they were judged to interfere with the CI's performance of duties. The physical medicine specialist indicated impairment of function by lifting more than 20 pounds, bending, sit-ups, push-ups, standing more than 15 minutes, and walking, among other things. The podiatrist indicated the CI was unable to run, jump, ruck or march due to pain in his feet. The orthopedic specialist indicated the CI's profile should be walk and run at own pace and distance, no jumping and no heavy lifting. It is conceded the multiple specialty examinations were not as thorough and clearly documented as would be ideal. However, the sports medicine physician who updated the MEB clearly states what each of the specialists had previously determined and that he was currently in agreement with them. In this way, he confirmed that following the passage of several months, there had been no change in the CI prognosis. Over the course of approximately 9 months, the CI was evaluated by four different types of musculoskeletal specialty physicians with consensus among them that his multiple conditions impaired his duty performance. He was also evaluated for the MEB at more than one point in time (November/December 2003 and September 2004), which is not always the case. Regarding the commander's statement only implicating the back condition, the minority voter opinion is the early commander's statement is not strong evidence against any other conditions impairing duty performance at separation. It was written prior to the performance of the member's specialty medical evaluations and not updated, as would be done currently. Given the volume and consistency of the medical opinions that the member's multiple musculoskeletal conditions impaired his full duty performance, the minority opinion is that there is not a preponderance of evidence that each of the unbundled conditions is not unfitting. Therefore, the dissenting member recommends each of the unbundled conditions is unfitting and eligible for disability rating, including each of the bilateral pelvic girdle, hips, knees, MTSS, ankle and foot conditions.

Minority rating recommendations:

Bilateral PFS. At the 20 November 2003 MEB examination, physical examination of the LEs was checked normal. At the 8 September 2004 MEB NARSUM examination, physical examination showed a normal gait and tandem gait. There was no effusion of either knee. Knee ROM was minus 5 degrees extension to 140 flexion (normal 0-140) bilaterally. There were no meniscal symptoms or joint line tenderness. There was mild patellar grind. At the 15 June 2004 VA C&P examination, physical examination showed an antalgic gait with complaint of back pain. He did not require assistive devices for ambulation or knee braces. The knees appeared normal. There was no swelling. There was mild tenderness in the medial joint line bilaterally. There was no instability. The CI was able to squat to flexion 140 degrees in a standing position. In the sitting position knee ROM was 0 degrees extension to 135 flexion, with production of increased discomfort after five repetitions. The VA rated each knee 10%, coded 5260 (limitation of leg flexion) based on the C&P examination. Based on the evidence the minority voter recommends a 10% rating for each knee for painful motion, coded 5299-5260 (analogous to limitation of leg flexion).

Bilateral MTSS. At the 20 November 2003 MEB examination, physical examination of the LEs was checked normal. At the 8 September 2004 MEB NARSUM examination, physical examination showed a normal gait and tandem gait. There was tenderness of the muscles of the thigh calf and anterior tibia. At the 15 June 2004 VA C&P examination, physical examination showed an antalgic gait with complaint of back pain. There was a mild amount of tenderness of the mid tibial regions without discoloration or swelling. The VA rated each periostitis condition 10%, coded 5299-5262 (analogous to impairment of the tibia). Based on the evidence, the minority voter recommends a 0% for each MTSS condition, coded 5022. According to the VASRD code 5022 (periostitis) periostitis or stress reactions/fractures is rated according to limitation of motion of the affected part, as arthritis (5003). The minority recommendations for disability rating of the knee and ankle conditions, (affected parts related to MTSS) are addressed separately in this case.

