RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: ARMY

CASE NUMBER: PD0900010 BOARD DATE: 20100121

SEPARATION DATE: 20060520

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SUMMARY OF CASE: This covered individual (CI) was an active duty Warrant Officer (Personnel) medically separated from the Army in 2006 after 14 years of service. The medical basis for the separation was a neck condition. This began after a motor vehicle accident in October, 2003. She was initially diagnosed with degenerative changes on x-ray and managed conservatively. Her pain persisted, along with radiation to the right arm associated with intermittent sensory symptoms. An MRI showed multilevel degenerative disc changes and small disc protrusions at C5/6 and C6/7. After consultation, surgery was deferred and she continued conservative management. She received temporary profiles and her symptoms worsened during a 2004-05 deployment to Korea when she required a lot of time in battle gear and suffered a fall. Aggressive conservative management was continued, including epidural injections, to no avail. Repeat MRI’s showed worsening stenosis and some disc protrusion at C4/5 with worsening involvement of the two lower levels. An EMG (nerve conduction study) for the right upper extremity (RUE) symptoms was normal. Neurosurgical management was discussed but electively deferred on a risk-benefit basis. MOS performance was impaired to the point that she was referred for a MEB. The MEB forwarded her cervical condition to the PEB as medically unacceptable IAW AR 40-501. Bilateral patellofemoral syndrome (knee condition), dyspnea, chronic abdominal pain and hearing loss were addressed in the NARSUM as additional conditions determined to be medically acceptable IAW AR 40-501. The PEB found only the cervical condition to be unfitting, and the CI was separated with a 10% disability rating.

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CI CONTENTION: In her application letter the CI states, ‘The rating of 10% was is [sic] not adequate for the pain I suffer caused by my injury.’ Her application lists bilateral shoulder, bilateral tinnitus and cervical radiculitis as additional conditions.

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RATING COMPARISON:

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| --- | --- |
| **Service PEB** | **VA (Pre-Separation) – All Effective 20060521** |
| **Condition** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Neck Pain | 5299-5242 | 10% | 20060203 | Neck Pain | 5242-5243 | 20% | 20060124 |
| Cervical Radiculitis | 8599-8515 | 10% | 20060124 |
| Bilateral Patellofemoral Syndrome | Not Unfitting | 20060203 | R Patellofemoral Syndrome | 5099-5024 | 0% | 20060124 |
| L Patellofemoral Syndrome | 5099-5024 | 0% | 20060124 |
| Dyspnea | Not Unfitting | 20060203 | Dyspnea | 6699-6604 | NSC | 20060124 |
| Chronic Abdominal Pain | Not Unfitting | 20060203 | Abdominal Pain | 7399-7319 | NSC | 20060124 |
| Hearing Loss | Not Unfitting | 20060203 | Bilateral Hearing Loss | 6100 | 0% | 20060124 |
| No Additional DA 3947 Entries. | Non-PEB X 2 / NSC X 2 | 20060124 |
| **TOTAL Combined: 10%** | **TOTAL Combined (*Includes Non-PEB Conditions*): 40%**   |

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ANALYSIS SUMMARY:

Neck Condition. There are three fairly concurrent goniometric range-of-motion (ROM) examinations in evidence. In addition to the measurements performed by the MEB examiner, there was a goniometric exam by Physical Therapy (P.T.) about a month later and the VA (pre-separation) rating examination. They are summarized in the chart below.

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| --- | --- | --- | --- |
| Cervical ROM | MEB - 12/14/05 | P.T. - 1/23/06 | VA C&P - 1/24/06 |
| Flexion | 40⁰ | 15⁰ | 20⁰ |
| Combined | 235⁰  | 65⁰ | 70⁰ |
| §4.71a Rating | 10% | 30% | 20% |

Two of the exams commented on spasm or tenderness; none documented abnormal contour. The MEB examiner did not specify if pain was the end-point of measurement or if the measurements were active or passive. The P.T. exam stated that all ROM’s were, ‘limited due to pain/guarding’. The VA examiner specified pain thresholds and deducted for declines on repetitive motion (deductions did not affect rating). The PEB rating was based on the MEB measurements as forwarded in the NARSUM. It was IAW VASRD §4.71a based on that evidence and did not reflect application of the USAPDA pain policy. The P.T. measurements would yield a §4.71a rating of 30%, based on the 15⁰ flexion. The VA examination (with a higher probative value premised on documented conformity with all of the VASRD rating details) was accurately rated 20%. It is noted that the two worse exams were only a day apart, and could reflect a period of exacerbation. Based on review of all the records, however, there is no way to make a ‘good day, bad day’ distinction without resorting to speculation. The P.T. examination favoring a 30% rating does not carry enough probative value on its own to support a recommendation for that rating. Based on the totality of the evidence, however, there is more than enough reasonable doubt in the CI’s favor to justify a Board recommendation of a 20% rating for the cervical condition. The pathology is a hybrid of the 5242 and 5243 VASRD codes as reflected in the VA rating decision, but degenerative disc disease over several levels is well encompassed by a non-hyphenated 5242 code.

Cervical Radiculitis. There is no question from the evidence that there was a RUE neuralgia and sensory neuropathy associated with the cervical disease. Radiation of the pain and intermittent sensory symptoms are described in the NARSUM and throughout the record. The EMG and physical examinations make it clear that there was no motor impairment, although the VA examiner noted ‘paresthesias’ (which is a symptom, not a finding) in a C6/7 dermatomal distribution of the right hand. The assessment of the functional impact of this condition is confused somewhat by the fact that the CI was also diagnosed with RUE carpal tunnel syndrome (CTS). This significantly overlaps with cervical pathology and confuses the etiology of all of the symptoms. The VA examiner made several references to wrist involvement in his history and physical and noted intermittent use of a wrist splint. This was diagnosed as tendonitis and not service connected in the rating decision. All of this points to CTS or wrist pathology as a significant component of the RUE symptoms. The VA examiner made the diagnosis, however, of cervical radiculitis as the cause for the RUE sensory symptoms. This was the foundation for the VA rating decision to code and rate it as a peripheral nerve injury. It is noted that the code chosen designates median nerve (CTS) pathology, not cervical radicular level pathology (which would force a 20% rating). It is also noted that, in spite of the radiculitis diagnosis, the VA physical examination of the cervical spine stated, ‘There are no signs of intervertebral disc syndrome with chronic and permanent nerve root involvement.’

Even if RUE radiculopathy complicating the unfitting cervical condition is conceded, there must be a clearly unfitting component of it to underpin a Board recommendation for adding it as separately unfitting. The Commander’s statement lumps the peripheral nerve symptoms in with the neck pain and ‘shoulder pain’ when describing interference with her performance. Interference with typing and computer work is specified. A clear adverse impact of her overall condition on the keyboard tasks, critical to her MOS, is articulated in the MEB and VA examinations. Neither examiner, however, cones down on the peripheral nerve component as a culprit. Clearly it contributed to the pain which was the limiting impairment, but pain is subsumed under the general spine rating IAW §4.71a which states, ‘with or without symptoms such as pain (whether or not it radiates)’. In light of the EMG and physical exams, it is hard to make a convincing argument that the sensory component was involved more than trivially with the CI’s ability to perform the keyboard tasks. The DA 199 statement ‘without significant neurologic or electrodiagnostic abnormality’ was an accurate one. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a Board recommendation to add a peripheral nerve code rating to her separation disability rating.

Additional DA 3947 Conditions. The CI suffered from bilateral knee pain which had developed without trauma over the last two years of her military service. This was aggravated by running and stair climbing, diagnosed as patellofemoral pain syndrome and managed conservatively. Her physical profile was L1 and it was not noted in the Commander’s statement. She suffered from dyspnea (shortness of breath) with exertion, but cardiovascular and pulmonary work-ups were negative. Her physical profile was P1 and the condition was not noted in the Commander’s statement. She underwent numerous gynecologic and gastroenterology specialty evaluations for chronic intermittent abdominal pain (onset 1982). The condition was not noted in the physical profile or in the Commander’s statement. She was additionally diagnosed with hearing impairment and fitted for a hearing aid in 2006. She carried an H2 profile for the condition, but there is no link to fitness in evidence and it was not noted in the Commander’s statement. All four of these conditions, as noted in the summary, were forwarded to the PEB as medically acceptable on the DA 3947. She received non-compensable ratings from the VA for the knee and hearing conditions. The dyspnea and abdominal pain were not service connected. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudications for any of these other MEB conditions.

Other Conditions. The CI’s Board application notes a bilateral shoulder condition with a 20% rating. She was not coded or rated for a shoulder condition in the VA rating decision at separation. She did note a shoulder problem on her MEB physical and shoulder pain was mentioned in the Commander’s statement. Shoulder pain (usually on the right) is mentioned in some exam notes in evidence, generally in the context of the cervical condition. Some bilateral tenderness of shoulder musculature is noted on the VA rating examination, but no specific condition was identified. A specific shoulder condition was not diagnosed on active duty and shoulder impairment was not specified in the U3 profile. The CI also notes tinnitus in her application. This was rated 10% by the VA. Although tinnitus is mentioned in some audiology notes in the record, it was not cited on MEB physical or noted in the DES packet. It is not therefore eligible for Board review. Regardless, it is rarely considered unfitting. The only other condition rated and service-connected by the VA is a headache condition. It was identified on the MEB physical and therefore is eligible for Board review. She was seen by a neurologist in 2003 for headaches and a normal brain MRI was documented. She was prescribed a prophylactic regimen, but no headache treatment was noted on her NARSUM medication list. The VA examiner noted chronic headaches with onset prior to enlistment. A frequency of one headache every ‘1.5 months’ was documented. The condition was rated 10% by the VA (service aggravated). Headache was not listed on the physical profile or mentioned in the Commander’s statement.

The Board has no reasonable basis for recommending the shoulder or headache conditions as additional unfitting conditions for separation rating, and does not have jurisdiction for considering tinnitus.

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BOARD FINDINGS: IAW DoDI 6040.44, provisions of DoD or Military Department regulations or guidelines relied upon by the PEB will not be considered by the Board to the extent they were inconsistent with the VASRD in effect at the time of the adjudication. The Board did not surmise from the record or PEB ruling in this case that any prerogatives outside the VASRD were exercised. In the matter of the neck condition, the Board unanimously recommends a rating of 20% coded 5242 IAW VASRD §4.71a. In the matter of the cervical radiculitis condition related to the unfitting neck condition, the Board unanimously agrees that it cannot recommend a finding of separately unfitting for additional disability rating. In the matter of the bilateral patellofemoral syndrome, dyspnea, chronic abdominal pain, hearing loss, shoulder and headache conditions; the Board unanimously agrees that it cannot recommend any findings of unfit for additional rating at separation. The tinnitus condition identified on the CI’s application to the Board remains eligible for ABMCR consideration.

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RECOMMENDATION: The Board recommends that the CI’s prior determination be modified as follows, effective as of the date of her prior medical separation.

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Cervical Pain with Degenerative Disc Disease and Right Upper Extremity Radiation | 5242 | 20% |
| **COMBINED** | **20%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090122, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

 MICHAEL F. LoGRANDE

 President

 Physical Disability Board of Review