Bilateral Ankle Pain. At the 20 November 2003 MEB examination, physical examination of the LEs was checked normal. At the 8 September 2004 MEB NARSUM examination, physical examination showed ankle ROM, in degrees, was dorsiflexion (DF) to 10 (normal 20), and plantar flexion (PF) to 25 (normal 45). There was tenderness diffusely across the entire ankle joint including the anterior, posterior tibialis and peroneal tendons. At the 15 June 2004 VA C&P examination, physical examination showed an antalgic gait with complaint of back pain. There was no discoloration or swelling of the ankles. Ankle ROM in degrees was DF to 15 degrees and PF to 40. No instability was noted. The ROM did not change after repetition. There was popping and discomfort of rotational motions of the bilateral ankles. The VA did not rate any condition of the ankles, nor did it appear the CI claimed an ankle condition. However, the VA rated the periostitis condition above based on slight ankle disability and as noted above, both cannot be rated IAW VASRD §4.14 (avoidance of pyramiding). The PEB included ankle pain in the bundled condition, but not periostitis. Based on the evidence the minority voter recommends a 10% rating for each ankle for moderate limitation of ankle motion, coded 5271.

Bilateral Foot Pain. At the 20 November 2003 MEB examination, on physical examination the feet were checked normal and the more detailed foot section of normal arch, pes cavus or pes planus symptomatic or asymptomatic was left blank. At the 8 September 2004 MEB NARSUM examination, on physical examination the CI had a normal gait and tandem gait. There was pes cavus with tenderness of the plantar fascia bilaterally. Ankle ROM showed decreased DF of 10 degrees. At the 15 June 2004 VA C&P examination, the CI reported daily pain of his feet, worse in the morning and improved throughout the day. He denied swelling or instability of his feet. He was found to have DJD of the left MTP. He did not use any type of assistive devices and no mention was made of orthotic use. Physical examination showed an antalgic gait with complaint of back pain. There was normal ROM of the left great toe. Ankle dorsiflexion was 15 degrees. There was normal mid, fore, and hind foot architecture bilaterally. There was normal Achilles tendon alignment of both feet without evidence of abnormal weight bearing. Based on the above evidence, the minority voter recommends a 10% for the bilateral foot condition, coded 5278 (pes cavus). VASRD code 5278 provides a 10% rating for pes cavus, whether unilateral or bilateral. The plantar fasciitis cannot be additionally rated for either foot without pyramiding and there was no ratable impairment of the left great toe with any applicable VASRD code for higher or additional rating of the feet.

Consistent with the DoDI 6040.44 standard of recommendations that are fair and equitable to both the Service and the CI, the Secretary is respectfully requested to consider the minority recommendation that each of the bundled bilateral conditions of the pelvic girdle, hips, knees, tibiae, ankles and feet are reasonably considered unfitting with a disability rating as follows: right and left pelvic girdle, each 0%, coded 5299-5252; right and left hip conditions, each 0%, coded 5299-5255; right and left PFS, each 10%, coded 5299-5260; right and left MTSS, each 0%, coded 5022; right and left ankle conditions, each 10%, coded 5271; and, right and left foot

conditions, rated 10% for the bilateral condition, coded 5278. Combined with the 20% back rating, the minority voter therefore supports a 60% combined rating with the bilateral factor.

CONDITION	VASRD CODE	PERMANENT RATING
Chronic Low Back Pain	5242	20%
Right Pelvic Girdle	5299-5252	0%
Left Pelvic Girdle	5299-5252	0%
Right Hip Condition	5299-5252	0%
Left Hip Condition	5299-5252	0%
Right PFS	5299-5252	10%
Left PFS	5299-5252	10%
Right MTSS	5022	0%
Left MTSS	5022	0%
Right Ankle Condition	5271	10%
Left Ankle Condition	5271	10%
Right Foot Condition	5278	10%
Left Foot Condition	5278	10%
	COMBINED	**60%**

AR20230008358, XXXXXXXXXX

Dear XXXXXXXXXX:

The Department of Defense Physical Disability Board of Review (DoD PDBR) reviewed your application and found that your disability rating should be modified but not to the degree that would justify changing your separation for disability with severance pay to a permanent retirement with disability. I have reviewed the Board's recommendation and record of proceedings (copy enclosed) and I accept its recommendation. This will not result in any change to your separation document or the amount of severance pay. A copy of this decision will be filed with your Physical Evaluation Board records. I regret that the facts of the case did not provide you with the outcome you may have desired.

This decision is final. Recourse within the Department of Defense or the Department of the Army is exhausted; however, you have the option to seek relief by filing suit in a court of appropriate jurisdiction.

A copy of this decision has been provided to the Department of Veterans Affairs.